Benefits Guide

American Eagle provides you with a comprehensive benefits package designed to help you meet the health and insurance needs of you and your eligible family members.

To help you make the most of those benefits, this Guide describes the major provisions of the plans and explains how you can use them effectively.

The benefits described in this Guide include:

- Health Care Benefits
  - Medical Coverage
  - Dental Coverage
  - Vision Coverage
- Employee Assistance Program
- Life Insurance & Accident Insurance
- Disability Benefits
- Flexible Spending Accounts
  - The Health Care Flexible Spending Account
  - The Dependent Day Care Flexible Spending Account

Additional Important Information

In addition to the descriptions of the benefits provided and how each plan works, this Summary Plan Description also provides general and plan specific information in the:

- About this Guide section
- Benefits at a Glance section
- General Eligibility section
- General Enrollment section
- Life Events section
- Additional Health Benefit Rules section
- Additional Life and Accident Insurance Rules section
- Plan Administration section
- Reference Information section, including a Contacts list, the Glossary, and the Archives of older versions of the Guide.

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About This Guide

This American Eagle Employee Benefits Guide ("Guide") contains the legal plan documents and the summary plan descriptions (SPDs) for the following plan: the Group Health and Welfare Benefits Plan for Employees of American Eagle Airlines and Its Affiliates.

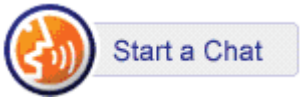
The provisions of this Guide apply to eligible employees of American Eagle Airlines, Inc. ("American Eagle") and Executive Airlines, Inc. ("Executive") employees on the United States payroll, spouses, dependents, and surviving spouses who elect coverage. The provisions of this Guide do not apply to employees of the EGS Division of American Eagle Airlines, Inc. and Executive Airlines, Inc.

In our efforts to provide you with full multi-media access to benefits information, American Eagle Airlines, Inc. and Executive Airlines, Inc. have created online versions of the Plans and SPDs. If there is any discrepancy between the online version and this Guide then the Plans contained in this Guide, plus the official notices of changes to the Plans will govern.

The Company reserves the right to modify, amend or terminate any of the Plans, any program described in this Guide, or any part thereof, at its sole discretion. Changes to the Plans, generally will not affect claims for services or supplies received before the change.

Only the Eagle Benefits Administration Committee (EBAC) is authorized to change the Plans. From time to time, you may receive updated information concerning changes to the Plans. Neither this Guide nor updated materials are contracts or assurances of compensation, continued employment, or benefits of any kind.

In the event of a conflict between the Plans' provisions contained in this Guide and the provisions contained in any applicable collective bargaining agreement (and/or insurance policies for fully insured programs), the collective bargaining agreement (and/or insurance policy for fully insured programs) shall govern in all cases with respect to employees covered by such agreement.



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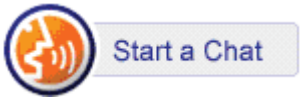
Benefits at a Glance

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	BCBS	Company and Employee Contributions, and General Assets of the Company
PPO Deductible	Self-funded	BCBS	Same as above
Out-of-Area	Self-funded	BCBS	Same as above
Minimum Coverage	Self-funded	BCBS	Same as above
HMOs (PR, USVI)	Insured	Humana or Triple S	Company and Employee Premiums
Dental Benefit	Self-funded	MetLife	Company and Employee Contributions
Vision Benefit			
Vision	Insured	Spectera®	Employee Contributions
EyeMed	Discount Program	EyeMed	Employer 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



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Type of Benefit	Self-Funded or Insured	Administrator or Insurer	Funding Mechanism
Disability Insurance			
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

In This Section

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Medical Benefits

The Company offers you the opportunity to enroll in medical coverage for you and your eligible dependents. The Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage options are self-funded by the Company and administered by your network/claims administrator. HMOs are insured programs.

Medical Benefit Options

Generally, you may choose one of the following Plan options (collectively, the "Medical Benefits"):

- Out-of-Area Coverage Option
- Minimum Coverage Option
- PPO-Deductible Option
- PPO-Copay Option
- Health Maintenance Organization (HMO) Option (for Puerto Rico employees); and

Some Medical Options are not offered in all locations. The PPO Options are offered in most locations, but if you live outside the network/claims administrator 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.

You may also waive coverage.

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/claims administrators:

- Blue Cross and Blue Shield of Texas

Each state will have one preferred network/claims administrator. Your preferred network/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/claims administrator. If you do not have an alternate address listed in Jetnet, your network/claims administrator is based on your permanent address.

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

Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options

Only employees who do not have adequate access to PPO providers will have the Out-of-Area Coverage as an option.

The Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options allow you to use any qualified licensed physician. When you use a network provider under the PPO-Deductible Option and the Minimum Coverage Option, you receive a higher level of benefits. Network providers have agreed to charge discounted fees for medical services. Generally, you pay a percentage of the cost for each visit or service and the plan pays the rest.

For details on the Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options, see "Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options" in the *Medical* section.

To see a comparison of your benefits under the Medical Options, see "Medical Benefit Options Comparison" in the *Medical* section.

PPO-Copay Option

You may decide whether to use network or out-of-network providers each time you need care under the PPO-Copay Option. When you use a network provider, you pay only a copayment or 20% coinsurance for most services. Effective 1/1/2010, a deductible will also be required for any coinsurance-based services.

If you go to a provider who is not part of the network, you are still covered for eligible, medically necessary services, but at a lower level of benefits, called the out-of-network benefit level. At the out-of-network benefit level, you pay a deductible and higher out-of-pocket amounts. For most out-of-network services, the plan pays 60% and you pay the remaining 40% after you satisfy the deductible.

For details on the PPO-Copay Option, see "PPO-Copay Option" in the *Medical* section.

Provider Networks for the Medical Options

The Medical Benefit Option you select determines the provider network you access. To see a comparison of your benefits under the Medical Options, see "Medical Benefit Options Comparison" in the *Medical* section.

Health Maintenance Organizations (HMOs)

HMOs provide medical care through a network of physicians, hospitals and other medical service providers. You must use network providers to receive coverage under the HMO. Your expenses, including prescription drugs and mental health care, are covered according to the rules of the HMO you select.

Most HMOs require you to choose a primary care physician (PCP) to coordinate your medical care and to obtain a referral from your PCP before receiving care from a specialist.

HMOs are offered only in Puerto Rico and St. Thomas and St. Croix USVI. HMOs offered in your area appear as options in the Benefits Enrollment Center on Jetnet during enrollment. When you enroll in an HMO, you will receive detailed information directly from that HMO.

For more details about HMOs, see "Health Maintenance Organizations (HMOs)" in the *Medical* section.

Prescription Drug Coverage

If you are enrolled in an Out-of-Area Coverage, Minimum Coverage, PPO-Deductible or PPO-Copay Option, you receive prescription drug coverage through the medical benefit. Coverage includes both retail pharmacy prescriptions (up to a 30-day supply) and mail order prescriptions (up to a 90-day supply). For details about this coverage see "Prescription Drug Benefits" in the *Medical* section.

If you participate in an HMO, contact the HMO for information about your prescription drug coverage.

Dental Benefit

The Company offers you the opportunity to enroll in the Dental Benefit to help pay for covered dental services. The Dental Benefit is self-funded by the Company and administered by MetLife.

The Dental Benefit offers a Preferred Dentist Program (PDP) — a voluntary network of over 120,000 participating dental locations nationwide who provide fee discounts to plan participants. You are not required to use a network dentist, but you will generally save money when you do. To access a list of network dentists in your area, log on to the MetLife website or call MetLife at 1-800-838-0875.

For details on the Dental Benefit, see the *Dental* section.

Vision Insurance Benefit

You have the opportunity to enroll in vision coverage, insured and administered by Spectera® , a national vision care company. The Vision Benefit offers a network of providers, including retail chains such as Eyemasters, as well as independent providers. To locate participating providers, log on to the Spectera ® Vision website or contact Spectera® at 1-800-638-3120.

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You can elect to receive services from a network provider or from an out-of-network provider. Covered supplies and services include exams, glasses (frames and lenses), and contact lenses. For details on this insurance, see the *Vision* section.

In addition, you may take advantage of the Vision Discount Program offered through EyeMed. For details on this benefit, see "EyeMed Vision Discount" in the *Vision* section.

Term Life Insurance Benefit

When you enroll in a medical Plan, the Company provides Basic Employee Term Life Insurance, which pays a benefit to your designated beneficiary in the event of your death. Optional levels of Voluntary Term Life Insurance coverage are also available to you. In addition, you can choose to enroll your eligible spouse and children in Spouse and Child Term Life Insurance, which pays you a benefit if your covered spouse or child dies.

Term Life Insurance pays a death benefit, but has no cash value and remains in effect only while premiums are being paid. The plans are insured by MetLife. You pay your share of any Voluntary coverage you choose through payroll deduction.

Employee Term Life Insurance Benefit

When you enroll in a medical Plan, the Company provides Basic Employee Term Life Insurance coverage equal to one times your annual salary at no cost to you.

When you are first eligible for benefits, you may elect Voluntary Term Life Insurance up to one level above the Company-provided basic coverage without providing proof of good health. You must complete a Statement of Health from MetLife if you wish to elect coverage in a greater amount. Voluntary Term Life Insurance coverage up to 6 times your pay is available, to a maximum of $2,000,000. After you enroll you may increase your Voluntary Term Life Insurance coverage by one level per year with proof of good health.

You may not waive Basic Employee Term Life Insurance. For details on this insurance, see "Employee Term Life Insurance" in the *Life Insurance Benefits* section.

Spouse and Child Term Life Insurance Benefit

You may purchase coverage for either your spouse or your children or for both spouse and children. Spouse Term Life Insurance is available in amounts up to 3 times your pay up to a maximum of $350,000. To add or increase Spouse Term Life Insurance, your spouse must complete and submit a statement of health to MetLife. Child Term Life Insurance provides $15,000 coverage for each covered child, and proof of good health is not required.

You pay the entire cost of any Spouse and Child Term Life coverage you select on an after-tax basis. Your spouse's rate is based on his or her age, but coverage for your children is based on a flat rate, regardless of the number of children covered.

For details on this insurance, see "Spouse and Child Term Life Insurance Benefits" in the *Life Insurance Benefits* section.

Accident Insurance

Accidental Death & Dismemberment Insurance (AD&D) and Voluntary Personal Accident Insurance (VPAI) Benefit

As an eligible employee enrolled in a Medical Benefit Option, you automatically receive Accidental Death & Dismemberment Insurance (AD&D) equal to one times your annual salary from the Company at no cost to you. You may also elect to purchase Voluntary Personal Accident Insurance (VPAI) for yourself and your family.

AD&D coverage pays a benefit to you if you are injured in an accident or to your beneficiary if you are killed in an accident. VPAI coverage pays additional benefits if you or your covered dependent is injured or killed as the result of an accident. See "AD&D and VPAI Benefits" in the *Accident Insurance Benefit* section for more information.

You may select VPAI coverage in $10,000 increments up to a maximum of $500,000. The amount of VPAI coverage for your covered spouse is $10,000 up to $350,000. Child AD&D provides $10,000 coverage for each dependent child, regardless of the number of children covered.

VPAI includes Travel Assistance Services for you and your covered dependents. See "Travel Assistance Services" in the *Accident Insurance Benefit* section.

Other Accident Insurance Benefits

The Company also provides other accident insurance under certain situations. These programs include Management Personal Accident Insurance (MPAI), Special Risk Accident Insurance (SRAI) and Special Purpose Accident Insurance (SPAI). Benefits from these insurance coverages are payable in addition to any benefits you may receive under the AD&D and VPAI insurance benefits.

MPAI provides coverage for management employees while traveling on Company business and for non-occupational accidents including any land or water vehicle coverage is three times your salary up to a maximum of $200,000.

SRAI provides coverage for management, agent, support staff and TWU employees for accidental death and dismemberment that occurs as a result of terrorism, sabotage or felonious assault while performing your duties anywhere in the world. SRAI pays a benefit of five times your annual base salary up to a maximum of $500,000.

SPAI coverage applies to management, agent, support staff and TWU employees. It pays up to $100,000 to each employee who is injured in an accident while engaging in an organized search because of a bomb threat or warning of the presence of an explosive device. Coverage does not apply to an aircraft that is airborne.

For details on this insurance, see "Other Accident Insurance" in the *Accident Insurance Benefit* section.

Disability Benefits

The Company offers you the opportunity to purchase Optional Short Term Disability Insurance (OSTD), as well as Long Term Disability (LTD) Insurance coverage in case you are unable to return to work when your sick pay ends.

Optional Short Term Disability Insurance (OSTD) Benefit

The OSTD insurance benefit is fully insured by MetLife and will pay up to 50% of your adjusted monthly salary if you are unable to work due to a non-occupational illness or injury. Benefits are payable only after you have used all of your accrued sick time or on the eighth day of your disability, whichever is later. Benefits end after a period of 26 weeks or when you recover, whichever is earlier.

You pay the cost of your OSTD insurance on an after-tax basis. The insurance is paid by employee contributions and administered by MetLife. For details on this insurance, see "Optional Short Term Disability Insurance Benefit" in the *Disability Benefits* section.

Long Term Disability (LTD) Insurance Benefit

The LTD Insurance Benefit is fully insured by MetLife and will replace a portion of your salary when you are unable to work as a result of a disability and you are continuously totally disabled for a period of four consecutive months (elimination period).

The monthly LTD benefit is calculated to equal 50% of your base monthly salary, up to the maximum allowed by federal law. Your benefit is reduced by any disability income payable during the same period, such as optional short term disability benefits or income from state disability programs, Social Security, or Workers' Compensation.

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The minimum LTD benefit for all employees is 10% of your pre-disability base monthly salary or $100 per month, whichever is greater.

You pay the cost of your LTD coverage on an after-tax basis. The LTD Insurance Benefit is funded through employee contributions, insured and administered by MetLife.

For details on the LTD Insurance Benefit, see "Long Term Disability Insurance Benefits" in the *Disability Benefits* section.

Flexible Spending Accounts Benefits

Health Care Flexible Spending Account

The Health Care Flexible Spending Account (HCFSA) allows you to set aside money on a before-tax basis to help pay for eligible health care expenses for yourself and eligible dependents. Paying for these expenses with before-tax money helps reduce your taxes.

Beginning January 1, 2013, the annual maximum amount you can contribute to a healthcare account will change from $5,000 to $2,500.

You may deposit up to $2,500 per calendar year to your HCFSA. Because of IRS rules, you lose any money in your HCFSA that is not used during the year it was deposited. However, effective November 1, 2005, you may carry over into the next calendar year any unused funds remaining in your HCFSA as of December 31—and you may use these carryover funds to reimburse eligible medical and dental expenses incurred not only in the year these funds were deposited, but also for eligible medical and dental expenses incurred from January 1 through March 15 of the following year.

For details on this benefit, see the *Health Care FSA* section.

Dependent Day Care Flexible Spending Account

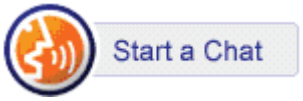
The Dependent Day Care Flexible Spending Account (DDFSA) allows you to set aside money on a before-tax basis to help pay for dependent day care expenses for your eligible dependents. Paying for these expenses with before-tax money helps reduce your taxes.

IRS rules limit the amount of money you can deposit into your DDFSA, and you lose any money in your DDFSA not used during the year it was deposited.

If you are married, you and your spouse must be employed or actively seeking employment to be eligible to receive reimbursement from your DDFSA. IRS rules limit the amount you may deposit and the type of expenses that may be paid from your DDFSA.

A single employee or an employee who files a joint income tax return with his or her spouse and both earn over $5,000 for the year, may deposit up to $5,000 per calendar year (a lower limit applies to employees who file separate returns and special rules apply if both spouses do not work).

Because of IRS rules, you lose any money in your DDFSA you do not use during the year it was deposited. However, effective November 1, 2005, you may carry over into the next calendar year any unused funds remaining in your DDFSA as of December 31—and you may use these carryover funds to reimburse eligible dependent day care expenses incurred not only in the year these funds were deposited, but also for eligible dependent day care expenses incurred from January 1 through March 15 of the following year. For details on this benefit, see the *Dependent Day Care FSA* section.



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General Eligibility

You may be eligible for coverage for yourself and your eligible dependents.

- You must provide proof of eligibility for certain dependent coverages.
- Spouses, common law spouses, Company-recognized Domestic Partners and dependent children are eligible for coverage under certain benefits.
- Some employees may be ineligible for coverage.

Determination of Eligibility

You are eligible for the **PPO Copay Option, PPO Deductible/Out of Area Option, Minimum Coverage Option, or an HMO** only if you reside where your network/claims administrator or HMO offers a network. Your eligibility 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 eligibility. If you do not have an alternate address listed in Jetnet, your eligibility is based on your permanent address.

In This Section **See Page**

Employee Eligibility

Active Employees

As a regular employee on the U. S. payroll of American Eagle Airlines Inc. or Executive (excluding the EGS Division), you are eligible for Company subsidized health benefits when you have completed one month of Company seniority.

If you are not at work on the date coverage would otherwise begin, coverage is effective on the date you are actively at work, unless you are not actively at work due to a health condition; then coverage is effective on the date coverage would otherwise begin. If you do not enroll for coverage when you are first eligible for benefits, you will receive no coverage. Your next opportunity to enroll will be during the annual open enrollment period for the following year.

For coverage requiring proof of good health, coverage becomes effective only after coverage is approved and your first contributions are paid either by you or through payroll deductions.

Upon completing one month of Company service, you will be able to enroll online at the Benefits Service Center. For more information about enrollment, see *General Enrollment*.

Employees Married to Other Employees

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

Change in spouse's employment: If one spouse ends his or her employment with the Company, the spouse who changes his or her employment is eligible for coverage as a dependent, (if he or she waives coverage under the subsidiary's health benefits). However if an employee is discharged for gross misconduct not related to any existing health condition for which treatment was provided for under the Plans, benefits or medical benefit options or dental benefit, he or she cannot be covered as a dependent of the active employee.

Spouse not eligible for full benefits: During the one-month waiting period required to be eligible for benefits, the new employee may be covered as the spouse of the active employee who already has benefits. If your spouse or Company-recognized Domestic Partner is working as a part-time employee, he or she may waive medical and dental coverage and be covered as a dependent under your coverage.

Spouse on leave of absence: For leaves such as a personal leave of absence, when Company-provided benefits terminate, a spouse on a leave of absence may continue to purchase coverage as an employee on leave or elect to be covered as the dependent of the actively working spouse, but not both.

The actively working spouse's health coverage determines the health benefit coverage for all dependents. Because a leave of absence is a Life Event (see *Life Events*), the actively working spouse may make changes to his or her other coverages.

The actively working spouse may elect to:

- Add the spouse on leave as a dependent
- Cover only eligible dependent children
- Cover both the spouse and children.

If an employee elects to be covered as a dependent during a leave of absence, the following conditions apply:

- Optional coverages the person elected as an active employee end, unless payment for these coverages is continued while on leave
- Proof of good health may be required to re-enroll or increase optional coverages upon the employee's return to work.

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

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Other Information

Eligible dependent children*:* If both spouses are covered under the Group Health and Welfare Benefits Plan, eligible dependent children are covered as dependents of the parent whose birthday occurs first in the calendar year, unless the parents elect otherwise. Contact HR Services at 800-447-2000 to change this requirement. Children cannot be covered under both parents' health benefits. See "Dependent Eligibility" on page 18 for additional information.

Contributions: If both you and your spouse are covered independently under the Group Health and Welfare Benefits Plan and select exactly the same medical or dental option at the same cost, your contributions will be adjusted to ensure you pay approximately the same for your total family coverage as you would if your spouse worked elsewhere. The savings will be divided equally and applied to both your paychecks.

Family deductibles: Family deductibles (described under "Key Features of the Medical Options" in the *Medical* section) apply if both employees choose the same medical option. If the parents choose different options, the family deductible applies to the employee covering the children and the individual deductible applies separately to the other parent.

HMO participation*:* If you and your spouse enroll in the same HMO, the entire family unit is covered under the male employee's name because of HMO administrative procedures. If the male spouse takes a Leave of Absence (LOA), coverage for the family unit transfers to the female spouse for the duration of the leave. Company-recognized Domestic Partners are eligible for HMO coverage.

Life insurance: Both employees are eligible to elect life insurance covering their spouse regardless of any other life insurance coverage the spouse has elected as an employee. Both parents may elect Child Term Life Insurance (see "Spouse and Child Term Life Insurance Benefits" in the *Life Insurance* section) for eligible dependent children.

Accident coverage: Each of you may enroll for yourself. You cannot be covered as an employee and a dependent; therefore, only the parent who elects medical coverage for the dependent children may elect family accident coverage, and the spouse must waive coverage. If your spouse works for an AMR subsidiary that does not offer accident coverage, you may elect Voluntary Personal Accident Insurance Benefits (see "AD&D and VPAI Benefits" in the *Accident Insurance* section) for him or her.

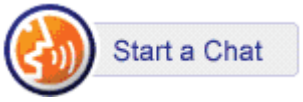
Flexible Spending Accounts: Deposits to the Health Care and Dependent Day Care Flexible Spending Accounts (see the *Health Care FSA* and the *Dependent Day Care FSA* sections) may be made by one or both spouses. Either of you may submit claims to the account. However, if only one spouse is making deposits to the account, claims must be submitted under that person's Social Security number. If you both make deposits, you may only contribute the maximum amount the law permits for a couple filing a joint tax return. You may not file claims for expenses incurred by a Company-recognized Domestic Partner or his or her dependents under your Flexible Spending Accounts according to federal law.

Eligibility During Leaves of Absence and Disability

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

When you begin a leave of absence (when your payroll transaction record is changed to reflect that you're on a leave of absence),

- HR Services sends you a letter acknowledging your leave, instructing you to access Jetnet to register your Leave of Absence Life Event, and requesting that you decide whether or not to continue your benefits while on your leave.
- Once you record your Life Event and benefit elections on the Benefits Service Center on Jetnet, it will display for you a confirmation statement showing your choices, the monthly cost of benefits, covered dependents, etc.
- If you have not received HR Services' letter within 10 days of being placed on a leave, contact HR Services immediately, so that you may continue your benefits while on leave.



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

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

Family Medical Leave of Absence (FMLA) or Military Leave

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

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

For a detailed description of each Leave of Absence, refer to the Leaves of Absence section or consult with your supervisor.

Eligibility After Age 65

As an active employee, your medical coverage continues for you and your covered dependents after you reach age 65 (or your spouse reaches age 65), unless you (or your spouse) notify the Company in writing that you want Medicare to be your only coverage.

If you elect Medicare as your only coverage, your Company-sponsored medical coverage will terminate, including coverage for your dependents. If your spouse elects Medicare as his or her only coverage, your spouse's Company-sponsored coverage will terminate.

Dependent Eligibility

Dependent eligibility requirements are different depending on the benefit coverage you elect.

Medical Coverage

An eligible dependent is an individual (other than the employee covered by the Plan) who lives in the United States, Puerto Rico, U.S. Virgin Islands, or who accompanies an employee on a Company assignment outside the U.S. and is related to the employee in one of the following ways:

- Spouse, not employed by the Company (Company-recognized Domestic Partners and their children are not eligible to participate in Flexible Spending Accounts).
- Child under age 26 who is not eligible for his or her own medical coverage through his or her employer.
- Incapacitated child age 26 or over who maintains legal residence with you and is wholly dependent upon you for maintenance and support.
- Child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.

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Dental and Vision Coverage

An eligible dependent is an individual (other than the employee covered by the Plan) who lives in the United States, Puerto Rico, U.S. Virgin Islands, or who accompanies an employee on a Company assignment outside the U.S. and is related to the employee in one of the following ways:

- Spouse, Company-recognized Domestic Partner or common law spouse.
- Unmarried child under age 23 who maintains legal residence with you.
- Child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.

Child Life Insurance and Child Accidental Death and Dismemberment (AD&D) Insurance

An eligible dependent is an individual (other than the employee covered by the Flexible Benefits Program) who lives in the United States, Puerto Rico, U.S. Virgin Islands, or who accompanies an employee on a Company assignment outside the U.S. Child means the following:

- Incapacitated child age 19 or over who maintains legal residence with you and is wholly dependent upon you for maintenance and support.
- Your natural child, adopted child (including a child from the date of placement with the adopting parents until the legal adoption) or stepchild (including the child of a Company-recognized Domestic Partner) who is:
  - under age 19 unmarried and supported by you; or
  - under age 23 and who is:
    - a full-time student at an accredited school, college or university that is licensed in the
      - jurisdiction where it is located;
      - unmarried;
      - supported by you; and
      - not employed on a full-time basis.

The term does not include any person who:

- Is in the military of any country or subdivision of any country; or
- Is insured under the Group Policy as an employee.
- For Texas residents Child means the following for Life Insurance:
- Your natural child, adopted child or stepchild (including the child of a Company-recognized Domestic Partner) who is under age 25 and unmarried.

The term also includes:

- Your grandchild who is under age 25, unmarried and who was able to be claimed by You as a dependent for Federal Income Tax purposes at the time You applied for Life Insurance.

A child will be considered Your adopted child during the period You are party to a suit in which You are seeking the adoption of the child.

- **The term does not include any person who:**
- is in the military of any country or subdivision of any country; or
- is insured under the Group Policy as an employee.

Spouse Life Insurance and Spouse Accidental Death and Dismemberment (AD&D) Insurance

An eligible dependent is an individual (other than the employee covered by the Plan) who lives in the United States, Puerto Rico, U.S. Virgin Islands, or who accompanies an employee on a Company assignment outside the U.S. and is related to the employee in one of the following ways:

- Spouse, Company-recognized Domestic Partner or common law spouse, not employed by the Company.

Determining a Child's Eligibility

For the purpose of determining eligibility, "child" includes your:

- Natural child
- Legally adopted child
- Natural or legally adopted child of a covered Company-recognized Domestic Partner as defined by the Plan
- For Medical coverage: Stepchild
- For Medical and Dental coverage: Stepchild, if the child lives with you, and you (the employee) either jointly or individually claim the stepchild as a dependent on your federal income tax return
- Special Dependent, if you meet all of the following requirements:
  - You must have legal custody and legal guardianship of the child.
  - The child must maintain legal residence with you and be wholly dependent on you for maintenance and support
  - You must submit a Special Dependent Statement**,** available in the eHR Center**,** to HR Services and HR Services must approve the form. (Complete and return the form to HR Services, along with copies of the official court documents awarding you custodianship or guardianship of the child.) You must receive confirmation from HR Services notifying you of its determination.
  - HR Services will send you a letter notifying you of its findings. If your request is approved, the notification letter will include an approval date. If you submit your request within 60 days of the date that legal guardianship or legal custodianship is awarded by the court, coverage for the child is effective as of that date, pending approval by HR Services. If you submit the request after the 60-day time frame, the child will not be added to your coverage.
- You are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a National Medical Support Notice issued by a state agency (see "Procedures upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice" in the *Additional Health Benefit Rules* section).

Coverage for an Incapacitated Child - Medical Coverage Only

An "incapacitated child" age 26 or older is eligible for continuation of coverage if all of the following criteria are met:

- The child was already continuously covered as your dependent under this Plan before reaching age 26
- The child is mentally or physically incapable of self-support.
- You file a Statement of Eligibility for Incapacitated Child and your network/claims administrator approves the application.
  - For Blue Cross and Blue Shield of Texas: Within 45 days of the date coverage would otherwise end
  - For HMOs: Contact your HMO for the time limit
- The child continues to meet the criteria for dependent coverage under this Plan.

- You provide additional medical proof of incapacity as may be required by your network/claims administrator from time to time. Coverage will be terminated and cannot be reinstated if you cannot provide proof or if your network/claims administrator determines the child is no longer incapacitated. If you elect to drop coverage for your child, you may not later reinstate it.
- And either the child maintains legal residence with you and is wholly dependent on you for maintenance and support, or you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency).

Proof of Eligibility

As a reminder, American Eagle Airlines and Its Affiliates reserve the right to request documented proof of dependent eligibility for benefits at any time. If you do not provide documented proof when requested, or if any of the information you provide is not true and correct, your actions will be considered a violation of the Rules of Conduct, available in the eHR Center, and may result in termination of employment, benefit or plan coverage termination, and recovery of any overpaid benefits.

Whether you:

- enroll dependents when you are first eligible to enroll in benefits, or
- enroll new dependents at annual enrollments, or
- enroll new dependents as the result of a Life Event,

You must submit to HR Services proof of the dependents' eligibility within 60 days of the date you request their enrollment. Proof that dependents you enroll qualify as your dependents includes (but is not limited to) official government-issued birth certificates, adoption papers, marriage licenses, etc. The proof of eligibility requirements are listed on Jetnet, under Benefits, in the Resources site, or you may contact HR Services for proof of eligibility requirements (see "Contact Information" in the *Reference Information* section).

Important: Your dependents' coverage and enrollment will be effective only after you have timely requested their enrollment and timely provided satisfactory proof of eligibility.

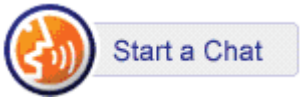
Dependents of Deceased Employees

If you have elected medical coverage for your spouse and children and you die as an active employee, your dependents' medical coverage will continue for 90 days at no contribution cost. Your covered dependents are also eligible to continue medical coverage and certain other benefit options for up to 36 months under COBRA (see "Continuation of Coverage - COBRA Continuation" in the *Additional Health Benefit Rules* section) at the full COBRA rate. This 90 days of coverage is part of the 36 months of COBRA coverage.

Your covered dependents can elect to continue Dental 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. To continue dental coverage, your dependents must pay contributions effective from the day of your death.

Common Law Spouse/Company-recognized Domestic Partners

Throughout this Guide, the term "spouse" is used to refer to your legally married spouse, as well as your eligible common law spouse or Company-recognized Domestic Partner unless Company-recognized Domestic Partners are addressed separately. Under current laws, a Company-recognized Domestic Partner is not eligible for certain health and welfare benefits under an ERISA-covered plan. We have identified where a Company-recognized Domestic Partner is not eligible for a certain benefit under the relevant section of this Guide.



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"Common law spouses" may be eligible for benefits if you live in a state that recognizes common law marriage and you have met the state's common law marriage requirements. To enroll your common law spouse for benefits, you must complete and return a Common-Law Marriage Recognition Request.

Applicants for common law recognition may not be married to other persons; additionally, applicants may not be of the same gender.

Although criteria vary by state, the following guidelines usually apply:

- The couple cohabitates for a specified period of time established by the state.
- The persons recognize each other as husband and wife.
- The persons hold each other out publicly as husband and wife.

A common law spouse is eligible for enrollment in Plan benefits only if your common law marriage is recognized and deemed (certified) legal by the individual state where the employee resides, and only if the employee and spouse have fulfilled the state's requirements for common law marriage.

"Company-recognized Domestic Partners" are defined by American Eagle Airlines, Inc. and Its Affiliates as two people in a spouse-like relationship who meet all of the following criteria:

- Are the same gender
- Reside together in the same permanent residence and have lived in a spouse-like relationship for at least six consecutive months
- Are both at least 18 years of age and are not related by blood in a degree that would bar marriage
- Are not legally married to, or the common law spouse or Company-recognized Domestic Partner of any other person and cannot enter into a marriage recognized as legal in all 50 states and under the laws of the United States.
- Submit a complete and valid Declaration of a Domestic Partnership from the Company-recognized Domestic Partner Enrollment Kit.

Company-recognized Domestic Partners and their eligible dependent children ARE eligible to be covered under the following benefits or Plans:

- Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options
- Health Maintenance Organizations
- Dental Benefit (for active employees, their spouse or Company-recognized Domestic Partner, and eligible dependents)
- Vision Insurance Benefit
- Accident Insurance Benefit
- Spouse Life Insurance Benefit (Company-recognized Domestic Partner)

Company-recognized Domestic Partners **ARE NOT** eligible to participate in:

- Flexible Spending Accounts (your Company-recognized Domestic Partner's health care expenses may not be reimbursed from your HCFSA)

After reviewing the Company-recognized Domestic Partner Kit, if you need additional information regarding benefits and privileges available to Company-recognized Domestic Partners, please contact HR Services by clicking on the "Start a Chat" button at the top of this page.

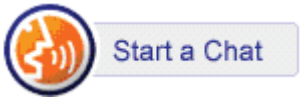
Ineligibility

None of the following individuals is eligible to participate in this benefits program:

- A leased employee, as defined in section 414(n) of the Internal Revenue Code;
- Any person (regardless of how such person is characterized, for wage withholding purposes or any other purpose, by the Internal Revenue Service, or any other agency, court, authority, individual or entity) who is classified, in the sole and absolute discretion of the Company as a temporary worker; this term includes any of the following former classifications:
  - temporary employee
  - provisional employee
  - associate employee
- An independent contractor;
- Employees of the EGS Division of American Eagle Airlines or Executive Airlines; or
- Any person:
  - who is not on the Company's salaried or hourly employee payroll (the determination of which shall be made by the Company in its sole and absolute discretion);
  - who has agreed in writing that he or she is not an employee or is not otherwise eligible to participate; or
  - whose compensation is reported to the Internal Revenue Service on a form other than a Form W-2, regardless of whether such person was treated as an employee for federal income tax purposes.

Parents and Grandchildren

Neither your parents nor grandchildren are eligible as dependents, regardless of whether they live with you or receive maintenance or support from you (unless you are the grandchild's legal guardian). However, you may be eligible for reimbursement of their eligible expenses under the Health Care and Dependent Day Care Flexible Spending Accounts (see the *Health Care FSA* and the *Dependent Day Care FSA* sections), if you claim your parent or grandchild as a dependent on your federal income tax return.



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Forms & guides can be located in the eHR Center of Jetnet at https://www.jetnet.aa.com/jetnet/go/ssoehr.asp?TargetDoc=XML=20

The Benefits Service Center is available at https://www.jetnet.aa.com/jetnet/go/ssomercer.asp

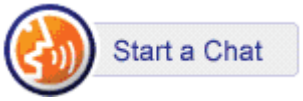
General Enrollment

You have the opportunity to select benefits tailored to your individual needs and preferences each year during annual enrollment. The annual enrollment period is in the fall. Employees enroll online using the Benefits Service Center, which can be accessed from the Benefits page of Jetnet.

- The Plan year is January 1 through December 31.
- If you do not enroll for benefits during the annual enrollment period, you will automatically default to your current selections (if available) for the following year, at the applicable rates for the following year.
- If one or more of your current selections are no longer available and you do not make another selection, you will be enrolled in the applicable benefit or plan designated as the default coverage for your work group.
- After annual enrollment is completed and the new benefit year has begun, you will only be able to make changes to your elections if you experience a qualifying Life Event.
- If you are adding new dependents to your benefits, you must submit to HR Services proof that these dependents qualify as your eligible dependents within 60 days of the date you enroll them.
- Life Event changes must be made within 60 days of the qualifying Life Event.

The Benefits Service Center

The Benefits Service Center (the online enrollment tool) on Jetnet reflects the current benefits coverages available to you and the rates for those coverages. The Benefits Service Center is updated before annual enrollment with your benefits options and the new rates for the upcoming Plan year – January 1 through December 31. You can access the Benefits Service Center from the Benefits page of Jetnet.



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In This Section — See Page

New Employee Enrollment

As an American Eagle or Executive Airlines employee, in order to receive coverage when first eligible, you must complete an online enrollment. If you do not complete the enrollment process, you will not be enrolled in any benefits, and your next opportunity to enroll will be during the annual open enrollment period for the following year. You will receive enrollment information shortly after you begin working. Upon completing one month of Company service, you will be eligible to receive Company subsidized medical, dental, basic life, basic accidental and vision benefits. You may elect coverage for yourself and your eligible dependents (see "Dependent Eligibility" in the *General Eligibility* section) and have a ONE-TIME opportunity to enroll in the following coverages without having to provide proof of good health:

- Long Term Disability Insurance Benefit (LTD)
- Optional Short-Term Disability Insurance (OSTD) Benefit
- Voluntary Term Life Insurance Benefit

  (You may choose Voluntary Term Life Insurance one level above the Company-provided amount without proof of good health. During future annual enrollments, you may only increase your life insurance one level each annual enrollment with proof of good health.)

Proof of good health is required if you wish to enroll in the above coverages later (if/when you are eligible) or to increase life insurance coverage levels. You must submit a complete Statement of Health from MetLife to add or increase Life Insurance coverage, or a Disability Coverage Enrollment Form for OSTD coverage, within 30 days after your enrollment deadline. If your statement of health is not postmarked within 30 days after the close of annual enrollment, your application for these coverages will not be considered, and you must wait until the next annual enrollment (or your next qualifying Life Event) to apply for any of these coverages.

Employees have the opportunity to select benefits tailored to individual needs and preferences. The Benefits Service Center on Jetnet reflects the current benefits coverages available to you and the rates for those coverages.

Default Coverage

Newly eligible employees who do not complete the enrollment process will not be enrolled in any benefits. Your next opportunity to enroll will be during the annual open enrollment period for the following year.

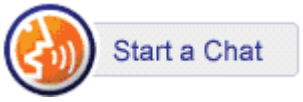
As a new employee, you can enroll for benefits when you are first eligible during your "enrollment window", and each year, during annual enrollment, you can enroll for benefits that will be effective the following year. Your Benefits Service Center will be updated annually with benefit options and new rates for the upcoming year.

This page indicates the default benefits that may be assigned and explains when default benefits apply.

During annual enrollment, if you do not make selections for the upcoming benefit year, you will default to the same benefits and plans (at the applicable new rates) as you are enrolled in for the current year with the following exceptions:

- **Flexible Spending Accounts (FSAs):** If you do not elect the FSA options, you default to "waive", and you will not have FSA accounts for the following year.
- **Current Plan Not Offered or Employee Not Eligible:** If you no longer qualify for the current year's benefit or plan, or if your current benefit or plan is no longer offered in your area, you must select a replacement benefit or option or "waive" coverage. If you do not either elect coverage or waive coverage, you will default to the coverages listed in the table below:

Benefit	Default	Comments
Medical Benefit Option	PPO Deductible	If your current medical benefit option is not available in your location, you and your eligible dependents will be enrolled in the PPO-Deductible option. If you are not eligible for the PPO-Deductible option, you and your eligible dependents will be enrolled in the Out-of-Area Coverage option. Employees with a Puerto Rico address will default to the Humana HMO if current plan is no longer available.
Dental Benefit Option	Dental Benefit	
Vision Insurance Benefit	No coverage	
Optional Short-Term Disability Insurance Benefit	No coverage	
Long-Term Disability Insurance Benefit	LTD Benefit	
Employee Life Insurance Benefit	Current coverage	1× salary if enrolled in a medical plan
Spouse Life Insurance Benefit	No coverage	
Child Life Insurance Benefit	No coverage	
AD&D Insurance Benefit	AD&D Benefit	1× salary if enrolled in a medical plan
VPAI Benefits	No coverage	
Flexible Spending Account Benefits (Health Care FSA, Dependent Day Care FSA)	No coverage	Your FSA accounts will default to $0.00 unless you enter an amount.



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Waiving Coverage

You may choose to waive coverage if you do not want to participate in the Company's Group Medical Benefits. Please keep in mind that your dependents will not receive coverage unless you are covered. You can reinstate your medical coverage during the year if you experience a qualifying Life Event such as marriage, divorce or the birth or adoption of a child.

How to Enroll

Follow these steps to enroll before your enrollment deadline:

Step 1: Visit the Enrollment Center on Jetnet

- Look over the information contained in the Benefits Service Center on Jetnet. The Benefits Service Center displays your benefit options for the remainder of the year and monthly costs for each.
- Verify that the personal information shown is correct.

Step 2: Review your dependents

- You may add your spouse and any eligible dependent children to records during enrollment.
- After you have added your dependents, if any, it is necessary to decide whether or not you wish to cover each dependent under your Group Medical Benefit Option before continuing with your enrollment for other benefits.
- Within 30 days of your enrolling your dependents for benefits, you must submit to HR Services proof that these dependents qualify as your eligible dependents. Proof that the dependents you enroll qualify as your dependents includes (but is not limited to) official government-issued birth certificates, adoption papers, marriage licenses, etc., as described in the Proof of Eligibility Requirements.

Step 3: Enroll

- You can enroll online on Jetnet any time before the enrollment deadline.
- Be sure to enroll by the deadline indicated on your online worksheet. Newly eligible employees that do not complete the enrollment process will not be enrolled in any benefits.
- You will not have another opportunity to enroll until the next annual open enrollment — or unless you experience a qualifying Life Event (see *Life Events*).

Coverage Levels

You may choose from the following levels of coverage for medical, dental and vision:

- Employee
- Employee + One
- Employee + Two or more.

When Coverage Begins

If you enroll by the enrollment deadline, your selected coverage (if different from default coverage) is retroactive to the date you are first eligible for benefits and your paycheck is adjusted as necessary. However, if a death or accident occurs before your enrollment is processed, the amount of Life Insurance and Accidental Death and Dismemberment Insurance coverage that will be paid is the amount under "Default Coverage" on page 27.

If you select an HMO and need medical care during this interim period, you must receive treatment from a network provider to receive network coverage. If not, you will have no coverage if enrolled in an HMO.

Paying for Coverage

Each year the Company reviews the benefit options offered to employees and the cost of each plan. Based on your employment status and the number of family members enrolled in your coverage, the Company pays a certain amount towards the cost of your benefits. Once you have completed one month of Company service, the Company pays the majority of the cost of your medical and dental coverage; you pay the remaining amount of the actual cost for providing these benefits.

Company-Provided Benefits

All employees are provided with basic benefits protection. These benefits include:

- **Medical Benefits.** You can choose from Out-of-Area Coverage, PPO-Deductible, PPO-Copay, Minimum Coverage or an HMO option (if available in your area). Your contributions fund a portion of the cost with the Company covering the majority of the cost.
- **Dental Benefit.** You contribute a portion of the contribution cost.
- **Basic Life Insurance** coverage based on your annual salary for benefits (See "Employee Term Life Insurance" in the *Life Insurance Benefits* section.)
- **Accidental Death and Dismemberment Insurance Benefit** of 1× your annual salary.
- **Vision Discount Program Benefit:** All employees who elect medical coverage will be offered this program. (See *Vision Benefits*).

Employee-Paid Benefits

In addition to these Company-provided benefits, you can select from a number of optional benefits for which you pay the full cost. These include:

- Vision Insurance Benefits
- Voluntary Term Life Insurance Benefits
- Voluntary Personal Accident Insurance Benefits for you alone or for you and your family
- Optional Short Term Disability Insurance Benefits
- Long Term Disability Insurance Benefits
- A Health Care Flexible Spending Account Benefit
- A Dependent Day Care Flexible Spending Account Benefit.

You pay the same amount for benefits each month, even if your number of pay periods varies from month to month (for example, if you are paid bi-weekly or weekly). Depending on your pay cycle, here is how payroll deductions work. (The amount may vary by a few cents due to rounding.) If you are paid:

- **Semi-monthly:** You always receive two paychecks per month, so the same amount is deducted from each paycheck.
- **Bi-weekly:** You generally receive two paychecks per month, so the same amount is deducted from the first two paychecks each month. However, in months with three pay periods, your last monthly paycheck will not have benefit deductions.
- **Weekly:** You generally receive four paychecks per month, so the same amount is deducted from the first four paychecks each month. However, in months with five pay periods, your last paycheck of the month will not have benefit deductions.

The amount deducted from your paycheck is your contribution to the cost of coverage. (The amount may vary by a few cents due to rounding.)

Taxation of Benefits

You pay for most benefits on a before-tax basis, which means the cost of your benefits is deducted from your pay before taxes are calculated. Tax withholding is calculated only on the remaining amount. Therefore, your contributions for before-tax benefits actually reduce your taxable income, and the amount of taxes withheld from your pay is also lower. However, a few benefits must be paid on an after-tax basis.

Here are a few important points about before-tax and after-tax benefits:

- Each before-tax dollar you contribute to your Dependent Day Care Flexible Spending Account reduces the eligible amount you may claim on your federal income tax return for the dependent day care tax credit. Consult your tax advisor to determine whether you would benefit more from the Dependent Day Care Flexible Spending Account or the federal dependent day care tax credit.
- When you calculate your federal income tax deduction for medical expenses, you may not include any money contributed before-tax to the Health Care Flexible Spending Account. If you anticipate having medical expenses of more than 7.5% of your adjusted gross income, you should consult your tax advisor before signing up for the Health Care Flexible Spending Account.
- According to the IRS, Company-recognized Domestic Partners are not allowed to participate in Flexible Spending Accounts.
- You do not pay federal (or most state or local) taxes or Social Security (FICA) taxes on your pay used to purchase before-tax benefits. Because this reduces your Social Security wages, before-tax benefits could reduce your future Social Security benefits by a small amount. If your taxable pay remains above the Social Security wage base ($106,800 for 2009), your before-tax benefits do not affect future Social Security benefits.

The following table summarizes options available to eligible employees under the benefit program for American Eagle Airlines, Inc. and Executive Airlines, Inc. employees. The second column shows whether you pay for the benefit before-tax. The third column indicates whether you may waive coverage (choose no coverage) for this benefit option.

Type of Benefits	Before-Tax?	May Waive?
Medical Benefit Options ▪ Out-of-Area Coverage Option ▪ PPO-Deductible Option ▪ PPO-Copay Option ▪ Minimum Coverage Option ▪ Health Maintenance Organizations Option (HMOs)	Yes	Yes*
Dental Benefit Option	Yes	Yes
Vision Insurance Benefit	Yes	Yes
Voluntary Term Life Insurance Benefit	Yes	Yes**
Voluntary Personal Accident Insurance Benefit	No	Yes
Spouse Term Life Insurance Benefit	No	Yes**
Child Term Life Insurance Benefit	No	Yes
Optional Short Term Disability Insurance Benefit	No	Yes**
Long Term Disability Insurance Benefit	No	Yes**
Health Care Flexible Spending Account Benefit	Yes	Yes***
Dependent Day Care Flexible Spending Account Benefit	Yes	Yes

* Your dependents cannot have coverage if you are not covered.

** Requires proof of good health any time you increase your level of coverage or if you waive coverage and later decide to elect it.

*** During the year, if you experience a qualifying Life Event, you may start or increase contributions to a Health Care Flexible Spending Account only if you are enrolling a dependent who was not previously covered.

Annual Enrollment

Each fall, eligible employees have the opportunity to select benefits for the following year. During the annual enrollment period, you can enroll online for coverage, make changes to your prior elections, or continue your previous elections at the applicable new rates. (New rates will be available in your Benefits Service Center on Jetnet.) With the exception of specific Life Events, annual enrollment is the only time you can change your coverage selections.

Any selections you make during annual enrollment are generally effective the following January 1. If proof of good health is required, the effective date for coverage, if approved, may be delayed to allow for review of your Statement of Health from MetLife (e.g., to add or increase Life Insurance coverage).

Some benefits and plans require proof of good health, if you elect these benefits or plans at any time after you first became eligible to enroll. During annual enrollment, if you want to:

- increase the amount of your employee or spouse term life insurance benefit;
- enroll in the Optional Short Term Disability Insurance Benefit, or
- enroll in the Long Term Disability Insurance Benefits

You must complete a Statement of Health from MetLife within 30 days after the close of annual enrollment. For example, if during annual enrollment for the 2009 benefit year (this occurs in October, 2008), you elect to increase the amount of your employee term life insurance benefit for 2009, you must submit your Statement of Health to MetLife no later than November 30, 2008. If your statement is submitted within 30 days after the close of annual enrollment, your application for these coverages will not be considered, and you must wait until the next annual enrollment (or your next qualifying Life Event) to apply for any of these coverages.

Please be aware of these important points:

The annual enrollment period occurs each fall.

- If you do not enroll for benefits during the annual enrollment period, you will automatically default to your current selections (if available) for the following year, at the applicable rates for the following year.
- If one of your current selections is no longer available, you will default to the applicable benefit or plan as listed in the table under "Default Coverage" on page 27.
- After annual enrollment, you will only be able to make changes to your elections if you experience a qualifying Life Event. (see the *Life Events* section).
- If you are adding new dependents to your benefits during the annual enrollment period, keep in mind that you must submit to HR Services proof that these dependents qualify as your eligible dependents within 30 days of the date you enroll them. Proof that the dependents you enroll qualify as your dependents includes (but is not limited to) official government-issued birth certificates, adoption papers, marriage licenses, etc. The proof of eligibility requirements are listed on Jetnet, under Benefits, in the Resources site, or you may contact HR Services for proof of eligibility requirements (see "Contact Information" in the *Reference Information* section).

Flexible Spending Account elections do not automatically carry over to the following year. If you do not enroll and enter an amount, you will not have FSA dollars in the following benefit plan year.

Special Enrollment Rights

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

- You and/or your dependents lose the other medical coverage because eligibility was lost for reasons including legal separation, divorce, death, termination of employment or reduced work hours (but not due to failure to pay premiums on a timely basis, voluntary disenrollment or termination for cause).
- The employer contributions to the other coverage have stopped.
- The other coverage was COBRA and the maximum COBRA coverage period ends.
- 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 cease to offer health benefits to the class of employees through which you (or one of your dependents) have coverage.
- Your employer and/or your dependent's employer cease 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.

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 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, contact HR Services (see "Contact Information" in the *Reference Information* section).

If you are adding new dependents to your benefits as a result of a Life Event, keep in mind that you must submit to HR Services proof that these dependents qualify as your eligible dependents. Proof that the dependents you enroll qualify as your dependents include (but are not limited to) official government-issued birth certificates, adoption papers, marriage licenses, etc. The proof of eligibility requirements are listed on Jetnet, under Benefits, in the Resources site, or you may contact HR Services for proof of eligibility requirements (see "Contact Information" in the *Reference Information* section).

Special Enrollment Rights Under The Children's Health Insurance Program Reauthorization Act of 2009 (CHIP)

If you and your dependent(s) are not enrolled in the Medical Benefits Option and you or your dependent(s) either:

- Lose Medicaid or CHIP coverage, or
- Become eligible for a state premium assistance program under Medicaid or CHIP, you have 60 days from the date of the event to enroll yourself and your dependent(s) in this benefit program.

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If you are not enrolled in this benefit program as an employee, you must enroll yourself in benefits at the time you enroll your dependent(s). Keep in mind that if you are adding dependent(s) to your benefits during this special enrollment period, you must submit to HR Services proof that these dependents qualify as your eligible dependents, and proof of loss of Medicaid or CHIP coverage, or proof of eligibility for the state premium assistance (under Medicaid or CHIP). Proof that the dependents you enroll qualify as your eligible dependents includes (but is not limited to) official government-issued birth certificates, adoption papers, etc., as described in the Proof of Eligibility Requirements.

When Coverage Ends

Coverage for you and your dependents ends when you terminate employment, cancel coverage, stop paying for coverage, or if you become ineligible for coverage (for example, due to a change in your job classification). See "Continuation of Coverage – COBRA Continuation" in the *Additional Health Benefit Rules* section. In addition, your dependent's coverage ends if the dependent no longer meets the eligibility requirements, as explained in Dependent Eligibility Criteria (see "Dependent Eligibility" in the *General Eligibility* section).

If you die as an active employee, your covered dependents continue to receive the same medical coverage they had before you died. COBRA Continuation Coverage continues for 90 days at no cost. At the end of 90 days, your eligible dependents are eligible to continue medical coverage for up to 36 months under COBRA at the full COBRA rate. The 90 days of coverage immediately following your death is included in the 36 months. Dental coverage is available for purchase through COBRA. All other coverages end at the time of your death.

While you are:

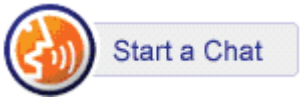
Receiving accrued sick pay, and during the first year (12 months) of an unpaid sick or injury-on-duty leave of absence you may keep the same benefits you had while actively working. You are responsible for paying your share of the cost for coverage. When you begin a leave of absence (when your payroll transaction record (PTR) is changed to reflect that you're on a leave of absence), HR Services sends you a letter acknowledging your leave and instructing you to access Jetnet to register your Leave of Absence Life Event and decide whether or not to continue your benefits while on your leave.

When you register your qualifying Life Event and benefit elections on Jetnet, it will display a confirmation statement showing your choices, the monthly cost of benefits, etc. If you have not received the HR Services letter within 10 days of being placed on leave, contact HR Services immediately so you may continue your benefits while on leave (see "Contact Information" in the *Reference Information* section).

For information regarding benefits that can be continued through COBRA, see "Continuation of Coverage - COBRA Continuation" in the *Additional Health Benefit Rules* section.

During the initial period of an absence for a disability, while you are receiving accrued sick pay and during the first year (12 months) of an unpaid sick or injury-on-duty leave of absence, the Company continues to pay its part toward the cost of your medical coverage for active employees, and you must pay your part of the cost, as well. You will receive a personalized Leave of Absence Worksheet from HR Services when the Payroll Transaction Request (PTR) placing you on unpaid leave is processed. The worksheet lists your benefits options during the leave, costs for benefit coverage, and the election deadline. If you elect to continue your medical and dental benefit, this coverage ends at the end of the 12th month of your leave.

Important: If you elect not to continue payment for your benefits during your leave of absence, your benefits will terminate while you are on leave. When you return to active status, you may reactivate most of your benefits; however, the Voluntary Term Life Insurance Benefit, OSTD Insurance Benefit and LTD Plan will require you to supply proof of good health in order to reactivate.



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Forms & guides can be located in the eHR Center of Jetnet at https://www.jetnet.aa.com/jetnet/go/ssoehr.asp?TargetDoc=XML=20

The Benefits Service Center is available at https://www.jetnet.aa.com/jetnet/go/ssomercer.asp

Life Events: Making Changes During the Year

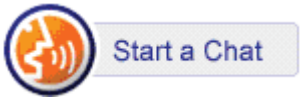
After annual enrollment is completed each year, you may only change your elections if you experience a qualifying Life Event and your change is consistent with that event. Allowable changes vary by the type of Life Event you experience, as shown in the "Table of Life Events and Permitted Benefit Changes" on page 37 and on the Life Events landing page on Jetnet.

When you experience a qualifying Life Event, keep these important thoughts in mind:

- Most Life Events can be processed online through Jetnet. Visit the Employee Self-Service Life Events page for a complete list of all Life Events and the correct procedures for processing your changes.
- If you process your Life Event within 60 days of the event, your changes are retroactive to the date the Life Event occurred (or the date proof of good health is approved, as applicable).
- 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.
- American Eagle Airlines, Inc. and Its Affiliates reserve the right to request documented proof of dependent eligibility for benefits at any time. If you do not provide documented proof when requested, or if any of the information you provide is not true and correct, your actions will be considered a violation of the Rules of Conduct and may result in termination of employment and termination of benefits coverage.

  If you are adding new dependents to your benefits as a result of a Life Event, keep in mind that you must submit to HR Services proof that these dependents qualify as your eligible dependents within 30 days of the date you enroll them. Proof that the dependents you enroll qualify as your dependents include (but are not limited to) official government-issued birth certificates, adoption papers, marriage licenses, etc., as described in the Proof of Eligibility Requirements.
- Any change in your cost for coverage applies on the date the change is effective. Catch-up contributions or deductions will be deducted from one or more paychecks after your election is processed at the discretion of the Plan Administrator.
- You cannot enroll your dependents for coverage if you are not covered.
- You may start or increase a Health Care Flexible Spending Account only if you have enrolled a dependent who was not previously covered.



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- Starting or increasing either Life, Accident, or Disability Insurance Benefits may require proof of good health and coverage will only be effective after the applicant is approved. If death occurs before a Life Event is processed, the amount of coverage payable is your current amount of Life and/or Accident Insurance. When you add Life or Accident Insurance Benefits, you must designate a beneficiary. Periodically thereafter, you may want to update your beneficiary designations, and you can make beneficiary changes on the Benefits Service Center. Once you complete and submit the online **Beneficiary Designation Form**, it supersedes all previous designations.
- If a death or accident occurs before your first-time enrollment is processed, the amount of Life Insurance and Accidental Death and Dismemberment Insurance Benefits that will be paid is your "default coverage." If you have coverage and you are requesting an increase, the amount payable is your current amount of coverage.
- You or your spouse may only increase your Life Insurance coverage by one level per year, with proof of good health.
- If you elect to enroll in any coverage requiring proof of good health, you must submit (postmarked) a completed, dated, and signed Statement of Health Form to MetLife within 30 days after your enrollment/election date. If your statement of health is not postmarked within 30 days after your enrollment/election date, your application for these coverages will not be considered, and you must wait until the next annual enrollment (or your next qualifying Life Event) to apply for any of these coverages.
- If you plan to cover your Company-recognized Domestic Partner under your Life Insurance, you must submit a MetLife Affidavit of Company-recognized Domestic Partnership. This form is part of the Company-recognized Domestic Partner Enrollment Kit.
- See also "Special Life Event Considerations" on page 44 for other information regarding Life Events that may trigger allowable changes in coverage.

In This Section

See Page

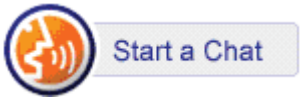
Table of Life Events and Permitted Benefit Changes

This table describes the changes you may make when certain life events occur.

If…	Then, You Can…
You become eligible for Company-provided benefits	Enroll online through the Benefits Service Center.
You get married or declare a Company-recognized Domestic Partner	▪ **Medical and Dental Options and Vision Insurance Benefit:** Add coverage for your spouse and eligible dependents; stop coverage for a dependent or yourself. Although you can add or drop coverage for dependents or yourself, you cannot change benefit options at this time. You may add or drop dental coverage. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage, however this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Add coverage for your spouse and/or child, or increase or decrease existing employee coverage ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse or yourself; increase or decrease existing coverage ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. However, Company-recognized Domestic Partners and their dependents are not eligible to participate in Flexible Spending Accounts.

If…	Then, You Can…
You divorce or legally separate, ***Your Company-recognized Domestic Partner relationship ends, or*** ***You obtain a protective order***	▪ **Medical and Dental Options and Vision Insurance Benefit:** Stop coverage for your spouse. Add coverage for yourself and/or your eligible dependents (dependent coverage may be subject to QMCSO—see "Qualified Medical Child Support Order" in the *Additional Health Benefit Rules* section). You cannot change benefit options at this time. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Stop coverage for your spouse and/or child, or increase or decrease existing employee coverage ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for yourself; stop coverage for spouse or child; increase or decrease existing employee coverage ▪ **Flexible Spending Accounts Benefits:** Start/stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. However, Company-recognized Domestic Partners and their dependents are not eligible to participate in Flexible Spending Accounts
You or your spouse becomes pregnant	▪ **Contact:** your network/claims administrator before the 16th week of pregnancy, if you are covered by the Out-of-Area, Minimum Coverage, PPO-Deductible or PPO-Copay Options ▪ **Contact:** The HMO, if you are covered by an HMO ▪ This does not permit you to make any changes in your benefit elections until the baby is born
You or your spouse gives birth or adopts a child or has a child placed with you for adoption or you add eligible dependent(s) to your household	▪ **Medical and Dental Options and Vision Insurance Benefit:** Start/add coverage for the dependent(s) and yourself, and/or your spouse. You cannot change benefit options at this time ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Add coverage for your child, increase or decrease existing coverage for you with proof of good health ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse or yourself; increase or decrease existing coverage ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions

If…	Then, You Can…
Your covered dependent no longer meets the plan's eligibility requirement	▪ **Medical and Dental Options and Vision Insurance Benefit:** Stop coverage for dependent. You cannot change benefit options at this time ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Stop coverage for your dependent; increase or decrease existing coverage for you with proof of good health ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions
Your dependent child attains age 13 or he no longer requires dependent day care ***OR*** ***Your elderly parent no longer requires dependent day care***	▪ **Dependent Day Care Flexible Spending Account:** Stop or reduce Dependent Day Care Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs.
Your spouse, Company-recognized Domestic Partner or dependent dies	▪ **Medical and Dental Options and Vision Insurance:** Stop coverage for your eligible spouse/Company-recognized Domestic Partner or dependent. You cannot change benefit options at this time. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only. ▪ **Voluntary Term Life Insurance Benefit:** Stop coverage for your eligible dependent; increase or decrease existing coverage for you with proof of good health. ▪ **Spouse Term Life Insurance Benefit:** Start or stop coverage. ▪ **Child Term Life Insurance Benefit:** Start or stop coverage. ▪ **Accidental Death & Dismemberment (AD&D) Insurance:** Stop coverage for your eligible spouse/Company-recognized Domestic Partner or dependent or start or stop coverage for yourself; increase or decrease existing coverage. ▪ **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs.



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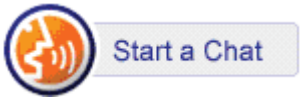
If…	Then, You Can…
Change in spouse's/Company-recognized Domestic Partner's employment or other health coverage ***OR*** ***spouse's/Company-recognized Domestic Partner's employer no longer contributes toward health coverage*** ***OR*** ***Your spouse's/Company-recognized Domestic Partner's employer no longer covers employees in your spouse's position***	▪ **Medical and Dental Options and Vision Insurance:** Add coverage for your eligible spouse, your eligible dependent or yourself; stop coverage for your eligible spouse, eligible dependent or yourself. You cannot change benefit plans at this time, if you were already enrolled. If you were not enrolled, you may enroll yourself and your eligible spouse/Company-recognized Domestic Partner or eligible dependent in the applicable benefit option. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only. ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage. ▪ **Spouse Term Life Insurance Benefit:** Start or stop coverage. ▪ **Child Term Life Insurance Benefit:** Start or stop coverage. ▪ **Accidental Death & Dismemberment (AD&D) Insurance:** Start or stop coverage for your eligible spouse/Company-recognized Domestic Partner, your dependent, or yourself; increase or decrease existing coverage. ▪ **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs.
You and/or your eligible dependent(s) declined AE medical coverage because you or they had coverage elsewhere (external to AE), and any of the following events occurs, you have 60 days from the date of the event to enroll yourself and/or your eligible dependents in a Medical Benefits Option: ▪ Loss of eligibility for other coverage due to legal separation, divorce, death, termination of employment, reduced work hours (this does not include failure to pay timely contributions, voluntary disenrollment, or termination for cause) ▪ Employer contributions for the other coverage stopped ▪ Other coverage was COBRA and the maximum COBRA coverage period ended	You have 60 days from the date of the event to enroll yourself and/or your eligible dependents in one of the Medical Benefit Options offered to you. You cannot change Medical Benefit Options at this time, if you are already enrolled. **This event allows you to add medical coverage only.**

If…	Then, You Can…
▪ Exhaustion of the other coverage's lifetime maximum benefit ▪ Other employer-sponsored coverage is no longer offered ▪ Other coverage (including HMO, other group health plan or arrangement) ends because you and/or your eligible dependents no longer reside, live, or work in its service area ▪ You have a new dependent via your marriage, your child's birth/adoption/placement for adoption with you	
You or your dependent exhausts a lifetime limit in another medical plan ***You or your dependents were enrolled in an HMO or another arrangement that will no longer cover you due to your failure to live, work or reside in the arrangement's service area***	▪ **Medical and Dental Options and Vision Insurance Benefit:** Add coverage for your spouse and eligible dependents, or yourself; stop coverage for spouse, your dependent, or yourself. You cannot change benefit options at this time, if you were already enrolled. If you were not enrolled, you may enroll yourself and your spouse and eligible dependents in any Medical Benefit Option ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions



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If…	Then, You Can…
You move to a new home address: ▪ Update your address online through Jetnet ▪ Submit a revised W-4 form for payroll tax purposes. The form is available online through Jetnet ▪ Contact other organizations such as the American Airlines Credit Union and C. R. Smith Museum directly to update your contact information ▪ Provide your new address and current emergency contact numbers to your supervisor, as well	▪ **Medical Option:** May select from medical options available in new location if you are covered under the PPO-Copay Option, PPO-Deductible Option or an HMO and you moved out of the service area to any area with different options available. Contact HR Services for more information. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage for your spouse and/or dependent; increase or decrease existing coverage ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions
You become disabled	▪ **Notify:** Your supervisor and download a **Disability Claim Form** from Jetnet ▪ **Complete and submit:** Your claim for disability benefits
You take a leave of absence	▪ **You will receive:** A personalized Leave of Absence Worksheet from HR Services when the Payroll Transaction Request (PTR) placing you on unpaid leave is processed. The worksheet lists your options during the leave, cost for benefits coverage, and the election deadline. ▪ **Your cost depends on:** The type of leave you are taking
You return from an unpaid leave of absence	▪ **Medical and Dental Options and Vision Insurance Benefit:** Resume coverage. You cannot change benefit options at this time ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage; increase or decrease existing employee coverage ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions

Forms & guides can be located in the eHR Center of Jetnet at https://www.jetnet.aa.com/jetnet/go/ssoehr.asp?TargetDoc=XML=20

The Benefits Service Center is available at https://www.jetnet.aa.com/jetnet/go/ssomercer.asp

https://www.jetnet.aa.com/jetnet/go/ssomercer.asp?AppID=CHAT

If…	Then, You Can…
You change from part-time to full-time or full-time to part-time	▪ **Medical and Dental Options and Vision Insurance Benefit:** Add coverage for your spouse and eligible dependents, or yourself; stop coverage for spouse, your dependent, or yourself. You cannot change benefit options at this time ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage for your spouse and/or dependent, or increase or decrease existing coverage ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions
You die	▪ **Continuation of Coverage:** Your dependents or Company-recognized Domestic Partner should contact your supervisor, who will coordinate with a Survivor Support representative in HR Services to assist with all benefits and privileges, including the election of Continuation of Coverage, if applicable.
Your Company-recognized Domestic Partner dies	▪ **Continuation of Coverage:** You will receive information about Continuation of Coverage through COBRA for the surviving children of your Company-recognized Domestic Partner, if you contact HR Services as required below ▪ **Contact:** HR Services within 60 days of your Company-recognized Domestic Partner's death to update your records and make the appropriate changes, if applicable, to your benefits coverage
You end your employment with the Company	▪ **Review:** When Coverage Ends within this Guide ▪ **Review:** The information you receive regarding Continuation of Coverage through COBRA ▪ **Contact:** HR Services for information
You transfer to another work group or subsidiary of AMR Corporation	**Contact:** Your supervisor, HR Services, or the new subsidiary to determine benefits available to you and to make new benefit elections
Benefit coverages are significantly improved, lowered or lessened by the Company (Plan Administrator/Sponsor will determine whether or not a change is "significant")	**Make changes to the applicable benefit coverages:** The Company will notify you of the allowable benefit changes, the time limits for making election changes and how to make changes at that time.
You are subject to a court order resulting from a divorce, legal separation, annulment, guardianship or change in legal custody (including a QMSCO) that requires you to provide health care coverage for a child	**Medical and Dental Options and Vision Insurance Benefit:** Start or add coverage for the dependent(s) and yourself. You cannot change benefit options at this time.

If…	Then, You Can…
You, your spouse or your dependent enroll in Medicare or Medicaid	**Medical and Dental Options and Vision Insurance Benefit:** Stop coverage for the applicable person. You cannot change benefit options at this time.
You or your dependent(s) lose Medicaid or CHIP coverage	▪ **Medical, Dental, and Vision Options:** Add coverage for yourself and your dependents. If you are already enrolled in Medical, Dental, Vision Options and are adding dependents, you cannot change medical or dental options at this time. ▪ **Voluntary Term Life Insurance Benefit:** No changes allowed at this time. ▪ **Voluntary Personal Accident Insurance Benefit:** No changes allowed at this time. ▪ **Flexible Spending Account Benefits:** You cannot start, stop, increase, or decrease Flexible Spending Account contributions.
You or your dependent(s) become eligible for a state premium assistance program (under Medicaid or CHIP)	▪ **Medical, Dental, and Vision Options:** Add coverage for yourself and your dependents. If you are already enrolled in Medical and Dental Options and are adding dependents, you cannot change medical or dental options at this time. ▪ **Voluntary Term Life Insurance Benefit:** No changes allowed at this time. ▪ **Voluntary Personal Accident Insurance Benefit:** No changes allowed at this time. ▪ **Flexible Spending Account Benefits:** You cannot start, stop, increase, or decrease Flexible Spending Account contributions.

Special Life Event Considerations

The following section explains special circumstances that may happen in your life and how these changes affect your benefits. You must take all of the steps described below for your special Life Event within 60 days of the date it occurs.

Special dependent: To cover a special dependent (foster child or child for whom you become the legal guardian), you must complete a Statement of Eligibility for Special Dependent and return it to HR Services at the address on the form, along with copies of the official court documents awarding you custodianship or guardianship of the child, regardless of the medical option you select. For detailed criteria regarding coverage for a special dependent, see also "Dependent Eligibility" in the *General Eligibility* section.

Stepchild: You may add coverage for a stepchild if the child lives with you and you the employee, either jointly or individually, claim the stepchild as a dependent on your federal income tax return.

Birth or adoption of a child: To add a natural child to coverage, you may use hospital records or an unofficial birth certificate as documentation of the birth. You should not wait to receive the baby's Social Security number or official birth certificate. These documents may take more than 60 days to arrive and prevent you from starting coverage effective on the baby's birth date.

To add an adopted child to your benefits coverage, you must supply a copy of the placement papers or actual adoption papers. Coverage for an adopted child is effective with the date the child is placed with you for adoption and is not retroactive to the child's date of birth.

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

Click on "Start a Chat" above and an HR Services representative will assist you with your selection. If you do not process your relocation Life Event within 60 days of your move, you will automatically be enrolled in another medical option and will receive a confirmation statement indicating your new coverage.

Benefit Coverages Affected by Life Events

Voluntary Term Life Insurance Benefit: You may only increase this coverage by one level per year with approved proof of good health.

Vision Insurance Benefit: You may add coverage for yourself and your eligible dependents if you experience a qualifying Life Event. The Vision Insurance Benefit is structured in a manner similar to the Medical Options the Company offers and is insured and administered by Spectera® a national vision care company. This coverage offers a network of providers and copayments for certain vision services.

Optional Short Term Disability Insurance Benefit: If you elect coverage, your choice remains in effect for two calendar years. After this time, you have the option to continue or waive future coverage. However, you may add coverage if you have experienced a Life Event with approved proof of good health.

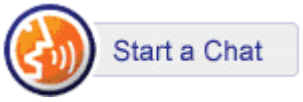
Flexible Spending Accounts Benefits: If you change the amount of your deposits during the year, claims from your Health Care Flexible Spending Account for eligible health care expenses incurred before the change are payable up to the original amount you elected to deposit. Claims for expenses incurred after the change are payable up to your newly elected deposit amount. You forfeit part of your balance when the deposits before your change are greater than your claims before the change and you reduce the amount you elect to deposit. Your Dependent Day Care Flexible Spending Account reimburses based on the deposits in your account at the time of the claim.

Remember, when you process a Life Event change, the change (if applicable) to your Flexible Spending Accounts is only valid for the remainder of the calendar year. If you process a Life Event change within the last 60 days of the year, there will not be time to process changes to your Flexible Spending Accounts for that year.

Benefit Coverages Not Affected by Life Events

The following benefits are not affected by Life Event changes, except as noted:

Medical Options: You may change medical options only if you relocate (see "Table of Life Events and Permitted Benefit Changes" on page 37). However, if you are enrolled in either the PPO-Copay, PPO-Deductible, Minimum Coverage, or Out-of-Area Option, you may not change from one of these options to another due to relocation, unless the option you were enrolled in previously is no longer available in your new location.



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Forms & guides can be located in the eHR Center of Jetnet at https://www.jetnet.aa.com/jetnet/go/ssoehr.asp?TargetDoc=XML=20

The Benefits Service Center is available at https://www.jetnet.aa.com/jetnet/go/ssomercer.asp

Medical Benefits Overview

The Company offers eligible employees the opportunity to elect medical coverage that provides protection for you and your covered dependents in the event of illness or injury. You may choose from several medical options offered to American Eagle employees, or you may waive coverage completely.

Some options may not be offered in all locations. During enrollment periods (as a new employee when you are first eligible for benefits, during the annual enrollment period), or if you experience a qualifying Life Event, the Benefits Service Center will reflect the options that are available to you.

- Out-of-Area Coverage, PPO-Deductible, PPO-Copay and the Minimum Coverage Options are self-funded by the Company. Your network and/or claims administrator administers these options; however, reimbursements for covered health care expenses are paid from the general assets of the Company, not by an insurance company.
- HMOs are insured options whose covered services are paid by the HMO. The Company pays a flat monthly premium and the HMO pays for all covered services. If you live in a location where an HMO is offered, it will be indicated as an option when you enroll online.
- You may waive coverage; however, your dependents cannot have coverage if you are not covered. You will not be able to file claims under a medical option of American Eagle Airlines and Its Affiliates if you waive coverage. You will not be able to enroll in coverage during the year unless you experience a qualified Life Event (see the "Table of Life Events and Permitted Benefit Changes" in the *Life Events* section).

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

Under the Out-of-Area Coverage you will receive the PPO in-network level of coverage. This benefit is offered to the Out-of-Area Coverage Option members because there is not a reasonable number of PPO providers within driving distance, as determined by your home zip code. If you live within a zip code that is covered by the PPO you will not be eligible for the Out-of-Area Coverage Option.

Refer to *General Eligibility* for details regarding eligibility for benefits, dependent coverage, and employees married to other employees.

Regardless of the medical coverage you select, you may take advantage of the Employee Assistance Program (EAP) offered by the Company (see *Employee Assistance Program* section for more information).

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In This Section

Key Features of the Medical Options

The following are key features of the Out-of-Area Coverage, PPO-Deductible, PPO-Copay, and Minimum Coverage Options. See "Covered Expenses" on page 78 for a list of specific covered expenses.

Medically necessary: Medical care is covered by the Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options when the care is medically necessary, is an Eligible Expense, and it is not excluded from coverage. The Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options also cover well-child care (up to age 2) and periodic mammograms. Under the PPO-Copay Option, the same medically necessary requirements apply. However, some services, such as routine physical exams and preventive care, are covered when you use a network provider. Please note that just because a physician orders a service does not mean the service is medically necessary.

Usual and prevailing fee limits: The amount of benefits paid for eligible expenses is based on the usual and prevailing fee limits for a particular service or supply in that geographic location. Because participating providers in the Preferred Provider Organization (PPO) network have agreed to discounted fees, the usual and prevailing fee limits do not apply to in-network services.

Individual annual deductible: Your annual deductible under the Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options is the amount of Eligible Expenses you must pay each year before your medical option coverage will start reimbursing you. After you satisfy the deductible, your selected medical option pays the appropriate percentage of the usual and prevailing fee limits for eligible covered medical services.

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

Refer to "Medical Benefit Options Comparison" on page 51 for more information regarding individual and family deductibles.

Claims: Participating PPO providers typically file claims for you; however, in some cases, you may be required to pay for services in advance and file a claim to receive reimbursement. You will need to file a claim if you receive services from an out-of-network provider or facility.

Annual out-of-pocket maximum: After you satisfy the annual out-of-pocket maximum for Eligible Expenses under the option you have selected for coverage, the medical option pays 100% of Eligible Expenses within usual and prevailing fee limits for the rest of the year.

- Under the Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options, all coinsurance amounts (except outpatient mental health care amounts and mail order prescription copayments) apply to the annual out-of-pocket maximum.
- For network services under the PPO-Deductible and PPO-Copay and Minimum Coverage Options, coinsurance amounts for hospital-based services apply to the annual network out-of-pocket maximum.
- Copayments and deductibles do not apply toward the annual network out-of-pocket maximum.

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CheckFirst: Under the Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options, you should contact your network and/or claims administrator to determine whether a proposed medical service is covered under the option (i.e., CheckFirst). If you are not using a network provider, you will also want to determine if the charges fall within the usual and prevailing fee limits. When you use a physician that participates in the PPO network, usual and prevailing fee limits do not apply because the PPO network provider has a contract fee arrangement with your network and/or claims administrator, and has agreed to accept this discounted contract fee as its billed fee. However, you may still need to use CheckFirst to determine whether the medical service is covered.*

QuickReview: Call for a QuickReview in the following situations:

- To pre-authorize (QuickReview) a surgery or hospitalization.
- If you are covered by the PPO-Deductible or PPO-Copay Option and are using out-of-network services, you must call your network and/or claims administrator to pre-authorize (QuickReview) any surgery or hospitalization.
- If you need emergency care, you should contact your network and/or claims administrator within 48 hours after you receive initial care to ensure you receive the network benefit level.

Injury by others: If someone else injures you and this Plan pays a benefit, the Company will recover payment from the third party. (This practice is known as *subrogation*, which is described in more detail under "Claims" in the *Plan Administration* section.)

Prescription drug benefits: The Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options cover medically necessary prescription drugs purchased at any retail pharmacy (e.g., Walgreen's, CVS, etc.) and offer discounted prescriptions at participating Express Scripts (formerly Medco) network pharmacies, including prescriptions for psychotherapeutic drugs.

The PPO-Deductible, PPO-Copay, Minimum Coverage and Out-of-Area Options cover medically necessary prescriptions with copayments or coinsurance when purchased at a participating retail pharmacy (up to a 30 day supply). When you visit a network pharmacy, it is important that you provide your insurance card to ensure that your out-of-pocket expenses are automatically applied to your prescription drug deductible. If you visit an out-of-network pharmacy, you must submit your receipts to your network and/or claims administrator to be reimbursed at the out-of-network benefit rate.

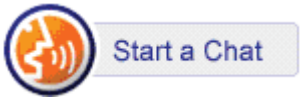
Prescription drugs covered by the Medical Options are described in "Covered Expenses" on page 78. Refer to "Prescription Drug Benefits" on page 85 for a description of the prescription drug benefit and to "Excluded Expenses" on page 90 for a list of drugs not covered by the medical options.

Medical Benefit Options Comparison

The following tables provide a summary of features under the Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options. Benefits are available for Eligible Expenses that are medically necessary and within the usual and prevailing fee limits for the Out-of-Area Coverage Option.

The tables show the amount or percentage you pay for Eligible Expenses, and you pay any amounts not covered by the options. If you are covered under Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options or you use out-of-network services or network hospital-based services under the PPO-Deductible or PPO-Copay or Minimum Coverage Options, you must satisfy any individual annual deductibles before the option pays benefits for Eligible Expenses.

* *The Annual Out-Of-Pocket Maximum does not include your annual deductible, expenses that are not covered or exceed the usual and prevailing fee limits and/or any copayments.*



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As you review the following Comparison of Options tables, please keep the following points in mind:

- The out-of-pocket maximum under the medical options applies to coinsurance amounts you pay (i.e., for hospital services, including inpatient and outpatient care and surgery). The out-of-pocket maximum does not include deductibles or copayment amounts, amounts not covered, amounts exceeding the usual and prevailing fee limits for the Out-of-Area Coverage.
- Visit your network and/or claims administrator website to determine if your physician is a network provider.

For information regarding eligible medical expenses and expenses that are excluded from coverage, refer to "Covered Expenses" on page 78 and "Excluded Expenses" on page 90.

PPO Deductible Option

Plan Features	In-Network	Out-of-Network
Deductibles/Maximums		
Individual Annual Deductible	$500	$1,000
Family Annual Deductible	$1,000	Not Applicable
Individual Annual Out-of-Pocket Maximum*	$2,000	$4,000
Preventive Care		
Annual Routine Physical Exam, including Well Woman Exam	Covered in network at 100%	Not Covered
Adult Immunizations	Covered in network at 100%	Not Covered
Pap Test	Covered in network at 100%	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)	Covered at 100% according to age guidelines, regardless of facility (deductible waived)	Not Covered
PSA screening and colorectal screening (according to age guidelines-routine coverage begins at age 50)	Covered in network at 100%	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)	Covered in network at 100%	Not Covered
Medical Services		
Primary Care Physician's Office Visit	20% coinsurance	40% coinsurance
Specialist Office Visit	20% coinsurance	40% coinsurance
Gynecological Care Visit	20% coinsurance	40% coinsurance if medically necessary

Plan Features	In-Network	Out-of-Network
Diagnostic Mammogram	20% coinsurance (if medically necessary); routine mammograms are covered according to specific guidelines - refer to Mammograms in "Covered Expenses" on page 78	40% coinsurance (if medically necessary); routine mammograms are covered according to specific guidelines - refer to Mammograms in "Covered Expenses" on page 78
Pregnancy - Physician Services	20% coinsurance	40% coinsurance
PSA and colorectal diagnostic exam	20% coinsurance	40% coinsurance
Second Surgical Opinion	20% coinsurance	40% coinsurance
Urgent Care Center Visit	20% coinsurance	40% coinsurance
Chiropractic Care Visit	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)
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance	40% coinsurance
Acupuncture: Medically necessary treatment (performed by a Certified Acupuncturist) only when acupuncture treatment has been proven both safe and effective treatment for such diagnosed illness or injury	20% coinsurance	40% coinsurance
Allergy Care	20% coinsurance	40% coinsurance
Diagnostic X-ray and Lab	20% coinsurance	40% coinsurance
Outpatient Services		
Outpatient Surgery in Physician's Office	20% coinsurance	40% coinsurance
Outpatient Surgery in a Hospital or Free Standing Surgical Facility	20% coinsurance	40% coinsurance
Pre-admission Testing	20% coinsurance	40% coinsurance
Hospital Services		
Inpatient Room and Board, including intensive care unit or special care unit	20% coinsurance	40% coinsurance
Ancillary services (including x-rays, pathology, operating room, and supplies)	20% coinsurance	40% coinsurance

Plan Features	In-Network	Out-of-Network
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	40% coinsurance
Inpatient Physician Services, Surgery, Anesthesia, and Medically Necessary Assistant Surgeon	20% coinsurance	40% coinsurance
Blood Transfusion	20% coinsurance	40% coinsurance
Organ Transplant	20% coinsurance	40% coinsurance
Emergency Ambulance	20% coinsurance	20% coinsurance
Emergency Room (hospital) Visit	20% coinsurance	20% 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)	40% coinsurance (max of 60 days per year in-network and out-of-network combined)
Home Health Care Visit	20% coinsurance	40% coinsurance
Home Infusion Therapy	20% coinsurance	40% coinsurance
Hospice Care	20% coinsurance	40% coinsurance
Other Services		
Tubal Ligation or Vasectomy (reversals are not covered)	20% coinsurance	40% coinsurance
Infertility Treatment	Not Covered	Not Covered
Radiation Therapy	20% coinsurance	40% coinsurance
Chemotherapy	20% coinsurance	40% coinsurance
Kidney Dialysis (if the dialysis continues more than 12 months, participants must apply for Medicare)	20% coinsurance	40% coinsurance
Supplies, Equipment, and Durable Medical Equipment (DME)	20% coinsurance	40% coinsurance
Mental Health and Chemical Dependency		
Inpatient Mental Health Care	20% coinsurance	40% coinsurance
Alternative Mental Health Center	20% coinsurance	40% coinsurance
Outpatient Mental Health Care Visit	20% coinsurance	40% coinsurance
Marriage Counseling	Not Covered	Not Covered
Detoxification (see details under "Covered Expenses" on page 78)	20% coinsurance	40% coinsurance
Chemical Dependency	20% coinsurance	40% coinsurance
Inpatient Chemical Dependency Rehabilitation	20% coinsurance	40% coinsurance

Plan Features	In-Network	Out-of-Network
Outpatient Chemical Dependency Rehabilitation	20% coinsurance	40% coinsurance
Prescription Medications		
Retail Pharmacy* (up to a 30 day supply)	Retail Card Program ▪ Generic:20% ($10 Min/$50 Max) ▪ Formulary Brand: (no generic available) 30% ($35 Min/$100 Max) **If you select a brand-name drug (formulary or non-formulary) when a generic is available, you will pay the 20% generic co-insurance, plus the cost difference between the generic and brand prices. Maximums do not apply.** ▪ Non-Formulary Brand: (if generic available) 50% ($50 Min/$125 Max)	Express Scripts (formerly Medco) 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) ▪ Formulary Brand: (no generic available) 30% ($75 Min/$200 Max) **If you select a brand-name drug (formulary or non-formulary) when a generic is available, you will pay the 20% generic co-insurance, plus the cost difference between the generic and brand prices. Maximums do not apply.** ▪ Non-Formulary Brand: (if generic available) 50% ($125Min/$275 Max)	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.	Member pays 100% of cost for maintenance drugs starting with 4th fill at retail	Not Applicable

Plan Features	In-Network	Out-of-Network
Oral Contraceptives (available only thru mail service)	Generic oral contraceptives, transdermal and intravaginal contraceptives are covered by mail only at 100% with no co-pay or co-insurance. If a brand contraceptive has a generic equivalent, you will be responsible for the cost difference between the generic and brand prices.	Not Covered
Over-The-Counter Medication	Not Covered	Not Covered
Other Information		
CHECKFIRST (predetermination of benefits via your network/claim administrator)	Call BCBS for a form, complete and mail	Call BCBS for a form, complete and mail

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

Disclaimer: If the provisions in the preceding summary chart differ from the other descriptions in this EBG, the EBG descriptions outside of the summary chart will prevail.

PPO Copay Option

Plan Features	In-Network	Out of Network
Deductibles/Maximums		
Individual Annual Deductible	$250	$750
Family Annual Deductible	$750	Not Applicable
Individual Annual Out-of-Pocket Maximum*	$2,000	$4,000
Preventive Care		
Annual Routine Physical Exam, including Well Woman Exam	Covered in network at 100%	Not Covered
Adult Immunizations	Covered in network at 100%	Not Covered
Pap Test	Covered in network at 100%	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)	Covered in network at 100%	Not Covered
PSA screening and colorectal screening (according to age guidelines-routine coverage begins at age 50)	Covered in network at 100%	Not Covered

Plan Features	In-Network	Out of Network
Well Child office visits and immunizations (Birth to age 18, Initial hospitalization, all immunizations up to 7 well child visits, birth to age 2)	Covered in network at 100%	Not Covered
Medical Services		
Primary Care Physician's Office Visit	$20 copayment*	40% coinsurance
Specialist Office Visit	$35 copayment*	40% coinsurance
Gynecological Care Visit	$20 copayment*	40% coinsurance if medically necessary
Diagnostic Mammogram	No cost if part of office visit or at an independent facility; 20% coinsurance if hospital outpatient	40% coinsurance (if medically necessary); routine mammograms are covered according to specific guidelines - refer to Mammograms in "Covered Expenses" on page 78
Pregnancy - Physician Services	$35 copayment* per visit $350 max copayment* per Pregnancy (includes prenatal/postnatal/delivery, hospital charges are the same as any hospitalization)	40% coinsurance
PSA and colorectal diagnostic exam	20% coinsurance	40% coinsurance
Second Surgical Opinion	$20 copay* PCP $35 copay* Specialist	40% coinsurance
Urgent Care Center Visit	$35 copayment*	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	40% coinsurance
Chiropractic Care Visit	$35 copayment* (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	$35 copayment* per visit (max copayment* of $350 per person per year)	40% coinsurance

Plan Features	In-Network	Out of Network
Acupuncture: Medically necessary treatment (performed by a Certified Acupuncturist) only when acupuncture treatment has been proven both safe and effective treatment for such diagnosed illness or injury	20% coinsurance	40% coinsurance
Allergy Care	$35 copayment* per visit (max copayment of $350 per person per year)	40% coinsurance
Diagnostic X-ray and Lab	20% coinsurance (if performed at a hospital. No cost if performed in physician's office or a network lab/radiology center)	40% coinsurance
Outpatient Services		
Outpatient Surgery in Physician's Office	$20 copay* PCP $35 copay* Specialist	40% coinsurance
Outpatient Surgery in a Hospital or Free Standing Surgical Facility	20% coinsurance	40% coinsurance
Pre-admission Testing	20% coinsurance	40% coinsurance
Hospital Services		
Inpatient Room and Board, including intensive care unit or special care unit	20% coinsurance for all hospital based services	40% coinsurance
Ancillary services (including x-rays, pathology, operating room, and supplies)	20% coinsurance for all hospital based services for all hospital based services	40% coinsurance
Inpatient Physician Services, Surgery, Anesthesia, and Medically Necessary Assistant Surgeon	20% coinsurance for inpatient hospital services	40% coinsurance
Blood Transfusion	20% coinsurance if performed at a hospital. No cost if performed in physician's office	40% coinsurance
Organ Transplant	20% coinsurance for inpatient hospital services	40% coinsurance
Emergency Ambulance	No Cost	20% coinsurance
Emergency Room (hospital) Visit	$200 copayment* (Waived if admitted to the hospital)	$200 copayment* (Waived if admitted to the hospital)

Plan Features	In-Network	Out of Network
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)	40% coinsurance (max of 60 days per year in-network and out-of-network combined)
Home Health Care Visit	$20 copayment*/day	40% coinsurance
Home Infusion Therapy	$20 copayment*/day	40% coinsurance
Hospice Care	20% coinsurance if performed at a hospital; $20 copayment* per day if home care	40% coinsurance
Other Services		
Tubal Ligation or Vasectomy (reversals are not covered)	$20 copay* PCP $35 copay* Specialist 20% coinsurance in hospital or freestanding surgical center	40% coinsurance
Infertility Treatment	Not Covered	Not Covered
Radiation Therapy	No cost if performed in a physician's office; 20% coinsurance if performed in a hospital; home health care $20 copay*/day if performed in a home setting	40% coinsurance
Chemotherapy	20% coinsurance if performed in a hospital or freestanding facility - $35 copay* if performed in a physician's office	40% coinsurance
Kidney Dialysis (if the dialysis continues more than 12 months, participants must apply for Medicare)	No cost if performed in a physician's office; 20% coinsurance if performed in a hospital or dialysis center	40% coinsurance
Supplies, Equipment, and Durable Medical Equipment (DME)	20% coinsurance for items rented or purchased from an in-network provider	40% coinsurance
Mental Health and Chemical Dependency		
Inpatient Mental Health Care	20% coinsurance for all hospital based services	40% coinsurance
Alternative Mental Health Center	20% coinsurance for all hospital based services	40% coinsurance
Outpatient Mental Health Care Visit	$35 copayment*	40% coinsurance
Marriage Counseling	Not Covered	Not Covered
Detoxification (see details under "Covered Expenses" on page 78)	20% coinsurance	40% coinsurance

Plan Features	In-Network	Out of Network
Chemical Dependency	20% coinsurance	40% coinsurance
Inpatient Chemical Dependency Rehabilitation	20% coinsurance	40% coinsurance
Outpatient Chemical Dependency Rehabilitation	$35 copayment*	40% coinsurance
Prescription Medications		
Retail Pharmacy* (up to a 30 day supply)	Retail Card Program ▪ Generic:20% ($10 Min/$50 Max) ▪ Formulary Brand: (no generic available) 30% ($35 Min/$100 Max) **If you select a brand-name drug (formulary or non-formulary) when a generic is available, you will pay the 20% generic co-insurance, plus the cost difference between the generic and brand prices. Maximums do not apply.** ▪ Non-Formulary Brand: (if generic available) 50% ($50 Min/$125 Max)	Express Scripts 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) ▪ Formulary Brand: (no generic available) 30% ($75 Min/$200 Max) **If you select a brand-name drug (formulary or non-formulary) when a generic is available, you will pay the 20% generic co-insurance, plus the cost difference between the generic and brand prices. Maximums do not apply.** ▪ Non-Formulary Brand: (if generic available) 50% ($125Min/$275 Max)	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.	Member pays 100% of cost for maintenance drugs starting with 4th fill at retail	Not Applicable

Plan Features	In-Network	Out of Network
Oral Contraceptives (available only thru mail service)	Generic oral contraceptives, transdermal and intravaginal contraceptives are covered by mail only at 100% with no co-pay or co-insurance. If a brand contraceptive has a generic equivalent, you will be responsible for the cost difference between the generic and brand prices.	Not Covered
Over-The-Counter Medication	Not Covered	Not Covered
Other Information		
CHECKFIRST (predetermination of benefits via your network/claim administrator)	Call BCBS for a form, complete and mail	Call BCBS for a form, complete and mail

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

Disclaimer: If the provisions in the preceding summary chart differ from the other descriptions in this EBG, the EBG descriptions outside of the summary chart will prevail.

Out of Area Coverage Option

Plan Features	Out-of-Area Coverage
Deductibles/Maximums	
Individual Annual Deductible	$500
Family Annual Deductible	$1,000
Individual Annual Out-of-Pocket Maximum*	$2,000
Preventive Care	
Annual Routine Physical Exam, including Well Woman Exam	Covered in network at 100%
Adult Immunizations	Covered in network at 100%
Pap Test	Covered in network at 100%
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)	Covered in network 100%
PSA screening and colorectal screening (according to age guidelines-routine coverage begins at age 50)	Covered in network at 100%

Plan Features	Out-of-Area Coverage
Well Child office visits and immunizations (Birth to age 18, Initial hospitalization, all immunizations up to 7 well child visits, birth to age 2)	Covered in network at 100%
Medical Services	
Primary Care Physician's Office Visit	20% coinsurance
Specialist Office Visit	20% coinsurance
Gynecological Care Visit	20% coinsurance
Diagnostic Mammogram	20% coinsurance (if medically necessary); routine mammograms are covered according to specific guidelines - refer to Mammograms in "Covered Expenses" on page 78
Pregnancy - Physician Services	20% coinsurance
PSA and colorectal diagnostic exam	20% coinsurance
Second Surgical Opinion	20% coinsurance
Urgent Care Center Visit	20% coinsurance
Chiropractic Care Visit	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance
Acupuncture: Medically necessary treatment (performed by a Certified Acupuncturist) only when acupuncture treatment has been proven both safe and effective treatment for such diagnosed illness or injury	20% coinsurance
Allergy Care	20% coinsurance
Diagnostic X-ray and Lab	20% coinsurance
Outpatient Services	
Outpatient Surgery in Physician's Office	20% coinsurance
Outpatient Surgery in a Hospital or Free Standing Surgical Facility	20% coinsurance
Pre-admission Testing	20% coinsurance
Hospital Services	

Plan Features	Out-of-Area Coverage
Inpatient Room and Board, including intensive care unit or special care unit	20% coinsurance
Ancillary services (including x-rays, pathology, operating room, and supplies)	20% 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
Inpatient Physician Services, Surgery, Anesthesia, and Medically Necessary Assistant Surgeon	20% coinsurance
Blood Transfusion	20% coinsurance
Organ Transplant	20% coinsurance
Emergency Ambulance	20% coinsurance
Emergency Room (hospital) Visit	20% 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)
Home Health Care Visit	20% coinsurance
Home Infusion Therapy	20% coinsurance
Hospice Care	20% coinsurance
Other Services	
Tubal Ligation or Vasectomy (reversals are not covered)	20% coinsurance
Infertility Treatment	Not Covered
Radiation Therapy	20% coinsurance
Chemotherapy	20% coinsurance
Kidney Dialysis (if the dialysis continues more than 12 months, participants must apply for Medicare)	20% coinsurance
Supplies, Equipment, and Durable Medical Equipment (DME)	20% coinsurance
Mental Health and Chemical Dependency	
Inpatient Mental Health Care	20% coinsurance
Alternative Mental Health Center	20% coinsurance

Plan Features	Out-of-Area Coverage
Outpatient Mental Health Care Visit	20% coinsurance
Marriage Counseling	Not Covered
Detoxification (see details under "Covered Expenses" on page 78)	20% coinsurance
Chemical Dependency	20% coinsurance
Inpatient Chemical Dependency Rehabilitation	20% coinsurance
Outpatient Chemical Dependency Rehabilitation	20% coinsurance
Prescription Medications	
Retail Pharmacy* (up to a 30 day supply)	Retail Card Program ▪ Generic:20% ($10 Min/$50 Max) ▪ Formulary Brand: (no generic available) 30% ($35 Min/$100 Max) **If you select a brand-name drug (formulary or non-formulary) when a generic is available, you will pay the 20% generic co-insurance, plus the cost difference between the generic and brand prices. Maximums do not apply.** ▪ Non-Formulary Brand: (if generic available) 50% ($50 Min/$125 Max)
Mail Service Pharmacy* (up to a 90 day supply)	▪ Generic: 20% ($25 Min/$125 Max) ▪ Formulary Brand: (no generic available) 30% ($75 Min/$200 Max) **If you select a brand-name drug (formulary or non-formulary) when a generic is available, you will pay the 20% generic co-insurance, plus the cost difference between the generic and brand prices. Maximums do not apply.** ▪ Non-Formulary Brand: (if generic available) 50% ($125Min/$275 Max)
Retail Service Pharmacy* (up to a 90 day supply) For Long-Term medications (taken for 3 months or more) beginning with 4th fill.	Member pays 100% of cost for maintenance drugs starting with 4th fill at retail
Oral Contraceptives (available only thru mail service)	Generic oral contraceptives, transdermal and intravaginal contraceptives are covered by mail only at 100% with no co-pay or co-insurance. If a brand contraceptive has a generic equivalent, you will be responsible for the cost difference between the generic and brand prices.
Over-The-Counter Medication	Not Covered
Other Information	
CHECKFIRST (predetermination of benefits via your network/claim administrator)	Call BCBS for a form, complete and mail

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

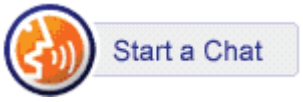
Disclaimer: If the provisions in the preceding summary chart differ from the other descriptions in this EBG, the EBG descriptions outside of the summary chart will prevail.

Minimum Coverage Option

Plan Features	In-Network	Out-of-Network
Deductibles/Maximums		
Individual Annual Deductible	$1,000	$2,000
Family Annual Deductible	$2,000	$4,000
Individual Annual Out-of-Pocket Maximum*	$3,000	$5,000
Preventive Care		
Annual Routine Physical Exam, including Well Woman Exam	Covered in network at 100%	Not Covered
Adult Immunizations	Covered in network at 100%	Not Covered
Pap Test	Covered in network at 100%	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)	Covered in network at 100%	Not Covered
PSA screening and colorectal screening (according to age guidelines-routine coverage begins at age 50)	Covered in network at 100%	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)	Covered in network at 100%	Not Covered
Medical Services		
Primary Care Physician's Office Visit	20% coinsurance	40% coinsurance
Specialist Office Visit	20% coinsurance	40% coinsurance
Gynecological Care Visit	20% coinsurance	40% coinsurance
Diagnostic Mammogram	20% coinsurance (if medically necessary); routine mammograms are covered according to specific guidelines - refer to Mammograms in "Covered Expenses" on page 78	40% coinsurance (if medically necessary); routine mammograms are covered according to specific guidelines - refer to Mammograms in "Covered Expenses" on page 78
Pregnancy - Physician Services	20% coinsurance	40% coinsurance
PSA and colorectal diagnostic exam	20% coinsurance	40% coinsurance
Second Surgical Opinion	20% coinsurance	40% coinsurance
Urgent Care Center Visit	20% coinsurance	40% coinsurance

Plan Features	In-Network	Out-of-Network
Chiropractic Care Visit	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)
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance	40% coinsurance
Acupuncture: Medically necessary treatment (performed by a Certified Acupuncturist) only when acupuncture treatment has been proven both safe and effective treatment for such diagnosed illness or injury	20% coinsurance	40% coinsurance
Allergy Care	20% coinsurance	40% coinsurance
Diagnostic X-ray and Lab	20% coinsurance	40% coinsurance
Outpatient Services		
Outpatient Surgery in Physician's Office	20% coinsurance	40% coinsurance
Outpatient Surgery in a Hospital or Free Standing Surgical Facility	20% coinsurance	40% coinsurance
Pre-admission Testing	20% coinsurance	40% coinsurance
Hospital Services		
Inpatient Room and Board, including intensive care unit or special care unit	20% coinsurance	40% coinsurance
Ancillary services (including x-rays, pathology, operating room, and supplies)	20% coinsurance	40% coinsurance
Inpatient Physician Services, Surgery, Anesthesia, and Medically Necessary Assistant Surgeon	20% coinsurance	40% coinsurance
Blood Transfusion	20% coinsurance	40% coinsurance
Organ Transplant	20% coinsurance	40% coinsurance
Emergency Ambulance	20% coinsurance	20% coinsurance
Emergency Room (hospital) Visit	20% coinsurance	20% 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)	40% coinsurance (max of 60 days per year in-network and out-of-network combined)
Home Health Care Visit	20% coinsurance	40% coinsurance

Plan Features	In-Network	Out-of-Network
Home Infusion Therapy	20% coinsurance	40% coinsurance
Hospice Care	20% coinsurance	40% coinsurance
Other Services		
Tubal Ligation or Vasectomy (reversals are not covered)	20% coinsurance	40% coinsurance
Infertility Treatment	Not Covered	Not Covered
Radiation Therapy	20% coinsurance	40% coinsurance
Chemotherapy	20% coinsurance	40% coinsurance
Kidney Dialysis (if the dialysis continues more than 12 months, participants must apply for Medicare)	20% coinsurance	40% coinsurance
Supplies, Equipment, and Durable Medical Equipment (DME)	20% coinsurance	40% coinsurance
Mental Health and Chemical Dependency		
Inpatient Mental Health Care	20% coinsurance	40% coinsurance
Alternative Mental Health Center	20% coinsurance	40% coinsurance
Outpatient Mental Health Care Visit	20% coinsurance	40% coinsurance
Marriage Counseling	Not Covered	Not Covered
Detoxification (see details under "Covered Expenses" on page 78)	20% coinsurance	40% coinsurance
Chemical Dependency	20% coinsurance	40% coinsurance
Inpatient Chemical Dependency Rehabilitation	20% coinsurance	40% coinsurance
Outpatient Chemical Dependency Rehabilitation	20% coinsurance	40% coinsurance
Prescription Medications		
Retail Pharmacy* (up to a 30 day supply)	Retail Card Program ▪ Generic:20% ($10 Min/$50 Max) ▪ Formulary Brand: (no generic available) 30% ($35 Min/$100 Max) **If you select a brand-name drug (formulary or non-formulary) when a generic is available, you will pay the 20% generic co-insurance, plus the cost difference between the generic and brand prices. Maximums do not apply.** ▪ Non-Formulary Brand: (if generic available) 50% ($50 Min/$125 Max)	Express Scripts will reimburse the amount the drug would have cost at a network pharmacy (less copayment amount)



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Plan Features	In-Network	Out-of-Network
Mail Service Pharmacy* (up to a 90 day supply)	▪ Generic: 20% ($25 Min/$125 Max) ▪ Formulary Brand: (no generic available) 30% ($75 Min/$200 Max) **If you select a brand-name drug (formulary or non-formulary) when a generic is available, you will pay the 20% generic co-insurance, plus the cost difference between the generic and brand prices. Maximums do not apply.** ▪ Non-Formulary Brand: (if generic available) 50% ($125Min/$275 Max)	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.	Member pays 100% of cost for maintenance drugs starting with 4th fill at retail	Not Applicable
Oral Contraceptives (available only thru mail service)	Generic oral contraceptives, transdermal and intravaginal contraceptives are covered by mail only at 100% with no co-pay or co-insurance. If a brand contraceptive has a generic equivalent, you will be responsible for the cost difference between the generic and brand prices.	Not Covered
Over-The-Counter Medication	Not Covered	Not Covered
Other Information		
CHECKFIRST (predetermination of benefits via your network/claim administrator)	Call BCBS for a form, complete and mail	Call BCBS for a form, complete and mail

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

Disclaimer: If the provisions in the preceding summary chart differ from the other descriptions in this EBG, the EBG descriptions outside of the summary chart will prevail.

Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options

How the Medical Options Work

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

Under the Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options, you are required to satisfy an annual deductible before the plan begins paying a percentage of the eligible, medically necessary expenses. The Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options allow you to use any qualified licensed physician. When you use a network provider under the Out-of-Area Coverage Option, you save and the company saves. See "Special Provisions," below for information regarding physicians, hospitals, and other medic al service providers that have agreed to charge discounted fees for medical services.

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. 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."

After meeting the annual deductible under the Out-of-Area Coverage and in-network under the PPO-Deductible and Minimum Coverage Options, the plan pays 80% of most eligible expenses for most medically necessary services. Your coinsurance is 20%. When using a non-network provider under the PPO-Deductible and Minimum Coverage Options, the plan pays 60% of most eligible expenses for most medically necessary services and your coinsurance is 40%. After you meet the annual out-of-pocket maximum, eligible medical services are covered at 100% for the remainder of the year.

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

For a detailed explanation of the eligible expenses and exclusions under the Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options, see "Covered Expenses" on page 78 and "Excluded Expenses" on page 90.

Special Provisions

The Out-of-Area Coverage, Minimum Coverage, and PPO-Deductible Options include the following special features:

Deductibles: You pay an annual $500 per person deductible under the Out-of-Area Coverage option with a family deductible of $1000. Under the PPO-Deductible option, you pay an annual $500 per person, $1000 family deductible for network services and an annual $1000 per person deductible for services received by out-of-network providers. Under the Minimum Coverage option, you pay an annual deductible of $1,000 per person or $2,000 per family for network services and an annual deductible of $2,000 per person or $4,000 per family for services received by out-of-network providers. Under the PPO Copay Option you pay an annual $250 per person, $750 family deductible for network services and an annual $750 per person deductible for services received by out-of-network providers.

Filing Claims: In most cases, when you use network providers they file claims for you.

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

Medical Discount Program: The medical options offer a voluntary preferred provider organization (PPO), which is a network of physicians, hospitals, and other medical service providers that have agreed to charge discounted fees for medical services. The Medical Discount Program helps save you and the Company money when you or a covered dependent needs medical care and chooses a participating provider.

This discount is automatic when you present your medical option ID card to a PPO provider, even if you are enrolled in the Out-of-Area Coverage Option. PPO network providers who contract with your network and/or claims administrator agree to provide services and supplies at discounted rates. When you use a network provider, you are not responsible for the difference between the amount charged by the network provider and the amount allowed by their contractual agreement with your network and/or claims administrator. Please keep in mind that some providers charge more than others for the same services. For this reason, using a participating provider may not always be the least expensive alternative. However, you will always receive a discount off that provider's normal fees.

In addition to the fee discounts from PPO providers, you receive another advantage. In most cases, you pay nothing to the physician at the time of service and the physician's office files your claim for you. You receive a bill for only the remaining amount that you are responsible for paying, such as your deductible or coinsurance amounts.

Contact your network and/or claims administrator to learn more details about this Medical Discount Program feature or go to your network and/or claims administrator's website for a list of PPO providers in your area. Because these network providers may change, you should confirm that your physician is part of the network whenever you make an appointment.

Please keep in mind the following situations when using PPO providers:

- If you go to a PPO hospital but receive services from a physician who is not a PPO provider, you receive the PPO discount for hospital charges, but the physician's fee is not eligible for the discount.
- If you use a PPO physician or hospital, charges for your lab services may not be eligible for the PPO discount if your physician or hospital uses a lab that is not part of the PPO network.
- Whenever possible, be sure to check with your provider in advance to ensure you receive the maximum discount.

Out-of-Network Services

- Under the Minimum Coverage and PPO Deductible Options, if you go to a provider who is not part of the network, you are still covered for eligible medically necessary services; however, coverage is at a lower level of benefits (out-of-network benefit level).
- At the out-of-network benefit level, you pay an annual per person per year deductible and higher out-of-pocket coinsurance amounts – for most services, the plan pays 60% and you pay the remaining 40% of covered out-of-network charges, after you satisfy the annual per person deductible. Additionally, you must pay any amount of the provider's billed fee that exceeds the Usual and Prevailing Fee Limit. Each time you or your covered dependent needs medical care, you choose whether to use a network or out-of-network provider.

Preventive care:

- Under the Minimum Coverage and PPO Deductible Options, in-network preventive care will be covered at 100%, without having to meet the annual deductible. (See "Medical Benefit Options Comparison" on page 51 for details).
- Under the Out-of-Area Coverage Option preventive care will be covered at 100% in-network or out-of-network, without having to meet the annual deductible. (See "Medical Benefit Options Comparison" on page 51 for details).

PPO-Copay Option

How the PPO-Copay Option Works

The PPO-Copay Option offers a network of physicians and hospitals that have agreed to provide medical services to participants at preferred rates. Check the location of network providers if you are considering enrolling in the PPO-Copay Option to be sure there are network providers near where you live or within a comfortable distance.

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

If 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 Primary Care Physician copayment rate will apply.

If you go to a provider who is not part of the network, you are still covered for eligible, medically necessary services, but at a lower level of benefits, called the out-of-network benefit level. At the out-of-network benefit level, you pay a deductible and higher out-of-pocket amounts. For most out-of-network services, the plan pays 60% and you pay the remaining 40% after you satisfy the deductible.

Advantages of the PPO-Copay Option include:

- Access to network providers wherever your network and/or claims administrator has a network location. For a list of network providers, visit your network and/or claims administrator's website to determine if your physician is in the network
- You can seek network specialist care without a referral from your Primary Care Physician (PCP); however, you are still encouraged to have a PCP coordinate all your medical needs
- Greater benefits and lower out-of-pocket costs when you use network providers.
- Covered preventive care from network providers.

If you live in a location where the PPO-Copay Option is offered, this option will be listed as an option in your Benefits Service Center on Jetnet. Eligibility for the PPO-Copay Option is determined using your network and/or claims administrator's standard access requirements based on your five-digit home ZIP code.

For a detailed explanation of the Eligible Expenses and exclusions under the PPO-Copay Option refer to the "Medical Benefit Options Comparison" on page 51, "Covered Expenses" on page 78 and "Excluded Expenses" on page 90.

In this section, the PPO-Copay Option may also be referred to as the "Plan".

Network Services

You may use physicians and other service providers who are part of the network, or you may use providers who are not part of the network (out-of-network). However, when you use network providers, you receive a higher level of benefits, (network benefit level).

Network providers who contract with your network and/or claims administrator agree to provide services and supplies at discounted rates. When you use a network provider, you are not responsible for the difference between the amount charged by the network provider and the amount allowed by their contractual agreement with your network and/or claims administrator.

Out-of-Network Services

If you go to a provider who is not part of the network, you are still covered for eligible medically necessary services; however, coverage is at a lower level of benefits (out-of-network benefit level).

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

For additional information regarding deductibles, see under "Special Provisions," below.

Primary Care Physicians

PCPs practice in pediatrics, family practice, general practice, or internal medicine. You are encouraged to establish a relationship with a PCP.

Specialist Care

To receive the network benefit level for care from a specialist, you do not need a referral from your PCP, but you must use a network specialist, and services must be eligible under the terms of the Plan. To receive the network level of benefits for mental health services, you must contact your network and/or claims administrator.

If you need the care of a specialist and the network in your area does not offer providers in that specialty, you should contact your PCP or your network and/or claims administrator to determine if a referral to an out-of-network specialist is needed. In these *rare* instances, your out-of-network care is covered at the network benefit level, but only with prior approval through your network and/or claims administrator.

After you have enrolled, you will receive a PPO-Copay Option ID card from your network and/or claims administrator indicating that you and your covered dependents are covered by the Plan. The ID card includes important phone numbers and should be presented each time you go to a network physician, other provider, or hospital.

Special Provisions

The following are some of the important features of the PPO-Copay Option.

Care while traveling: If you have a medical emergency while traveling, get medical attention immediately. If you need urgent (not emergency) care, you should call your network and/or claims administrator for a list of network providers and urgent care facilities. However, if it is after hours, seek treatment but call your network and/or claims administrator within 48 hours. If you go to a network provider, you should only have to pay your copayment or coinsurance and your claim should be filed for you.

If you go to an out-of-network provider, you or a family member will need to call your network and/or claims administrator within 48 hours of your care. You will need to submit a claim, but are eligible for the network level of benefits if you follow these procedures.

Continuing care: In the event you are newly enrolled in the PPO-Copay Option, and you or a covered family member has a serious illness, or you or your spouse are in the 20th (or later) week of pregnancy, you may ask your network and/or claims administrator to evaluate your need for continuing care. You may be eligible to continue with your current care provider at the network benefit level, even if that provider is not part of the network. Contact your network and/or claims administrator for more information.

Copayments vs. coinsurance: What you pay for eligible medical services depends on where you receive those services. At the network benefit level, you pay a fixed copayment for services such as physician office and specialist visits, including any tests or treatment received during that visit.

For services received in a network hospital-based setting, you pay a 20% coinsurance (a percentage of the cost) after satisfying your in-network deductible. For eligible out-of-network services, you must first satisfy an annual per person deductible, and then you pay the higher out-of-network coinsurance amount.

Deductibles: For eligible in-network services, you pay an annual per person deductible and for eligible out-of-network services (including but not limited to hospital-based services), you pay an annual per person deductible.

Emergency care: If you have a medical emergency, go directly to an emergency facility. You or a family member must call your network and/or claims administrator within 48 hours of your emergency care to be eligible for the network benefit level. You should arrange any follow-up treatment through your physician. If you receive services at an out-of-network facility, you will need to submit a claim.

Filing Claims: In most cases, when you use network providers, they file your claims for you.

Hospital out-of-pocket maximum: You pay 20% coinsurance for network hospital-based services up to an annual out-of-pocket maximum of $2,000 per covered person per year after you satisfy the annual deductible. Hospital-based services include: hospital facility charges, free-standing surgical facilities, physician charges, room and board, diagnostic testing, x-ray and lab fees, anesthesia, dialysis, chemotherapy, MRIs, and mammograms.

Copayments for network office visits, prescription drug copayments and coinsurance, out-of network deductibles, and non-hospital network coinsurance amounts[1] do not apply to the annual out-of-pocket maximum.

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

Leaving the service area: With the exception of the annual enrollment period, the only other time you may change your election for coverage under the PPO-Copay Option is if you relocate out of your network service area.

If you move out of your PPO-Copay Option's network service area, you may either stay enrolled in the PPO-Copay Option (if available in your new location), select another medical plan available in your new location or, you may waive coverage. You must contact HR Services to process a relocation Life Event within 60 days of the event. This allows you to update your records and make a new benefits coverage selection, if applicable. If you do not notify HR Services of your election, you will be enrolled in a plan offered in your new location. (See "Default Coverage" in the *General Enrollment* section.)

Network administrator: Your network and/or claims administrator establishes standards for participating providers, including physicians, hospitals, and other service providers. They carefully screen providers and verify their medical licenses, board certifications, hospital admitting privileges, and medical practice records. They also periodically monitor whether participating providers continue to meet network standards. The network administrator performs all these selection and accreditation activities.

When you use network providers, you receive a higher level of benefits, called in-network benefits.

Preventive care: You and each covered family member are eligible to receive benefits for annual routine physical exams, well-woman exams, and well-child exams provided by your network PCP or a network obstetrician/gynecologist.

Special health programs: In addition to the coverage available to all PPO-Copay Option participants, many of the network locations offer special programs. Although these programs may vary by network location, examples of special programs include `wellness, disease management, and pre-natal. Not all of these are available in each network. Call your network and/or claims administrator for information.

Urgent care: If you are in your network service area and need urgent care, but you do not have an actual emergency, contact your network and/or claims administrator first and they will direct you to an appropriate place for care. You are eligible for the network benefit level if you follow these procedures.

Health Maintenance Organizations (HMOs)

HMOs are insured programs whose covered services are paid by the HMO. Both Triple S and Humana Health Maintenance Organizations (HMO) are offered to employees living in Puerto Rico, Triple S is offered to employees living in the U.S. Virgin Islands

HMOs include a network of physicians, hospitals, and other medical service providers. Your medical care is only covered when you use network providers. When you enroll in an HMO, a primary care physician (PCP) usually coordinates your medical care. Most HMOs require you to obtain a referral from your PCP before receiving care from a specialist.

Features of HMOs include:

- A network of providers
- A primary care physician who coordinates your covered medical care
- Low copayments for covered services
- Covered preventive care
- No claims to file

If you elect an HMO, your HMO coverage replaces medical coverage offered through the Out-of-Area Coverage, Minimum Coverage PPO-Deductible and PPO-Copay Options. Your benefits, including prescription drugs from physicians and dentists, as well as mental health care, are covered according to the rules of the HMO you select. For example, some HMOs do not cover dental prescriptions.

Under most HMOs, chemical dependency rehabilitation for HMO participants will be coordinated by the Employee Assistance Program (EAP), and will be covered as described in "Covered Expenses" on page 78. However, some HMOs provide their own chemical dependency rehabilitation programs to comply with state insurance laws. Detoxification is covered under the HMO.

HMOs provide their members with comprehensive health care services for a fixed monthly payment.

HMOs offered through the benefit program are completely independent of the Company. Because each HMO is an independent organization, the benefits, restrictions, and conditions of coverage vary from one HMO to another and the Company cannot influence or dictate the coverage provided.

Under the Eagle Plan, Company-recognized Domestic Partners of employee participants of American Eagle Airlines, Inc. and Its Affiliates will be eligible to be covered under the Humana Puerto Rico and Triple S HMOs.

Benefits

If you enroll in an HMO, you will receive information from the HMO describing the services and exclusions of that HMO. Review that material carefully. Benefits provided by the HMO often differ from benefits provided under the other medical plans offered by the Company.

Most of your other elections are not affected by your decision to participate in an HMO.

HMO Contact Information

HMO Name	HMO Customer Service Phone No.	Website Address	Group Numbers
Humana Puerto Rico	1-787-282-7900 ext. 5500	http://www.pr.humana.com/	3262
TRIPLE-S, Inc – Puerto Rico	1-787-749-4777	http://www.ssspr.com/	1-08500

Additional Rules for HMOs

Grandfathered Status for Certain Medical Benefit Options

This Group Health and Welfare Benefits Plan for Employees of American Eagle Airlines and Its Affiliates believes the Humana of Puerto Rico Health Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the medical option listed above may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator, see contact numbers in open enrollment material or plan documents. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or http://www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Problems and Complaints

Each HMO has a grievance procedure or policy to appeal claim denials or other issues involving the HMO. Call your HMO for information on filing complaints or grievances.

If You and Your Spouse Work for the Company

If you and your spouse enroll in the same HMO, the entire family unit is covered in the male employee's name because of HMO administrative procedures. If the male spouse takes a Leave of Absence (LOA), coverage for the entire family unit is transferred to the female spouse for the duration of the leave.

Children Living Outside the Service Area

If your child does not live with you, either because the child is a student or because you are providing the child's coverage under a Qualified Medical Child Support Order (QMCSO) (see "Qualified Medical Child Support Order" in the *Additional Health Benefit Rules* section), you must contact the HMO to find out whether the child can be covered. If the HMO cannot cover the child, you may be required to select one of the other medical options.

Termination of Coverage

Your HMO coverage terminates on the date your employment terminates or you move out of the HMO service area. If your employment terminates, you may be eligible to continue HMO coverage under COBRA. You may also apply for individual HMO coverage.

Following is special information about termination of coverage that applies to HMOs:

- **Leaving the service area:** With the exception of the annual enrollment period, the only other time you may change your election for HMO coverage is if you move out of the HMO's service area.

  If you move out of your HMO's service area, you may register this move as a Life Event on Jetnet, and enroll in Eagle medical option offered for your new area. To make another election following your move, call HR Services within 60 days of your move. If you do not notify HR Services of your election, you will be enrolled in a medical option offered in your new area and will receive a confirmation statement indicating your new coverage

- **Active employees over age 65:** If you or your covered spouse reaches age 65 and becomes eligible for Medicare while covered under an HMO, most HMOs allow you to continue coverage. Coordination of benefits applies. The HMO is primary and Medicare is secondary (as explained in Coordination of Benefits) as long as you are an active employee.

CheckFirst (Pre-Determination of Benefits)

If you are covered by the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible or the PPO-Copay Option, CheckFirst allows you to find out if:

- The recommended service or treatment is covered by your selected Medical Option
- Your physician's proposed charges fall within the Plan's usual and prevailing fee limits.

If you are covered by the PPO-Deductible or the PPO-Copay Option and you are using a PPO provider, the provider's fees will always be within the usual and prevailing fee limits. However, you may want to contact your network/claims administrator at the appropriate CheckFirst number for your medical option to determine if the proposed services are covered under your selected Medical Option.

To use CheckFirst, you may either submit a CheckFirst Pre-Determination of Medical Benefits Form to your network/claims administrator before your proposed treatment, or you may call your network/claims administrator to obtain a pre-determination of benefits by phone or to request the pre-determination form. If you are having outpatient surgery, your network/claims administrator will coordinate with your network/claims administrator (as part of the QuickReview for Hospital Pre-authorization process) to determine the medical necessity of your proposed surgery before making a pre-determination of benefits. Your network/claims administrator will mail you a written response.

Before calling CheckFirst (your network/claims administrator), or completing the CheckFirst Pre-determination of Medical Benefits form, you will need the following information from your physician:

- Diagnosis
- Clinical name of the procedure and the CPT code
- Description of the service
- Estimate of the charges
- Physician's name and office ZIP code
- Name and ZIP code of the hospital or clinic where surgery is scheduled.

Even if you use CheckFirst, your network/claims administrator reserves the right to make adjustments upon receipt of your claim if the actual treatment or cost is different than the information submitted for predetermination of benefits.

For hospital stays, CheckFirst can predetermine the amount payable by the Plan. A CheckFirst pre-determination does not pre-authorize the length of a hospital stay or determine medical necessity. You must call your network/claims administrator for pre-authorization (see "QuickReview (Pre-Authorization)" on page 77 for hospital pre-authorization).

Although you may find CheckFirst beneficial whenever you need medical treatment, there are two circumstances when you may especially benefit by using CheckFirst. Use this predetermination procedure if your *physician* recommends either of the following:

- **Assistant surgeon**: A fee for an assistant surgeon is only covered when there is a demonstrated medical necessity. To determine if there is a medical necessity, you must use the CheckFirst procedure.
- **Multiple surgical procedures:** If you are having multiple surgical procedures performed at the same time, any procedure that is not the primary reason for surgery is covered at a reduced reimbursement rate because surgical preparation fees are included in the fee for the primary surgery. You must use CheckFirst to find out how the Plan reimburses the cost for any additional procedures.

QuickReview (Pre-Authorization)

Regardless of which medical plan you are enrolled in, you or your provider acting on your behalf are required to request pre-authorization (QuickReview) before any hospital admission, or within 48 hours (or the next business day if admitted on a weekend) following emergency care. If you do not use QuickReview, your expenses are still subject to review and will not be covered under the Plan if they are considered not medically necessary.

If you are covered by an HMO: Contact the HMO for any hospitalization.

When to Request a QuickReview

Any portion of a stay that has not been approved through the QuickReview process is considered not medically necessary and will not be covered. For example, if QuickReview determines that five hospital days are medically necessary for your condition and you stay in the hospital seven days, charges for the extra two days will not be covered. Your physician should contact QuickReview to request pre-authorization for approval of any additional hospital days.

Call for a QuickReview in the following situations:

- Before you are admitted to the hospital for an illness, injury, surgical procedure, or pregnancy
- Within 48 hours after an emergency hospital admission (or the next business day if you are admitted on a weekend)
- Before outpatient surgery to ensure that the surgery is considered medically necessary
- During the first 16 weeks of pregnancy to participate in your medical option's healthy pregnancy program.
- Before you undergo testing or treatment for sleep disorders
- Before you contemplate or undergo any organ transplant.

If your physician recommends surgery or hospitalization ask your physician for the following information:

- Diagnosis and diagnosis code
- Clinical name of the procedure and the CPT code
- Description of the service
- Estimate of the charges
- Physician's name and telephone number
- Name and telephone number of the hospital or clinic where surgery is scheduled.

If your illness or injury prevents you from personally contacting QuickReview, any of the following may call on your behalf:

- A family member or friend
- Your physician
- The hospital

QuickReview will tell you:

- Whether the proposed treatment is considered medically necessary and appropriate for your condition
- The number of approved days of hospitalization
- In some cases, QuickReview may refer you for a consultation before surgery or hospitalization will be authorized. To avoid any delays in surgery or hospitalization, notify QuickReview as far in advance as possible

If you receive pre-authorization of a hospital stay over the phone, ask for written confirmation of the pre-authorization. QuickReview does not determine whether you are eligible for benefits under the Plan or how much you will be reimbursed. For information on eligibility or coverage, contact your network/claims administrator at the appropriate CheckFirst number.

After you are admitted to the hospital, the QuickReview program provides case management services to monitor your stay. If you are not discharged from the hospital within the authorized number of days, your network/claims administrator consults with your physician and hospital to verify the need for any extension of your stay. If you are discharged from the hospital and then readmitted or transferred to another hospital for treatment of the same illness you must contact QuickReview again to authorize any additional hospitalization.

If you are scheduled for outpatient surgery, you should call your network/claims administrator. If you do not call, you may be subject to a retrospective review of the surgery to determine whether it was medically necessary. This means you or your physician may be asked to provide medical documentation to support the medical necessity of your surgery before any claim will be paid.

The QuickReview program does not guarantee that benefits will be paid. QuickReview reserves the right to make adjustments upon receipt of the final claim papers if the actual service differs from the pre-authorization information that was submitted.

Covered Expenses

This section contains descriptions of the eligible medical expenses (listed alphabetically) that are covered under the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options when medically necessary. Benefits for some of these eligible expenses vary depending on the medical option you have selected and whether or not you use network providers. The “Medical Benefit Options Comparison” on page 51 demonstrates how most services are covered.

For a list of items that are excluded from coverage, refer to “Excluded Expenses” on page 90.

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

Allergy care: Charges for medically necessary physician’s office visits, allergy testing, shots, and serum are covered. (See “Excluded Expenses” on page 90 for allergy care not covered under the Plan).

Ambulance: Medically necessary professional ambulance services and air ambulance once per illness or injury to and from:

- The nearest hospital qualified to provide necessary treatment in the event of an emergency
- The nearest hospital or convalescent or skilled nursing facility for inpatient care

Air ambulance services are covered when medically necessary services cannot be safely and adequately performed in a local facility and the patient’s medical condition requires immediate medical attention for which ground ambulance services might compromise the patient’s life. Ambulance services are only covered in an emergency and only when care is required en route to or from the hospital.

Ancillary charges: Ancillary charges including charges for hospital services, supplies, and operating room use.

Anesthesia expenses: Anesthetics and administration of anesthetics. Expenses are not covered for an anesthesiologist to remain available when not directly attending to the care of a patient.

Assistant surgeon: The Medical Options only cover assistant surgeon’s fees when the procedure makes it medically necessary to have an assistant surgeon. To determine whether an assistant surgeon is considered medically necessary, use the CheckFirst pre-determination procedure.

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

Blood: Coverage includes blood, blood plasma, and expanders. Benefits are paid only to the extent there is an actual expense to the participant.

Chiropractic care: Under the Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options, coverage includes medically necessary services of a restorative or rehabilitative nature provided by a chiropractor practicing within the scope of his or her license. Under the PPO-Copay Option, you are limited to 20 visits per year for combined network and out-of-network chiropractic care.

Convalescent or skilled nursing facilities: Under the Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options, these facilities are covered at 50% of the most common semi-private room rate in that geographic area for inpatient hospital expenses for up to 60 days per illness (for the same or related causes) after you are discharged from the hospital for a covered inpatient hospital confinement of at least three consecutive days. Under the PPO-Copay Option, these facilities are covered the same as hospitalization, except there is a combined maximum stay of 60 days per illness or injury for network and out-of-network facilities.

To be eligible, the confinement in a convalescent or skilled nursing facility must begin within 15 days after release from the hospital and be recommended by your physician for the condition which caused the hospitalization.

Eligible Expenses include room and board, as well as services and supplies (excluding personal items) that are incurred while you are confined to a convalescent or skilled nursing facility, are under the continuous care of a physician, and require 24-hour nursing care. Your physician must certify that this confinement is an alternative to a hospital confinement, and, your network/claims administrator must approve your stay. Custodial Care is not covered.

Cosmetic surgery: Medically necessary expenses for cosmetic surgery are only if they are incurred under either of the following conditions:

- As a result of a non-work related injury
- For replacement of diseased tissue surgically removed.

Other cosmetic surgery is not covered because it is not medically necessary.

Dental Care: Dental expenses for medically necessary dental examination, diagnosis, care, and treatment of one or more teeth, the tissue around them, the alveolar process, or the gums, only when care is rendered for:

- Accidental injury(ies) to sound natural teeth, in which both the cause and the result accidental, due to an outside and unforeseen traumatic force
- Fractures and/or dislocations of the jaw
- Cutting procedures in the mouth (this does not include extractions, dental implants, repair or care of the teeth and gums, etc., unless required as the result of accidental injury (as set forth in the first bullet under Dental Care above).

Detoxification: Detoxification, covered as a medical condition when alcohol and drug addiction problems are sufficiently severe to require immediate inpatient medical and nursing care services. Contact QuickReview for authorization.

Dietician services: Under the PPO-Copay Option, coverage includes services recommended by your network provider and provided by a licensed network dietician. Dietician services are not covered under the Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options.

Durable medical equipment (DME): Reimbursement for the rental of DME is limited to the maximum allowable equivalent of the purchase price. The Plan may, at its option, approve the purchase of such items instead of rental. Replacement of DME is covered only when medically necessary for a change in a patient's condition (improvement or deterioration) or due to the natural growth of a child. Replacement of DME resulting from normal wear and tear is not covered.

Coverage includes the initial purchase of eyeglasses or contact lenses required because of cataract surgery.

Emergency room: Charges for services and supplies provided by a hospital emergency room to treat medical emergencies. You must call QuickReview within 48 hours of an emergency resulting in admission to the hospital.

Facility charges: Charges for the use of an outpatient surgical facility, when the facility is either an outpatient surgical center affiliated with a hospital or a free-standing surgical facility.

Hearing care: Covered expenses include medically necessary hearing exams and up to one hearing aid for each ear per year. Cochlear implants and osseointegrated hearing implant systems (such as BAHAs) are covered if medically necessary.

Hemodialysis: Removal of certain elements from the blood through selective diffusion for treatment of kidney failure.

Home health care: Home health care, when your physician certifies that the visits are medically necessary for the care and treatment of a covered illness or injury. Custodial care is not covered.

You should call QuickReview to be sure home health care is considered medically necessary.

Hospice care: Eligible Expenses medically necessary for the care and treatment of a terminally ill covered person. Expenses in connection with hospice care include both facility and outpatient care. Hospice care is covered when approved by QuickReview.

Inpatient room and board expenses: Under the Out-of-Area Coverage and Minimum Coverage Options, hospital room and board charges are covered at 80% up to the most common semi-private room rate in that geographic area. If the hospital does not have semi-private rooms, the Plan considers the eligible expense to be 90% of the hospital's lowest private room rate. The PPO-Deductible and PPO-Copay Options pay based on the negotiated rates with that particular network hospital.

Intensive care, coronary care, or special care units (including isolation units): Coverage includes room and board and medically necessary services and supplies.

Mammograms: Medically necessary diagnostic mammograms, regardless of age.

Coverage under the Out-of-Area Coverage, Minimum Coverage and out-of-network under the PPO-Deductible and PPO-Copay Options for routine mammograms for female employees and female dependents is based on the following guidelines:

- Once between ages 35 and 39 to serve as a baseline against which future mammograms will be compared
- Once every one to two years from ages 40 to 49 as recommended by your physician
- Once every year beginning at age 50.

Under the PPO-Deductible and PPO-Copay Options network coverage, mammograms are covered if ordered by a network provider.

Mastectomy: Certain reconstructive and related services are covered following a medically-necessary mastectomy, including:

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

Medical supplies: Covered medical supplies include, but are not limited to:

- Oxygen, blood, and plasma
- Sterile items including sterile surgical trays, gloves, and dressings
- Needles and syringes
- Colostomy bags
- The initial purchase of eyeglasses or contact lenses required because of cataract surgery

Non-sterile or disposable supplies such as Band-Aids and cotton swabs are not covered.

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Multiple surgical procedures: Out-of-Area Coverage, Minimum Coverage and out-of-network under the PPO-Deductible and PPO-Copay Options, reimbursement for multiple surgical procedures is at a reduced rate because surgical preparation fees are included in the fee for the primary surgery. To determine the amount of coverage, and to be sure the charges are within the usual and prevailing fee limits, use the CheckFirst pre-determination program. The PPO-Deductible and PPO-Copay Options pay benefits based on the negotiated rate with the participating network surgeon.

Newborn nursery care: Hospital expenses for a healthy newborn baby are considered under the baby's coverage, not the mother's.

To enroll your newborn baby in your health benefits, you must process a Life Event change within 60 days of the birth. 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. The filing or payment of a maternity claim does not automatically enroll the baby.

You can process most Life Event changes online through the Benefits Service Center.

Nursing care: Coverage includes medically necessary private duty care by a licensed nurse, if it is of a type or nature not normally furnished by hospital floor nurses.

Oral surgery: Hospital charges in connection with oral surgery involving teeth, gums, or the alveolar process, only if it is medically necessary to perform oral surgery in a hospital setting rather than in a dentist's office. If medically necessary, the medical option will pay room and board, anesthesia, and miscellaneous hospital charges. Oral surgeons' and dentists' fees are not covered under the medical options. However, they may be covered under the Dental Benefit.

Outpatient surgery: Charges for services and supplies for a medically necessary surgical procedure performed on an outpatient basis at a hospital, freestanding surgical facility, or physician's office. You should pre-authorize the surgery through QuickReview to ensure the procedure is medically necessary.

Physical or occupational therapy: Medically necessary restorative and rehabilitative care by a licensed physical or occupational therapist when ordered by a physician

Physician's services: Office visits and other medical care, treatment, surgical procedures, and post-operative care for medically necessary diagnosis or treatment of an illness or injury. The Medical Options cover office visits for certain preventive care, as explained under *Preventive Care*.

Pregnancy: Charges in connection with pregnancy, only for female employees and female spouses of male employees. Prenatal care and delivery are covered when provided by a physician or midwife who is registered, licensed, or certified by the state in which he or she practices.

Within the first 16 weeks of pregnancy, you should call QuickReview to pre-authorize your hospitalization and take advantage of the healthy pregnancy program your plan offers.

Delivery may be in a hospital or birthing center. Birthing center charges are covered when the center is certified by the state department of health or other state regulatory authority. Prescription prenatal vitamin supplements are covered. Federal law prohibits the plan from limiting your length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery, or from requiring your provider to obtain pre-authorization for a longer stay. However, federal law does not require you to stay any certain length of time. If, after consulting with your physician, you decide on a shorter stay, benefits will be based on your actual length of stay.

Charges in connection with pregnancy for covered dependent children are covered only if due to certain complications of pregnancy, for example: ectopic pregnancy, hemorrhage, toxemia, placental detachment, and sepsis.

Prescription drugs: Medically necessary prescription drugs that are approved by the Food and Drug Administration (FDA) and prescribed by a physician or dentist for treatment of your condition.

See "Prescription Drug Benefits" on page 85 for details of the prescription drug benefit. Prescriptions related to infertility treatment, weight control, and oral contraceptives (used for family planning or birth control) are not covered. See "Excluded Expenses" on page 90 for additional information regarding drugs that are excluded from coverage.

Medically necessary medications are also covered for the following special situations:

- Medications administered and entirely consumed in connection with care rendered in a physician's office are covered as part of the office visit.
- Medications which are to be taken or administered while you are covered as a patient in a licensed hospital, extended care facility, convalescent hospital, or similar institution which operates an on-premises pharmacy are covered as part of the facility's ancillary charges.

Certain types of medicines and drugs that are not covered by the medical benefits may be reimbursed under the Health Care Flexible Spending Accounts (HCFSAs) (see the *Health Care FSA* section).

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

Prostheses: Prostheses (such as a leg, foot, arm, hand, or breast) necessary because of illness, injury, or surgery. Replacement of a prosthesis is only covered when medically necessary because of a change in the patient's condition (improvement or deterioration) or due to the natural growth of a child. Replacement of a prosthesis resulting from normal wear and tear is not covered.

Radiology (x-ray) and laboratory expenses: Examination and treatment by x-ray, radium, or other radioactive substances, imaging/scanning (MRI, PET, CAT, and ultrasound), diagnostic laboratory tests, and routine mammography screenings for women (see Mammograms for guidelines). Please note that under the PPO-Deductible and PPO-Copay Options, your network coverage depends on whether the care is received in a hospital-based setting or a physician's office or laboratory facility. (See copayment vs. coinsurance under "Special Provisions" in "PPO-Copay Option" on page 71 for details).

Reconstructive surgery: Surgery following an illness or injury, including contralateral reconstruction to correct asymmetry of bilateral body parts, such as breasts or ears.

Under the Women's Health and Cancer Rights Act, covered reconstructive services include:

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

Speech therapy: Restorative and rehabilitative care and treatment for loss or impairment of speech when the treatment is medically necessary because of an illness (other than a mental, psychoneurotic, or personality disorder), injury, or surgery. If the loss or impairment is caused by a congenital anomaly, surgery to correct the anomaly must be performed before the therapy.

Surgery: When medically necessary and performed in a hospital, free-standing surgical facility, or physician's office. (See "QuickReview (Pre-Authorization)" on page 77 and "CheckFirst (Pre-Determination of Benefits)" on page 76 for details about hospital pre-authorization and pre-determination of benefits.)

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Temporomandibular joint dysfunction (TMJD): Eligible Expenses under the medical benefits include only the following, if medically necessary:

- Injection of the joints
- Bone resection
- Application of splints, arch bars, or bite blocks if their only purpose is joint stabilization and not orthodontic correction of a malocclusion
- Manipulation or heat therapy.
- Crowns, bridges, or orthodontic procedures for treatment of TMJD are not covered.

Transplants: Expenses for transplants or replacement of tissue or organs if they are medically necessary and not experimental, investigational, or unproven services. Benefits are payable for natural or artificial replacement materials or devices.

Donor and recipient coverage is as follows:

- If the donor and recipient are both covered under the Plan, expenses for both individuals are covered by the Plan
- If the donor is not covered under the Plan and the recipient is covered, the donor's expenses are covered to the extent they are not covered under any other medical plan, and only if they are submitted as part of the recipient's claim.
- If the donor is covered under the Plan but the recipient is not covered under the Plan, no expenses are covered for the donor or the recipient

The total benefit paid under this Plan for the donor's and recipient's expenses will not be more than any Plan maximums applicable to the recipient.

You may arrange to have the transplant at a network transplant facility rather than a local network hospital. Although using a network transplant facility is not required, these centers specialize in transplant surgery and may have the most experience, the leading techniques, and a highly qualified staff.

It is important to note that the listed covered transplants are covered only if the proposed transplant meets specific criteria—not all transplant situations will be eligible for benefits. Therefore, you **must** contact QuickReview as soon as possible for pre-authorization **before** contemplating or undergoing a proposed transplant. The following transplants are covered if they are medically necessary for the diagnosed condition and are not experimental, investigational, unproven, or otherwise excluded from coverage under the Medical Options, as determined in the sole discretion of the Plan Administrator and its delegate, the claims processor:

- Artery or vein
- Bone
- Bone Marrow or stem cell
- Cornea
- Heart
- Heart and Lung
- Heart valve replacements
- Implantable prosthetic lenses in connection with cataract surgery
- Intestine
- Kidney
- Kidney and Pancreas

- Liver
- Liver and Kidney
- Liver and Intestine
- Pancreas
- Pancreatic islet cell (allogenic or autologous)
- Prosthetic bypass or replacement vessels
- Skin

Transportation expenses: Regularly scheduled commercial transportation by train or plane, when necessary for your emergency travel to and from the nearest hospital that can provide inpatient treatment not locally available. Only one round-trip ticket is covered for any illness or injury and will be covered only if medical attention is required en route. For information on ambulance services, see Ambulance in this section.

Tubal ligation and vasectomy: These procedures are covered; however, reversal of these procedures is not covered.

Urgent care: Charges for services and supplies provided at an urgent care clinic are covered. You should contact your network provider or your network/claims administrator for authorization before seeking care at an urgent care clinic, or if you are traveling and need urgent medical care. If your network/claims administrator's office is closed, seek treatment and then call your network/claims administrator within 48 hours to ensure that you receive the network level of benefits.

Well-child care: Under the Out-of-Area Coverage, Minimum Coverage and out-of-network coverage under the PPO-Deductible and PPO-Copay Options, children up to age two are covered for initial hospitalization following birth, all immunizations, and up to seven well-child care visits.

Wigs and hairpieces: Active employees and eligible dependents are covered up to a $350 lifetime maximum for an initial synthetic wig or hairpiece, if purchased within six months of hair loss. The wig must be prescribed by a physician for a covered medical condition causing hair loss. These conditions include, but are not limited to: chemotherapy, radiation therapy, alopecia areata, endocrine disorders, metabolic disorders, cranial surgery, or severe burns. This benefit is subject to the usual and prevailing fee limits, deductibles, copayments, coinsurance, and out-of-pocket limits of the selected medical option.

Replacement wigs or hairpieces are not covered, regardless of any change in the patient's physical condition. Hair transplants, styling, shampoo, and accessories are also excluded.

Mental Health and Chemical Dependency Benefits

Mental Health Care

Covered expenses include medically necessary inpatient care (in a psychiatric hospital, acute care hospital, or an alternative mental health care center) and outpatient care for a mental health disorder.

Inpatient mental health care: When you are hospitalized in a psychiatric hospital for a mental health disorder, expenses during the period of hospitalization are covered the same as inpatient hospital expenses (see inpatient room and board expenses under "Covered Expenses" on page 78), up to Plan maximums.

Alternative mental health care center – residential treatment: Under the PPO Copay, Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options, such treatment is covered at 80%, when you use network providers and 60% when you use out-of-network providers.

Alternative mental health care center – intensive outpatient and partial hospitalization: Under the PPO copay, Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options, such treatment is covered at 80%, when you use network providers and 60% when you use out-of-network providers.

Outpatient mental health care: Under the Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options, such treatment is covered at 80% when you use network providers and 60% when you use out-of-network providers.

Under the PPO-Copay Option, you pay a $35 copay per visit if you use network providers and 40% co-insurance if you use out-of-network providers.

Chemical Dependency Care

Chemical dependency rehabilitation: Covered chemical dependency rehabilitation expenses for treatment of drug or alcohol dependency can be inpatient, outpatient, or a combination. The Plan does not cover expenses for a family member to accompany the patient being treated, although many chemical dependency treatment centers include family care at no additional cost. You must obtain EAP approval for all cases resulting from regulatory or company policy violations.

Detoxification: Chemical dependency rehabilitation does not include detoxification. Detoxification is considered a medical procedure and is reimbursed under the Plan's regular medical provisions. However, the following provisions apply:

- You must call your network/claims administrator for approval (QuickReview) of detoxification.
- To receive the network benefit level under the PPO-Deductible or PPO-Copay Option, detoxification treatment must be approved by your network/claims administrator within 48 hours of admission for detoxification.
- If you are covered by the PPO-Deductible or PPO-Copay Option and you do not receive your network/claims administrator approval for detoxification, coverage is provided at the out-of-network benefit level, even if you use a network facility.

Prescription Drug Benefits

The prescription drug program for the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options is administered by Express Scripts (formerly Medco). Drugs prescribed by a physician or dentist may be purchased either at retail pharmacies or through the Mail Service prescription drug option.

For information on drugs that are covered, see "Covered Expenses" on page 78. For drugs that are excluded, refer to "Excluded Expenses" on page 90.

Prescription drug coverage under an HMO is administered by the individual HMO.

Retail Drug Coverage

As a medical plan participant, you may have your prescriptions filled at any pharmacy. However, if you present your Express Scripts ID card at a network pharmacy, you will have access to negotiated discount prices. The prescription drug program administered by Express Scripts, has over 51,000 network pharmacies throughout the United States, Puerto Rico, and the U.S. Virgin Islands. The network includes nine out of ten retail pharmacies nationwide. To request a list of participating pharmacy chains, call Express Scripts at 1-866-544-2994 or visit the Express Scripts website.

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

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

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

Contact Express Scripts at 1-866-544-2994 to determine if the brand-name drug you are taking is on the formulary list. You can also locate this information on the Express Scripts website.

Drug Type	Retail Prescriptions	Mail Order Prescriptions
Generic Drug	You pay 20%, with a minimum of $10 and a maximum of $50 per prescription	You pay 20% for a 90-day supply, with a minimum of $25 and a maximum of $125 per prescription
Formulary Brand Drug	You pay 30%, with a minimum of $35 and a maximum of $100 per prescription	You pay 30% for a 90-day supply, with a minimum of $75 and a maximum of $200 per prescription
Non-Formulary Brand Drug	You pay 50%, with a minimum of $50 and a maximum of $125 per prescription	You pay 50% for a 90-day supply, with a minimum of $125 and a maximum of $275 per prescription

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

If you select a brand-name drug (formulary or non-formulary) when a generic is available, you will pay the 20% generic co-insurance, plus the cost difference between the generic and brand prices. Maximums do not apply.

** Oral contraceptives, transdermal and intravaginal contraceptives are covered by mail only at 100% with no co-pay or co-insurance. If a brand contraceptive has a generic equivalent, you will be responsible for the cost difference between the generic and brand prices.

Retail Refill Allowance

Coverage is provided for up to three fills of long-term maintenance drugs at retail. Unless you begin using the Express Scripts Pharmacy mail-order service by the fourth fill, you will be responsible for 100% of the discounted cost when you purchase the drug retail.

Drug Type	If you use a retail pharmacy for your initial Rx purchase and two refill Rx purchases…	If you use a retail pharmacy for refills of maintenance medication beyond the two refill limit…
Generic Drug*	You pay 20%, with a minimum of $10 and a maximum of $50 per prescription	You pay 100%
Formulary Brand Drug	You pay 30%, with a minimum of $35 and a maximum of $100 per prescription	You pay 100%
Non-Formulary Brand Drug	You pay 50%, with a minimum of $50 and a maximum of $125 per prescription	You pay 100%

** Oral contraceptives, transdermal and intravaginal contraceptives are covered by mail only at 100% with no co-pay or co-insurance. If a brand contraceptive has a generic equivalent, you will be responsible for the cost difference between the generic and brand prices. New!*

If you select a brand-name drug (formulary or non-formulary) when a generic is available, you will pay the 20% generic co-insurance, plus the cost difference between the generic and brand prices. Maximums do not apply.

Filling Prescriptions

Follow these steps to fill prescriptions at a network pharmacy:

- Present your Express Scripts ID card to the pharmacy and pay the appropriate copay/coinsurance.
- Follow these steps to fill prescriptions at an out-of-network pharmacy:
- Pay the full retail price (undiscounted) for the prescription and obtain a receipt when you pick up your prescription.

File a claim for reimbursement with Express Scripts. Express Scripts will reimburse the patient based on the discounted cost of the medication minus the applicable copay/coinsurance. Reimbursement will be accompanied by an EOB.

* *The provisions marked by the box that says "New!" have changed since the Employee Benefits Guide was last updated. To review the previous version of the Guide, see the Archives section.*

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If you elected to participate in the Health Care Flexible Spending Account (see the *Health Care FSA* section), your retail drug out-of-pocket expense is eligible for reimbursement.

If you have questions concerning this program, call the Express Scripts Member Services number on your Express ScriptsExpress Scripts ID card. If you have questions about the benefit amount paid, call your network/claims administrator.

Claim Filing Deadline

You must submit all claims, including prescription drug claims, within one year of the date expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.

Prior Authorization

To be eligible for benefits, certain covered prescriptions require prior authorization by Express Scripts to determine medical necessity before you can obtain them at a participating pharmacy or through the mail service option.

When you fill your prescription, Express Scripts will send a message instructing your pharmacist to call Express Scripts. A Express Scripts pharmacist will then contact your physician to review the request for approval. Express Scripts sends both you and your physician a letter about the authorization review. If authorization is approved, the system automatically allows refills for the original approved time up to one year. In the event a pharmacy does not fill a prescription, the pharmacy's denial shall not be treated as a claim for benefits, instead you must file a claim with the Claims Administrator for the medication to initiate the benefit claim and appeal procedures under the medical benefits option.

Prior authorizations expire and must be renewed. You will receive the expiration with your approval and a reminder 30 days prior with instructions on how to renew.

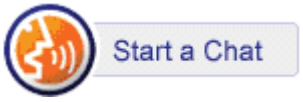
To request prior authorization, ask your physician's office to initiate the Prior Authorization by calling the PA hotline 1-800-753-2851. Express Scripts will fax the required prior authorization criteria to your physician.

Express Scripts will advise you whether your prior authorization is approved or denied. If it is denied, they will explain the reason for denial.

Specialty Pharmacy Services

Specialty pharmacy services are services dedicated to providing a broad spectrum of outpatient prescription medicines and integrated clinical services to patients on long-term therapies which support the treatment of complex and chronic diseases.

Accredo Health Group, a subsidiary of Express Scripts, is designed to help you meet the particular needs and challenges associated with the administration and handling of these medications.



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Prescriptions prescribed to manage the following medical conditions must be filled at one of Accredo's Health Group pharmacies through Express Scripts:

- Anemia/Neutropenia
- Growth Hormone
- Hemophilia
- Hepatitis C
- Immune Deficiency Therapy
- Metabolic Disorders
- Multiple Sclerosis
- Oral Cancer Drugs
- Osteoporosis
- Rheumatoid Arthritis and Other Autoimmune Conditions
- Pulmonary / Pulmonary Arterial Hypertension
- Other Various Indications

Please note: Specialty Agents are added as required/appropriate.

Whether these prescriptions are self-administered or administered in a physician office, effective August 1, 2009, the prescriptions to treat the above conditions will no longer be reimbursed through your medical plan and must be filled through Accredo by Express Scripts. Express Scripts can ship the prescription to the patient's home for self-administration or to the physician's office for medications which are to be administered by a physician.

The applicable copayment associated with the prescription drug benefit will apply to the Specialty Pharmacy prescriptions.

Mail Service Prescription Drug Option

As a participant in the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options, you and your covered dependents are eligible for the Mail Service Prescription Drug Option offered through Express Scripts (formerly Medco). You may use the mail service option to order prescription drugs you take on an ongoing basis to treat chronic medical conditions such as allergies, arthritis, diabetes, emphysema, heart disease, high blood pressure, thyroid disease, and ulcers. You may also purchase injectable drugs that are approved by the Food and Drug Administration (FDA) for self-administration.

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

Drug Type	Retail Prescriptions	Mail Order Prescriptions
Generic Drug*	You pay 20%, with a minimum of $10 and a maximum of $50 per prescription	You pay 20% for a 90-day supply, with a minimum of $25 and a maximum of $125 per prescription
Formulary Brand Drug	You pay 30%, with a minimum of $35 and a maximum of $100 per prescription	You pay 30% for a 90-day supply, with a minimum of $75 and a maximum of $200 per prescription

Drug Type	Retail Prescriptions	Mail Order Prescriptions
Non-Formulary Brand Drug	You pay 50%, with a minimum of $50 and a maximum of $125 per prescription	You pay 50% for a 90-day supply, with a minimum of $125 and a maximum of $275 per prescription

** Generic oral contraceptives, transdermal and intravaginal contraceptives are covered by mail only at 100% with no co-pay or co-insurance. If a brand contraceptive has a generic equivalent, you will be responsible for the cost difference between the generic and brand prices.

New![*]

If you select a brand-name drug (formulary or non-formulary) when a generic is available, you will pay the 20% generic co-insurance, plus the cost difference between the generic and brand prices. Maximums do not apply.

You may use the mail service program to fill prescriptions for treatment of mental health conditions. You should compare the cost of a 90-day supply of psychotherapeutic drugs through the mail service program to the cost of copayments for three 30-day supplies from a retail pharmacy to determine which will cost you less.

Generic Drugs

Many drugs are available in generic form. Your prescription will be substituted with a generic when available and your physician considers it appropriate. A-rated generic drugs are used because they generally cost less and have the same therapeutic effect and active ingredients as their brand equivalents. By using A-rated generic drugs, you save money for yourself and the Company. If a brand name drug is not specified, your prescription may be filled with the generic. However, if you elect to fill a prescription with a brand name drug and a generic is available, you will pay the 20% generic co-insurance, plus the cost difference between the generic and brand prices. (This applies, even if your doctor writes the prescription for a brand name drug.)

Ordering Mail Service Prescriptions

Initial order: To place your first order for a prescription through the mail service option, follow these steps:

- Provide the information requested on the back of your mail service order envelope, and complete and enclose the patient profile form found in your initial packet from Express Scripts. (The profile will not be necessary on refills or future orders unless your health changes significantly.)
- Insert the original written prescription signed by your physician.
- If the prescription is for a non-medically necessary oral contraceptive, or you elect to take a brand name drug when a generic is available, call Express Scripts or visit the Express Scripts website to find out how much you must pay for the prescription.
- Indicate the desired method of payment on the mail service order envelope. You may charge your payment to a major credit card (MasterCard, VISA, or Discover) or pay by personal check or money order. If paying by check or money order, enclose your payment with the order. Do not send cash.
- Mail your order to the address on the order envelope

You may request a mail order envelope using the Mail Order Form or you may contact Express Scripts at 1-866-544-2994 to request an envelope.

Internet Refill Option

The Internet gives you access to Express Scripts 24 hours a day, seven days a week. Using Express Scripts online, you can order prescription drug refills, check on the status of your order, request additional forms and envelopes, or locate a network pharmacy near you on the Express Scripts website.

To refill a prescription online, you will simply need to supply your Express Scripts member ID number (Social Security number), the prescription (RX) numbers you want to refill and the method of payment. Verify your address on file and review your order. When you order refills online, you will receive a detailed summary of your order, including costs. Please allow up to 14 days for delivery of your prescription.

[*] *The provisions marked by the box that says "New!" have changed since the Employee Benefits Guide was last updated. To review the previous version of the Guide, see the Archives section.*

Other Refill Options

If you elect not to use the Internet refill option, place your order at least two weeks before your current supply runs out in one of the following two ways:

- Call at 1-866-544-2994 to request a refill. They will need your Express Scripts ID number, current mailing address, and Express Scripts Health Rx Services prescription number
- If you prefer to order by mail, complete a mail service order envelope and attach your Express Scripts refill prescription label to the form or write the prescription refill number on the envelope. Include your payment with your order.

Maximum Medical Benefits

Express Scripts Rx Services sends you a statement with each prescription they fill. The statement advises you of your copayment, and the amount the Company paid. The amount the Company paid is applied to your maximum medical benefit (explained further in "Key Features of the Medical Options" on page 50).

Reimbursement of Copayments

Your mail service copayments for prescription drugs are not eligible for reimbursement under the Medical Options. However, if you elected to participate in the Health Care Flexible Spending Account, you may submit your copayment for reimbursement. (See the *Health Care FSA* section for details.)

Excluded Expenses

The following items are excluded from coverage, under all Medical Benefit Options offered to employees of American Eagle Airlines, Inc. or Executive Airlines, Inc. (excluding HMO coverage), unless otherwise stated. For exclusions under an HMO, check with the HMO directly.

Allergy testing: Specific testing (called provocative neutralization testing or therapy), which involves injecting a patient with varying dilutions of the substance to which the patient may be allergic.

Alternative and/or Complementary medicine: Evaluation, testing, treatment, therapy, care and medicines that constitute alternative or complementary medicine, including but not limited to herbal, holistic, and homeopathic medicine.

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

Claim forms: The Plan will not pay the cost for anyone to complete your claim form.

Care not medically necessary: All services and supplies considered not medically necessary.

Cosmetic treatment:

- Medical treatments solely for cosmetic purposes (such as treatments for hair loss, acne scars, liposuction, and sclerotherapy for varicose veins or spider veins)
- Cosmetic surgery, unless medically necessary and required as a result of accidental injury or surgical removal of diseased tissue

Counseling: All forms of marriage and family counseling

Custodial care and custodial care items: Custodial care and items such as incontinence briefs, liners, diapers, and other items when used for custodial purposes, unless provided during an *inpatient* confinement in a hospital or convalescent or skilled nursing facility.

Developmental therapy for children: Charges for all types of developmental therapy.

Dietician services: Dietician services are covered only under the PPO-Copay Option and only if you are using network providers. Contact your network/claims administrator or your network provider to determine what services are covered. All other dietician services are excluded.

Drugs:

- Drugs, medicines, and supplies that do not require a physician's prescription and may be obtained over-the-counter, regardless of whether a physician has written a prescription for the item. (This exclusion does not apply to diabetic supplies, which are limited to insulin, needles, chem-strips, lancets, and test tape.)
- Drugs which are not required to bear the legend "Caution-Federal Law Prohibits Dispensing Without Prescription"
- Covered drugs in excess of the quantity specified by the physician or any refill dispensed after one year from the physician's order
- Contraceptive drugs, patches, or implants when used for family planning or birth control. Even though oral contraceptives are not covered, you may order these drugs through the mail service prescription program and receive a discount. (See "Mail Service Prescription Drug Option" under "Prescription Drug Benefits" on page 85).
- Drugs requiring a prescription under state law, but not federal law
- Medications or products used to promote general well-being such as vitamins or food supplements (except for prenatal vitamins, which are covered prior to/during pregnancy)
- Drugs prescribed for cosmetic purposes (such as Minoxidil)
- Medications used primarily for the purpose of weight control
- Drugs used to treat infertility, or to promote fertility
- Drugs labeled "Caution-Limited by Federal Law to Investigational Use," drugs not approved by the Food and Drug Administration (FDA), or experimental drugs, even though the individual is charged for such drugs
- Any and all medications not approved by the Food and Drug Administration (FDA) as appropriate treatment for the specific diagnosis.
- Medications or products used for smoking or tobacco use cessation.

Ecological and environmental medicine: See Alternative and/or Complementary Medicine

Educational testing or training: Testing or training that does not diagnose or treat a medical condition (for example, testing for learning disabilities is excluded)

Experimental, Investigational, or Unproven treatment: Medical treatment, procedures, drugs, devices, or supplies that are generally regarded as experimental, investigational, or unproven, including, but not limited to:

- Treatment for Epstein-Barr Syndrome
- Hormone pellet insertion
- Plasmapheresis

See the Experimental, Investigational or Unproven treatment definitions in the Glossary.

Eye care: Eye exams, refractions, eye glasses or the fitting of eye glasses, contact lenses, radial keratotomy or surgeries to correct refractive errors, visual training, and vision therapy.

Foot care: Diagnosis and treatment of weak, strained, or flat feet including corrective shoes or devices, or the cutting or removal of corns, calluses, or toenails. (This exclusion does not apply to the removal of nail roots.)

Free care or treatment: Care, treatment, services, or supplies for which payment is not legally required.

Government-paid care: Care, treatment, services, or supplies provided or paid by any governmental plan or law when the coverage is not restricted to the government's civilian employees and their dependents. (This exclusion does not apply to Medicare or Medicaid.)

Infertility treatment: Expenses or charges for infertility treatment *or* testing and charges for treatment or testing for hormonal imbalances that cause male or female infertility, regardless of the primary reason for hormonal therapy.

Items not covered include, but are not limited to the following: medical services, supplies, procedures for or resulting in impregnation, including in-vitro fertilization, artificial insemination, embryo transfer, embryo freezing, gamete transfer, zygote transfer, and reversal of tubal ligations or vasectomies. Drug therapy, including treatment for ovarian dysfunction, and infertility drugs such as, for example, Clomid or Pergonal, are also excluded.

Only the initial tests are covered to diagnose systemic conditions causing or contributing to infertility, such as infection or endocrine disease. Also, the repair of reproductive organs damaged by an accident or certain medical disorders are eligible for coverage.

Lenses: No lenses are covered except the first pair of medically necessary contact lenses or eye glasses following cataract surgery.

Massage therapy: All forms of massage and soft-tissue therapy, regardless of who performs the service.

Medical Error Events: Services or supplies charged by the health care provider that are directly associated with, resulting from, or caused by medical mistakes, medical or surgical error or complication, medical negligence or malpractice, preventable illness, preventable injury, or certain preventable complications arising from medical or surgical treatment, as defined by the Center for Medicare and Medicaid Services and identified as "never events". For more information on what comprises these events, go to http://www.cms.gov/ >Site Tools & Resources>Media Release Database. There you'll find fact sheets and news releases about these "never events".

Medical records: Charges for requests or production of medical records.

Missed appointments: If you incur a charge for missing an appointment, the Plan will not pay any portion of the charge.

Nursing care:

- Care, treatment, services, or supplies received from a nurse that do not require the skill and training of a nurse
- Private duty nursing care that is not medically necessary, or if medical records establish that such care is within the scope of care normally furnished by hospital floor nurses
- Certified nurses' aides.

Organ donation: Expenses incurred as an organ donor, when the recipient is not covered under the Plan.

Pregnancy for dependents: Prenatal care and delivery charges are excluded for covered dependent children unless the charges are due to certain complications. Examples of covered complications include ectopic pregnancy, hemorrhage, toxemia, placental detachment, and sepsis.

Preventive care: Coverage for preventive care is covered 100% when you use an in-network provider.

Relatives: Coverage is not provided for treatment by a medical practitioner (including, but not limited to: a nurse, physician, physiotherapist, or speech therapist) who is a close relative (spouse, child, brother, sister, parent, or grandparent of you or your spouse, including adopted and step relatives).

Sleep disorders: Treatment of sleep disorders, unless it is considered medically necessary.

Sex changes: Sex change, gender reassignment/revision, treatments or transsexual and related operations.

Sexual Performance Treatment: Prescription medications (including but not limited to, Viagra, Levitra, or Cialis), procedures, devices, or other treatments prescribed, administered, or recommended to treat erectile dysfunction or other sexual dysfunction, or for the purpose of producing, restoring, or enhancing sexual performance/experience.

Speech therapy: Except as described in "Covered Expenses" on page 78, expenses are not covered for losses or impairments caused by mental, psychoneurotic, or personality disorders or for conditions such as learning disabilities, developmental disorders, or progressive loss due to old age. Speech therapy of an educational nature is not covered.

TMJD: Except as described in "Covered Expenses" on page 78, diagnosis or treatment of any kind for temporomandibular joint disease or disorder (TMJD), or syndrome by a similar name, including orthodontia to treat TMJD. Crowns, bridges, or orthodontic procedures to treat TMJD are not covered.

Transportation: Transportation by regularly scheduled airline, air ambulance, or train for more than one round trip per illness or injury.

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

War-related: Services or supplies when received as a result of a declared or undeclared act of war or armed aggression.

Weight reduction: Hospitalization, surgery, treatment, and medications for weight reduction other than for approved treatment of diagnosed morbid obesity. Contact QuickReview (or HMO if applicable) to determine if treatment is covered.

Wellness items: Items that promote well-being and are not medical in nature, and which are not specific for the illness or injury involved (including but not limited to, dehumidifiers, air filtering systems, air conditioners, bicycles, exercise equipment, whirlpool spas, and health club memberships). Also excluded are:

- Services or equipment intended to enhance performance (primarily in sports-related or artistic activities), including strengthening and physical conditioning
- Services related to vocation, including but not limited to: physical or FAA exams, performance testing, and work hardening programs

Contact your network/claims administrator (CheckFirst) to determine if your option covers a specific preventive service for a particular medical condition.

Work-related: Medical services and supplies for treatment of any work-related injury or illness sustained by you or your covered dependent, whether or not it is covered by Workers' Compensation, occupational disease law, or other similar law.

Filing Claims

Your network/claims administrator is the claims processor for the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options. Your network/claims administrator provides claim services; however, they do not insure the health benefits. Benefits for these medical options are self-funded, which means that all claims are paid from the Company's general assets.

Regardless of which medical option you are enrolled in, if you received services from a Medical Discount Program PPO provider, your provider will generally file the claim for you. If you use a non-network provider or for any reason you must file the claim yourself, follow the procedures below:

- Complete a Medical Benefit Claim Form (instructions are provided on the form)
- Submit the completed form to your network/claims administrator, along with all itemized receipts (originals) from your physician or other health care provider. A cancelled check is not acceptable.

Each bill or receipt submitted to your network/claims administrator must include the following:

- Name of patient
- Date the treatment or service was provided
- Diagnosis of the injury or illness for which treatment or service was given
- Itemized charges for the treatment or service
- Provider's name, address, and tax ID number

Be sure to make copies of the original itemized bill or receipt provided by your physician, hospital, or other medical service provider for your own records. Photocopies are not accepted by your network/claims administrator.

All medical claims payments are sent to you along with an Explanation of Benefits (EOB) explaining the amount paid, unless your physician, hospital, or other medical provider has agreed to accept assignment of benefits (see "Assignment of Benefits" in the *Plan Administration* section). In this case, the EOB will be mailed to you and the payment mailed to your provider.

It is very important that you fully complete the sections of the form regarding other possible coverage. Examples of other possible coverage include a spouse's group health plan, Workers' Compensation, Medicare, Champus and no-fault motor vehicle insurance.

If you have questions about your coverage or your claim, contact your network/claims administrator or Express Scripts.

Claims Filing Deadline

You must submit all claims, including prescription drug claims, within one year of the date expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.

Notwithstanding the above, the Department of Health and Human Services ("HHS") and the Center for Medicare and Medicaid Services ("CMS") or any other agency of the HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

The full claims procedure is described in detail under "Claims" in the *Plan Administration* section.

Employee Assistance Program (EAP)

The Company recognizes that alcohol and drug dependency and other serious personal problems affect an employee's health and job performance. The Employee Assistance Program (EAP) helps employees obtain treatment for these problems before health, safety, and work performance are compromised. The EAP is available to all employees and their dependents at no cost.

The EAP protects confidentiality. Contacting the EAP for assistance does not jeopardize job security and advancement opportunities. However, the Company will not knowingly allow employees to work if there is a question concerning fitness for duty. In addition, EAP participation does not relieve an employee of the obligation to comply with Company rules and regulations.

The EAP is accessible through the following individuals. Both adhere to strict guidelines of confidentiality.

- EAP representatives:
  - Members of the EAP staff who facilitate and implement the EAP.
  - Accessible to employees and dependents who require information or assistance.

  EAP representatives can provide referrals to mental health professionals for employees enrolled in the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options. Any employee or dependent seeking help for an alcohol or drug problem must call the EAP, regardless of which medical option he or she is enrolled in.
- Employee coordinators:
  - Employees who volunteer to assist in overall EAP coordination. Employee coordinators are not mental health care professionals, but rather are appointed within each union group and trained by an EAP representative. Management and non-management coordinators volunteer to assist non-union employees.

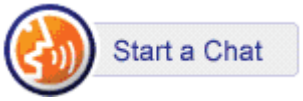
Chemical Dependency and Rehabilitation

Referral to treatment centers is a valuable service of the EAP. Employees seeking admission to an alcohol or drug treatment facility for themselves or a dependent must contact either an EAP representative or the AMR Medical Department. EAP representatives can arrange for needed treatment at a licensed treatment facility.

The Medical Benefit Options or Plan only reimburse the cost of chemical dependency treatment and rehabilitation programs that are pre-approved either by an EAP representative or the AMR Medical Department and are eligible for coverage under the Plan. Expenses for rehabilitation are not covered if you fail to follow the proper procedures in seeking treatment. EAP approval does not guarantee coverage for the claim if the expense is not eligible for coverage or if you or your dependent is not covered by the Medical Benefit Options or Plan.

The EAP can also refer you to counseling professionals, credit services, and other services to help you resolve personal problems. For more detailed information concerning the EAP, its procedures, and guidelines, contact an EAP representative.

Employee Assistance Program (EAP)



https://www.jetnet.aa.com/jetnet/go/ssomercer.asp?AppID=CHAT

Forms & guides can be located in the eHR Center of Jetnet at https://www.jetnet.aa.com/jetnet/go/ssoehr.asp?TargetDoc=XML=20

The Benefits Service Center is available at https://www.jetnet.aa.com/jetnet/go/ssomercer.asp

Dental Benefits

The Dental Benefit pays benefits for routine dental care and treatment for disease, defect and injury. The Plan is self-funded by the Company and claims are processed by MetLife.

ID cards are not necessary under the Dental Benefit. The dental provider's office is responsible for verifying eligibility.

Key Features of the Dental Benefit New!*

Feature	Dental Benefit	
	In-Network	***Out of Network***
Annual Deductible	$50 per person	$50 per person
Preventive Service (exams, cleanings, maximum 2 visits per year routine x-rays once per year)	100% In-Network Deductible Waived	80% Out-of-Network after $50 deductible
Basic (Sealants, Space Maintainers, Amalgam/Resin Composite Fillings, Pulp Capping, Endodontic, Oral Surgery, Periodontics)	80% In- or Out-of-Network after $50 deductible	
Major Services (Crowns, Bridges, Dentures, Implants)	50% In- or Out-of-Network after $50 deductible	
Orthodontia Services (eligible dependent children only; no deductible applies)	50% In- or Out-of-Network up to a maximum of $1,500	
Maximum Benefit (per person per year)	$1,250	$1,000
Maximum Lifetime Orthodontia Benefit (per dependent child)	$1,500	$1,500

In This Section

* *The provisions in the table below the note that says "New!" have changed since the Employee Benefits Guide was last updated. To review the previous version of this table, see the Archives section.*

How the Dental Benefit Option Works

The following is information you need to know about Dental Benefit coverage and circumstances that determine how benefits are paid:

Medically necessary: Only dental services that are medically necessary are covered by the Dental Benefit. Cosmetic services are not covered.

Usual and prevailing fee limits: The amount of benefits paid for eligible expenses is based on the usual and prevailing fee limits for that service in that geographic location.

Pre-determination of benefits: If your dentist estimates that charges for a procedure will be substantial, you should request pre-determination of benefits before you receive treatment. However, it is recommended that you obtain pre-determination for any proposed procedure. To request pre-determination from the claims processor, your dentist may complete the standard Dental Claim Form, indicating that it is for pre-determination of benefits.

Alternative treatment: If you undergo a more expensive treatment or procedure when a less expensive alternative is available, the Dental Benefit pays benefits based on the less expensive procedure that is consistent with generally accepted standards of appropriate dental care.

When expenses are incurred: For purposes of determining Dental Benefit coverage and benefits, the dental expense is deemed to be incurred at the time of the initial treatment or preparation of the tooth.

The Preferred Dentist Program (PDP): The Dental Benefit offers a network of participating dentists nationwide (general dentists and specialists) at locations who provide fee discounts to Dental Benefit participants. You are not required to use PDP network dentists, but will benefit from cost savings when you do. You can request a customized directory of participating dentists in your area by calling MetLife (see "Contact Information" in the *Reference Information* section) or by visiting the MetLife website.

Injury by others: If you are injured by someone else and your dental plan pays a benefit, the Company will recover payment from the third party (see "Subrogation" under "Claims" in the *Plan Administration* section).

Health Care Flexible Spending Account: Dental expenses are eligible for reimbursement and will automatically roll over to your account if you participate in a Health Care Flexible Spending Account, unless you inform your network/claims administrator that you want to discontinue the automatic rollover feature. If you cover a Company-recognized Domestic Partner or a dependent of a Company-recognized Domestic Partner, you must inform the FSA administrator that you want to discontinue the automatic rollover feature. See "Eligible Expenses" in the *Health Care FSA* section for important details.)

Coordination of benefits: If you or a covered dependent has coverage under any other group dental plan, the Dental Benefit coordinates benefits with the other plan. (See "Coordination of Benefits" in the *Additional Health Benefit Rules* section for additional information.)

Covered Expenses

To be covered by the Dental Benefit Option, a dental expense must be medically necessary and provided by a duly qualified and licensed dentist or physician (unless specifically excluded). Charges for covered items must be within the usual and prevailing fee limits. The following dental services and supplies are covered by the Dental Benefit:

Dentures and bridgework: Full and partial dentures and fixed bridgework, including:

- Installation of the initial appliance to replace natural teeth extracted, including adjustments within six months of installation
- Replacement if the appliance is more than five years old and cannot be repaired (Appliances that are over five years old but can be made serviceable will be repaired, not replaced)
- Installation of the appliance for teeth missing as a result of a congenital anomaly. (Charges are limited to the allowance for a standard prosthetic device.)

The total allowance for both a temporary and permanent denture or bridge is limited to the maximum benefit for a permanent denture or bridge. Charges are determined from the date the first impression is taken.

Extractions, necessary surgery, and related anesthetics: These services are considered covered dental treatments. However, fractures and dislocations of the jaw are included under Medical Benefit Options.

Fillings and crowns: Composite, silver (amalgam) or porcelain fillings and plastic restorations subject to the following:

- Porcelain crowns are covered only for the 10 front upper and 10 front lower teeth
- Porcelain or plastic facings on crowns posterior to the second bicuspid are not covered
- Gold fillings and crowns are covered only when the tooth cannot be restored with other materials
- Crowns may only be replaced if the existing crown is more than five years old, regardless of the reason for the replacement.

Implants: Dental implants, inlays, and onlays only if medically necessary and approved by independent dental consultants selected by the Company are covered at 50%.

Night guards: Also referred to as occlusal guards and bruxism appliances are covered at 50% one per two year period.

Oral examinations, x-rays, and laboratory tests: The following are covered if necessary to determine dental treatment:

- Full mouth x-ray once in any five-year period
- Adult Bitewing x-ray one per calendar year
- Other x-rays necessary to propose diagnosis or examine progress of treatment.

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

Preventive treatment:

- Exams twice per calendar year
- Routine x-rays once per calendar year
- Teeth cleaning twice per calendar year
- Fluoride treatments twice a year for children under age 14. For children over 14 and adults fluoride treatments are allowed once a year.
- Sealants for children under age 15 (not covered on or after the child's 15th birthday)
- Space maintainers.

Root canals: Root canals and other endodontic treatments are covered. The charge for root canal therapy is considered to have been incurred on the date the tooth is opened.

Covered Orthodontia Expenses

The dental plan covers orthodontic treatment for an 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. Orthodontic coverage includes examinations, x-rays, laboratory tests, and other necessary treatments and appliances. There is no deductible for orthodontic treatments, and payments for orthodontia do not reduce the annual maximum benefit for other services.

The following explains additional information about orthodontia coverage:

Ongoing dental coverage: To remain eligible for coverage of orthodontic treatments that extend into a new coverage period (for example, the next calendar year), you must continue to cover the patient under your dental option during each annual enrollment period.

Payment of claims: Payment for orthodontia is made according to the following procedures (regardless of the payment method you arrange with your provider):

- The provider of service (orthodontist) should submit one billing that reflects the total cost of the patient's orthodontic treatment — even if the duration of treatment moves across calendar years. The Dental Benefit will pay up to the maximum 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).
- Coordination of benefits applies if the patient has other orthodontia coverage. If the patient has primary coverage under another plan, the amount paid for orthodontia under that plan will be deducted from the $1,500 maximum orthodontia benefit.

Health Care Flexible Spending Account

If you participate in the Health Care Flexible Spending Account (HCFSA), the total cost of the patient's orthodontic treatment (based upon the lump sum billing from the orthodontist) will be reimbursed from your HCFSA in one lump sum, up to the amount you elected to contribute for the year. Other dental services are also eligible for reimbursement, as explained in "Eligible Expenses" in the *Health Care FSA* section). The FSA administrator is PayFlex.

Excluded Expenses

The following expenses are not eligible for reimbursement under the Dental Benefit:

Anesthesia: General anesthetics (unless provided for oral surgery or periodontics).

Cosmetic treatment: Treatment or services partly or completely for cosmetic purposes or characterization or personalization of dentures or appliances for specialized techniques.

Crowns or appliances: Crowns, adjustments, or appliances used to splint teeth, increase vertical dimensions, or restore occlusion. Replacement of crowns less than five years old will not be covered, regardless of the reason for replacement.

Education or training: Education, training, or supplies for dietary or nutritional counseling, personal oral hygiene, or dental plaque control.

Free care: Charges for services or supplies that you are not legally required to pay.

Medical expenses: Any charge for dental care or treatment that is an eligible expense under your Medical Benefit Option.

Prescription drugs: Dental prescriptions. (These are covered under the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options. However, some HMOs do not cover dental prescriptions.)

Relatives: Treatment by a dentist or physician who is a close relative, including your spouse, children, adopted and step relatives, sisters and brothers, parents, and grandparents of you or your spouse.

Replacement dentures or bridges: Replacement charges for full or partial dentures or a fixed bridge that is less than five years old. Appliances that are over five years old but can be made serviceable will be repaired, not replaced. Any charges that exceed the cost of a standard prosthetic appliance.

Services not provided by dentist or physician: Any service not provided by a dentist or physician, unless performed by a licensed dental hygienist under the supervision of a dentist or physician, or for x-ray or laboratory tests ordered by a dentist or physician

Temporary dentures, crowns, or bridges after 12 months: A temporary fixture, such as a temporary denture, crown, or bridge that remains in place for 12 months or more is considered permanent and the cost of replacement is only covered when the item is more than five years old.

Temporomandibular joint dysfunction (TMJD): TMJD is considered an illness and has limited coverage only under the Medical Benefit Options (see *Medical Benefits Overview* for more information).

U. S. government services or supplies: Charges for services or supplies furnished by or for the U. S. government.

Usual and prevailing: Charges that exceed the usual and prevailing fee limits.

War-related: Services or supplies received as a result of a declared or undeclared act of war or armed aggression.

Work-related claims: Dental care received because of a work-related injury or illness sustained by you or your covered dependent, whether or not it is covered under Workers' Compensation, occupational disease law, or similar law.

Filing Claims

MetLife is the claims processor for the Dental Benefit; however, MetLife does not insure these benefits. Benefits for the Dental Benefit are self-funded, which means all claims are paid from the Company's general assets.

Completing the Dental Claim Form

The following is a summary of how to file claims for dental expense benefits:

- Complete the top portion of the Dental Expense Claim Form. Follow the instructions that accompany the form and then present the form to your dentist, who completes the remaining portion.
- Mail the completed claim form to MetLife at the address on the form.
- All dental claims payments are sent to you along with an Explanation of Benefits (EOB) explaining the amount paid. Payments may, however, be sent directly to your dentist or other dental provider if your provider accepts Assignment of Benefits (see "Assignment of Benefits" in the *Plan Administration* section). If you assign benefits to the service provider, the EOB will be mailed to you and the payment mailed to your provider.

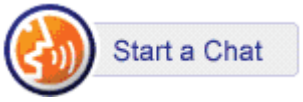
Claim Filing Deadline

You must submit all dental claims within two years of the date the expenses were incurred. Claims submitted more than 24 months after expenses were incurred will not be considered for payment. Notwithstanding the above, the Department of Health and Human Services ("HHS") and the Center for Medicare and Medicaid Services ("CMS") or any other agency under the HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

Additional Rules

The following sections of the *Additional Health Benefit Rules* section apply to the Dental Benefits.

- "Qualified Medical Child Support Order"
- "Coordination of Benefits"
- "Coordination with Medicare"
- "Continuation of Coverage - COBRA Continuation"



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Forms & guides can be located in the eHR Center of Jetnet at https://www.jetnet.aa.com/jetnet/go/ssoehr.asp?TargetDoc=XML=20

The Benefits Service Center is available at https://www.jetnet.aa.com/jetnet/go/ssomercer.asp

Vision Benefits

There are two plans that can help you save money on your vision care:

- Spectera® Vision
- EyeMed Vision Discount

In This Section **See Page**

Spectera® Vision

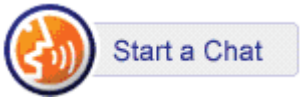
The Company offers employees and their eligible dependents the opportunity to participate in the Spectera® Vision Benefit. The Vision Benefit is insured and administered by Spectera® a national vision care company, and offers a network of providers and copayment for certain vision services.

Spectera® vision's network of providers includes retail chains, such as Eyemasters, as well as independent providers. You can locate participating providers by visiting the Spectera® website, or you can contact Spectera® at 1-800-638-3120 directly to locate a provider. To review the Spectera® Vision Program, refer to the Spectera® Vision Rates and Services chart and Spectera® Vision Care Brochure on the Spectera® website.

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

Spectera® Vision Insurance Benefits

If you use a network provider, the Spectera® Vision Insurance Benefit covers the following services, with the benefit available each calendar year, for each covered member. (The insurance also offers access to discounted laser eye surgery procedures.)



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Spectera® Vision Insurance Network Provider Benefits

Covered Services	You Pay…
Exam	$10 copayment
Contact lenses (in lieu of lenses and frames)	
Selection contact lenses	$25 copayment
Selection contact lenses, disposable	$25 copayment (for up to 6 boxes per year)
Non-selection contact lenses or ***Special contact lenses (gas permeable, bifocal, astigmatism lenses, etc).***	$150 allowance toward the evaluation, fitting fees, and contact lenses
Patient Options	
Progressive lenses and tints, etc.	No additional charge (is included in the $25 copayment for lenses)
Scratch-coating protection for lenses	No additional charge (is included in the $25 copayment for lenses

Out-of-Network Provider Benefits

Service	Reimbursement Schedule
Exam	Up to $40
Single Vision Lenses	Up to $40
Bifocal Lenses	Up to $60
Trifocal Lenses	Up to $80
Lenticular Lenses	Up to $80
Frame	Up to $45
Elective Contact Lenses	Up to $105
Medically Necessary Contact Lenses	Up to $210

Participating Providers (network) copayments and non-covered patient options are paid to participating providers by Spectera® Vision Insurance Benefits participants.

Non-participating providers (Out-of-Network) participants pay the full fee to the provider and file claims with Spectera® Vision. Spectera® Vision reimburses the participant for services rendered up to the maximum allowance.

Copayments do not apply to out-of-network benefits. Call Spectera® Vision at 1-800-638-3120 to obtain a claim form for out-of-network services.

Cost

Like the Medical Benefit Options offered by the Company, you may participate in the Spectera® Vision Insurance Benefit, and your contributions will be payroll-deducted. If you elect a Medical Benefit Option, the same dependents that are covered under your Medical Benefit Option must also be covered under the Vision Insurance Benefit.

Additional Rules

The following sections of the *Additional Health Benefit Rules* section apply to the Spectera® Vision Insurance Benefit.

- "Qualified Medical Child Support Order"
- "Coordination of Benefits"
- "Coordination with Medicare"
- "Continuation of Coverage - COBRA Continuation"

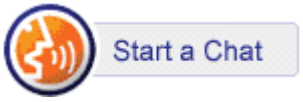
EyeMed Vision Discount

This Vision Discount Plan is a preferred provider discount program contracted through EyeMed. EyeMed has a national network of more than 4,000 chain and independent optical stores.

With EyeMed you'll receive savings averaging 37% on lenses and frames, a 20% savings on contact lenses and any sundry items and a 10% savings on disposable contacts. EyeMed preferred pricing limits the amount EyeMed providers can charge for a comprehensive eye examination. The EyeMed preferred pricing cannot be used in conjunction with any other promotion.

How the EyeMed Vision Discount Works

You receive an annual EyeMed membership card to present at participating optical stores. Presenting the card at the time of purchase entitles you to discounts on eyeglass lenses, frames, contact lenses, and sundry items. No claim form or special paperwork is required. To find the nearest participating EyeMed optical store, call the toll-free number listed on your membership card and ask for the location nearest you.



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Life Insurance Benefits

The Company offers eligible employees the opportunity to participate in an Employee Term Life Insurance Benefit as well as Spouse and Child Term Life Insurance Benefit. Employee Term Life Insurance coverage is for you only and pays a benefit to your designated beneficiary in the event of your death. Spouse and Child Term Life Insurance cover your eligible spouse and children only and pay you a benefit if your covered spouse or child dies. Optional levels of Voluntary Term Life Insurance coverage are also available (see "Voluntary Term Life Insurance Benefits" under "Employee Term Life Insurance" on page 108).

All life insurance benefits are paid solely by and through the insurance policies by the insurer. No life benefits are available outside of the insurance policy.

If you plan to cover a Company-recognized Domestic Partner under this life insurance, you must submit the MetLife Affidavit of Company-recognized Domestic Partnership.

"Term Life Insurance" is coverage that pays a death benefit, but has no cash value and remains in effect only during the time premiums are being paid. These coverages are insured by MetLife and you pay your share of the cost of Voluntary coverage, if any, through payroll deduction.

In This Section — See Page

Employee Term Life Insurance

Basic Life Insurance Benefits

As an eligible employee, the Company provides you Basic Term Life Insurance coverage of one times your base annual salary when you enroll in a medical benefit option.

You may not waive your Basic Term Life Insurance Benefits.

Voluntary Term Life Insurance Benefits

The Company provides you Basic Term Life coverage equal to one times your base annual salary. When you are first eligible for benefits, you may elect up to one level above the Company-provided coverage without providing proof of good health. You must complete a Statement of Health from MetLife if you wish to elect amounts greater than this. Coverage that requires proof of good health becomes effective only after MetLife approves your application and only after you (the employee) pay the first contribution, either directly or through payroll deduction. Rates for voluntary life insurance are based on your age. 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).

After you enroll, you may only increase your coverage by one level per year with proof of good health. The maximum Voluntary Term Life Insurance allowed is six (6) times your pay up to a maximum of $2,000,000 not including the Basic Life Insurance.

Below are the options that are available in the following amounts:

- Basic plus 1 times your base annual salary
- Basic plus 2 times your base annual salary
- Basic plus 3 times your base annual salary
- Basic plus 4 times your base annual salary
- Basic plus 5 times your base annual salary
- Basic plus 6 times your base annual salary

Coverage After Age 65

Basic Life Insurance coverage for active employees age 65 and over decreases annually as shown below. Although the amount of the benefit decreases, employees pay the full cost for the benefit they elect.

Age	Percentage Of Total Benefit Elected	Age	Percentage Of Total Benefit Elected
65	92%	71	56%
66	85%	72	52%
67	78%	73	48%
68	72%	74	44%
69	66%	75	41%
70	61%	76 and over	38%

Coverage If You Become Disabled

If you become permanently and totally disabled while covered, all of your Term Life Insurance coverage continues at no cost to you. To qualify for this benefit, you must become permanently and totally disabled before age 60 and up to age 65 be absent from work at least nine consecutive months because of your disability.

Permanent and total disability exists if all of the following requirements are met:

- You are not engaged in any gainful occupation
- Because of illness, injury, or both, you are completely unable to engage in any occupation for which you are reasonably fit
- Your disability is such that your inability to work will probably continue for the rest of your life.

To apply for a waiver of Basic and Voluntary Term Life Insurance contributions, you must file your claim with MetLife between the 9th and 12th month after the date your disability began. Claims filed after the 12th month will not be considered. Contact HR Services to request a claim form. Click on the "Start a Chat" button on the top of this page.

If you became disabled before January 1, 1995, and are approved for this waiver, your Basic and Voluntary Term Life Insurance coverage continues at no cost to you as long as you remain permanently and totally disabled.

MetLife will require you to submit proof of your continuing disability at least once a year. Proof may include examination by doctors designated by the insurance company. If this proof is not submitted, coverage will terminate.

Will Preparation and Estate Resolution Services

If you enroll for Voluntary Term Life Insurance you will be eligible to receive Will Preparation and Estate Resolution Services from Hyatt Legal Plans, a MetLife company, at no cost. Will Preparation provides that you and your spouse (or Company-recognized Domestic partner) may access an attorney participating in the Hyatt Legal Plan's network for the preparation or updating of an existing will at no additional charge.

In the event of your death, Estate Resolution Services provides your beneficiaries and/or Executor of your estate the opportunity to speak with an attorney regarding probate matters.

In order to utilize one of these services, please contact Hyatt Legal Plans at 1-800-821-6400.

Accelerated Benefit Option

The Accelerated Benefit Option (ABO) allows terminally ill people the opportunity to receive a portion of their life insurance during their lifetime. This money can be used to defray medical expenses or replace lost income during the last months of an illness and is not subject to income tax. The remaining portion of the life insurance benefit is payable to the named beneficiary when the covered person dies.

The ABO benefit is available to employees who have Company-provided Term Life Insurance (active or on sick leave) and their spouses covered under Spouse Term Life Insurance. Employees who are approved as permanently and totally disabled (as defined in Permanent and Total Disability and who continue the active amount of life insurance) are also eligible for an ABO.

To qualify for an ABO payout, the covered person must have an injury or illness that is expected to result in death within six months, with no reasonable prospect for recovery. A physician's certification is required, and all applications are subject to review and approval by MetLife's medical department. Based on this review, the claim is either paid or denied. If it is paid, you may not later change the amount of your life insurance coverage.

ABO payout for approved claims is 50% of your total Employee Term Life Insurance (Basic and Voluntary) or Spouse Term Life coverage, up to a maximum of $250,000. Therefore, any life insurance coverage in excess of $500,000 is not eligible for the ABO. In addition, a minimum of $15,000 in life insurance coverage is required to be eligible.

Your life insurance premiums must be current at the time of the ABO application. If you are on sick leave and have allowed your coverage to default to the Company-provided amount, you are only eligible to receive ABO benefits on that coverage amount. After an ABO payout, you are no longer permitted to change life insurance coverage levels. Employees who have irrevocably assigned their life insurance benefits (as explained below) are not eligible for ABO benefits. Contact HR Services for information and assistance in filing an application for an ABO. Click on the "Start a Chat" button on the top of this page.

Requesting the Accelerated Benefit Option

Contact HR Services for information on filing a request for an Accelerated Benefits Option (ABO). Click on the "Start a Chat" button on the top of this page.

Filing a Claim

MetLife insures all life insurance benefits under a group insurance policy. They also process all claims. The following is a short summary of the procedures for filing a claim for Term Life Insurance benefits:

- Upon receiving notice of an active employee's death, the supervisor should contact HR Services to provide notification of the death. Click on the "Start a Chat" button on the top of this page. Please also refer to the Death of an Employee Forms..
- HR Services notifies other applicable areas of the Company of your death and begins to process insurance claims or other survivor benefits and privileges.
- HR Services determines your most recently named beneficiary and confirms the amount of life insurance.
- HR Services sends a letter to the designated beneficiary contact verifying the amount of life insurance payable by the plan. They will enclose a Beneficiary Life Insurance Claim Statement and any other forms that each beneficiary must complete.
- When HR Services receives the completed Beneficiary Life Insurance Claim Statement and a certified copy of the death certificate, they will ensure a claim is filed with MetLife on behalf of your beneficiary.

The life insurance claim will be paid approximately four to six weeks after MetLife receives all necessary documentation.

Spouse and Child Term Life Insurance Benefits

You may cover either your spouse (under Spouse Term Life Insurance) or your children (under Child Term Life Insurance), or you may cover both your spouse and your children.

Spouse and Child Term Life Insurance options are as follows:

Option	Amount of Benefit
Spouse Term Life Insurance	
ES1	1 times your pay
ES2	2 times your pay
ES3	3 times your pay, up to $350,000 maximum
WAV	No coverage
Child Term Life Insurance	
EC1	$15,000 for each covered child
WAV	No coverage

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

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.

The following table defines pay for Employee Term Life Insurance:

Employee Status	Definition of Pay
Regular Full-time Employee	Base annual salary or annualized hourly pay plus market rate differentials, but excluding bonus and overtime
Converted Part-time Employees	Annualized hourly pay
Regular Part-time Employees	Average base salary
Employees on Temporary Assignment	Pay for the last permanent position held

You pay the entire cost for any Spouse and Child Term Life coverage you select. You elect coverage at the rate shown on your Enrollment Worksheet and pay for this coverage with after-tax contributions. Your spouse's rate is based on your spouse's age, but coverage for your child(ren) is based on a flat rate, regardless of the number of children covered.

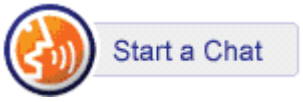
The cost of coverage for both the employee and spouse plans will increase or decrease during the year if the amount of your coverage fluctuates due to changes in your pay.

Filing a Claim

All life insurance benefits are provided under a group insurance policy issued by MetLife. MetLife also processes and pays all claims.

The following is a short summary of the procedures for filing a claim for Spouse or Child Term Life Insurance benefits:

- Upon the death of your covered spouse or child, you or your supervisor should inform HR Services of the death. Click on the "Start a Chat" button on the top of this page. You are the sole beneficiary for your spouse or child's term life insurance.
- After HR Services is notified of the death, it sends you a letter verifying the amount of life insurance payable. The letter will include a *Beneficiary Life Insurance Claim Statement*.
- Complete the *Beneficiary Life Insurance Claim Statement* and return it, along with a certified copy of the death certificate, to HR Services. Upon receipt of both items, HR Services will submit the claim to MetLife on your behalf.
- The life insurance claim will be paid in approximately four to six weeks after MetLife receives all necessary documentation. You may assign part of the benefits to pay funeral expenses, (see "Assignment of Benefits" in the *Additional Life and Accident Insurance Rules* section.)
- When a spouse or covered dependent dies, you may want to make changes to your benefits coverages. To process these changes, contact HR Services. Click on the "Start a Chat" button on the top of this page. For a list of allowable changes that may be appropriate at this time, see *Life Events*. For your convenience, the letter you receive from HR Services includes a Beneficiary Designation Form. You can also make any necessary changes to the beneficiary designations you have on file online in the Benefits Service Center.



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Total Control Account

When a claim is processed, MetLife establishes a Total Control Account for you if your share is $5,000 or more (smaller amounts are paid in a lump sum). MetLife then deposits all insurance proceeds into the account, which is an interest-bearing checking account that earns interest at competitive money market rates and is guaranteed by MetLife. MetLife sends you a personalized checkbook, and you may withdraw some or all of the proceeds and interest whenever necessary. In addition, MetLife sends you a description of alternative investment options. The Total Control Account gives you complete control over the money, while eliminating the need to make immediate financial decisions at a difficult time.

For income tax purposes, proceeds deposited into the Total Control Account are treated the same as a lump-sum settlement. Because the tax consequences of life insurance proceeds may vary, the Company strongly recommends that you consult a tax advisor.

MetLife will only pay interest on life insurance claims (to cover the time between death and date of payment) if you live in a state that requires interest payments. Because state insurance laws vary, calculation of interest differs from state to state.

Accident Insurance Benefit

As an eligible employee, you automatically receive Accidental Death & Dismemberment Insurance (AD&D) equal to 1× your annual salary from the Company, at no cost to you. You may also elect to purchase Voluntary Personal Accident Insurance (VPAI) for yourself and your family.

In the event of an accidental injury, VPAI and AD&D pay benefits to:

- You in the case of certain accidental injuries to you
- You in the event of your covered dependent's death (VPAI only)
- Your named beneficiary in the event of your death.

VPAI coverage also includes the following features:

- You pay premiums through convenient before-tax payroll deduction
- Coverage is available for you, your spouse and dependent children (if any)
- You may select coverage in $10,000 increments up to $500,000. If you elect family coverage the amount of insurance for your family members is a percentage of the amount elected, and is based on the composition of your family at the time of loss, as shown in the table below:

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

Coverage is available without regard to previous health history

- The plan provides broad 24-hour protection, year round, including coverage during travel
- Benefits are payable in addition to any other insurance you may have
- With VPAI coverage, you are also eligible for Travel Assistance Services (see "Travel Assistance Services" on page 118).

All accident insurance benefits are paid solely by and through the insurance policies by the insurer. No accident benefits are available outside of the insurance policy.

In This Section

Covered Losses and Accident Benefits

A covered loss includes death, paralysis, or loss of limb, sight, speech, or hearing. The Accidental Death and Dismemberment Insurance (AD&D) Voluntary Personal Accident Insurance (VPAI) coverages pay a benefit if you (or a covered dependent for VPAI) have a loss within one year of an accidental injury. If you experience more than one loss from the same accident, the coverages pay the largest amount applicable to one loss.

The following table explains when an injury is covered as a loss:

If Injury Is To:	It Must Be:
Hand or foot	Severed through or above the wrist or ankle joint
Arm or Leg	Severed through or above the elbow or knee joint
Eye	The entire, irrecoverable loss of sight
Thumb and index finger	Severed through or above the metacarpophalangeal joint (the point where the finger is connected to the hand)
Speech	An irrecoverable loss of speech that does not allow audible communication in any degree
Hearing	An irrecoverable loss of hearing in both ears, that cannot be corrected with any hearing aid or device

AD&D and VPAI Benefits

The following table shows the portion of benefits that the AD&D and VPAI coverages pay if you (or your covered dependent for VPAI) have an accidental injury that results in a loss:

If Injury Results In:	Benefit Is:
Death	Full benefit amount
Loss of two or more members (hand, foot, eye, leg, or arm)	Full benefit amount
Loss of speech and hearing in both ears	Full benefit amount
Quadriplegia (total paralysis of both upper and both lower limbs)	Full benefit amount
Paraplegia (total paralysis of both legs)	Full benefit amount
Hemiplegia (total paralysis of the arm and leg on one side of the body)	Full benefit amount
Loss of one arm	3/4 benefit amount
Loss of one leg	3/4 benefit amount
Loss of one hand, foot, or eye	1/2 benefit amount
Loss of speech	1/2 benefit amount
Loss of hearing in both ears	1/2 benefit amount
Loss of thumb and index finger on the same hand	1/4 benefit amount

If your accidental injury results in the loss of use of a limb (arm or leg) within one year from the date of an accident, the AD&D and VPAI Insurance Benefits pay the following benefits:

Injury	Benefit
Loss of Use of two limbs	2/3 benefit amount
Loss of use of one limb	1/2 benefit amount

Loss of use must be complete and irreversible in the opinion of a competent medical authority.

Special VPAI Benefit Features

The Voluntary Personal Accident Insurance (VPAI) offers several special features. These features do not apply to Accidental Death & Dismemberment (AD&D).

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

Child care benefit: If you or your spouse dies as the result of an accident and your child is covered under the family VPAI, the coverage pays the surviving spouse an annual benefit of 5% of the total coverage amount (up to $7,500 per year) for the cost of surviving children's care in a licensed child care facility. This benefit is payable up to five years or until the child enters first grade, whichever occurs first.

COBRA reimbursement: If you die as a result of an accident an your spouse and child are covered under the family VPAI, the coverage pays your dependents an additional annual benefit of 3% of your VPAI coverage amount to assist them in paying for continuation of group medical coverage, up to $6,000 per year. This COBRA reimbursement benefit may be paid for up to three years or for the duration of your dependents' COBRA eligibility. To be eligible for this benefit, your spouse and dependent children must be covered under the family VPAI as well as your Medical Benefit Option.

Coma benefit: If you or a covered dependent becomes comatose as the result of an accident within 31 days of the accident, you receive 1% per month of the VPAI death benefit amount each month for up to 11 months. This benefit ends the earliest of:

- The month the covered person dies
- The end of the 11th month for which the benefit is payable
- The end of the month in which the covered person recovers.

This benefit is payable after a 31-day waiting period which begins on the day the covered person becomes comatose.

If the covered person remains comatose after 11 months, the coverage pays the amount of coverage for accidental death reduced by benefits already paid for injury or paralysis. If the covered person dies as the result of the accident while the coma benefit is payable, the coverage pays benefits for accidental death.

In addition to other VPAI exclusions, the coma benefit has one other exclusion. Benefits are not payable for a loss resulting from illness, disease, bodily infirmity, medical or surgical treatment, or bacterial or viral infection, regardless of how it was contracted. However, a bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning is covered.

Coma benefits are paid to the legal guardian or person responsible for the care of the comatose patient. The claims processor determines who is most responsible if a legal guardian is not named.

Payment of the coma benefit to the legal guardian or person responsible for care does not change the designated beneficiary in the event of death.

Common disaster benefit: If you elect family VPAI coverage and, as the result of a common accident, you or your spouse dies within one year of the covered accident, the spouse's loss of life benefits will be increased to 100% of your amount of coverage. However, the combined benefits of you and your spouse will not be more than $1 million.

Counseling and bereavement benefits: VPAI pays an additional benefit if you or an insured family member dies, becomes comatose, or is paralyzed or suffers accidental dismemberment as a result of a covered accident. VPAI will pay for up to five sessions of medically necessary bereavement and trauma counseling, at a maximum of $100 per session, for expenses incurred within one year of the date of the covered accident. Benefits are payable for the insured and any of the insured's immediate family members including mothers/fathers-in-law, and brothers/sisters-in-law.

Double benefit for dismemberment of children: If a covered child experiences a loss as the result of an accident, the benefit amount is double (to a maximum benefit of $60,000). This provision does not apply if death occurs within 90 days of the accident.

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

Escalator benefit: Your VPAI benefits will automatically increase by 3% of your elected benefit amount each year up to a maximum of 15% after five continuous years. This increased coverage is provided at no additional cost. If coverage ends for any reason, such as layoff, unpaid sick leave of absence, or termination of contributions, any previous escalator benefit is lost. A new five-year escalator benefit period starts if you decrease your coverage or re-enroll. If you increase your level of coverage, you will retain the escalator benefit that has accrued on the previous amount and will begin a new five-year escalator period for the additional amount of coverage.

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

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

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

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

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

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

Seat belt benefit: If you or your covered dependent dies in an accident as the driver or passenger of any land vehicle (including Company-owned cars, pickups, and commercial vehicles) and the covered person was properly wearing a seat belt at the time of the accident, the coverage pays an additional 20% of the benefit applicable to you or your dependent, to a maximum of $25,000. If the vehicle was not equipped with seat belts or the accident report shows seat belts were not in proper use, no seat belt benefit is payable.

Special education benefit: If either parent dies as the result of an accident and you, your spouse, and your children are all covered by the family VPAI, the coverage pays 5% of that parent's total coverage amount (up to $10,000 per year) to each dependent child for higher education. This benefit is payable for up to four consecutive years, as long as the child is enrolled in school beyond 12th grade. If coverage is in force but there are no children who qualify at the time of the accident, the coverage pays an additional $1,000 to the designated beneficiary.

Spouse critical period: If you or your covered spouse dies as a result of an accident, VPAI pays the surviving spouse an additional monthly benefit of 0.5% of the deceased person's coverage amount. This benefit, provided to help the surviving spouse cope with the difficult period immediately following a death, is paid monthly for 12 months.

Spouse retraining benefit: If you die accidentally and your spouse is also covered by the family VPAI, the coverage pays up to a maximum of $10,000 for your spouse to enroll as a student in an accredited school within 365 days of your death. This benefit is in addition to all other benefits.

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

Waiver of premium: If you elect VPAI coverage for you and your dependents and you die as the result of an accident, any VPAI coverage you have elected for your spouse and children continues without charge for 24 months.

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

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

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

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

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

In addition, this insurance provides a permanent and total disability (PTD) benefit of $200,000 per covered individual 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.

Travel Assistance Services

If you elect Voluntary Personal Accident Insurance (VPAI) coverage for yourself, you may also take advantage of travel assistance services when you and your covered family members travel internationally. This package of valuable services and benefits is called CIGNA Secure Travel and is provided by Worldwide Assistance Services, Inc.

Through CIGNA Secure Travel, you have access to more than 250,000 service professionals in over 200 countries. These agents are available 24 hours a day, seven days a week to provide you with the highest level of service whenever you need it.

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CIGNA Secure Travel offers the following services for international travel:

- Services before your departure, including:
  - Immunization requirements
  - Visa and passport requirements
  - Foreign exchange rates
  - Embassy/consular referral
  - Travel/tourist advisories
  - Temperature and weather conditions
  - Cultural information
- Prescription assistance to refill a prescription that has been lost, stolen, or depleted
- Assistance in replacing lost luggage, documents, and personal items
- Legal referrals to local attorneys, embassies, and consulates
- Medical referrals to local physicians, dentists, and medical treatment centers in the event of an accident or illness (The legal referral services listed in the preceding bullet are a benefit of VPAI coverage; however, you will need to pay for any professional services rendered. You must also follow your Medical Benefit Option rules in order to receive reimbursement for any eligible expenses.)
- Emergency message relay to notify friends, relatives, or business associates if you have a serious accident or illness while traveling
- Emergency medical evacuation for transportation to the nearest adequate hospital or treatment facility if medically necessary
- Repatriation of remains in the event of death overseas to cover the cost of returning remains to the place of residence and arranging necessary government authorizations to transfer remains
- Return of dependent children (who are under age 16) traveling with a covered member and who are left unattended when the covered member is hospitalized (Worldwide Assistance Services will arrange and pay for their transportation home. If someone is needed to accompany the children, a qualified escort will be arranged and expenses paid. Children do not have to be covered under VPAI for this benefit.)

If a covered member is traveling alone and must be hospitalized for 10 or more consecutive days, arrangements will be made and paid to provide round-trip economy class transportation for an immediate family member or friend designated by the covered member from his/her home to the place where the covered member is hospitalized. (Worldwide Assistance Services will also arrange and pay for a maximum of $100 per day for up to seven days for meals and accommodations for the family member or friend while they are visiting the hospitalized covered member.)

Take care of all your beneficiary designations in one efficient online process. Visit *My Beneficiaries* under the Benefits section on Jetnet. Please keep in mind that wording is important when designating a beneficiary, and you can designate an unlimited number of beneficiaries. Once the online form is completed and submitted, it supersedes all previous designations. See "Beneficiaries" in the *Additional Life and Accident Insurance Rules* section for more information on designating beneficiaries.

Exclusions

The AD&D and VPAI Insurance policies do not cover loss caused by or resulting from any of the following:

- Intentionally self-inflicted injuries, suicide, or attempted suicide
- Declared or undeclared act of war within the U.S. or any nation of which you are a citizen
- An accident that occurs while you are serving full-time active duty for more than 30 days in the armed forces of any country or international authority
- Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity, or any bacterial infection other than bacterial infection caused by an accidental cut or wound
- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from the vehicle or device while:
  - The vehicle is being used for experimental purposes
  - You are operating, learning to operate, or serving as a member of the crew of an aircraft other than an aircraft operated by or under contract with the Company
- Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a licensed physician (accidental ingestion of a poisonous substance is covered, as well as accidents caused by use of legal, over-the-counter drugs)
- Commission of a felony including, but not limited to: robbery, rape, arson, murder, kidnapping, or burglary.

Filing a Claim

Voluntary Personal Accident Insurance (VPAI) and Accidental Death & Dismemberment Insurance (AD&D) are provided under group insurance policies issued by the Life Insurance Company of North America (LINA). CIGNA processes all claims for LINA. The following is a short summary of the procedure for filing a claim for VPAI and AD&D benefits:

- Contact HR Services to request a CIGNA Claim Form within 30 days of the death or injury. Click on the "Start a Chat" button on the top of this page. (In the event of your death, your supervisor will notify Survivor Support Services, who will coordinate filing for VPAI and AD&D benefits, similar to the procedures outlined for life insurance claims in Term Life Insurance). Complete the form according to accompanying directions. All claims must be submitted on CIGNA forms.
- Send the completed claim form to HR Services along with documentation of the claim (such as a police report of an accident and a certified copy of the death certificate). HR Services sends the claim to CIGNA for processing.
- CIGNA processes claims within 90 days from the day they are received. In some cases, however, more time may be needed. If this is the case with your claim, CIGNA notifies you that an additional 90 days will be required. At any point during the claim review period, you may be asked to supply additional information and/or submit to a medical examination at LINA's expense.
- If your claim is approved the insurance proceeds will be deposited into a CIGNA Resource Manager Account (similar to a money market checking account) which earns interest.
- If your claim is denied, you or your beneficiary will be notified in writing. Notification explains the reasons for the denial and specifies the provisions of the LINA group policy that prevent approval of the claim. The notification may also describe what additional information, if any, could change the outcome of the decision.
- If your claim is denied or you have not received a response by the end of the second 90-day review period, you may request a review of your claim.
- No one may take legal action regarding the claim until 60 days after filing the claim. No legal action may be taken more than three years after filing the claim (five years in Kansas or six years in South Carolina). You must exhaust your administrative appeals before filing any legal action regarding a claim denial.

Conversion Rights

You can convert up to $250,000 in VPAI coverage for you and your spouse and up to $10,000 in coverage for each eligible child to individual policies offered by Life Insurance Company of North America (LINA) within 31 days of termination of coverage if coverage terminates for one of the following reasons:

- Your employment ends
- Your eligibility ends (However, a dependent who is no longer eligible for coverage may not convert to an individual policy while you remain eligible for coverage.)
- The coverage ends.

Contact LINA at 800-238-2125 for details on conversion.

Insurance Policy

The terms and conditions of this AD&D and VPAI coverages are set forth in the group insurance policies issued by Life Insurance Company of North America (LINA). These group policies are available for review from LINA. In the event of a conflict between the description in this Guide and the provisions of the insurance policies, the insurance policies will govern.

Other accident insurance, including Special Risk Accident Insurance and Special Purpose Accident Insurance, is provided under group insurance policies issued by LINA (see *Other Accident Insurance* below). CIGNA processes and pays all claims for LINA. To file a claim, you (or your supervisor for your beneficiary, in the event of your death) should contact HR Services. Click on the "Start a Chat" button on the top of this page.

Other Accident Insurance

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

- Premiums are paid by the Company.
- Coverage is provided without regard to your health history.
- The insurance provides 24-hour protection while you are traveling on Company business, from the time you leave until you return home or to your base, whichever occurs first.
- Benefits are payable in addition to any other insurance you may have.
- Covered losses include death or loss of limb, sight, speech, or hearing. The insurance pays a benefit if you have a loss within one year of an accidental injury. For a description of injuries and how benefits are paid, see "Covered Losses and Accident Benefits" on page 114.
- No more than one Other Accident Insurance Benefit will be paid with respect to injuries resulting from one accident. If you have more than one loss from the same accident, you are entitled to the largest benefit amount for a single loss.
- Benefits payable under these other accident coverages do not reduce any accident benefits you may receive under the AD&D and VPAI insurance coverages.

The Company also provides other accident insurance under certain situations. These programs include Management Personal Accident Insurance (MPAI), Special Risk Accident Insurance (SRAI) and Special Purpose Accident Insurance (SPAI). Benefits from these programs are payable in addition to any benefits you may receive under the AD&D and VPAI plans.

MPAI Benefits

MPAI provides coverage for management employees while traveling on Company business and for non-occupational accident including any land or water vehicle coverage is three times your salary up to a maximum of $200,000.

SRAI Benefits

SRAI provides coverage for management, agent, support staff and TWU employees for accidental death and dismemberment that occurs as a result of terrorism, sabotage or felonious assault while performing your duties anywhere in the world. SRAI pays a benefit of five times your annual base salary up to a maximum of $500,000.

SRAI pays a benefit of five times your annual base salary up to a maximum of $500,000. This coverage only applies to employees on active payroll. SRAI benefits are reduced by any benefits you receive under MPAI.

SPAI Benefits

This coverage applies to management, agent, support staff and TWU employees. It pays up to $100,000 to each employee who is injured in an accident while engaging in an organized search because of a bomb threat or warning of the presence of an explosive device. Coverage does not apply to an aircraft that is airborne.

The plan also pays up to $100,000 to non-flight employees injured in an accident while riding on Company business as passengers, mechanics, observers or substitute flight attendants in any previously tried, tested and approved aircraft operated by a properly certified pilot.

Policy Aggregates

An accident may involve more than one employee. Total benefits to all covered employees involved in a single incident are limited to:

- $5,000,000 per aircraft under MPAI
- $10,000,000 per accident under SRAI
- $2,000,000 per aircraft accident under SPAI.

If benefits for one incident would exceed the limit, benefits are distributed to beneficiaries in proportion to the amounts of insurance covering all employees who suffer losses in the same incident.

Exclusions

These accident insurance policies do not cover losses caused by or resulting from any of the following:

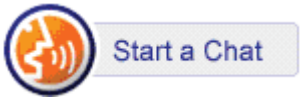
- Suicide, attempted suicide, or intentional self-inflicted injuries
- Declared or undeclared act of war (Under SRAI, hostile acts of foreign governments are not covered within the U.S.)
- An accident that occurs while you are serving on full-time, active duty in the armed forces of any country or international authority
- Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity, or any bacterial infection other than bacterial infection caused by an accidental cut or wound

- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting, while:
  - The vehicle is used for test or experimental purposes
  - You are operating, learning to operate, or serving as a member of the crew except while riding solely as a passenger, mechanic, substitute flight attendant, or acting as a crewmember on any aircraft owned by or under contract to American Eagle Airlines and Its Affiliates
  - Being operated under the direction of any military authority other than transport-type aircraft operated by the Military Airlift (MAC) of the United States of America or a similar air transport service of any other country
- Commuting to and from work (SRAI Plan)
- While a driver/occupant of any conveyance engaged in race/speed test (MPAI Plan)

Insurance Policy

The terms and conditions of the Other Accident Insurance coverages are set forth in the group insurance policies issued by the Life Insurance Company of North America (LINA). The group policies are available for review from the Plan Administrator.

In the event of a conflict between the description in this Guide and the provisions of the insurance policies, the insurance policies will govern.



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Disability Benefits

The following summary helps you understand the benefits you may be eligible to receive in the event of an illness or disability. Both Optional Short Term Disability Benefits and Long Term Disability Benefits are not taxable income because you pay for this coverage with after-tax contributions.

Optional Short Term Disability Insurance (OSTD)

When Benefits Begin

The later of:

- eighth day of your illness or disability
- when sick pay is exhausted. (Refer to the *Employee Policy Guide* for a summary of sick pay benefits.)

When Benefits End

- The earlier of the date the claims processor determines you are no longer disabled
- You become gainfully employed in any type of job except under the Return-to-Work Program (see "Return-to-Work Program" on page 137)
- the 26-week maximum period ends
- you die.

Amount of Benefit

- 50% of adjusted monthly salary (reduced by any state disability benefits you are eligible to receive).

Long Term Disability Insurance Benefit (LTD)

When Benefits Begin

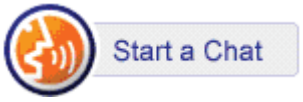
The latest of:

- the date you are disabled for four consecutive months
- the latest day you received salary/pay from the Company (both salary continuance [if applicable] and sick pay)—sick pay must be exhausted
- the last day you receive other benefits for this disability.

When Benefits End

The earlier of the date:

- the claims processor determines you are no longer disabled
- you become gainfully employed in any type of job for any employer, except under the Return-to-Work Program (see "Return-to-Work Program" on page 137)
- the date you reach age 65 (unless disabled after age 60)
- you reach the maximum benefit period (see Exclusions and Limitations)
- you die.



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Amount of Benefit

- 50% of base monthly salary up to $16,666.67 as of your last day paid (reduced by benefits from other sources). See "Benefits from Other Sources" on page 136.
- If you are enrolled in Long Term Disability (LTD) coverage, you will receive the full OSTD benefit, plus you will receive a minimum benefit from LTD (to begin the later of 4 months from the date of disability or when sick pay is exhausted). Once the 26 weeks of OSTD are exhausted, the full LTD benefit will be payable.
- The minimum LTD benefit for both full-time and part-time employees is the greater of 10% of your pre-disability base monthly salary on your last day worked or $100 per month.
- Average monthly salary for a part-timer is based on average weekly earnings for the last six (6) months up to a maximum allowed by Federal Law.

In This Section — See Page

Optional Short Term Disability Insurance Benefit

How the OSTD Insurance Benefit Works

Optional Short Term Disability Insurance (OSTD) protects you in the event you are not able to work due to a non-occupational illness or injury. 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. For regular, full-time employees, adjusted monthly salary is defined as your annual base salary or annualized hourly pay plus skill and license premiums and market differentials. It does not include profit sharing, bonus, overtime, or incentive pay. All OSTD benefits are paid solely by and through the insurance policies by the insurer. For converted and part-time employees, "adjusted monthly salary" is based on average weekly earnings for the last six (6) months.

No OSTD benefits are available outside of the insurance policy.

Before electing OSTD insurance, you should consider your accrued sick time because OSTD benefits are not payable until all of your accrued sick pay is used.

The OSTD insurance also offers a *Return-to-Work Program* (see "Return-to-Work Program" on page 137) that allows you to go back to work on a trial basis while recovering from a disability.

The cost of OSTD insurance is collected through payroll deductions. If you enroll, your selection remains in effect for two (2) calendar years. If you choose not to enroll when you are first eligible and decide to enroll later, proof of good health is required. You may add coverage if you experience a qualifying Life Event. Your OSTD insurance will not become effective until you are actively at work and a payroll deduction has been taken.

If you are unable to work your normal work schedule for any reason, you must address your work status with your supervisor. This is true regardless of whether you receive OSTD pay.

Eligibility

Actively at Work or Active Work 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:

- the Policyholder's place of business;
- an alternate place approved by the Policyholder; or
- a place to which the Policyholder's business requires you to travel.

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

Definition of Total Disability

You are considered totally disabled if you are not gainfully employed in any type of job for wage or profit and are unable to perform major and substantial duties pertaining to your own occupation because of sickness or accidental bodily injury.

Disabled or Disability means that, due to sickness, or as a direct result of accidental injury:

- You are receiving appropriate care and treatment and complying with the requirement of such treatment; and
- You are unable to perform each of the material duties of your own occupation.

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

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

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

The Company's approval of your sickness or injury leave of absence is independent of disability benefit determination and should not be construed as validation of your disability claim or any guarantee of benefits payable for your disability claim.

OSTD Insurance Benefits

If you have a qualifying disability, the OSTD benefit covers the difference between any state-provided benefit and 50% of your adjusted weekly monthly salary on your last day worked. The maximum covered salary is $200,000.

In some cases, OSTD benefits may be limited:

- If you are based in California, Hawaii, New Jersey, New York, Rhode Island, or Puerto Rico, you may be eligible for state disability benefits. Employees based in California, Hawaii, and Rhode Island must apply directly to the state for benefits.
- If you have accrued a significant number of unused sick days, you would not be able to collect OSTD until you have used all those days.
- If you are enrolled in the Long Term Disability Insurance Benefit (LTD), you will receive the full benefit of the OSTD benefit, plus you will receive a minimum benefit from LTD (to begin the later of four months from the date of disability or when sick pay is exhausted). Once the 26 weeks of OSTD are exhausted, the full LTD benefit will be payable.

The OSTD benefits you receive are not taxable income because you pay for this coverage with after-tax contributions.

Filing a Claim

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

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

The following is a summary of how you file a claim for disability benefits:

- You only need to file one claim to request benefits under the OSTD Insurance Benefit, state disability plans (other than California, Rhode Island, and Hawaii, which have their own forms that must be filed directly with the respective states), and LTD Insurance Benefit. You or your supervisor should request the Disability Claim Form as soon as you become disabled.
- You, your supervisor, and your attending physician must each complete part of the form:
  - *Disability Claim Employer Statement:* Your supervisor completes this page.
  - *Disability Claim Employee Statement:* You complete this page. Be sure to sign the Reimbursement Agreement on the back of the form (see "Benefits from Other Sources" on page 136).
  - Disability Claim Attending Physician Statement: Your physician completes this page.

The completed sections may be mailed together or separately to the claims processor at the address on the form.

After the claims processor receives the form, your claim will be processed. Sometimes the claims processor may request additional information. You will be notified of the decision regarding your claim. Notification and/or payment is made directly to you.

MetLife is the claims processor for the Optional Short Term Disability Insurance Benefit. The OSTD and state disability coverages are insured plans (including state plans in New Jersey, New York, and Puerto Rico). The states of California, Hawaii, and Rhode Island administer their own disability plans.

Return to Work Program

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

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

Family Care Incentive

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

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

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

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

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

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

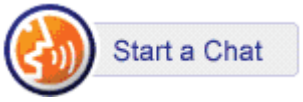
Care to your family member may not be provided by a member of your immediate family.

When Benefits Begin

Provided you qualify, OSTD is payable on the eighth day of disability or when your accrued paid sick time is exhausted, whichever is later. If you are collecting vacation pay when OSTD benefits become payable, OSTD will not begin until your vacation pay ends. Benefits are payable for a maximum of 26 weeks.

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

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



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Recovery from a Disability

- For purposes of this subsection, the term Active Work only includes those days you actually work.
- The provisions of this subsection will not apply if your insurance has ended and you are eligible for coverage under another group short term disability plan.

If You Return to Active Work Before Satisfying Your Elimination Period

- If you return to active work before satisfying your Elimination Period and then become disabled, you will have to complete a new elimination period.

If You Return to Work After Completing Your Elimination Period

- If you return to active work after you begin to receive weekly benefits, we will consider you to have recovered from your disability.
- If you return to active work for a period of 60 days or less, and then become disabled again due to the same or related sickness or accidental injury, we will not require you to complete a new elimination period. For the purpose of determining your benefits, we will consider such disability to be part of the original disability and will use the same pre-disability earnings and apply the same terms, provisions and conditions that were used for the original disability.

Benefits from Other Sources

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

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

When Benefits End

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

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

If and when you return to work, you or your supervisor must notify MetLife to stop benefit payments. This ensures proper closure of your claim and avoids possible overpayment. You are responsible for reimbursing the OSTD Insurance for any overpayments you receive.

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Exclusions and Limitations

OSTD Insurance Benefit has the following exclusions and limitations:

- If you are based in California, Hawaii, New York, New Jersey, Puerto Rico, or Rhode Island, then OSTD benefits are offset. Employees based in these states receive similar benefits that are provided in compliance with applicable state law. If the state benefit is less than the OSTD benefit, an OSTD benefit is payable. If the state benefit is more than the OSTD benefit, an OSTD benefit is not payable.
- Benefits are not payable if you are disabled as a result of a work-related accident or sickness. An injury or illness is not considered work-related for OSTD purposes if the claim is denied by Workers' Compensation.
- If you become disabled before the effective date, you are not covered under this insurance until you return to work and deductions are taken from your pay.
- Benefits are payable to employees. Dependents are not eligible for this benefit.
- Benefits are not payable if you are disabled as a result of committing or trying to commit a felony, assault or other serious crime.
- Benefits are not payable if you are disabled as a result of self-inflicted injuries or attempted suicide.
- Benefits are not payable if caused by a declared or undeclared act of war.
- Benefits are not payable unless you are receiving Appropriate Care and Treatment for your disabling condition from a duly qualified physician.
- Benefits may be reduced if you participate in a return-to-work program.
- **Preexisting Conditions Exclusion:** You are not covered under this benefit for a disability if you received medical care or treatment for the disability within the three months before the effective date of this coverage. However, after you have been covered for twelve months, this limitation on disability no longer applies, and you may receive benefits. (Also see the Glossary for the OSTD insurance benefit definition of a preexisting condition).

Long Term Disability Insurance Benefits

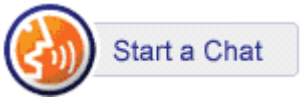
How the Benefit Works

The Company offers eligible employees the opportunity to participate in a Long Term Disability (LTD) Plan.

LTD benefits replace a portion of your salary when you are unable to work as a result of a disability. Most absences from work due to disability are generally of short duration and covered by paid sick time or Optional Short Term Disability (OSTD) benefits. However, some absences may continue for longer periods. LTD coverage provides you protection during these extended absences. LTD coverage also provides you the opportunity to return to work on a trial basis and to participate in a rehabilitation program. You pay the cost of LTD coverage through payroll deductions with after-tax contributions. If you choose not to enroll when you are first eligible and later decide to enroll, proof of good health is required.

The Company provides limited salary protection for non-work related disabilities through accrued sick pay and Optional Short Term Disability Insurance (OSTD) benefits. OSTD Insurance benefits end after a maximum period of 26 weeks. If you also participate in the LTD Insurance Benefit, your LTD benefits begin after the latest of:

- the date you are disabled for four consecutive months; the latest day you received salary/pay from the Company (both salary continuance [if applicable] and sick pay); or
- the last day you receive other benefits for this disability.



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Definition of Total Disability

During the elimination period and the first 24 months for which LTD benefits are payable, you are considered totally disabled if you are not gainfully employed in any type of job for wage or profit, and are unable to perform major and substantial duties of your own occupation because of sickness or accidental bodily injury.

After 24 months for which benefits are payable, you are considered totally disabled if you are not gainfully employed in any type of job for any employer, and are unable to perform major and substantial duties of any occupation or employment for wage or profit for which you have become reasonably qualified by training, education, or experience.

The only conditions under which you may be gainfully employed in any type of job for wage or profit and still be considered totally disabled are described under "Mandatory Rehabilitation Program Incentive" on page 138.

Should you become disabled and your occupation require a license, a loss of that license in itself will not automatically qualify you for disability benefits.

The Company's approval of your sickness or injury leave of absence is independent of disability benefit determination and should not be construed as validation of your disability claim or any guarantee of benefits payable for your disability claim.

You will be required to receive Appropriate Care and Treatment during your disability. Appropriate Care and Treatment means medical care and treatment that is:

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

LTD Benefits

LTD benefits are not taxable income because you pay for this coverage with after-tax contributions.

Full-time employees: Your monthly LTD benefit, together with benefits from other sources, equals 50% of your base monthly salary on your last day paid. Your maximum monthly benefit will be $16,667.67

Part-time employees: Your monthly LTD benefit, together with benefits from other sources, is 50% of your base monthly salary on your last day paid. (Average monthly salary is based on average weekly earnings for the last six (6) months up to a maximum allowed by Federal Law.)

The minimum LTD benefit for both full-time and part-time employees is the greater of 10% of your pre-disability base monthly salary on your last day worked or $100 per month.

Whether you are a full-time or part-time employee, the amount you receive from the LTD Insurance Benefit is reduced by your income from other sources, including, but not limited to, other disability plans, unemployment benefits, Social Security Disability Benefits, and benefits from Workers' Compensation, occupational disease law, or other similar law. If you have a family and are eligible for family Social Security Disability Benefits, total payments from all sources will not be more than 80% of your base monthly salary on your last day paid.

The LTD Insurance Benefit provides you the opportunity to participate in a Mandatory Rehabilitation Incentive Program. This Program allows you to increase your Monthly Benefit by 10% by re-entering the work environment. The Mandatory Rehabilitation Incentive Program is separate from the Workers' Compensation Transitional Duty program for employees with a work-related injury or illness. Employees participating in the Transitional Duty program are not eligible for the Mandatory Rehabilitation Incentive Program. For details, see "Mandatory Rehabilitation Program Incentive" on page 138.

Claim determinations for this benefit will be made on the basis of a "National Economy." National Economy means the geographic area in which you reside and also offers suitable employment opportunities within a reasonable travel distance. Should you move after the date of your disability both your former and current residence is considered to be within your "Local Economy."

Elimination Period

The elimination period is the waiting period before LTD benefits are payable. It extends until the latest of the following:

- The date you have been continuously totally disabled for four (4) consecutive months
- The last day of salary continuation (injury-on-duty pay, sick pay or vacation pay) during total disability.

Duration of Benefits

After you qualify for LTD benefits, if you remain disabled, you receive a monthly benefit for the following maximum period:

Age at Which Disability Begins	Maximum Duration of Benefits
60 or younger	To age 65
61	3-3/4 years
62	3-1/2 years
63	3 years
64	2-1/2 years
65	2 years
66	1-3/4 years
67	1-1/2 years
68	1-1/4 years
69 and over	1 year

During your disability, you may be required to provide additional medical information or submit to periodic physical exams to confirm your continuing disability. LTD benefits end if you do not agree to undergo a physical exam or provide the required information.

Filing a Claim

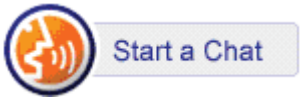
You should file your Long Term Disability (LTD) claim as soon as you become disabled. Do not wait until your sick pay is used up or until your four-month elimination period expires — *file your claim immediately.* The latest you can file your LTD claim is one (1) year after your disability began. If you file your disability claim beyond this one-year deadline, your claim will not be accepted and you will not be eligible for LTD Insurance Benefits.

The following is a summary of how you file a claim for disability benefits:

- You only need to file one claim to request benefits under the OSTD, state disability plans (other than California, Rhode Island, and Hawaii which have their own forms that must be filed directly with the respective states), and LTD programs. You or your supervisor should request the Disability Claim Form as soon as you become disabled.
- You, your supervisor, and your attending physician must each complete part of the form:
  - *Disability Claim Employer Statement*: Your supervisor completes this page.
  - *Disability Claim Employee Statement*: You complete this page. Be sure to sign the Reimbursement Agreement on the back of the form (see "Benefits from Other Sources" on page 136).
  - Disability Claim Attending Physician Statement: Your physician completes this page.

The completed sections may be mailed together or separately to the claims processor at the address on the form.

After the claims processor receives the form, your claim will be processed. Sometimes the claims processor may request additional information. You will be notified of the decision regarding your claim. Notification and/or payment is made directly to you.



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When Benefits Begin

Provided you qualify, LTD benefits are payable at the end of the elimination period — the latest of the following dates:

- the date you are disabled for four consecutive months;
- the latest day you received salary/pay from the Company (both salary continuance and sick pay) — sick pay must be exhausted; or
- the last day you receive other benefits for your disability.

If you are collecting vacation pay when LTD benefits become payable, your LTD benefits will not begin until your vacation pay ends. If you return to work in a capacity comparable to your pre-disability status during the elimination period, you are still considered continuously disabled if you become totally disabled again due to the same or related sickness or injury within 60 days after returning to work in your pre-disability occupation or other comparable work. However, days worked do not count toward your elimination period.

If you have received LTD benefits for an earlier disability and become totally disabled again, your most recent disability is considered part of the previous disability. However, this provision does not apply if you have returned to work in a capacity comparable to your pre-disability status for at least three months, or, if the cause of the later disability is totally unrelated to the earlier disability. If it is considered a separate period of disability, you must satisfy a new elimination period.

When Benefits End

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

- The date your benefits expire, as explained in Duration of Benefits
- The date you reach age 65 (unless disabled after age 60)
- The date you are no longer disabled (e.g., you no longer meet the definition of total disability; you are no longer receiving Appropriate Care and Treatment, etc.)
- The date you become gainfully employed in any type of job, except under the Mandatory Rehabilitation Incentive Program (see “Mandatory Rehabilitation Program Incentive” on page 138).
- The date you die
- The date benefits end, if disability is due to a mental health disorder subject to the Exclusions and Limitations described below
- The date you fail to provide required Proof of continuing disability
- The date you cease to participate in a Rehabilitation Program
- The date you fail to have a medical exam as required.

If and when you return to work, you or your supervisor must contact MetLife to stop benefit payments. This ensures proper closure of your claim and avoids possible overpayment. You are responsible for repayment of any overpayments you receive.

If your employment terminates from a sickness or injury Leave of Absence (LOA) and you are receiving LTD benefits, these LTD benefits will continue until you meet one or more of the conditions listed above. However, when you meet one or more of these conditions and your LTD benefits terminate, your LTD coverage also terminates at the same time. After your LTD benefits and LTD coverage terminate, any later recurrence or relapse of your disabling condition, or your development of any other disabling condition, will not reactivate your LTD coverage, will not result in any reinstatement of LTD benefits, and will not cause any LTD benefits to resume.

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Exclusions and Limitations

The LTD Insurance Benefit has the following exclusions and limitations:

- If you become disabled before the effective date, you are not covered under the LTD Insurance Benefit until you return to work and deductions are taken from your pay.
- You are not covered under the LTD Insurance Benefit for a disability if you received medical care or treatment for the disability within the three months before the effective date of coverage. However, after you have been covered for 12 months, this limitation on disability no longer applies, and you may receive benefits.
- If you are disabled due to a mental health disorder (this includes mental health disorders, emotional disease, and/or alcohol/chemical/substance abuse/dependency), disability benefits under this coverage will end when you have received a maximum of 24 months of LTD Insurance Benefits for the entire time you are covered under the LTD Insurance Benefit. This maximum benefit applies to the duration of your participation in this coverage. As part of a mental health disability, chemical abuse/dependency includes, but is not limited to, both prescription and over-the-counter medications, as well as illicit/illegal drugs; substance abuse/dependency includes, but is not limited to, any other non-drug substances such as aerosol propellants, glue, etc. However, this duration limitation will not apply to a Disability resulting from schizophrenia, dementia or organic brain disease. Should you be confined in a Hospital or Mental Health Facility at the end of this 24 month period, benefits will continue to be paid during your confinement. If you are discharged and continue to be disabled, benefits will continue up to a 90 day recovery period. If during this 90 day recovery period, you should be reconfined for at least 14 days, your benefits will continue during that confinement and one additional 90 day recovery period.

This 24-month maximum disability benefit applies whether or not you have been hospitalized, with the following exceptions:

- If you are confined in a hospital at the end of this 24-month maximum benefit period, benefits continue as long as you are confined.
- To enable a necessary recovery period, benefits also continue for up to 90 days following your release from hospital confinement, provided you were confined for at least 14 consecutive days.
- If you are reconfined during this 90-day recovery period, benefits continue during your reconfinement, together with another 90-day recovery period, provided you are reconfined for at least 14 consecutive days.
- Benefits are not payable unless you are receiving appropriate and reasonable care for your disabling conditions from a duly-qualified physician.
- Benefits are not payable if you are disabled as a direct or indirect result of committing or trying to commit a felony, assault, or other serious crime, or are engaged in an illegal occupation, regardless of whether or not you are ever charged with a crime or for engaging in an illegal occupation.
- Benefits are not payable if you are disabled as a result of intentionally self-inflicted injuries or an attempted suicide.
- Benefits are not payable if you are disabled as a result of a declared or undeclared act of war.
- Benefits are payable only to employees. Dependents are not eligible for this benefit.

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

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

Benefits from Other Sources

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

- Periodic benefits for loss of time because of this disability under:
  - Any employee benefit coverage for which the Company has paid any part of the cost or made payroll deductions, including a Company-sponsored annuity contract or disability retirement benefits plan, or installment payments for permanent total disability.
  - Any government law including no-fault motor vehicle insurance, other than a law providing benefits for military services.
  - Any state or public employee retirement or disability plan.
- Periodic benefits for loss of time due to a work-related injury or illness or by reason of any Workers' Compensation, occupational disease law, or other similar law.
- Unemployment benefits.
- Social Security Disability Benefits (SSDB) based on the amount of SSDB in effect as of the LTD benefit start date. This may not apply if your disability is a result of a pregnancy or if your disability lasts less than one year. Periodic increases in monthly SSDB income (through cost-of-living increases) and additional Social Security retirement and survivor benefits are not subtracted from LTD benefits.
- Earnings from employment activity not approved under return-to-work guidelines.
- A government compulsory benefit plan or program which provides payment for loss of time from your job due to disability, whether such payment is made directly by the plan, program or third party.
- Any sick pay, vacation pay or other salary continuation plan that your Company provides.
- 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.

To alleviate potential financial hardship while waiting for a determination on a claim for Social Security, Workers' Compensation, or other such benefits described above, you may request that such benefits not be deducted from your

LTD benefits. The Reimbursement Agreement is within the Disability Claim Form. It states that you agree to reimburse the appropriate amount of LTD benefits paid if Social Security, Workers' Compensation, or other such benefits are later payable.

Social Security Disability Benefits

Because the amount of LTD benefits you receive is influenced by Social Security Disability Benefits (SSDB), you must apply for SSDB as soon as possible.

Within six months after your LTD claim is approved, you must provide evidence to the claims processor that you have filed for SSDB or that your application has been denied. This does not apply if your disability is the result of pregnancy or is expected to last less than one year. Otherwise, your SSDB benefits will be estimated and your LTD benefits will be reduced by the estimated amount.

Evidence may include a denial of benefits by the Social Security Administration, failure to qualify because of the length of your disability, or a copy of the Receipt of Claim Form given to you by the Social Security Administration at the time of application. Please note that if your initial application is denied, you must file for reconsideration and/or appeal to the Social Security Administration.

Return-to-Work Program

While you are disabled, we encourage you to work if possible. Your monthly benefit will be increased by the Mandatory Rehabilitation Program Incentive; however your monthly benefit will also be reduced by Other Income which may reduce your disability benefit. Your monthly benefit will not be reduced by the amount you earn from working, except that the amount you receive from working, your adjusted monthly benefit and any income from any other source cannot exceed 100% of your pre-disability earnings.

After the first twenty-four months following your waiting period, we will reduce your monthly benefit by 50% of the amount you earn from working while disabled. If your attempt to return to work is unsuccessful, you may return to your former LTD status and receive your former benefit, provided you remain disabled and satisfy all other coverage provisions.

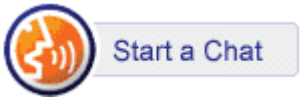
Employees who are participating in the Workers' Compensation Transitional Duty program are not eligible for this Return-to-Work Program, and vice versa.

Following are the steps required to participate in the Return-to-Work Program:

- A request for consideration is initiated either by you, your supervisor, your physician, or the claims processor.
- The request is distributed to all parties above, and all must agree that you may return to work on a trial basis.
- When your return-to-work plan has been approved by all parties, MetLife will document the plan for signature. Documentation will include the following:
  - Written agreement from your physician, supervisor, and you that you may return to work
  - Statement of approximate length of time for the trial work period
  - Statement of hours to be worked per day and rate of pay. (If hours per day vary, the claims processor will need regular bi-weekly or semi-monthly reports of earnings and hours worked.)
- The claims processor notifies you or your supervisor whether your return-to-work request has been approved.

If you are allowed to participate in the Return-to-Work Program, your supervisor must notify the claims processor of the date you return to work. In addition, if and when you can no longer work, both your supervisor and physician must send written notification to the claims processor of this change. If you return to work for the Company under this program, your supervisor should indicate "Returning to Work" on your Payroll Transaction Request (PTR).

Your LTD payroll deductions will not resume until you are actively at work under the Return-to-Work Program for one consecutive year or when you are no longer disabled.



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Mandatory Rehabilitation Program Incentive

If you are receiving LTD benefits, you may be eligible to receive assistance through the Mandatory Rehabilitation Benefit. Your participation in this program is mandatory and your monthly benefit will be increased by 10%. This increase will take effect before your Benefit is reduced by any other income.

By participating in this program your monthly benefit plus the amount you earn from any other source cannot exceed 100% of your Pre-Disability Earnings.

Rehabilitation Benefits may cover expenses such as:

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

The Case Manager handling your case will coordinate your return to work program. 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.

Health Care FSA

The Health Care Flexible Spending Account (HCFSA) allows you to direct part of your pay through payroll deductions into a special account ***before*** it is taxed by the federal government. In most cases, this money is exempt from state and local taxes as well. You benefit by being able to pay for certain expenses with tax-free money. The amount of tax savings depends on your personal situation and your effective tax percentage.

If you establish an FSA during the year, you are only eligible for reimbursement of expenses you incur after becoming an FSA participant. Additionally, you receive reimbursement from your FSAs only for eligible expenses incurred during the same calendar year in which you deposit money into your account. However, effective November 1, 2005, you may carry over into the next calendar year any unused funds remaining in your FSA as of December 31—and you may use these carryover funds to reimburse not only eligible expenses incurred in the same year in which the funds were deposited, but also for eligible expenses incurred from January 1 through March 15 of the following year.

Eligible expenses that can be reimbursed from your Health Care FSA (HCFSA) include medical, dental, and vision expenses, and other expenses not paid by your Medical Benefit Option, such as deductibles, copayments/coinsurance, oral contraceptives, physical examinations, and infertility treatment. Any amounts above the usual and prevailing fee limits may be reimbursed from your HCFSA. IRS rules specify the types of expenses eligible for reimbursement from your HCFSA.

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

The FSA administrator is PayFlex. The PayFlex HealthHub website 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 This Section

Enrolling in a Flexible Spending Account

You may enroll in either a Health Care or Dependent Day Care FSA or both (if you have eligible dependents participating in day care) during the following times:

- As a new employee when first enrolling for benefits
- If you experience a qualifying Life Event such as a marriage, birth, adoption or adding an eligible dependent to your household (process your Life Event or enroll online through the Benefits Service Center on Jetnet)
- During annual enrollment.

NOTE: If you elect both a Health Care and Dependent Day Care Flexible Spending Account, you should understand that the deposits and accounts are maintained separately. This means deposits to one account cannot be used to pay expenses that are eligible under the other account.

Please note that the FSA administrator cannot enroll you in an FSA. You can only enroll in an FSA through the Benefits Service Center on Jetnet.

How the Health Care FSA Works

Maximum Annual Allowable Deposit

You may deposit up to $2,500 per calendar year to you HCFSA. Because of IRS rules, you lose any money in your HCFSA that is not used during the year in which it was deposited.

Changing HCFSA Options

If you stop or reduce the amount of your deposits mid-year due to a Life Event, claims from your HCFSA (for eligible health care expenses incurred before the change) are payable up to the original amount you elected to deposit. Claims for expenses incurred after the change are payable up to the amount of your newly-elected deposit amount. You forfeit part of your balance when the deposits made before your change are greater than your claims before the change.

You lose any money in your HCFSA not used during the year it was deposited. In addition, you can only stop or reduce your election midyear if you experience certain Life Events. (See *Life Events*). For this reason, you should give careful thought and planning to your enrollment decision and your election amount.

Who Is Covered

You may receive reimbursement of expenses for a different range of dependents, other than those covered under your selected Medical Benefit Option. Eligible dependents for the HCFSA include your spouse and children, as defined in your Medical Benefit Option (even if you don't elect coverage for them), and your parents or other dependents if you claim them as dependents on your federal income tax return.

Because of IRS rules, Company-recognized Domestic Partners are not considered eligible dependents under your HCFSA.

HCFSA Funds Availability: Following your first deposit, the full amount of your intended deposits for the entire year is available for your use. This benefit specifies which expenses may be paid out of your HCFSA.

Eligible Expenses

Expenses that can be reimbursed through a HCFSA include the following:

- Out-of-pocket expenses, deductibles, coinsurance, and copayments not paid by your Medical or Dental Benefit Options or your Vision Insurance Benefit
- Out-of-pocket expenses, deductibles, coinsurance, and copayments incurred from other health, dental, or vision coverage.
- Certain types of over-the-counter items purchased without a prescription and used to alleviate or treat personal injuries or sicknesses of the employee and/or the eligible dependents may be eligible for reimbursement through your HCFSA. For instance, insulin, bandages, crutches and contact lens solution, etc. Refer to the list of eligible items by visiting the PayFlex HealthHub website.

Reimbursable Expenses

Some examples of medical expenses that ***may not*** be covered under your Medical Benefit Option but ***may*** be reimbursed under your HCFSA include, but are not limited to, the following:

- Acupuncture
- Ambulance service
- Artificial insemination
- Bandages, support hose, other pressure garments (when prescribed by a physician to treat a specific ailment)
- Birth control (prescription only)
- Blood, blood plasma, or blood substitutes
- Braces, appliances, or equipment, including procurement or use
- Car controls for the handicapped
- Charges in excess of usual and prevailing fee limits
- Chromosome or fertility studies
- Confinement to a facility primarily for screening tests and physical therapy
- Experimental procedures
- Foot disorders and treatments such as corns, bunions, calluses, and structural disorders
- Halfway house care
- Home health care, hospice care, nurse, or home health care aides
- Hypnosis for treatment of illness
- Immunizations
- In-vitro fertilization
- Learning disability tutoring or therapy
- Nursing home care
- Physical exams
- Physical therapy
- Prescription drug copayments
- Prescription vitamins
- Psychiatric or psychological counseling

- Radial keratotomies and lasik procedures
- Sexual transformation or treatment of sexual dysfunctions or inadequacies
- Smoking cessation program costs and prescription nicotine withdrawal medications
- Speech therapy
- Syringes, needles, injections
- Transportation expenses to receive medical care, including fares for public transportation and private auto expenses (consult your tax advisor for the current IRS mileage allowance)
- Well-child care exams
- Work-related sickness or injury (not covered by Workers' Compensation).

For a full list of covered medical expenses, go to the IRS website.

Other expenses that may be reimbursed under your HCFSA include:

- Hearing expenses, including hearing aids, special instructions or training for the deaf (such as lip reading), and the cost of acquiring and training a dog for the deaf
- Vision expenses, including eyeglasses, contact lenses, ophthalmologist fees (not paid by the Vision Insurance Benefit), the cost of a guide dog for the blind, and special education devices for the blind (such as an interpreter).

Some examples of dental expenses that may not be covered under your Dental Benefit Option, but may be reimbursed under your HCFSA include, but are not limited to the following:

- Anesthesia
- Cleaning more than twice per year
- Charges in excess of usual and prevailing fee limits
- Drugs and their administration
- Experimental procedures
- Extra sets of dentures or other dental appliances
- Medically necessary orthodontia expenses for adults or dependents
- Myofunctional therapy
- Replacement of dentures or bridgework less than five years old
- Replacement of lost, stolen, or missing dentures or orthodontic devices.

The total cost of the patient's orthodontic treatment (based upon receipt of the lump sum billing from the orthodontist) will be reimbursed from your HCFSA in one lump sum, up to the amount you elected to contribute for the year. Thus, your orthodontist should bill for the total cost of orthodontia treatment in one lump sum. For additional information about coverage for orthodontia, refer to "Covered Orthodontia Expenses" under "Covered Expenses" in the *Dental Benefit* section.

Excluded Expenses

Expenses that may not be reimbursed through your HCFSA include, but are not limited to:

- Capital expenses
- Air conditioning units
- Structural additions or changes

- Swimming pools
- Whirlpool
- Wheelchair ramps
- Cosmetic medical treatment, surgery, and prescriptions and cosmetic dental procedures, such as cosmetic tooth bonding or whitening
- Electrolysis
- Health club fees and exercise classes (except in rare cases for treatment of medically —diagnosed obesity where weight loss is part of the program and other alternatives are not available)
- Marriage and family counseling
- Massage therapy
- Medical insurance premiums
- Personal care items including cosmetics and toiletries
- Transportation expenses for the handicapped to and from work
- Vacation travel for health purposes
- Vitamins and nutritional supplements
- Weight loss programs (unless for treatment of medically diagnosed Obesity).

For a more complete listing, visit the PayFlex HealthHub website.

Receiving Reimbursement

You may receive reimbursement from your HCFSA through two different methods. How you receive reimbursement depends on the medical option you elect during 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 on the PayFlex HealthHub website.

All PPO Copay and HMO participants who have a HCFSA can elect to receive an FSA Debit Card or you can also submit a Flexible Spending Account Claim Form for reimbursement on the PayFlex HealthHub website or complete a paper claim and send it to PayFlex by fax or mail.

All participants have the option to file online or paper claims with PayFlex. See the PayFlex HealthHub website for more information.

Beginning January 1, 2013, if you had an FSA for 2012 and did not elect an FSA for 2013, you will file any remaining 2012 FSA claims through PayFlex using online and/or paper claims. See the PayFlex HealthHub website for more information.

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

Automatic Reimbursement Feature: If you are enrolled in any of the Medical Benefit Options offered to employees (other than HMOs), amounts that are not reimbursed under your Medical Benefit Option (such as deductibles and your coinsurance amounts or copayments) are, in most cases, automatically processed as reimbursements from your HCFSA. Similarly, amounts not reimbursed by the Dental Benefit will be automatically forwarded to your HCFSA for reimbursement. Your administrator will process these claims and make reimbursement payment to you (either by mailing you a check or by making a direct deposit to your bank account, if you have elected to receive reimbursement, via direct deposit).

All FSA enrollees who elected the FSA Debit Card reimbursement option during annual enrollment will receive a PayFlex (HealthHub) Debit FSA Card – this is different than your regular medical ID card. This FSA Debit Card (also referred to as the "FSA Card") carries information about your FSA account(s), including your account balance(s). Your FSA Debit Card can be used at providers, pharmacies, mail order pharmacies, or other medical providers that accept MasterCard to pay for certain FSA-eligible expenses at the time and point of service. Each year that you participate in an HCFSA, your existing FSA Debit card will be updated with your selected HCFSA amount.

When you incur an HCFSA –eligible expense (for example, when you incur an expense for a doctor's office visit under the Copay Plan), simply present your FSA Debit Card to the provider. The doctor's office will bill a charge for your copayment, and run this charge against your FSA Debit Card – the FSA Debit Card will pay your copayment directly from your HCFSA to the doctor's office; thus, you don't have to pay the copayment from your own funds, you don't have to submit the HCFSA claim to the FSA administrator, and you don't have to wait for HCFSA reimbursement. You must use the FSA Debit Card if you received one.

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

Filing Claims

You **must** file a claim for reimbursement from your HCFSA in the following circumstances:

- You have an expense that is eligible for reimbursement from the HCFSA and the claim is not automatically reimbursed.
- The expense is eligible for HCFSA reimbursement but is not covered by the Medical Benefit Option or Dental Benefit or the Vision Insurance Benefit (such as vision exams).
- Certain types of over-the-counter (OTC) medicines and drugs purchased without a prescription and used to alleviate or treat personal injuries or sicknesses of the employee and the employee's covered dependents may be eligible for reimbursement through your HCFSA. Refer to the list of OTC drugs and medications by category (those that are reimbursable, those that are excluded, and dual purpose drugs and medicines that qualify under certain circumstances) by visiting the PayFlex HealthHub website.
- You have stopped the account's Automatic Rollover Feature (explained above).

To file a claim you must complete a **Reimbursement Accounts Claim Form** available online through the PayFlex HealthHub website. Be sure to attach documentation of your expenses, i.e., a receipt from the medical service provider, to the form.

For OTC expenses, be sure your documentation includes the original receipt with the name of the over-the-counter product, the price, and the date of purchase. When a letter of medical necessity is required in order for an OTC product to qualify as a reimbursable expense, you must submit the letter with your reimbursement claim. To determine if your OTC medicine is reimbursable, refer to the OTC Drugs and Medications by Category list (on the PayFlex HealthHub website).

If you have other coverage, for example through your spouse's employer, you must first submit your claim to that coverage and receive the other plan's Explanation of Benefits (EOB) before filing for reimbursement from your HCFSA. You should stop the account's Automatic Rollover Feature by logging on to the PayFlex HealthHub website to access your account or calling your network/claims administrator (see "Contact Information" in the *Reference Information* section).

If your claim is approved, reimbursement checks are written to you. You will also receive a statement of your account with each reimbursement check.

You have until June 15 of the following year to submit claims incurred during the current calendar year. Claims not postmarked by April 30th are ineligible for reimbursement.

After you have made your first deposit to your HCFSA through payroll deduction, the entire amount you have agreed to deposit for the calendar year is available for your use. Expenses incurred before you began participating in the account are not reimbursable.

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 reimbursed for eligible expenses. All participants may submit claims for reimbursement on the PayFlex HealthHub website or complete a paper claim and send it to PayFlex by fax or mail. The fax number and mailing address are available on the PlayFlex HealthHub website.

Your medical option	Your reimbursement method is…
PPO Copay Plan	▪ For the Health Care FSA, you will choose between an FSA debit card and auto reimbursement at the time of enrollment. ▪ For the Dependent Day Care FSA, you will have to file online, paper or fax claims. ▪ The FSA card will only work under the HCFSA.
PPO Deductible/Out of Area Coverage	▪ For the Health Care FSA, you will not be able to elect an FSA card; you will automatically default to auto reimbursement. ▪ For the Dependent Day Care FSA, you will have to file online, paper or fax claims.
Minimum Coverage Plan	▪ For the Health Care FSA, you will not be able to elect an FSA card; you will automatically default to auto reimbursement. ▪ For the Dependent Day Care FSA, you will have to file online, paper or fax claims.
HMO	▪ For the Health Care FSA, you will receive an FSA debit card. ▪ For the Dependent Day Care FSA, you will have to file online, paper or fax claims.
Waive Medical Coverage	▪ For the Health Care FSA, you will receive an FSA debit card. ▪ For the Dependent Day Care FSA, you will have to file online, paper or fax claims.

2-1/2 Month Carryover of Unused HCFSA Funds

You may carry over into the next calendar year any unused funds remaining in your HCFSA as of December 31—and you may use these carryover funds to reimburse eligible expenses incurred not only in the year in which the funds were deposited, but also eligible expenses incurred between January 1 and March 15, inclusive, of the following calendar year. For example, if you still have $300 or unused funds in your 2008 HCFSA on December 31, 2008, that $300 can be carried over into 2009, and you have until March 15, 2009 to incur the eligible expense to be reimbursed from this carryover amount of $300. However, you must have incurred the eligible expense on or before March 15, 2009, and you must submit the carryover claim for reimbursement by June 15, 2009.

IMPORTANT—this June 15 filing deadline applies to BOTH claims submitted for expenses incurred during the year in which you deposited the funds, AND claims incurred during the $2\frac{1}{2}$ month carryover period.

If you plan to submit claims for reimbursement of the carryover amount, it will be necessary for you to file such claims with your network/claims administrator using the special claim form available on Benefits Service Center — your network/claims administrator's Grace Period Extension Form. You cannot use your FSA Debit Card to pay for expenses incurred in the carryover period. Likewise, you cannot use automatic rollover to pay for expenses incurred in the carryover period. If you have questions or need further information, contact HR Services or your network/claims administrator (see "Contact Information" in the *Reference Information* section).

Continuation of Coverage

If your employment terminates for any reason (i.e., furlough, resignation, etc.), your FSAs are cancelled, along with your other benefits. You may elect to continue your HCFSA as part of your Continuation of Coverage options (see "Continuation of Coverage - COBRA Continuation" in the *Additional Health Benefit Rules* section) available through Benefit Concepts, the COBRA administrator. Benefit Concepts will mail a COBRA package to your home address (or to the address you provide) after your termination is processed. If you do not continue your HCFSA through COBRA, claims incurred after the date of your termination are not payable, and you forfeit any deposits that were made and not used before your termination date.

Dependent Day Care FSA

The Dependent Day Care Flexible Spending Account (DDFSA) allows you to direct part of your pay through payroll deductions into a special account ***before*** it is taxed by the federal government. In most cases, this money is exempt from state and local taxes as well. You benefit by being able to pay for certain expenses with tax-free money. The amount of tax savings depends on your personal situation and your effective tax percentage.

If you establish an FSA during the year, you are only eligible for reimbursement of expenses you incur after becoming an FSA participant. Additionally, you receive reimbursement from your FSAs only for eligible expenses incurred during the same calendar year in which you deposit money into your account. However, effective November 1, 2005, you may carry over into the next calendar year any unused funds remaining in your FSA as of December 31—and you may use these carryover funds to reimburse not only eligible expenses incurred in the same year in which the funds were deposited, but also for eligible expenses incurred from January 1 through March 15 of the following year.

The Dependent Day Care FSA (DDFSA) pays eligible day care expenses for your children and certain adult dependents while you and your spouse (if you are married) work.

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

The FSA administrator is PayFlex for both the Health Care Flexible Spending Account and the DDFSA. The PayFlex HealthHub website 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 This Section

Enrolling in a Flexible Spending Account

You may enroll in either a Health Care or Dependent Day Care FSA or both (if you have eligible dependents participating in day care) during the following times:

- As a new employee when first enrolling for benefits
- If you experience a qualifying Life Event such as a marriage, birth, adoption or adding an eligible dependent to your household (process your Life Event or enroll online through the Benefits Service Center on Jetnet)
- During annual enrollment.

NOTE: If you elect both a Health Care and Dependent Day Care Flexible Spending Account, you should understand that the deposits and accounts are maintained separately. This means deposits to one account cannot be used to pay expenses that are eligible under the other account.

Please note that the FSA administrator cannot enroll you in an FSA. You can only enroll in an FSA through the Benefits Service Center on Jetnet.

How the DDFSA Works

You lose any money in your DDFSA not used during the year it was deposited. In addition, you can only change your election mid-year if you experience certain Life Events (see *Life Events*). For this reason, you should give careful thought and planning to your enrollment decision and your election amount.

You may carry over into the next calendar year any unused funds remaining in your DDFSA as of December 31—and you may use these carryover funds to reimburse eligible expenses incurred not only during the same year in which you deposit money into your account, but also for eligible expenses incurred between January 1 and March 15 of the following year. For example, if you deposited money into your 2008 DDFSA to help pay for child care, you must have incurred the child care expenses during the 2008 calendar year or between January 1, 2009 and March 15, 2009, inclusive. For purposes of the DDFSA, you are deemed to have incurred expenses for a service at the time the service is provided (rendered).

Conditions for Deposit and Maximum Allowable Deposit Amounts

You and your spouse (if you are married) must be employed or actively seeking employment to be eligible to receive reimbursement from your DDFSA. This benefit limits the amount you may deposit and the type of expenses that may be paid from your DDFSA.

Your family and tax filing status determine the maximum amount you can deposit per calendar year:

- A single employee may deposit up to $5,000.
- A couple filing a joint income tax return, where both spouses participate in DDFSAs, may deposit a combined amount of up to $5,000.
- A couple filing separate income tax returns may each deposit up to $2,500.
- A couple (if both individuals are employed) may deposit up to $5,000 or the income amount of the lower-paid spouse (if it is less than $5,000).

If your spouse has no income because he or she is a full-time student, is disabled and needs day care, or is unable to take care of your dependents because of a disability, you can still make deposits to your DDFSA. These circumstances allow you to deposit up to $200 per month if you have one eligible dependent, or up to $400 per month for two or more dependents.

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.

Who Is Covered

You may claim dependent day care expenses for your eligible dependents including:

- Children under age 13
- A person over age 13 (including your child, spouse, or parent) if the person meets all of the following criteria:
  - Lives with you and depends on you for support, and
  - Is claimed as a dependent on your federal income tax return, and
  - Is physically or mentally incapable of self-care, and
  - Has a gross income less than the federal income tax personal exemption for current year.

Because of IRS rules, Company-recognized Domestic Partners are not considered eligible dependents under your DDFSA.

DDFSA Guidelines

Because any unused money in your DDFSA is lost at the end of the year, consider the following guidelines when enrolling in this benefit:

- Carefully determine the number of weeks of dependent care you will purchase. Estimate and deduct weeks that might include vacation, illness, school or occasions when your dependents might have free care or not require care or as many hours of care.
- Do not anticipate expenses you are not sure about, such as day care for a child not yet born. The birth of a child is considered an eligible Life Event, and you may begin participation in a DDFSA.

Eligible Expenses

Expenses paid to the following providers may be reimbursed through your DDFSA, if you can provide their Social Security or taxpayer identification number:

- A licensed child-care center or adult day care center, including church or non-profit centers
- A private kindergarten — utilized for day care of the child(ren), rather than for educational purposes. If the private kindergarten provides both day care and educational services for your dependent child(ren), only the day care portion of the kindergarten's charges are eligible for reimbursement. The private kindergarten must separate and itemize its charges on its invoices for payment, clearly separating the day care expenses from the educational expenses. If the private kindergarten cannot or will not provide a separation/itemization of charges on its invoice, no reimbursement will be made from your DDFSA
- A babysitter inside or outside your home if the sitter does not care for more than six children at a time (not including the sitter's own dependents)
- A housekeeper whose duties include dependent day care
- A relative who cares for your dependents but is neither your spouse nor your dependent child under age 19
- Someone who cares for an elderly or disabled dependent inside or outside your home
- Au pairs (foreign visitors to the U. S. who perform day care and domestic services in exchange for living expenses, provided the au pair agency is a non-profit organization or the au pair obtains a U. S. Social Security number for identification purposes).

Receiving Reimbursement

Participation in a DDFSA will require either online, paper or fax reimbursement. Reimbursement Accounts Claim Forms are available online through the PayFlex HealthHub website.

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 on the PayFlex HealthHub website.

You may file claims for eligible expenses at any time. Unlike the HCFSA, you may only be reimbursed from the DDFSA up to the amount you have actually deposited at the time you submit the claim. If your account balance is less than the amount you request, your reimbursement will only equal the amount in your account. However, unpaid amounts are automatically paid as additional deposits are made to cover them.

Because most dependent day care expenses must be paid in advance, you may receive reimbursement for these services in advance, within certain guidelines. You can request reimbursement for services pre-paid up to 30 days in advance if the care provider verifies, in writing, that advance day care payments are non-refundable.

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

Filing Claims

When you file a DDFSA claim, only money already deposited in your account is available to you. If your account holds less money than the amount of your claim, only the balance in your account is reimbursed to you. The remaining amount of your claim is paid to you automatically as additional deposits are made.

To file a claim, complete a Flexible Spending Account Claim Form and attach original receipts for your day care expenses. Be sure to include documentation of your expenses, including a paid receipt from your day care and the day care provider's name, address, and Social Security or taxpayer identification number. Claims not postmarked by June 15 are ineligible for reimbursement. You can also submit a claim for reimbursement on the PayFlex HealthHub website.

Your first claim may take up to four weeks to process. Thereafter, claims are processed weekly.

Because most employees are required to pay for dependent day care in advance, you may file a claim for prepaid expenses up to 30 days in advance, instead of waiting until services are rendered. To be reimbursed for prepaid expenses, the dependent day care provider must verify on the claim form that the advance day care payment has been received and is non-refundable. Advance payments are only reimbursable for services to be rendered within a 30-day period.

If your claim is approved, reimbursement checks are written to you. You will receive a statement of your account with each reimbursement check. You may also view your account online by visiting the claims administrator's website. Plus, if you provide your e-mail address when you visit the claims administrator's website, you will receive e-mail confirmation that your claim has been processed.

You have until June 15 of the following year to submit claims incurred during the current calendar year. Claims not postmarked after April 30 are not eligible for reimbursement. Expenses incurred before you began participating in this benefit, or after you suspend/terminate this benefit are not reimbursable.

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 on the PayFlex website or complete a paper claim and send it to PayFlex by fax or mail. The fax number and mailing address are available on the HealthHub PayFlex website (see "Contact Information" in the *Reference Information* section).

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

You may elect to have your reimbursements deposited directly into your checking or savings account, simply by providing your account information online via the Direct Deposit link on the HealthHub PayFlex website.

If you had an FSA for 2012 and did not elect an FSA for 2013, you can still file your remaining 2012 FSA claims manually through March 15, 2013. See the HealthHub PayFlex website for more information.

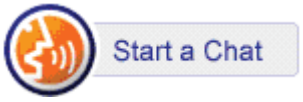
You have until March 15 to use your prior year's balance and until June 15 to file claims.

2-1/2 Month Carryover of Unused DDFSA Funds

Effective November 1, 2005, you may carry over into the next calendar year any unused funds remaining in your DDFSA as of December 31—you may use these carryover funds to reimburse eligible expenses incurred not only in the year in which the funds were deposited, but also eligible expenses incurred between January 1 and March 15, inclusive, of the following calendar year. For example, if you still have $300 or unused funds in your 2008 DDFSA on December 31, 2008, that $300 can be carried over into 2009, and you have until March 15, 2009 to incur the eligible expense to be reimbursed from this carryover amount of $300. However, you must have incurred the eligible expense on or before March 15, 2009, and you must submit the carryover claim for reimbursement by June 15, 2009.

IMPORTANT—this June 15 filing deadline applies to BOTH claims submitted for expenses incurred during the year in which you deposited the funds, AND claims incurred during the $2\frac{1}{2}$ month carryover period.

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



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Additional Health Benefit Rules

The provisions described in this section apply to the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options, HMOs, Dental Benefit, Vision Insurance Benefit, and the HCFSA Benefit.

In This Section **See Page**

Qualified Medical Child Support Order

Federal law authorizes state courts and administrative agencies to issue Qualified Medical Child Support Orders (QMCSOs). A QMCSO may require you to add your child as a dependent for health and dental benefit in some situations, typically a divorce. If you are subject to a QMCSO, your choice of benefits may be affected. For example, if the child doesn't live in the same location as you, you may not be eligible for Health Maintenance Organization (HMO) coverage.

The following procedures have been adopted and amended with respect to medical child support orders received by group health benefits and plans maintained for employees of participating American Eagle Airlines, Inc. and Its Affiliates. These procedures shall be effective for medical child support orders issued on or after the Omnibus Budget Reconciliation Act of 1993 (OBRA) relating to employer-provided group health plan benefits.

These Procedures are for health coverage under the Group Health and Welfare Benefits Plan for Employees of American Eagle Airlines, Inc. and Its Affiliates ("the Plan"), consisting of the following options:

- Out-of-Area Coverage Option
- Minimum Coverage Option
- PPO-Deductible Option
- PPO-Copay Option
- Health Maintenance Organization (HMO)
- Dental Benefit
- Vision Benefits

Use of Terms

The term "Plan" as used in these procedures refers to the options and benefits described above, except to the extent that a plan is separately identified.

The term "Participant," as used in these procedures, refers to a Participant who is covered under the Plan and has been deemed (by the court) to have the responsibility of providing medical support for the child under one or more of the coverages under the Plan as those benefits/terms are defined in the Plan described above.

The term "Alternate Recipient" as used in these procedures, refers to any child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant.

The term "Order," as used in these procedures, refers to a "medical child support order," which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under such plan, or (ii) enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.

The term "QMCSO" or "NMSN," as used in these procedures, refers to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), which is a medical child support order creating or recognizing the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive health benefits with respect to a Participant under a plan and that meets the requirements set out in these procedures, or a notice from a state agency ordering the coverage of an a Alternate Recipient under health benefits with respect to a Participant under a plan and that meets the requirements to be an NMSM decreed to be a QMCSO.

The term "Plan Administrator," as used in these procedures, refers to American Eagle Airlines, Inc., and Its Affiliates acting in its capacity as Plan Sponsor and Administrator to the Plan described above.

Procedures Upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice

Notice that a Participant is a party to a matter wherein an Order may be entered must be provided in writing to the Plan Administrator by delivering such notice to the attention of the Plan Administrator at:

P. O. Box 619616
MD 5141-HDQ, DFW
Airport, TX 75261-9616.

In addition, QMCSOs or NMSNs should be delivered to the same address.

Upon receipt (or within 15 days of receipt) by the Plan Administrator of a request for information on health coverage or a state agency notice to enroll a child, the Plan Administrator will send out a letter notifying the requesting party that it has received the order or notice and describing the Plan's procedures for determining whether the order is qualified or a notice is received, whether the coverage is available under the Plan to the child and the steps to be taken by the custodial parent or agency to effectuate coverage.

Upon receipt of an Order, or upon request, the Plan Administrator will advise each person or party specified in the medical child support order that, in order to be a QMCSO or NMSN, the Order must satisfy the requirements of ERISA and OBRA '93 before the Plan Administrator is obligated to comply with its terms. These requirements state that the Order:

- Must be a "medical child support order," which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under such plan, or (ii) enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.
- Must relate to the provision of a medical child support and create or recognize the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive health benefits with respect to a Participant under a Plan and that meets the requirements set out in these procedures.
- Must affirm that all Alternate Recipients shall fulfill the eligibility requirements for coverage under the Plan.
- Does not require the Plan to provide any type or form of benefit or option that is not otherwise available under the Plan.

Must clearly specify:

- The name and last known mailing address of the Participant and the name and address of each alternate recipient covered by the Order
- A reasonable description of the coverage that is to be provided by the Plan to each Alternate Recipient or the manner that the coverage shall be determined;
- The period to which the Order applies (if no date of commencement of coverage is provided, or if the date of commencement of coverage has passed when the Order is approved, the coverage will be provided prospectively only, starting as soon as administratively practicable following the approval of the Order).
- The name of each Plan to which the Order applies (or a description of the coverage to be provided);
- A statement that the Order does not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan (except as a condition of receiving federal assistance for Medicaid
- The fact that all Plan contributions with regard to the Alternate Recipient shall be deducted from the Participant's pay.

American Eagle Airlines, Inc. and Its Affiliates does not provide interim coverage to any employee's dependent during the pendency of a QMCSO or NMSN review. A dependent's entitlement to benefits under the Plan prior to the approval of a QMCSO or an NMSN is determined by the dependent's eligibility and enrollment in the Plan in accordance with the terms of the Plan. Without a QMCSO or NMSN American Eagle Airlines cannot be held liable if an employee's dependent is either (i) not enrolled in coverage in the Plan, or (ii) is eliminated from coverage in the Plan. In addition, neither American Eagle Airlines, Inc. and Its Affiliates nor the Plan has any obligation to automatically or immediately enroll (or to enroll at the next available enrollment period or at any other time) an employee's dependent except upon application by the employee in accordance with the terms of the Plan, or in accordance with a QMCSO or NMSN. If the requesting party needs assistance in preparing or submitting a QMCSO or NMSN, he or she may contact the Plan Administrator or go to the U.S. Department of Labor website for more information on QMCSOs and NMSNs and for sample NMSN Forms or obtain a sample National Medical Support Notice.

Review of a Medical Child Support Order or Notice

Not later than 20 business days after receipt by the Plan Administrator of a medical child support order, the Plan Administrator shall review the Order to determine if it meets the criteria to make it a QMCSO or NMSN. Under OBRA '93, a state-ordered medical child support order is not necessarily a Qualified Medical Child Support Order. Thus, before the Plan honors the Order, the Order must meet the requirements for a QMCSO or NMSN specified above.

Procedures Upon Final Determination

The Participant, Alternate Recipient and any party specified in the medical child support order shall be notified of the acceptance of the medical child support order or national medical support notice as being qualified. Once the Order is determined to be a QMCSO or NMSN, the Plan Administrator will follow the terms of the Order and shall authorize enrollment of the Alternate Recipient as well as have any payments for such coverage deducted from the payroll of the Participant. In addition, a copy of the appropriate health benefit guide and claim forms shall be mailed to the Alternate Recipient (when an address is provided) or, in care of the Alternate Recipient, at the issuing agency's address. If the Participant is not enrolled, the Plan Administrator shall enroll the Participant as well as the child in the coverage. Notification will occur within 40 business days of receipt of the Order or notice.

If the Plan Administrator determines that the Order is not qualified, then the Plan Administrator shall notify the Participant, the Alternate Recipient, the state agency issuing the notice, or any designated representative in writing of such fact within 40 business days of receipt of the Order or notice. The notification will state the reasons the Order or notice is not a QMCSO or NMSN and that the Plan Administrator shall treat the Participant's benefits as not being subject to the Order. Any subsequent determination that an Order is a QMCSO will be administered prospectively only.

Appeal Process

If the Participant or Alternate Recipient wishes to dispute the terms of the QMCSO or NMSN, he or she must file an Application for Appeal within 60 days of receiving notification of denial of the medical child support order's or medical support notice's qualification. Appeals will be reviewed by the Eagle Benefits Administration Committee (EBAC) in accordance with ERISA and the terms and provisions of the Plan and notify the Participant or Alternate Recipient within 60 days of receipt of the appeal of their decision. A copy of the Plan's appeal procedures, as set forth in the Employee Benefits Guide (the formal Plan Document and Summary Plan Description) shall be provided upon request.

Coordination of Benefits

These coordination of benefits provisions apply to health benefits described in this Guide.

This section explains how to coordinate coverage between the Company-sponsored Medical and Dental Benefit and any other benefits/plans that provide coverage for you or your eligible dependents.

If you or any other covered dependents have primary coverage (see "Which Plan is Primary" in this section) under any other group medical or group dental benefit/plan, your Company-sponsored Medical and Dental Benefit will coordinate to avoid duplication of payment for the same expenses. The benefit program will take into account all payments you have received under any other benefits/plans, and will only supplement those payments up to the amount you would have received if your Company-sponsored Medical and Dental Benefit were your only coverage.

If your dependent is covered by another benefit/plan and the PPO-Copay Option is his/her secondary coverage, the PPO-Copay Option pays only up to the maximum benefit amount payable under the PPO-Copay Option, and only after the primary benefit/plan has paid. The maximum benefit payable depends on whether the network or out-of-network providers are used.

If you or your dependent is hospitalized when coverage begins, your prior coverage is responsible for payment of medical services until you are released from the hospital. If you have no prior coverage, the benefit program will pay benefits only for the portion of the hospital stay occurring after you became eligible for coverage under the benefit program for American Eagle employees.

If you or your dependent is hospitalized when your benefit program coverage changes from one Medical Benefit Option to another, your prior coverage is responsible for payment of eligible expenses until you or your dependent is released from the hospital.

Other Plans

The term "other group medical benefit/plan" or "other group dental benefit/plan" in this section includes any of the following:

- Employer-sponsored benefits/plans under which the employer pays all or part of the cost or takes payroll deductions, regardless of whether the plans are insured or self-funded
- Government or tax-supported programs, including Medicare or Medicaid
- Property or homeowner's insurance or no-fault motor vehicle coverage, except if the plan participant has purchased this coverage
- Other individual insurance policies

Which Plan Is Primary

When a person is covered by more than one plan, one plan is the primary plan and all other plans are considered secondary plans. The primary plan pays benefits first and without consideration of any other plan. The secondary plans then determine whether any additional benefits will be paid after the primary plan has paid. Proof of other coverage will be required from time to time.

The following determines which plan is primary:

- Any plan that does not have a coordination of benefits provision is automatically the primary plan.
- A plan that has a coordination of benefits provision is the primary plan if it covers the individual as an employee.
- A plan that has a coordination of benefits provision is the secondary plan if it covers the individual as a dependent or as a laid-off or retired employee.
- If a participant has coverage as an active full-time or part-time employee under two employee plans, and both plans have a coordination of benefits provision, the plan that has covered the employee the longest is primary.
- Any benefits payable under Medical Benefit Options or Dental Benefit and Medicare are paid according to federal regulations. In case of a conflict between Medical or Dental Benefit provisions and federal law, federal law prevails.
- If the coordination of benefits is on behalf of a covered child
  - For a natural child or adopted child, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. If the parents are divorced, these rules still apply, unless a Qualified Medical Child Support Order (QMCSO) specifies otherwise.
  - For a stepchild or special dependent, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. A stepchild not living in the employee's home is not an eligible dependent under the benefit program, regardless of any child support order.

If the other plan has a gender rule, that plan determines which plan is primary.

When Coverage Ends

Coverage for you and your spouse will automatically terminate on the earliest of:

- The date this Plan or benefit option terminates
- The last day for which your contribution has been paid
- The date you are no longer eligible for this coverage.
- The date the Plan Administrator determines in its sole discretion that you have made a false statement on any enrollment form or claim form or filed a fraudulent request with the Plan.

Your spouse's coverage will automatically terminate on the earliest of:

- The date this plan or benefit option terminates
- The last day for which your spouse's contribution has been paid
- The date he or she is no longer your spouse
- The date you are no longer eligible for this plan or benefit option
- The date the Plan Administrator determines in its sole discretion that you have made a false statement on any enrollment form or claim form or filed a fraudulent request with the plan or benefit option.
- The date your surviving spouse remarries
- For a Company-recognized Domestic Partner, 90 days after your death

Expenses incurred after the date your coverage (or your spouse's coverage) terminates are not eligible for reimbursement under the plan or benefit option.

Coordination with Medicare

Benefits for Individuals Who Are Entitled to Medicare

If you (or one of your dependents) are entitled to Medicare benefits, the following rules apply:

- The American Eagle Airlines, Inc. plan is the primary payer — in other words, your claims go to the American Eagle Airlines, Inc. plan first — if you are currently working for a participating American Eagle Airlines, Inc. or Its Affiliates.
- If you become eligible for Medicare due to you (or your dependent) having end-stage renal disease, then American Eagle Airlines, Inc. is the primary payer for the first 30 months of Medicare entitlement due to end-stage renal disease. At the end of the 30-month period, Medicare will become the primary payer.
- If you become eligible for Medicare due to becoming eligible for Social Security disability and if your coverage under this plan is due to the current employment status of the employee, then this plan (the American Eagle Airlines, Inc. plan) pays primary.
- Effective January 1, 2006, the federal Medicare program activates the Medicare Part D Benefit—Medicare benefits for prescription drug expenses. If you (or your dependent(s)) are entitled to Medicare benefits—including Medicare Part D—the aforementioned rules apply.
- The American Eagle Airlines, Inc. plan pays secondary and Medicare is the primary payer if you (or your dependent) are covered by Medicare, do not have end-stage renal disease and you are not currently working for the American Eagle Airlines, Inc. and Its Affiliates.
- If you (or your dependent) are over age 65 and the American Eagle Airlines, Inc. plan would otherwise be the primary payer because you are still working, you or your dependent may elect Medicare as the primary payer of benefits. If you do, benefits under the American Eagle Airlines, Inc. plan will terminate.

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Benefits for Disabled Individuals

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

Under the coordination of benefits rule for individuals who qualify for Medicare because of disability, Medicare is the primary payer; in other words, your claims go to Medicare first. If Medicare pays less than the current benefit allowable by the American Eagle Airlines, Inc. and Its Affiliates plan, the American Eagle Airlines, Inc plan will pay the difference, up to the maximum current benefits allowable. In addition, if Medicare denies payment for a service that the American Eagle Airlines, Inc. plan considers eligible, the American Eagle Airlines, Inc. plan will pay up to its normal benefit amount after you meet the calendar-year deductible, if any. When Medicare is the primary payer, no benefits will be payable under the American Eagle Airlines, Inc. plan for eligible Medicare benefits that are not paid because you did not enroll, qualify, or submit claims for Medicare coverage. This same rule applies if your doctor or hospital does not submit bills to Medicare on your behalf. Medicare generally will not pay benefits for care received outside the United States. Contact your local Social Security office for more information on Medicare benefits.

Continuation of Coverage — COBRA Continuation

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

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

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

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

* Although a Company-recognized Domestic Partner and his/her children do not have rights to COBRA Continuation of Coverage under existing federal law, American Eagle Airlines, Inc. and Its Affiliates currently offers them the opportunity to continue health coverages that would be lost when certain events occur, however this may change.

Eligibility

Eligibility for COBRA Continuation of Coverage depends on the circumstances that result in the loss of existing coverage for you and your eligible dependents. The sections below explain who is eligible to elect COBRA Continuation of Coverage and the circumstances that result in eligibility for this coverage continuation.

COBRA Continuation of Coverage for You and Your Dependents – Qualifying Events

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

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

COBRA Continuation of Coverage for Your Dependents Only – Qualifying Events

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

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

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

How to Elect COBRA Continuation of Coverage

Solicitation for COBRA Continuation of Coverage

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

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

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

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

Enrolling in COBRA Continuation of Coverage

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

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

You and your dependents may each independently elect COBRA Continuation of Coverage. Once you elect COBRA Continuation of Coverage, the first premium for the period beginning on the date you lost coverage through your election is due 45 days after you make your election.

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

If you waive COBRA Continuation of Coverage and then decide that you want to elect to continue coverage within your 60-day election period, you may only obtain coverage effective after you notify the Plan Administrator. If you want to revoke your prior waiver, you must notify Benefit Concepts before your 60-day election period expires.

Refund of Premium Payments for COBRA Continuation of Coverage

If you elect COBRA Continuation of Coverage and later discover that you do not meet the eligibility requirements for coverage, for example, if you become entitled to (enrolled in) Medicare benefits, you must contact Benefit Concepts at 1-866-629-0274 immediately, but no later than three months after you make your first premium payment in order for you to be eligible for a refund. No payments will be refunded after this three-month period, regardless of the reason.

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

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

Processing Life Events After COBRA Continuation of Coverage is in Effect

If you elect COBRA Continuation of Coverage for yourself and later marry or *declare a Company-recognized Domestic Partner*, give birth, or adopt a child while covered by COBRA Continuation of Coverage, you may elect coverage for your newly-acquired dependents after the qualifying event. To add your dependents, contact Benefit Concepts, the COBRA administrator, at 1-866-629-0274, *within 60 days* of the marriage, Company-recognized Domestic Partner relationship, birth, or adoption.

A new dependent may be a participant under this coverage for the remainder of your continuation period (18, 29, or 36 months, depending on the qualifying event). This new dependent will not have the right to continue coverage on his or her

own if there is a divorce, end of Company-recognized Domestic Partner relationship, or another event that causes loss of coverage**.** You may add a newborn child or a child newly placed for adoption to your COBRA Continuation of Coverage. You should notify Benefit Concepts and the Plan Administrator of the newborn or child newly placed for adoption within 60 days of the child's birth or placement for adoption. All rules and procedures for filing and determining benefit claims under the Plan for active employees also apply to COBRA Continuation of Coverage.

If you have questions regarding COBRA Continuation of Coverage, contact Benefit Concepts at 1-866-629-0274.

Paying for or Discontinuing COBRA Continuation of Coverage

To maintain COBRA Continuation of Coverage, you must pay the full cost of COBRA Continuation of Coverage on time, including any additional expenses permitted by law. Your first payment is due within 45 days after you elect COBRA Continuation of Coverage. Premiums for subsequent months of coverage are due on the first day of each month for that month's coverage. If you elect COBRA Continuation of Coverage, you will receive a payment invoice from Benefit Concepts indicating when each payment is due. Payments are due even if you have not received your payment coupons. Failure to make the required payment on or before the due date, or by the end of the grace period will result in termination of COBRA coverage, without the possibility of reinstatement. All checks shall be made payable to Benefit Concepts and sent to:

Benefit Concepts
P.O. Box 9222
Chelsea, Mass. 02150-9222.

When COBRA Continuation of Coverage Begins/Ends

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

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

- The maximum continuation period (18, 29, or 36 months) expires (See also "Eligibility" on page 160 under *Continuation of Coverage — COBRA Continuation*).
- Payment for COBRA Continuation of Coverage is not postmarked within 30 days after the date payment is due. Checks returned for non-sufficient funds ("NSF" or "bounced") are considered non-payment. If full payment is not received (postmarked) within the grace period specified on the invoice, your coverage will be terminated, without the possibility of reinstatement
- The Plan participant who is continuing coverage becomes covered under any other group medical plan, unless that plan contains a pre-existing condition limitation that affects the plan participant. In that event, the participant is entitled to COBRA Continuation of Coverage up to the maximum time period.
- The Plan participant continuing coverage becomes entitled to Medicare
- The Company no longer provides the coverage for any of its employees or their dependents

See also "Dependents of Deceased Employees" under "Dependent Eligibility" in the *General Eligibility* section.

Extended Continuation of Medical Coverage for Qualifying Pilots

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

Eligibility for Extended Continuation of Medical Coverage for Qualifying Pilots

Eligibility

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

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

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

Solicitation For, Enrollment In, and Payment For, Extended Continuation of Medical Coverage for Qualifying Pilots

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

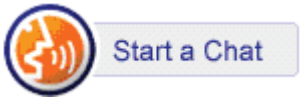
Paying for or Discontinuing Extended Continuation of Medical Coverage

To maintain Extended Continuation of Medical Coverage, you must pay the full cost of Extended Continuation of Medical Coverage on time, including any additional expenses permitted by law. Premiums for the Extended Continuation of Medical Coverage are due on the first day of each month for that month's coverage. If you elect Extended Continuation of Medical Coverage, you will receive a payment invoice from Benefit Concepts indicating when each payment is due. Payments are due even if you have not received your payment coupons. Failure to make the required payment on or before the due date, or by the end of the grace period will result in termination of Extended Continuation of Medical Coverage, without the possibility of reinstatement. All checks shall be made payable to Benefit Concepts and sent to:

Benefit Concepts
P.O. Box 9222
Chelsea, Mass. 02150-9222.

When Extended Continuation of Medical Coverage for Qualifying Pilots Begins/Ends

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



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

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

If you have questions regarding Extended Continuation of Medical Coverage, contact Benefit Concepts at 1-866-629-0274.

COBRA Continuation of Coverage for Employees in the Uniformed Services

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

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

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

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

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

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

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

COBRA Continuation of Coverage While on a Family and Medical Leave

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

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

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

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

Other Special Rules

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

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

From September 1, 2008 through December 2009

American Recovery and Reinvestment Act of 2009 (ARRA)

If you (the employee/retiree) experience(d) involuntarily termination of your employment during the period beginning September 1, 2008 and ending December 31, 2009, and are eligible for COBRA continuation of coverage, you might be eligible to participate in the COBRA contribution subsidy program provided under ARRA. If you are eligible, this program pays 65% of the contribution amount you are required to pay for COBRA continuation coverage, and you are required to pay 35%. This subsidy will be paid for up to nine (9) months.

Employees/retirees whose employment terminate(d) between September 1, 2008 and December 31, 2009 will receive information from the COBRA administrator, advising who is eligible to receive this subsidy, how to elect this subsidy, income qualifications, and other information. Not all employees/retirees whose employment terminated during this period of time will be eligible for the COBRA subsidy; thus, read your information carefully. If you have questions, contact your COBRA administrator (see "Contact Information" in the *Reference Information* section). Helpful information about this COBRA subsidy is also on the U.S. Department of Labor website).

Impact of Failing to Elect COBRA Continuation of Coverage on Future Coverage

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

Additional Questions

If you have any additional questions about COBRA Continuation of Coverage or if you are a Pilot who has questions about electing Extended Continuation of Medical Coverage, you should contact Benefit Concepts (see "Contact Information" in the *Reference Information* section).

Certificate of Coverage

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

Other Employees Obligations

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

HIPAA Certificate of Creditable Coverage

If you lose your coverage (or when you notify HR Services of your dependent's loss of coverage), you will automatically be sent a certificate of creditable coverage showing how long you had been covered under the Plan. This document will provide the proof of coverage you may need to reduce any subsequent medical plan's pre-existing medical condition limitation period that might otherwise apply to you. If you elect COBRA continuation coverage, when that coverage ends, you will receive another certificate of coverage within the 24 months after your coverage has ended. You may also request a certificate of creditable coverage within the 24 months after your coverage has ended.

To request a certificate of creditable coverage, contact HR Services (see "Contact Information" in the *Reference Information* section), either by phone or by email, or by mail and ask for a HIPAA certificate of creditable coverage.

Surviving Spouses of Active Employees

If your spouse* was covered under any Company-sponsored Medical Benefit Option, he or she remains eligible for that option for 90 days after your death with no contributions. At the end of 90 days, your spouse* may elect Continuation of Coverage under COBRA for up to 36 months (including the 90 days). See "Continuation of Coverage — COBRA Continuation" on page 159.

* If you die while you and your Company-recognized Domestic Partner are covered under any Company-sponsored Medical Benefit Option, your surviving Company-recognized Domestic Partner receives medical coverage for 90 days from the date of your death, provided he or she pays the active plan contribution rates to continue coverage. At the end of the 90-day period, your Company-recognized Domestic Partner may elect Continuation of Coverage under COBRA for up to 36 months. The 90 days of coverage are included in the 36 months.

Additional Life and Accident Insurance Rules

This section includes rules that apply to the life and accident insurance.

In This Section **See Page**

Beneficiaries

In the event of your death, Life Insurance coverage benefits are paid to the named beneficiaries on file with HR Services.

Unless prohibited by law, your life insurance benefits are distributed as indicated on your Beneficiary Designation Form on file with HR Services. For this reason, you should consider updating your beneficiary designation periodically, especially if you get married, declare a Company-recognized Domestic Partner, or you or your spouse give birth or adopt a child, or if you get divorced or cease to have a Company-recognized Domestic Partner relationship. Beneficiary Designation can be completed online in the Benefits Service Center.

The table below provides sample wording for the most common beneficiary designations:

Type Of Designation	Sample Wording*
One person, related	Jane Doe, spouse
One person, not related	Jane Doe, friend
Your estate	Estate
Member of a given religious order	Mary L. Jones, known in religious life as Sister Mary Agnes, niece
Two beneficiaries with the right of survivorship	John J. Jones, father, and Mary R. Jones, mother, equally or to the survivor
Three or more beneficiaries with the right of survivorship	James O. Jones, brother, Peter I. Jones, brother, Martha N. Jones, sister, equally or to the survivor(s)
Unnamed children	My children living at my death
One contingent beneficiary	Lois P. Jones, wife, if living; otherwise, Herbert I. Jones, son
Unnamed children as contingent beneficiaries	Lois P. Jones, wife, if living; otherwise, my children living at my death
Trustee (a trust agreement must be in existence)	ABC Trust Company of Newark, NJ, Michael W. Jones, Trustee, in one sum, under Trust Agreement dated (insert date)

* Always include your beneficiary's address

If none of the suggested designations meets your needs, contact an attorney for assistance.

When a beneficiary is a minor (under the legal age defined by the beneficiary's state of residence), a guardian must be appointed in order for the life insurance benefits to be paid. MetLife requires a certified court document appointing the guardian of the minor's estate or property. If the beneficiary does not have a guardian, the life insurance benefits will be retained by MetLife and interest will be compounded daily until the minor child reaches the legal age.

To avoid complications in paying beneficiaries, an organization or endowment should not be named unless it is a legal entity (has a legal existence, such as a corporation or trust that has been legally established). If you designate a trust, MetLife assumes that the designated trustee is acting in proper fiduciary capacity unless written notice to the contrary is received at the home office of MetLife. MetLife and the Company are not liable for any payment made to a trustee before receiving such written notice. If the full amount of your insurance is not payable to the trustee or if a testamentary trustee is named, write to MetLife for assistance in proper documentation.

If your beneficiary is not living at the time of your death, the benefits under your coverage are paid to the first class of surviving family members in the order outlined below:

- Spouse
- Children or stepchildren (or children or stepchildren of Company-recognized Domestic Partner)
- Parents
- Brothers and sisters
- Estate

For dependent coverage, you are the sole beneficiary. If a covered dependent dies at the same time or within 24 hours of your death, benefits are divided equally among members of the first class of beneficiaries in which there is a relative of the covered dependent. The classes of beneficiaries are listed above in the order they would be considered.

If your beneficiary does not survive you (for example, you are both killed in a common disaster) benefits are paid to your estate according to the terms of the policy.

Take care of all your beneficiary designations in one efficient process available online at *My Beneficiaries* under the *Benefits* section of Jetnet. Please keep in mind that wording is important when designating your beneficiary, and you can designate an unlimited number of beneficiaries. Once the online form is completed and submitted, it supersedes all previous designations. If your marriage or Company-recognized Domestic Partner relationship ends, you should immediately complete new beneficiary designations.

Accident Insurance Beneficiaries

You are the beneficiary for all covered losses resulting from accidental injury. You should designate a beneficiary to receive benefits in the event of your accidental death. If you do not designate a beneficiary, your beneficiary is the same as your Term Life Insurance beneficiary. If your beneficiary is not living at the time of your death, benefits are paid according to the terms of the insurance policy.

Taxation of Life Insurance

If your total coverage is more than $50,000, you may owe taxes on the value of your coverage over $50,000. This value is called imputed income. IRS regulations require the Company to report employee federal wages and deduct Social Security taxes (FICA) on imputed income from your paycheck and report it on your Form W-2 each year (see example).

Under IRS regulations, imputed income is based on your age and the monthly cost per $1,000 of life insurance over $50,000. To determine your monthly amount of imputed income, multiply the rate in the following IRS table by the amount of your insurance coverage over $50,000.

Age of Employee on December 31	Monthly Cost of $1,000 of Insurance
Under 25	$.05
25-29	.06
30-34	.08
35-39	.09
40-44	.10
45-49	.15
50-54	.23
55-59	.43
60-64	.66
65-69	1.27
70 and over	2.06

An example of how imputed income works:

Assume a 30-year-old employee earning $3,000 per month selects three times salary of Voluntary Term Life Insurance coverage. The following calculations show the employee's taxable imputed income:

1. Figure the amount of Term Life Insurance coverage:

   $36,000 salary × 3 = **$108,000**

2. Figure the taxable amount of coverage (amount over $50,000):

   $108,000 – $50,000 = $58,000

3. Divide that amount by $1,000:

   $58,000 / $1,000 = 58

4. Multiply the result by the IRS rate from the table above for an employee who is age 30:

   58 × $0.08 = $4.64

The monthly imputed income shown on this employee's paycheck will be $4.64. This is the amount that is subject to federal income and Social Security taxes. Spouse and Child Term Life Insurance are purchased after-taxes. Therefore, it is not subject to taxation as imputed income.

Portability and Conversion

Portability

Voluntary Term Life Insurance has a portability feature which means you may continue your life insurance coverage if you leave the Company or retire. The rates for this continuing coverage are not the same as those you pay as an active employee, but they are preferred group rates based on your age. MetLife will provide the rate schedule if you apply for portability. The minimum amount of coverage you may continue is $20,000 and the maximum amount is your current voluntary amount of life insurance coverage. Spouse, Child and Basic Life Insurance may not be continued under the portability feature. (However, Spouse, Child and Basic Life Insurance may be converted to an individual policy.) To apply for this continuing coverage, you must submit an application form to MetLife within 31 days after you leave or retire from the Company.

Contact HR Services to request a portability application or call MetLife toll free at 1-866-492-6983 to discuss provisions relating to portability plans.

Conversion

Subject to policy provisions, you can convert all or any part of your Basic and/or Voluntary Term Life Insurance coverage to a personal policy (other than term life insurance) offered by MetLife without providing proof of good health, if coverage terminates for one of the following reasons:

- Your employment ends or you are no longer in a class that is eligible for Term Life Insurance coverage
- The coverage ends, and you have been covered under this insurance for at least five years
- Coverage for your particular job classification ends, and you have been covered under this insurance for at least five years

If you are applying for a personal policy because your employment terminated, the amount of the policy may not be more than the amount of your Term Life Insurance on the day your coverage ended.

If you are applying for a personal policy because this Plan ended or changed, and you have been covered for at least five years, the amount of your policy will not be more than the lesser of the following:

- The amount of your coverage on the day it ended, less any amount of life insurance you may be eligible for under any group policy that takes effect within 31 days of the termination of this coverage
- $10,000.

You or your spouse or child can convert all or any part of the Spouse or Child Term Life Insurance coverage to a personal policy (other than term life insurance) offered by MetLife if coverage terminates for one of the following reasons:

- Your employment ends or you are no longer in a class that is eligible for Spouse or Child Term Life Insurance coverage
- The coverage ends and your spouse or child has been covered under this insurance for at least five years
- Coverage for your particular job classification ends and your spouse or child has been covered under this insurance for at least five years
- You die
- Your spouse or child no longer qualifies as a dependent.

To convert to a personal policy, you must call MetLife toll free at 1-877-275-6387 to begin the conversion process.

If you or your dependent should die during the 31-day period, whether or not you have applied for the conversion policy or portability, MetLife will pay the appropriate beneficiary a death benefit equal to the amount of life insurance you had on the date coverage terminated.

Verbal Representations

Nothing you say or that you are told regarding this insurance is binding on anyone unless you or your beneficiary have something in writing from the Company and MetLife confirming your coverage.

Assignment of Benefits

You may irrevocably assign the value of your life insurance coverage. This permanently transfers all right, title, interest, and incidents of ownership, both present and future, in the benefits under this insurance coverage. Anyone considering assignment of life insurance coverage should consult a legal or tax advisor before taking such action.

If you assign your benefits, you are obligated to fulfill any conditions you have agreed to with your assignee. MetLife's only obligation is to pay the life insurance benefits due at your death.

Your beneficiary may assign a portion of his or her benefit directly to the funeral home to cover the cost of the funeral. To assign benefits to a funeral home, the beneficiary signs an agreement with the funeral home. The funeral home sends a copy of the signed agreement and an itemized statement of funeral expenses to HR Services. When MetLife processes the claim, a separate check for this portion of the benefit will be paid directly to the funeral home.

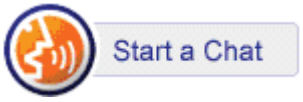
Total Control Account

When a claim is processed, MetLife establishes a Total Control Account for each beneficiary whose share is $5,000 or more. (Smaller amounts are paid in a lump sum.) All insurance proceeds are deposited into this interest-bearing checking account that pays competitive money market interest rates and is guaranteed by MetLife.

MetLife sends a personalized checkbook to your beneficiary, who may withdraw some or all of the proceeds and interest whenever necessary. In addition, MetLife sends descriptions of alternative investment options to your beneficiary. The Total Control Account gives your beneficiary complete control over the money, while eliminating the need to make immediate financial decisions at a difficult time.

For income tax purposes, proceeds deposited into the Total Control Account are treated the same as a lump-sum settlement. Because the tax consequences of life insurance proceeds may vary, the Company strongly recommends that you or your beneficiary contact your tax advisor.

MetLife will only pay interest on a life insurance claim (to cover the time between death and date of payment) if the beneficiary lives in a state that requires interest payments. Because state insurance laws vary, calculation of interest differs from state to state.



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Plan Administration

This section includes administrative information about your benefits.

In This Section **See Page**

Plan Information

The Plans listed below are sponsored by American Eagle Airlines, Inc. and Its Affiliates as that term is defined under ERISA Section 3(16)(B). These plans all share the same plan number: 501.

The Group Health and Welfare Benefits Plan for Employees of American Eagle Airlines, Inc. and Its Affiliates. This plan includes:

- Medical Benefits
  - Out-of-Area Coverage Option
  - Minimum Coverage Option
  - PPO-Deductible Option
  - PPO-Copay Option
  - Health Maintenance Organizations
- Dental Benefit
- Vision Insurance Benefit
- Term Life Insurance Benefits
- Optional Term Life Insurance Benefits
- Spouse and/or Child Term Life Insurance Benefits
- Accidental Death & Dismemberment Insurance Benefits
- Voluntary Personal Accident Insurance Benefit
- Special Risk Accident Insurance Benefit
- Special Purpose Accident Insurance Benefit
- Management Personal Accident Insurance Benefit
- Optional Short Term Disability Insurance Benefit
- Long Term Disability Insurance Benefit
- Health Care Flexible Spending Account Benefit
- Dependent Day Care Flexible Spending Account Benefit

Administrative Information

Plan Sponsor and Administrator

American Eagle Airlines, Inc.

Mailing address:

Mail Drop 5141-HDQ1
P. O. Box 619616
DFW Airport, Texas 75261-9616

Street address (do not mail to this address):

4333 Amon Carter Blvd.
Fort Worth, Texas 76155

The Plan Administrator for Second Level Claim Appeals

Eagle Benefits Administration Committee (EBAC)
American Eagle Airlines, Inc.
Md 5134-Hdq1
P.O. Box 619616
DFW Airport, TX 75261-9616

Agent For Service of the Legal Process

Managing Director, Benefits and Productivity
American Airlines, Inc.

Mailing address:

Mail Drop 5187-HDQ1
P. O. Box 619616
DFW Airport, Texas 75261-9616

Express Delivery address:

4333 Amon Carter Blvd.
Fort Worth, Texas 76155

Claims Processor

The claims processors for each benefit or plan vary and are listed in "Contact Information" in the *Reference Information* section.

Employer ID Number

38-2036404

Plan Year

January 1 through December 31

Participating Affiliates

American Eagle Airlines, Inc.

Executive Airlines, Inc.

Plan Amendments

The Eagle Benefits Administration Committee (EBAC), under the authority granted to it by the Board of Directors through the Chief Executive Officer of American Eagle Airlines, Inc., has the sole authority to interpret, construe, determine claims, and adopt and/or amend employee benefit plans. The Eagle Benefits Administration Committee (EBAC), in consultation with actuaries, consultants, Employee Relations, Human Resources, and the Legal Department, has the discretion to adopt such rules, forms, procedures, and amendments it determines are necessary for the administration of the Plan according to their terms, applicable law, regulation, collective bargaining agreements, or to further the objectives of the Plan. The EBAC may take action during a meeting if at least half the members are present or by a unanimous written decision taken without a meeting and filed with the Chairman of the EBAC.

The administration of the Plan shall be under the supervision of the Plan Administrator. The Employer hereby grants the EBAC the authority to administer and interpret the terms and conditions of the Plan and the applicable legal requirements related thereto. It shall be a principal duty of the EBAC to see that the administration of the Plans is carried out in accordance with its terms, for the exclusive purpose of providing benefits to Participants and their beneficiaries in accordance with the documents and instruments governing the Plan. The EBAC will have full power to administer the Plans in all of their details, subject to the applicable requirements of law. For this purpose, the EBAC's powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by the Plan:

- To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law and to request extension of time periods hereunder and request additional information
- To interpret and construe the terms of the Plan, their interpretation thereof in good faith to be final and conclusive upon all persons claiming benefits under the Plan
- To decide all questions concerning the Plan, and to determine the eligibility of any person to participate in or receive benefits under the Plan and to determine if any exceptional circumstances exist to justify any extensions
- To compute the amount of benefits that will be payable to any Participant or other person, organization or entity, to determine the proper recipient of any benefits payable hereunder and to authorize the payment of benefits, all in accordance with the provisions of the Plan and the applicable requirements of law
- To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan
- To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such action to be by written instrument and in accordance with ERISA Section 405; and
- To delegate its authority to administer Claims for benefits under the Plan by written contract with a licensed third party administrator
- To the extent permitted by law, to rely conclusively upon all tables, valuations, certificates, opinions and reports which are furnished by accountants, counsel or other experts employed or engaged by the EBAC.

Plan Funding

The coverage for the following benefits is self-funded through both Company and employee contributions:

- Out-of-Area Coverage Option
- Minimum Coverage Option
- PPO-Deductible Option
- PPO-Copay Option
- Dental Benefit

Health Maintenance Organizations (HMOs) are fully insured and are funded through both Company and employee contributions.

Coverage for the following benefits is fully insured and premiums are paid by the Company:

- Basic Term Life Insurance Benefit
- Basic Accidental Death & Dismemberment Insurance Benefit
- Special Risk Accident Insurance Benefit
- Special Purpose Accident Insurance Benefit
- Management Personal Accident Insurance Benefit.

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The following benefits are fully insured and paid entirely by employee contributions:

- Optional (Voluntary) Levels of Employee Life Insurance Benefit
- Spouse and/or Child Term Life Insurance Benefit
- Optional Short Term Disability Insurance Benefit
- Vision Insurance Benefit
- Voluntary Personal Accident Insurance Benefit
- Long Term Disability Insurance Benefit

Collective Bargaining Agreement

The types of benefits (medical and dental benefit, life insurance benefits) described in this Guide are maintained subject to a collective bargaining agreement. A copy of the collective bargaining agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator. This agreement is also available for review during normal business hours at the corporate offices of American Eagle Airlines, Inc. (see "Contact Information" in the *Reference Information* section).

Assignment of Benefits

You may request that the claims processor pay your service provider directly by assigning your benefits.

You may assign medical and dental benefits for eligible expenses incurred for hospital care, surgery, dental care, or medical treatment for illness or injury. You may only assign benefits to the person or institution that provides the services or supplies for which these benefits are payable.

For information about assigning life insurance benefits, see "Assignment of Benefits" in the *Additional Life and Accident Insurance Rules* section.

Claims

Confidentiality of Claims

The Company and its agents (including the claims processors) will use the information you furnish to substantiate your claim and determine benefits. The information may be forwarded to the Company medical director or other independent consultants for medical review or appropriate medical follow-up. In addition, certain individuals within the Company will have access to this information to carry out their duties to administer the coverages properly.

The Company treats your medical information as confidential and discloses it only as may be required for the administration of the Plan or as may be required by law. For additional information, see "Compliance with Privacy Regulations" on page 186.

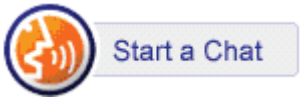
Payment of Benefits

Benefits will be paid to you unless you have assigned payment to your service provider (see Assignment of Benefits). Benefits are paid after the claims processor receives satisfactory written proof of a claim. If any benefit has not been paid when you die, or, if you are legally incapable of giving a valid release for any benefit, the claims processor may pay all or part of the benefit to:

- Your guardian
- Your estate
- Any institution or person (as payment for expenses in connection with the claim)
- Any one or more persons among the following relatives: your eligibility Company-recognized Domestic Partner, parents, children, brothers, or sisters.

Payment of a claim to anyone described above releases the Plan Administrator from all further liability for that claim.

The right to benefits under the Plan may not be exchanged for, or substituted for, other benefits or cash compensation.



Right to Recovery

If claims payments are more than the amount payable under the Plans, the claims processor may recover the overpayment. The claims processor may seek recovery from one or more of the following:

- Any plan participant to or for whom benefits were paid
- Any other self-funded plans or insurers
- Any institution, physician, or other service provider, or
- Any other organization.

The claims processor is entitled to deduct the amount of any overpayments from any future claims payable to you or your service providers.

Subrogation

Subrogation is third party liability. Subrogation applies if the plans have paid any benefits for your injury or illness and someone else (including any insurance carrier) is, or may be, considered legally responsible.

The Plans have the right to collect payment from the third party (or its insurance carrier) for the medical treatment of your injury or illness. The Plans subrogate (substitute) their own rights for your rights and have a lien of first priority on any recovery you receive. This means the Plans must be paid first from any settlement or judgment you receive and the Plans shall have a lien of first priority over any recovery you receive that will not be reduced by any "make whole" or similar doctrine. The Plans may assert this right to pursue recovery independently of you.

As a condition for receiving benefits under the Plans, you agree to:

- Cooperate with the Plans to protect the Plans' subrogation rights
- Provide the Plans with any relevant information they request
- Obtain consent of the Plans before releasing any party from liability for payment of medical expenses
- Sign and deliver documents regarding the Plans' subrogation claim, if requested. (Refusal to sign these documents does not diminish the Plans' subrogation rights.)
- Agree to hold amounts received in a constructive trust for the benefit of the Plans.
- The Plans' claims and lien shall not be reduced by any "make whole" or similar doctrine and shall not be reduced by the expenses you incur to obtain any recovery.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not directly or indirectly affect or influence the subrogation rights of the Plans.

The Plans will pay all legal costs of the plan regarding subrogation. You are responsible for paying your own legal costs. The Plans will not pay your or others' legal costs associated with subrogation.

Claim Processing Requirements

Time Frame for Initial Claim Determination

For claims for medical benefits, the processing rules vary by the type of claim. For urgent care claims (see the definition, below) and pre-service claims (claims in which the service has not yet been rendered, and/or that require approval of the benefit or precertification before receiving medical care), the claims processor or benefit administrator will notify you of its benefit determination (whether adverse or not) within the following time frames:

- Twenty four hours after receipt of a claim initiated for urgent care (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification), or
- Fifteen days after receipt of a pre-service claim.

For post-service claims (claims that are submitted for payment after you receive medical care), the claims processor or benefit administrator will notify you of an adverse benefit determination within 30 days after receipt of a claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.

For urgent care claims, if you fail to provide the claims processor or benefit administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the claims processor or benefit administrator must notify you within 24 hours of receiving your claim of the specific information needed to complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of:

- The claims processor or benefit administrator's receipt of the requested information, or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

For pre- and post-service claims, a 15-day extension may be allowed to make a determination, provided that the claims processor or benefit administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the claims processor or benefit administrator must notify you before the end of the first 15- or 30-day period of the reason(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is necessary for pre- and post-service claims due to your or your authorized representative's failure to submit necessary information, the Plan's time frame for making a benefit determination is stopped from the date the claims processor or benefit administrator sends you an extension notification until the date you respond to the request for additional information.

In addition, if you or your authorized representative fails to follow the Plan's procedures for filing a pre-service claim, you or your authorized representative must be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided within five days (24 hours in the case of a failure to file a pre-service claim involving urgent care) following the failure. Notification may be oral, unless you or your authorized representative requests written notification. This paragraph only applies to a failure that:

- Is a communication by you or your authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters, and
- Is a communication that names you, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

Urgent Care Claims

Urgent care claims are those that, unless the special urgent care deadlines for response to a claim are followed, either:

- Could seriously jeopardize the patient's life, health or ability to regain maximum function, or
- In the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested in the claim for benefits.

An individual acting on behalf of the Plan, applying the judgment of a prudent layperson who has an average knowledge of health and medicine, can determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient's medical condition determines that the claim involves urgent care, it must be considered an urgent care claim.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.

Note: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a Plan amendment or Plan termination.

If You Receive an Adverse Benefit Determination on a Health/Welfare Benefit Plan Claim

The claims processor or benefit administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination.
- References to the specific Plan provisions on which the benefit determination is based
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary.
- A description of the Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination.
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request.
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the adverse benefit determination concerns a claim involving urgent care, a description of the expedited review process applicable to the claim.

Disability Claims

All disability benefit claims must be submitted in such written or electronic format and must contain such information as may be prescribed by the claims processor. After the claims processor has reviewed the claim for disability benefits and obtained any other information that it deems necessary or relevant, the claims processor shall notify you within a reasonable period of time not to exceed 45 days after receipt of the acceptance or denial of the claim. The 45-day period during which a claim for disability benefits is reviewed may be extended by the claims processor for up to 30 days, provided the claims processor both determines that such an extension is necessary due to matters beyond the control of the Plan and you are notified of the extension prior to the expiration of the initial 45-day period of the time and date by which the Plan expects to render a decision. If prior to the end of the initial 30-day extension the Plan Administrator determines that a decision cannot be reached within the initial extension period, the period for making the decision can be extended for up to an additional 30-day period provided the claims processor notifies you or your designated representative of the circumstances requiring the extension and the date by which a decision will be made. If your claim for Disability Benefits is denied, in whole or in part, the claims processor shall notify you of the denial in writing and shall advise you of the right to appeal the denial and to request a review. The Notice shall contain:

- Specific reasons for the denial;
- Specific references to the Plan provisions on which the denial is based;
- A description of any information or material necessary to perfect the claim;
- An explanation of why this material is necessary;
- An explanation of the Plan's appeal and review procedure, including a statement of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review; and
- If an internal rule, guideline or protocol was used in making the decision, either a copy of such rule, guideline or protocol must be provided or a statement that such rule, guideline or protocol was used and that it will be provided upon request.

Effect of Failure to Submit Required Claim Information

If the claims processor determines you failed or refused to comply in a timely manner with any reasonable request for information in connection with your claim (including, but not limited to, claim forms, medical examinations, medical information or reports and appropriate medical information release forms) you shall be deemed to have abandoned your claim for Disability Benefits as of the date you fail or refuse to comply and you shall not be entitled to any further Disability Benefits. However, your claim shall be reinstated upon your compliance with the claims processor's request for information or upon a demonstration to the satisfaction of the claims processor that under the circumstances the claims processor's request is not reasonable. If a claim is abandoned and subsequently reinstated, payments otherwise due you for the period between abandonment and reinstatement may be paid retroactively at the sole and exclusive discretion of the claims processor, taking into consideration the cause or reason for your failure or refusal, the length of the period, and other facts or circumstances the claims processor deems relevant.

All Other Claims

All benefit claims must be submitted in such written or electronic format and must contain such information as may be prescribed by the claims processor. After the claims processor has reviewed the claim for benefits and obtained any other information which it deems necessary or relevant, the claims processor shall notify you within a reasonable period of time not to exceed 90 days after receipt of the acceptance or denial of the claim. The 90-day period during which a claim for benefits is reviewed may be extended by the case manager or claims processor for up to 90 days, provided the claims processor both determines that such an extension is necessary due to matters beyond the control of the Plan and you are notified of the extension prior to the expiration of the initial 90-day period of the time and date by which the Plan expects to render a decision. If prior to the end of the initial 90-day extension the Plan Administrator determines that a decision cannot be reached within the initial extension period, the period for making the decision can be extended for up to an

additional 90-day period provided the claims processor notifies you or your designated representative of the circumstances requiring the extension and the date by which a decision will be made. If your claim for disability benefits is denied, in whole or in part, the claims processor shall notify you of the denial in writing and shall advise you of the right to appeal the denial and to request a review. The Notice shall contain:

- Specific reasons for the denial
- Specific references to the Plan provisions on which the denial is based
- A description of any information or material necessary to perfect the claim
- An explanation of why this material is necessary
- An explanation of the Plan's appeal and review procedure, including a statement of the Participant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review; and
- If an internal rule, guideline or protocol was used in making the decision, either a copy of such rule, guideline or protocol must be provided or a statement that such rule, guideline or protocol was used and that it will be provided upon request.

Effect of Failure to Submit Required Claim Information

If the claim processor determines you failed or refused to comply in a timely manner with any reasonable request for information in connection with your claim (including, but not limited to, claim forms, medical examinations, medical information or reports and appropriate medical information release forms) you shall be deemed to have abandoned your claim for benefits as of the date you fail or refuse to comply and you shall not be entitled to any further benefits. However, your claim shall be reinstated upon your compliance with the claims processor's request for information or upon a demonstration to the satisfaction of the claims processor that under the circumstances the claims processor's request is not reasonable. If a claim is abandoned and subsequently reinstated, payments otherwise due you for the period between abandonment and reinstatement may be paid retroactively at the sole and exclusive discretion of the claims processor, taking into consideration the cause or reason for your failure or refusal, the length of the period, and other facts or circumstances the claims processor deems relevant.

Appealing a Denial

This information regarding appeals is for the above referenced non-grandfathered plans. This contains revised appeal information and requirements.

The Patient Protection and Affordable Care Act (PPACA) has changed the rules, requirements and procedures for the processing of group health plan claims and for the reevaluation and determination of adverse benefit determinations (i.e., appeals), to be effective on July 1, 2011; however, there are other rules and provisions that the U.S. Department of Labor is currently reviewing. Those rules carry a compliance date of January 1, 2012. American Eagle Airlines, Inc. – sponsored health and welfare benefit plans are, we believe, in compliance with the U.S. Department of Labor's regulations as of their most recent interpretation and guidance.

As the U.S. Department of Labor and U.S. Department of Health and Human Services continue to provide updated regulations, clarification and guidance on these claim procedures, American Eagle Airlines, Inc., as sponsor and administrator of its health and welfare benefit plans, will modify its claim and appeal procedures to comply with these regulations, and will incorporate those regulations in this Guide in a timely manner in compliance with the federal regulations, guidance and interpretation.

Important Information about Health Care Provider's Appeals

As a participant in the American Eagle Airlines, Inc. – sponsored health and welfare benefit plans, you have the right) under federal law known as ERISA) to appeal adverse benefit determinations through the American Eagle Airlines Inc. two-tiered appeal processes, as described in this section of the Guide.

However, your network health care providers, through their provider contracts with the network claims administrator or benefit administrator, also have the option to appeal adverse benefit determinations – to the extent that the adverse benefit determinations affect their benefit payments from the network claims administrator or benefit administrator. Your network health care providers may appeal directly to the network claims administrator - with or without your knowledge and/or consent. These "provider appeals" are separate and distinct form your appeal rights under ERISA, *unless the providers specify that their provider appeals are being filed with the network and/or claim administrator on your behalf.*

If the provider specifies in its appeal that the appeal is being filed on your behalf, the appeal *will not be considered* in your ERISA First Level Appeal filed with the network claims administrator or benefit administrator. If the provider does not specify in its appeal that the appeal is being filed on your behalf, the provider's appeal *will not be considered* as your ERISA First Level Appeal. Thus, if you then decide to appeal the adverse benefit determination, you must file both the First Level and Second Level Appeals, as described in this section of the Guide (or if the appeal is an urgent care appeal, you must file under the "urgent care appeal" process, as described in this section of the Guide).

Procedures for Appealing an Adverse Benefit Determination

As a participant in the Company-sponsored health and welfare benefit plans, you have the right to appeal adverse benefit determinations. Adverse benefit determinations include denial, withholding and reduction of benefits described in the plans, and eligibility/enrollment determinations that prevent you or your dependents form obtaining coverage under the plans. Adverse benefit determinations also include rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).

American Eagle Airlines, Inc., as Sponsor and Administrator for the Company-sponsored health and welfare benefit plans, has a two-tiered appeal process — referred to as First Level and Second Level Appeals.

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 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.

With respect to adverse benefit determinations made on all self-funded benefits or plans (listed below), both the First Level Appeals and Second Level Appeals are conducted by the claims processor or benefit administrator that rendered the adverse benefit determination:

- Medical Benefits (including prescription drug coverages/options)
- Dental Benefit

For Flexible Spending Account Benefits, the First Level Appeal will be handled by the benefits administrator and the Second Level Appeal will be conducted by the Eagle Benefits Administration Committee (EBAC) at American Eagle Airlines, Inc.

For administrative, eligibility, and enrollment issues on any and all employee welfare benefits or plans offered, the First Level Appeal will be conducted by the claims processor or benefit administrator and the Second Level Appeal will be conducted by the Eagle Benefits Administration Committee (EBAC) at American Eagle Airlines, Inc.

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

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

The appeal process is defined by the respective insurers and HMOs (thus, it might not be a two-tiered process). The insurers and HMOs make the final appeal determinations for their respective insured coverages/benefits. Each insurer or HMO has its own appeal process, and you should contact the respective insurer or HMO for information on how to file an appeal (see "HMO Contact Information" under "Health Maintenance Organizations (HMOs)").

If you receive an adverse benefit determination, you must ask for a First Level Appeal review from the claims processor or benefit administrator. You or your authorized representative have 180 days following the receipt of a notification of an adverse benefit determination within which to file a first Level Appeal. If you do not file your First Level Appeal (with the claims processor or benefit administrator) within this time-frame, you waive your right to file the First and Second Level Appeals of the determination.

To file a First Level Appeal with the claims processor or benefit administrator, please complete an Application for First Level Appeal, and include with the Application all comments, document, records, and other information relating to the denied/withheld benefit. (The Application for First Level Appeal provides information about what to include with your appeal. You can download and print this Appeal Form or you can request the form from HR Services at (click on the "Start a Chat" button on the top of this).

The claims or benefit administrator will review your First Level Appeal and will communicate its First Level Appeal decision to you in writing,

- for pre-service claims – within 30 days of receipt of your First Level Appeal
- for post-service claims – within 60 days of receipt of your First Level Appeal
- for urgent care claims – within 24 hours of receipt of your First Level Appeal
- for disability claims, within 45 days of receipt of your First Level Appeal. If the claims processor or benefit administrator requires additional time to obtain information needed to evaluate your First Level Appeal for disability, it may have an additional 45 days to complete your First Level Appeal (the claims processor or benefit administrator will notify you if this additional time period is needed to complete a full and fair review of your case). For disability claims, this process may also be referred to as a First Level Review.
- for all other claims for all benefits other than medical or disability, within 60 days of receipt of your First Level Appeal, if the claims processor or benefit administrator requires additional time to obtain information needed to complete your First Level Appeal for non-medical and non-disability benefits, it may have an additional 60 to complete your First Level Appeal (the claims processor or benefit administrator will notify you that this additional time period is needed to complete a full and fair review of your case).

Upon your receipt of the First Level Appeal decision notice upholding the prior denial — if you still feel you are entitled to the denied/withheld benefit — you must file a Second Level Appeal as referenced below.

With respect to adverse benefit determinations made on all self-funded benefits or plans (listed below), both the First Level Appeals and Second Level Appeals are conducted by the claims processor or benefit administrator that rendered the adverse benefit determination:

- Medical Benefits (including prescription drug coverages/options)
- Dental Benefit

For Flexible Spending Account Benefits, administrative, eligibility, and enrollment issues on any and all employee welfare benefits or plans offered, the First Level Appeal will be conducted by the claims processor or benefit administrator and the Second Level Appeal will be conducted by the Eagle Benefits Administration Committee (EBAC) at American Eagle Airlines, Inc.

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If you receive an adverse benefit determination on the First Level Appeal, for Flexible Spending Account Benefits, administrative, eligibility, and enrollment issues on any and all employee welfare benefits or plans offered, you must ask for a Second Level Appeal review from the EBAC at American Eagle Airlines, Inc. You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination on the First Level Appeal within which to file a Second Level Appeal. If you do not file your Second Level Appeal (with the EBAC) within this time frame, you waive your right to file the Second Level Appeal of the determination.

If you receive an adverse benefit determination on the First Level Appeal, you must ask for a Second Level Appeal review from the EBAC at American Eagle Airlines, Inc. You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination on the First Level Appeal within which to file a Second Level Appeal. If you do not file your Second Level Appeal (with the EBAC) within this time frame, you waive your right to file the Second Level Appeal of the determination.

To file a Second Level Appeal with the EBAC, please complete an Application for Second Level Appeal, and include with the Application all comments, documents, records, and other information — including a copy of the First Level Appeal decision notice — relating to the denied/withheld benefit. (The Application for Second Level Appeal provides information about what to include with your appeal. You can download and print this Appeal Form or you can request the form from HR Services at (click on the "Start a Chat" button on the top of this page).

The EBAC will review your Second Level Appeal and will communicate its Second Level Appeal decision to you in writing.

Upon its receipt, your Second Level Appeal will be reviewed in accordance with the terms and provisions of the Plans and the guidelines of the EBAC. Appointed officers of American Eagle Airlines, Inc. are on the EBAC. In some cases, the EBAC designates another official to determine the outcome of the appeal. Your case, including evidence you submit and a report from the claims processor or benefit administrator, if appropriate, will be reviewed by the EBAC or its designee(s).

The Second Level of Appeal is mandatory for all Flexible Spending Account Benefits, administrative, eligibility, and enrollment issues on any and all employee welfare benefits or plans offered, 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.

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your claim if it:
  - Was relied upon in making the benefit determination
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
  - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination

- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental)
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision
- In the case of a claim for urgent care, an expedited review process in which:
  - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination
  - All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, fax or other available similarly prompt method.

You must use and exhaust Plan's administrative claims and appeals procedure before bringing a suit in federal court. Similarly, failure to follow the Plans' prescribed procedures in a timely manner will also cause you to lose your right to sue under ERISA 502(a) regarding an adverse benefit determination.

No action may be brought more than two years after the adverse benefit determination is made on final appeal (or Second Level Appeal) with the EBAC.

If you have exhausted your administrative claim and appeal procedures, you may only bring suit in a federal district court if you file your action or suit within two years of the date after the adverse benefit determination is made on final appeal.

Compliance with Privacy Regulations

Notice of Privacy Rights – Health Care Records

This notice applies to all Plan Participants of the participating company of American Eagle Airlines, Inc. and Executive Airlines, Inc. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice is effective as of January 1, 2009, and applies to health information received about you by the healthcare components of the Group Health and Welfare Benefits Plan for Employees of American Eagle Airlines, Inc. and Its Affiliates (particularly, the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options, the HMOs, Dental Benefit, Vision Insurance Benefit, Health Care Flexible Spending Accounts Benefit) and any other group health plan for which American Eagle Airlines, Inc. serves as plan sponsor and administrator. You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") mandated the issuance of regulations to protect the privacy of individually identifiable health information which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations") and as amended by the Genetic Information Nondiscrimination Act ("GINA") and the American Recovery and Reinvestment Act ("ARRA").. As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information that is created or received by the Plan (your "Protected Health Information" or "PHI"). This notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan's duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of HHS and the office to contact for further information about the Plan's privacy practices. The following uses and disclosures of your PHI may be made by the Plan:

For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claims for benefits are covered under the Plan, and disclosures to obtain reimbursement under insurance, reinsurance or stop-loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by American Eagle Airlines, Inc. and Its Affiliates for any of the purposes described above.

For Treatment. Your PHI may be used or disclosed by the Plan for purposes of treating you (for example, if your doctor requests information on what other drugs you are currently receiving).

For the Plan's Operations. Your PHI may be used as part of the Plan's health care operations. Health care operations would include quality assurance, underwriting and premium rating to obtain renewal coverage or securing or placing a contract for reinsurance of risk, including stop-loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and customer service and resolution of internal grievances.

When Required by Law. The Plan may also be required to disclose or use your PHI for certain other purposes (for example, if certain types of wounds occur that require reporting, or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena).

For Workers' Compensation. The Plan may disclose your PHI as authorized by you or your representative and to the extent necessary to comply with laws relating to Workers' Compensation and similar programs providing benefits for work-related injuries or illnesses if either, (1) the health care provider is a member of the employer's workforce and provides health care to the individual at the request of the employer, the PHI is provided to determine if the individual has a work-related illness or injury or to provide medical surveillance of the workplace, and the information is required for the employer to comply with OSHA or with laws with similar purposes, or (2) you authorize the disclosure. You must authorize the disclosure in writing and you will receive a copy of any authorization you sign.

Pursuant to Your Authorization. Any other use or disclosure of your PHI will be made only with your written authorization and you may revoke that authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. The revocation of your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself.

For Appointment Reminders and Health Plan Operations. Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, information on treatment alternatives, or other health-related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

To the Plan Sponsor. Information may be provided to the Sponsor of the Plan, provided that the Sponsor has certified that this information will not be used for any other benefits, employee benefit plans or employment-related activities.

Other Uses or Disclosures of Protected Health Information

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release

Disclosure of your Protected Health Information to family members, other relatives and your close Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family's or friend's involvement with your care or payment for that care, and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosures for which authorization or opportunity to object is not required

Use and disclosure of your PHI is allowed without your authorization or any opportunity to agree or object under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.
- When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made.
- Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.
- The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.
- For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person or to report certain types of wounds. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- The Plan may use or disclose PHI for research, subject to certain conditions.

When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization. state laws may provide you with additional rights or protections.

Rights You May Exercise

To Request Restrictions on Disclosures and Uses. You have the right to request restrictions on certain uses and disclosures of your PHI in writing. However, the Plan is not required to agree to any restriction you may request. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to American Airlines HR Services, P.O. Box 9741, Providence, RI 02940-9741.

To Access. You have the right to request access to your PHI and to inspect and copy your PHI in the designated record set under the policies and procedures established by the Plan. The designated record set is the series of codes that make up each electronic claim. This does not include psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or PHI that is maintained by a covered entity

that is a clinical laboratory. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to American Airlines HR Services, P.O. Box 9741, Providence, RI 02940-9741. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

To Amend. You have the right to request an amendment to your PHI in writing under the policies established by the Plan. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Requests for amendment of PHI in a designated record set should be made to American Airlines HR Services, P.O. Box 9741, Providence, RI 02940-9741. You or your personal representative will be required to complete a written form to request amendment of the PHI in your designated record set.

To Receive an Accounting. You have the right to receive an accounting of any disclosures of your PHI, other than those for payment, treatment and health care operations. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2003.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

To Obtain a Paper Copy of This Notice. An individual who receives an electronic Notice of Privacy Practices has the right to obtain a paper copy of the Notice of Privacy Practices from the Plan upon request. To obtain a paper copy of this Notice, to American Airlines HR Services, P.O. Box 9741, Providence, RI 02940-9741.

To Request Confidential Communication. You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. Such requests should be made to American Airlines HR Services, P.O. Box 9741, Providence, RI 02940-9741.

A Note About Personal Representatives

You may exercise your rights through a personal representative (e.g., having your spouse/Company-recognized Domestic Partner call for you). Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public
- a signed authorization completed by you
- a court order of appointment of the person as the conservator or guardian of the individual, or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan is required to abide by the terms of the notice that is currently in effect. The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

However, the minimum necessary standard will not apply in the following situations: (1) disclosures to or requests by a health care provider for treatment; (2) uses or disclosures made to the individual; (3) disclosures made to the Secretary of the U.S. Department of Health and Human Services; (4) uses or disclosures made pursuant to an authorization you signed; (5) uses or disclosures in the designated record set; (6) uses or disclosures that are required by law; (7) uses or disclosures that are required for the Plan's compliance with legal regulations; and (8) uses and disclosures made pursuant to a valid authorization.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA. The Plan may use or disclose a "Limited Data Set" that may be used by the Plan provided the Plan enters into a Limited Data Set agreement with the recipient of the Limited Data Set. Disclosures of a Limited Data Set need not be included in any accounting of disclosures by the Plan.

You have the right to file a complaint with the Plan or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with American Eagle Airlines, Inc., c/o Eagle Benefits Administration Committee, 4333 Amon Carter Blvd., MD 5485Ft. Worth, TX 76155, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

You may also file a complaint with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human Services, within 180 days of any alleged violation. You may obtain the address of the appropriate regional office of the Office for Civil Rights from American Eagle Airlines. If you would like to receive further information, you should contact American Eagle Airlines, Inc., c/o EBAC, 4333 Amon Carter Blvd., MD 5485, Ft. Worth, TX 76155. This notice will first be in effect on January 1, 2009 and shall remain in effect until you are notified of any changes, modifications or amendments.

How American Eagle Airlines, Inc. and Executive Airlines, Inc. May Use Your Health Information

American Eagle Airlines, Inc. ("Eagle") administers many aspects of the Eagle Group Health and Welfare Plan (the "Plan") for employees of American Eagle Airlines, Inc. and Its Affiliates, which are listed below, on behalf of American Eagle Airlines, Inc. and Its Affiliates, including American Eagle Airlines and Executive Airlines. Eagle, as the plan sponsor and/or plan administrator of the Plan may use and disclose your personal medical information (called "Protected Health Information") created and/or maintained by the Plans that it receives from the Plans as permitted and/or required by, and consistent with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Regulations found at 45 CFR Part 164, Subpart A. This includes, but is not limited to, the right to use and disclose a participant's PHI in connection with payment, treatment and health care operations.

This Applies To

The information in this section applies only to health-related benefit plans that provide "medical care," which means the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body, transportation primarily for and essential to medical care, and insurance covering medical care. This means that, for the Plans listed above, only the health-related benefits, including medical, dental, vision, prescription drug, mental health, and health care flexible spending account benefits, are subject to the limitations described in this section. The EAP is included only to the extent that it is involved in the administration of medical benefits.

This Section Does Not Apply To

By law, the HIPAA Privacy rules, and the information in this section, do *not* apply to the following benefit plans:

- Disability plans (short-term and long-term disability)
- Life insurance plans, including accidental death & dismemberment (AD&D)
- Workers' compensation plans, which provide benefits for employment-related accidents and injuries
- Property and casualty insurance.

In addition, AMR Corporation and its subsidiaries may have personal medical information about you that is used for routine employment activities. Medical information held or used by AMR Corporation and its subsidiaries in its employment records for employment purposes is *not* subject to the HIPAA Privacy rules.

This includes, but is not limited to, medical information, files or records related to compliance with government occupational and safety requirements, the Americans with Disabilities Act (ADA) or other employment law requirements, occupational injury, disability insurance eligibility, sick leave requests or justifications, drug or alcohol screening results, workplace medical surveillance, fitness-for-duty test results, or other medical information needed to meet Federal Aviation Administration (FAA), Department of Transportation (DOT), or other company policy or government requirements. Information used by the EAP in its role in administering employment-related programs, such as drug and alcohol testing, is not subject to the HIPAA Privacy rules.

The Plan will disclose PHI to the employer Plan Sponsor (American Eagle Airlines, Inc. and Its Affiliates only upon receipt of a certification by the employer that the plan documents have been amended to incorporate all the required provisions as described below. To the extent that PHI is maintained by the Plan, American Eagle Airlines and Its Affiliates have agreed to:

- Not use or further disclose the information other than as permitted or required by this Employee Benefits Guide, as it may be amended by American Eagle Airlines, Inc. and Its Affiliates from time-to-time, or as required by law
- Ensure that any agents, including a subcontractor, to whom the Plans give PHI, agree to the same restrictions and conditions that apply to the employer Plan Sponsor with respect to such information

- Not use or disclose PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor employer, unless that use or disclosure is permitted or required by law (for example, for Workers' Compensation programs) or unless such other benefit is part of an organized health care arrangement with the plan
- To the extent that the employer Plan Sponsor becomes aware that there is any use or disclosure of PHI that is inconsistent with the permitted uses or disclosures, to report such improper uses or disclosures to the Plan
- Make available PHI in accordance with individual rights to review their PHI
- Make available PHI for amendment and consider incorporating any amendments to PHI consistent with the HIPAA rules
- Upon request and to the extent mandated by applicable law, make available the information required to provide an accounting of disclosures in accordance with the HIPAA rules
- Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Plan
- Agree to the same restrictions and conditions that apply to the Plan with respect to such information and enter into Business Associate agreements that comply with the standards for such agreements in the Privacy Regulations
- Enter into limited data set use agreements when the Plan discloses data de-identified in compliance with the requirements for a limited data set as provided in the Privacy Regulations pursuant to a Limited Data Set use or disclosure agreement which meets the standards of the Privacy Regulations
- Terminate any Business Associate agreement or Limited Data Set agreement in the event the Plan becomes aware of a pattern of noncompliance with the terms of the agreement
- Provide the individual who is the subject of the PHI with the opportunity to request restrictions on the PHI's disclosure in accordance with the Plan's policy on requesting restrictions on disclosure of PHI
- Provide the individual who is the subject of the PHI with the opportunity to request confidential communication of PHI from the Plan to the individual in accordance with the Plan's policies and procedures
- Incorporate any amendments or corrections to PHI when such amendment is determined to be required by the Plan's policy on amendment of PHI
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plans available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plans
- If feasible, return or destroy all PHI received from the Plans that the employer Plan Sponsor still maintains in any form. The employer Plan Sponsor will retain no copies of PHI when no longer needed for the purpose for which disclosure was made. An exception may apply if the return or destruction is not feasible, but the Plan must limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible, and
- Ensure that there is an adequate separation between the Plan and the employer Plan Sponsor as will be set forth below.

Separation of American Eagle Airlines, Inc. and Executive Airlines, Inc. and the Group Health Plan

The following employees or classes of employees or other persons under the control of American Eagle Airlines and Its Affiliates or as delegated to American Airlines, Inc., HR Services to provide any necessary administrative services, shall be given access to Protected Health Information (PHI) for the purposes related to the Plan:

- Compensation and Benefits employees involved in health plan design and strategy, vendor selection, and administration of the Plans, and including the Plan Managers, and administrative assistants, secretarial and support staff; as well as any Retirement Strategy employees involved in health plan issues

- Eagle Benefits Administration Committee (EBAC), its delegated authority, and individuals due to their role in governing health plan matters, including reviewing and approving plan design changes, rendering appeal decisions, and other health plan administrative matters
- HR Services personnel who assist with day-to-day health plan operations, including Vendor Relations personnel; employees involved in receiving, reviewing and processing Qualified Medical Child Support Orders; and all call center personnel, case coordinators and support staff who assist employees by answering questions, researching issues and resolving health plan problems, including those administering the Travel program; Leave of Absence coordinators working with health plan enrollment issues; Survivor Support counselors, who assist with health plan issues for survivors; and administrative assistants, secretarial and support staff for the employees listed
- Instructors who train HR Services personnel, and thus have access to the call center systems
- HR Records Room personnel responsible for managing benefit plan record storage
- Certain operational support personnel, but only those involved in investigating health plan fraud or abuse
- Executive Compensation employees, including secretarial and support staff, who assist Company executives and certain other employees with health plan enrollment and payment issues on a day-to-day basis
- AA Medical and Occupational Health Services employees, including the Corporate Medical Director, EAP Manager, EAP nurses and support staff providing services through the Employee Assistance Program (EAP), including review and approval of mental health and substance abuse claims under the Plan, but only to the extent of their involvement with the Plan
- Legal department employees, including Employment Attorneys, ERISA counsel, Labor Attorneys, and Litigation Attorneys, and any other attorneys involved in health plan legal matters, and including paralegals and administrative assistants, and Legal Records Room personnel who manage record storage
- Human Resource (HR) Quality Assurance personnel responsible for financial management of the health plans, including the HR Controller; HR Delivery Operations personnel; health plan Benefits Analysts monitoring financial trends; and their administrative assistants, secretarial and support staff
- Financial Reporting Group employees involved in audits and financial reporting for the group health plans, and including the secretarial and support staff for these employees
- Employee Relations personnel, but only those involved in grievance processes or mediation/arbitration processes
- Internal Audit employees, but only for purposes of auditing administrative processes related to the group health plans, and including the secretarial and support staff for these employees
- Benefits & Travel Technology personnel who maintain key human resource and benefits systems used to transmit, store or manage PHI, and including the secretarial and support staff for these employees
- Information Technology Services (ITS) management personnel, including certain team leads and other designated personnel managing IT infrastructure for systems used by HR and Benefits, including administrative staff, key vendor managers and certain management personnel responsible for disaster recovery procedures, and
- On a need-to-know basis, appropriate personnel employed by the employer Plan Sponsor as independent contractors who have executed Business Associate agreements with the plan to provide other necessary administrative services to the Plan that include, but are not limited to:
  - Insurance agents retained to provide consulting services and obtain insurance quotes
  - Actuaries retained to assess the Plan's ongoing funding obligations
  - Data aggregation specialists engaged to facilitate the collection and organization of Plan liabilities
  - Consulting firms engaged to design and administer Plan benefits

- Financial accounting firms engaged to determine Plan costs; and
- Claims processing companies engaged to assist the Plan Administrator in the processing of claims made against the Plan.
- American Airlines, Inc, to the extent of services rendered for the Plan via any transitional services agreement.

Access to and use of PHI by such employees and other persons described above is restricted to administration functions for the Plan performed by American Eagle Airlines, Inc., including payment and health care operations.

American Eagle Airlines, Inc. and Its Affiliates shall provide an effective mechanism for resolving any issues of noncompliance by such employees or persons. American Eagle Airlines' Rules of Conduct, as outlined in the Employee Policy Guide, including disciplinary procedures, will apply to such issues of employee noncompliance.

Non-compliance Issues

If the persons described above do not comply with the requirements included in this portion of the Plan, the Plan Sponsor shall provide a mechanism for resolving issues of non-compliance, including disciplinary sanctions for the individuals involved in the violation, which sanctions are included in the policy on sanctions for violation of the privacy policies and procedures. The Plan's Policy Regarding Sanctions for Violation of the HIPAA Privacy Policies and Procedures shall be followed along with the Group Health Plan's Policy and Procedure on Mitigation of Damages for Violative Disclosure of Protected Health Information in the event of any violation of the Plan's HIPAA Privacy Provisions in this Article.

Organized Health Care Arrangement

The Plan is part of an organized health care arrangement. This organized health care arrangement is maintained by American Eagle Airlines, Inc. and Its Affiliates.

The Group Health and Welfare Benefits Plan for Employees of American Eagle Airlines, Inc. and Its Affiliates with respect to the benefits and benefit options providing medical benefits, dental benefits, vision benefits, health care flexible spending accounts and the HMOs offered hereunder, and any other Group Health Plan for which American Eagle Airlines, Inc. serves as Plan Administrator.

The health plans or health care components that are part of this organized health care arrangement may disclose or use PHI to the other plans within the organized health care arrangement for the purposes described in the regulations and in the section entitled "Notice of Privacy Rights – Health Care Records" in the "Compliance with Privacy Regulations" on page 186.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of the Plan's benefits that relate to an individual to whom health care is provided. A disclosure for payment will be limited to the minimally necessary information unless the disclosure occurs in the form of the standard for the electronic transactions. An authorization is not required to permit a disclosure or use for payment unless the disclosure involves psychotherapy notes or the use of the information for marketing. Payment activities include, but are not limited to, the following:

- Determination of eligibility, coverage and cost sharing amounts (for example, the reasonable or usual and customary cost of a service or supply, benefit plan maximums, coinsurance, deductibles and copayments as determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;

- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Determining medical necessity, experimental or investigational treatment or other coverage reviews or reviews of appropriateness of care or justification of charges (including hospital bill audits);
- Processing utilization review, including precertification, preauthorization, concurrent review, retrospective review, care coordination or case management;
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for such purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- Obtaining reimbursements due to the Plan.

Health Care Operations – A disclosure for Health Care Operations will be limited to the amount minimally necessary. Health Care Operations include, but are not limited to, the following activities:

- Quality assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating providers and plan performance, including accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the Plan, including but not limited to:
  - Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
  - Participant service, including the provision of data analyses for participants or the plan sponsors;
  - Resolution of internal grievances; and
  - The sale, transfer, merger, or consolidation of all or part of the Plan with another covered entity, or an entity that following such activity will become a covered entity, and due diligence related to such activity.

Treatment – Disclosures for treatment are not limited by the minimally necessary requirement if the disclosures are made to, or the requests are made by a health care provider for the treatment of an individual. Treatment means the provision, coordination or management of health care and related services by one or more health care provider(s). Treatment includes:

- The coordination or management of health care by a health care provider and a third party;
- Consultation between health care providers about an individual patient; or
- The referral of a patient from one health care provider to another.

Limited Data Set. The Plan may disclose PHI in the form of a limited data set as provided in 45 CFR §164.514(e) provided that the disclosure is in accordance with such provisions.

Your Rights Under ERISA

Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Normally, the Plan Administrator should be able to help resolve any problems that might develop or answer any questions about rights to benefits under the Plan. We believe that the Plan that has been developed is only good if you receive the benefits to which you are entitled. We encourage you to come to us if you have any questions or problems. In addition, as already noted, the Plan documents and other related information will be made available if you wish to study these materials. However, if you feel your rights under ERISA have been violated, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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Assistance with Your Questions

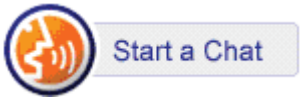
If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

For general information contact:

HR Services
MD 5141-HDQ1
c/o American Airlines, Inc.
P. O. Box 619616
DFW Airport, Texas 75261-9616
1-800-447-2000

Web Address: Jetnet.aa.com. Select the Benefits page. You may chat live with HR Services by clicking on the Chat with HR Services icon on the Benefits page of Jetnet.

For information about your claims, contact the appropriate claims processor or benefits plan administrator at the addresses and phone numbers located in "Contact Information" in the *Reference Information* section.



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Reference Information

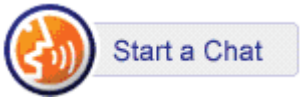
This section provides useful reference materials. It includes:

- "Contact Information" on page 199,
- a "Glossary" on page 203, and
- "Archives" on page 213.

Contact Information

The following table lists the names, addresses, phone numbers, and Websites (when available) for these important contacts.

For Information About:	Contact:	At:
Health and Welfare Benefits General questions, information updates, and request forms	HR Services American Eagle Airlines MD 5141-HDQ P.O. Box 619616 DFW Airport, TX 75261-9616	1-800-447-2000 Chat live with HR Services: Click on the "Start a Chat" button on the top of this page. Chat hours are 8:00 a.m. to 5:00 p.m. CT, Monday through Friday Website: Jetnet.aa.com
Medical Coverage		
Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-800-496-3310Website: https://www.jetnet.aa.com/jetnet/go/ssobcbs.asp Provider directory: http://www.bcbstx.com/americaneagle/
Health Maintenance Organizations (HMOs) Option	Triple S	1-787-749-4777 Website: http://www.ssspr.com/
Puerto Rico employees only	Humana	Website: http://www.humana.com/ 1-787-282-7900
Maximum Medical Benefit Requests	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-800-496-3310 Website: https://www.jetnet.aa.com/jetnet/go/ssobcbs.asp Provider directory: http://www.bcbstx.com/americaneagle/



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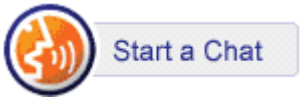
For Information About:	Contact:	At:
Coverage for Incapacitated Child and Special Dependents (PPO-Deductible and PPO-Copay Options)	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-800-496-3310 Website: https://www.jetnet.aa.com/jetnet/go/ssobcbs.asp Provider directory: http://www.bcbstx.com/americaneagle/
CheckFirst (Predetermination of Benefits) (Except HMOs)		
Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-800-496-3310 Website: https://www.jetnet.aa.com/jetnet/go/ssobcbs.asp Provider directory: http://www.bcbstx.com/americaneagle/
QuickReview (Pre-authorization for hospitalization)		
Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-800-496-3310 Website: https://www.jetnet.aa.com/jetnet/go/ssobcbs.asp Provider directory: http://www.bcbstx.com/americaneagle/
Prescription Drugs (Except HMOs)		
Mail Service Prescription Drug Option (Mail Order Pharmacy Service)	Medco Pharmacy P. O. Box 650322 Dallas, TX 75265-0322	1-866-544-2994 Website: https://www.jetnet.aa.com/jetnet/go/ssomedco.asp
Prescriptions - Prior Authorization	Express Scripts® (formerly Medco)	1-800-753-2851 (Member Services)
Retail Prescriptions - Phone Inquiries	Express Scripts® Member Services	1-866-544-2994 Website: https://www.jetnet.aa.com/jetnet/go/ssomedco.asp
Filing Retail Prescription Claims	Express Scripts® P. O. Box 14711 Lexington, KY 40512	N/A
Employee Assistance Program		
Employee Assistance Program	EAP	1-800-555-8810

https://www.jetnet.aa.com/jetnet/go/ssomercer.asp?AppID=CHAT

For Information About:	Contact:	At:
Dental Coverage		
Dental Benefit - Claims Processor	MetLife American Eagle Dental Claim Unit P.O. Box 981282 El Paso, TX 79998-1282	1-866-838-0875 (For eligibility, claim and provider listings) For claims tracking, to review your coverage options, or to locate a network dentist, visit the MetLife Website at https://www.jetnet.aa.com/jetnet/go/ssometlife.asp. You will be prompted to enter a company name. Enter "American Eagle". To continue the sign-in process, enter your uniquely-created "User Name" and "Password". If you are a first-time visitor to the site, click on "register here" under "Welcome to MyBenefits" or click the "Register Now" icon on the left. Follow the prompts to establish your account. If you have problems accessing the site, please contact MetLife's technical help desk at 1-877-9MET-WEB (1-877-963-8932), or email info@metlife.com.
Vision Insurance		
Vision Discount Program	EyeMed	1-877-226-1116 Website: http://www.enrollwitheyemed.com/
Vision Insurance Benefit	Spectera® Vision, Inc.) 2811 Lord Baltimore Drive Baltimore, MD 21244	1-800-638-3120 Website: https://www.myspectera.com/members/index.jsp
Life Insurance		
Term Life Insurance Benefit	MetLife American Eagle Airlines Customer Unit P.O. Box 3016 Utica, NY 13504-3016	1-800-638-6420 1-877-275-6387 (for Information on Conversion)



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For Information About:	Contact:	At:
Accident Insurance		
Accidental Death & Dismemberment (AD&D) Insurance Benefit, Voluntary Personal Accident Insurance Benefit, and Other Accident Insurance Benefits	CIGNA Group Insurance (for Life Insurance Company of North America) P. O. Box 22328 Pittsburgh, PA 15222 CIGNA Secure Travel	1-800-238-2125 From U.S. and Canada: 1-800-368-7878 From all other locations: 1-202-331-1596
Disability Coverage		
Disability Benefits: ***Optional Short Term Disability Insurance Benefit*** ***Long Term Disability Insurance Benefit***	MetLife Disability American Eagle Airlines Claim Unit P. O. Box 14590 Lexington, KY 40511-4590	1-888-533-6287 Website access for claims tracking and coverage information: https://www.jetnet.aa.com/jetnet/go/ssometlife.asp
Flexible Spending Accounts (FSAs)		
Health Care and dependent Day Care FSAs	PayFlex Systems USA, Inc. PO Box 3039 Omaha, NE 68103-3039	Telephone: 1-800-284-4885 Fax: 1-402-231-4310 Website: https://www.jetnet.aa.com/jetnet/go/ssopayflex.asp
Continuation of Coverage (COBRA)		
Continuation of Coverage (COBRA Administrator)	Benefit Concepts P.O. Box 246 Barrington, RI 02806	1-866-629-0274 Website: http://www.avantserve.com/
Other Information		
Eagle Benefits Administration Committee	EBAC American Eagle Airlines MD 5134-HDQ P.O. Box 619616 DFW Airport, TX 75261-9616	ICS or 1-817-967-1412
Employee's Withholding Allowance Certificate Form W-4	Payroll American Eagle MD 790-TUL 7645 E. 63rd Street Tulsa, OK 74133	ICS or 1-918-254-7439 Email to: AMR.Payroll.Customer.Service@aa.com

For Information About:	Contact:	At:
Other Options (Not Company Sponsored) The following program options are offered to eligible employees (and eligible dependents). However, American Eagle Airlines, Inc. does not sponsor these programs. For any information about these program options, please contact the sponsor(s) directly:		
Group Prepaid Legal Services	Hyatt Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114-2507	1-800-438-6388
Group Homeowners' and/or Automobile Insurance	Metropolitan Property & Casualty Insurance Company 477 Martinsville Road, 4th Floor Liberty Corner, NJ 07938	1-800-438-6388

Glossary

Accidental injury

An injury caused by an outside and unforeseen traumatic force, independent of all other causes.

Alternative and/or Complementary Medicine

Diverse medical health care systems, practices, and products that are not considered to be part of conventional medicine. Alternative and/or complementary medicine have not been proven safe and effective through formal scientific studies and scientific clinical trials conducted by the National Institutes of Health (National Center for Complementary and Alternative Medicine) or that are not recognized in Reliable Evidence as safe and effective treatments for the illness or injury for which they are intended to be used. Alternative and/or complementary medicine lack proof of safety and efficacy through formal, scientific studies or scientific clinical trials conducted by the National Institutes of Health or similar organizations recognized by the National Institutes of Health. Some examples of complementary and/or alternative medicine are:

- Mind-body interventions (meditation, mental healing, creative outlet therapy etc.)
- Biological therapies (herbal therapy, naturopathic or homeopathic treatment, etc.)
- Manipulative or body-based treatment (body-work, massage, rolfing, etc.)
- Energy therapies (qi-gong, magnetic therapies, etc).

These examples are not all inclusive, as new forms of alternative and/or complementary medicine exist and continue to develop. Other terms for complementary and/or alternative medicine include (but are not limited to) unconventional, non-conventional, unproven, and irregular medicine or health care.

Alternative mental health care centers

These centers include residential treatment centers and psychiatric day treatment facilities (see definitions in this section).

Ancillary charges

Charges for hospital services, other than professional services, to diagnose or treat a patient. Examples include fees for x-rays, lab tests, medicines, operating rooms, and medical supplies.

Appropriate Care and Treatment (Applies to OSTD and LTD Insurance Benefits)

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

Assignment of benefits

You may authorize the claims processor to directly reimburse your medical service provider for your eligible expenses by requesting that the provider accepts assignment of benefits. When you request assignment of benefits, you avoid paying the full cost of the medical service up front, filing a claim, and waiting for reimbursement. Your medical service provider generally files your medical claim for you if he or she accepts assignment.

Bereavement counseling

Counseling provided by a licensed counselor (usually a certified social worker, advanced clinical practitioner, or clinical psychologist) to assist the family of a dying or deceased plan participant with grieving and the psychological and interpersonal aspects of adjusting to the participant's death.

Chemical dependency treatment center

An institution that provides a program for the treatment of alcohol or other drug dependency by means of a written treatment plan that is approved and monitored by a physician. This institution must be:

- Affiliated with a hospital under a contractual agreement with an established system for patient referral
- Accredited by the Joint Commission on Accreditation of Health Care Organizations
- Licensed, certified, or approved as an alcoholism or other drug dependency treatment program or center by any state agency that has the legal authority to do so.

Chiropractic care

Medically necessary diagnosis, treatment, or care for an injury or illness when provided by a licensed chiropractor.

Coinsurance

You pay a percentage of eligible expenses and the Medical Benefit Option pays the remaining percentage. For example, after you satisfy your deductible under the PPO-Deductible Option, you pay 20% coinsurance for most covered medical services and the PPO-Deductible Option pays 80%.

Common accident

With regard to Accidental Death and Dismemberment (AD&D), this refers to the same accident or separate accidents that occur within one 24-hour period.

Company

American Eagle Airlines, Inc. and Its Affiliates.

Convalescent or skilled nursing facility

A licensed institution that:

- Mainly provides inpatient care and treatment for persons who are recuperating from illness or injury
- Provides care supervised by a physician
- Provides 24-hour nursing care by nurses who are supervised by a full-time registered nurse
- Keeps a daily clinical record of each patient
- Is not a place primarily for the aged or persons who are chemically dependent
- Is not an institution for rest, education, or custodial care.

Conventional Medicine

Medical health care systems, practices, and products that are proven and commonly accepted and used throughout the general medical community of medical doctors, doctors of osteopathy, and allied health professionals such as physical therapists, registered nurses, and psychologists. Conventional medicine has been determined safe and effective, and has been accepted by the National Institutes of Health, United States Food and Drug Administration, Centers for Disease Control or other federally recognized or regulated health care agencies, and has been documented by Reliable Evidence as both safe and effective for the diagnosis and/or treatment of the specific medical condition. Other terms for conventional medicine include (but are not limited to) allopathy, western, mainstream, orthodox, and regular medicine.

Copayments

You pay a specific dollar amount for certain covered services when you use network providers. For example, under the PPO-Copay Option you pay $20 for an office visit to your primary care physician (PCP) and $30 for a specialist visit.

Custodial care

Care that assists the person in the normal activities of daily living and does not provide any therapeutic value in the treatment of an illness or injury.

Deductible

The amount of eligible expenses a person or family must pay before a benefit or plan will begin reimbursing eligible expenses.

Dental

Dental refers to the teeth, their supporting structures, the gums, and/or the alveolar process.

Detoxification

Twenty-four hour medically directed evaluation, care, and treatment of drug-and alcohol-addicted patients in an inpatient setting. The services are delivered under a defined set of physician-approved policies and procedures or clinical protocols.

Developmental therapy

Therapy for impaired childhood development and maturation. Examples of developmental therapy include treatments that assist a child in walking, speech proficiency (word usage, articulation, and pronunciation), and socialization skills. Developmental therapy is not considered rehabilitative unless the function had been fully developed and then lost due to injury or illness.

Durable medical equipment (DME)

Medical equipment intended for use solely by the participant for the treatment of his or her illness or injury. DME is considered to be lasting and would have a resale value. DME must be usable only by the participant and not the family in general.

The equipment must be medically necessary and cannot be primarily for the comfort and convenience of the patient or family. A statement of medical necessity from the attending physician and a written prescription must accompany the claim. DME includes, but is not limited to: prosthetics, casts, splints, braces, crutches, oxygen administration equipment, wheelchairs, hospital beds, and respirators.

Eligible medical expenses or Eligible expenses

The benefit or plan covers the portion of regular, medically necessary services, supplies, care, and treatment of non-occupational injuries or illnesses up to the usual and prevailing fee limits, when ordered by a licensed physician acting within the scope of his or her license and that are not for services or supplies that are excluded from coverage.

Emergency

An injury or illness that happens suddenly and unexpectedly and could risk serious damage to your health or is life threatening if you do not get immediate care. Examples include poisoning, drug overdose, multiple trauma, uncontrolled bleeding, fracture of large bones, head injury, severe burns, loss of consciousness, and heart attacks.

Enter-on-duty date

The first date that you are on the U.S. payroll of American Eagle Airlines, Inc. as a regular employee.

Experimental or investigational service or supply

A service, drug device, treatment, procedure, or supply is experimental or investigational if it meets any of the following conditions:

- It cannot be lawfully marketed without approval of the U. S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished;
- Reliable evidence shows that the drug, device, procedure, or medical treatment is the subject of ongoing phase I, II, or III clinical trials or under study (or that the consensus of opinion among experts is that further studies or clinical trials are necessary) to determine its maximum tolerated dose, toxicity, safety, or efficacy, both in diagnosis and treatment of a condition and as compared with the standard means of treatment or diagnosis;
- The drug or device, treatment or procedure, has FDA approval, but is not being used for an indication or at a dosage that is accepted and approved by the FDA or the consensus of opinion among medical experts;
- Reliable Evidence shows that the medical service or supply is commonly and customarily recognized throughout the physicians profession as accepted medical protocol, but is not being utilized in accordance or in compliance with such accepted medical protocol and generally recognized standards of care;
- The drug, device, treatment or procedure that was reviewed and approved (or that is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function, or a drug, device, treatment or procedure that is used with a patient informed consent document that was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function;
- A drug, device, treatment or procedure for which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis;

- The treatment or procedure is less effective than conventional treatment methods; or
- The language appearing in the consent form or in the treating Hospital's protocol for treatment indicates that the Hospital or the Physician regards the treatment or procedure as experimental.

See the definition of "Reliable evidence" on page 212.

Explanation of benefits

A statement provided by the claims processor that shows how a service was covered by the plan, how much is being reimbursed, and what portion (if any) is not covered.

Free-standing surgical facility

An institution primarily engaged in medical care or treatment at the patient's expense and that is:

- Eligible to receive Medicare payments
- Supervised by a staff of physicians and provides nursing services during regularly scheduled operating hours
- Responsible for maintaining facilities on the premises for surgical procedures and treatment
- Not considered part of a hospital.

Home health care agency

A public or private agency or organization licensed to provide home health care services in the state in which it is located.

Home health care

Services that are medically necessary for the care and treatment of a covered illness or injury furnished to a person at his or her residence.

Hospice care

A coordinated plan of care that treats the terminally ill patient and family as a family unit. It provides care to meet the special needs of the family unit during the final stages of a terminal illness. Care is provided by a team of trained medical personnel, homemakers, and counselors. The hospice must meet the licensing requirements of the state or locality in which it operates.

Incapacitated child

A child who is incapable of self-support because of a physical or mental condition and who legally lives with the employee and wholly depends on the employee for support.

Infertility treatment or testing

Includes medical services, supplies, and procedures for or resulting in impregnation, and testing of fertility or for hormonal imbalances which cause male or female infertility (regardless of the primary reason for the hormone therapy). Infertility treatment or testing includes, but is not limited to: all forms of in-vitro fertilizations, artificial insemination, embryo transfer, embryo freezing, gamete transfer, zygote transfer, and reversals of tubal ligations or vasectomies, drug therapy, including drug treatment for ovarian dysfunction, and infertility drugs, such as Clomid or Pergonal.

Inpatient or hospitalization

Medical treatment or services provided at a hospital when a patient is admitted and confined, for which a room and board charge is incurred.

Life Event

Certain circumstances or changes that occur during an employee's life that qualify the employee or dependents for specific changes in coverage options.

Loss or impairment of speech or hearing

Those communicative disorders generally treated by a speech pathologist, audiologist, or speech language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both, and that fall within the scope of his or her license or certification.

Mammogram or mammography

The x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube filter compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views of each breast.

Maximum medical benefit

The maximum medical benefit is the most a benefit or plan will pay for eligible expenses during the entire time a person is covered by the benefit or plan.

When you have exhausted your maximum medical benefit your medical coverage terminates, and you do not receive the annual restoration of benefits. You are not eligible for any future increases in the maximum medical benefit.

Even if you have exhausted your maximum medical benefit, your covered eligible dependents may continue their existing medical coverage under the benefit or plan up to their maximum medical benefit (as long as they meet the eligibility requirements).

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

If you and your covered eligible dependents exhaust the maximum medical benefit, you may continue other coverages/benefits in the benefit or plan, e.g., life and/or accident insurance, dental coverage, flexible spending accounts, or the disability coverages. The medical coverage is the only coverage that terminates for the affected individual.

Medical Benefit

The Company offers eligible employees the opportunity to elect medical coverage that provides protection for you and your covered dependents in the event of an illness or injury. You may choose the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible or PPO-Copay Options, a Health Maintenance Organization (HMO), or you may waive coverage completely.

The Medical Options and HMOs are not offered in all locations.

Medical necessity or medically necessary

A medical or dental service or supply required for the diagnosis or treatment of a non-occupational, accidental injury, illness, or pregnancy. The benefit or plan determines medical necessity based on and consistent with standards approved by the claims processor's medical personnel. To be medically necessary, a service, supply, or hospital confinement must meet all of the following criteria:

- Ordered by a physician (although a physician's order alone does not make a service medically necessary)
- Appropriate (commonly and customarily recognized throughout the physician's profession) and required for the treatment and diagnosis of the illness, injury, or pregnancy
- Unavailable in a less intensive or more appropriate place of service, diagnosis, or treatment that could have been used instead of the service, supply, or treatment given

Either:

- Safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications
- Provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institute of Health for a life-threatening or seriously debilitating condition. The treatment must be considered safe with promising efficacy as demonstrated by accepted clinical evidence reported by generally recognized medical professionals or publications.

A service or supply for an illness or injury must meet the above conditions to be considered medically necessary. A service is not considered medically necessary if it is educational, experimental, or unproven in nature.

In the case of hospital confinement, the length of confinement and hospital services and supplies are considered medically necessary to the extent the claims processor, QuickReview, or your network administrator determines them to be:

- Appropriate for the treatment of the illness or injury
- Not for the patient's scholastic education, vocation, or training
- Not custodial in nature.
- A determination that a service or supply is not medically necessary may apply to all or part of the service or supply.

Mental Health Disorder

A neurosis, psychoneurosis, psychopathy, psychosis, mental or emotional disease or disorder of any kind listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, or any subsequent edition which constitutes the most recent edition of this manual.

Multiple Surgical Procedures

Surgical procedures performed at the same time as the primary surgical procedure, which are medically necessary but were not the primary reason for surgery.

Network

A group of physicians, hospitals, pharmacies, and other medical service providers who have agreed to provide discounted fees for their services.

Nurse

This term includes all of the following professional designations:

- Registered Nurse (R.N.)
- Licensed Practical Nurse (L.P.N.)
- Licensed Vocational Nurse (L.V.N.)
- Nursing services are covered only when medically necessary and the nurse is licensed by the State Board of Nursing and if the nurse is not living with you or related to you or your spouse.

Obesity

A condition in which an individual either (i) has a body weight greater than 30% above the ideal or desirable weight on standard height-weight tables, or (2) is male and has a body mass index greater than 27.8 or is female and has a body mass index of greater than 27.3. Obesity includes obesity that constitutes morbid obesity as well as all other forms of obesity.

Original Medicare

The term used by the Health Care Financing Administration to describe the coverage available under Medicare Parts A and B and D.

Outpatient

Medical treatment or services provided at a hospital or clinic for a patient who is not admitted to the hospital for an overnight stay.

Over-the-Counter (OTC)

Drugs, products, and supplies that do not require a prescription by federal law.

Primary Care Physician

A network physician who specializes in family practice, internal medicine, or pediatrics and who coordinates all of the network medical care for a participant in a PPO Option or an HMO.

Physician

A licensed practitioner of the healing arts acting within the scope of his or her license. The term does not include:

- You
- Your spouse
- A parent, child, sister, or brother of you or your spouse.

The term physician includes, but is not limited to, the following licensed individuals, listed alphabetically:

- Audiologist
- Certified social worker or advanced clinical practitioner
- Chiropractor
- Clinical psychologist
- Doctor of osteopathy (D.O.)
- Doctor of Medicine (M.D.)
- Nurse anesthetist
- Nurse practitioner
- Physical or occupational therapist
- Physician Assistant (PA)
- Speech pathologist or speech language pathologist or therapist.

Pre-existing condition (or pre-existing condition limitation)

A pre-existing condition includes any physical or mental condition that was diagnosed or treated before the participant's original coverage effective date (the date first enrolled in coverage) in a health plan and which will not be covered under that plan for a specified period after enrollment.

Pre-existing condition (Applies to OSTD Insurance Benefit)

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

Preferred Provider Organization (PPO)

A group of physicians, hospitals, and other health care providers who have agreed to provide medical services at negotiated rates. The Medical Options' Medical Discount Program and the Dental Benefits Preferred Dentist Program are both PPOs.

Prescription

Drugs and medicines that must, by federal law, be accompanied by a physician's written order and dispensed only by a licensed pharmacist. Prescription drugs also include injectable insulin and prenatal vitamins while pregnant.

Primary Surgical Procedure

The surgery prescribed based on the primary diagnosis.

Prior authorization for prescriptions

Authorization by the prescription drug program administrator that a prescription drug for the treatment of a specific condition or diagnosis meets all of the medical necessity criteria.

Proof of Good Health, Statement of Health

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

- Increase levels of Life Insurance
- Add Long Term Disability Insurance Benefit or Optional Short Term Disability Insurance Benefit (for workgroups that offer this Plan and/or benefit)
- Coverage amounts will not increase nor will you be enrolled in these coverages until the Plan Administrator approves your Proof of good health.

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

You may obtain a Life Insurance Statement of Health Form from MetLife for each benefit plan or on the eHR Center.

Provider

The licensed individual or institution that provides medical services or supplies. Providers include physicians, hospitals, pharmacies, surgical facilities, dentists, and other covered medical or dental service and supply providers.

Psychiatric day treatment facility

A mental health institution that provides treatment for individuals suffering from acute mental health disorders. The institution must:

- Be clinically supervised by a physician who is certified in psychiatry by the American Board of Psychiatry and Neurology
- Be accredited by the Program of Psychiatric Facilities of the Joint Commission on the Accreditation of Health Care Organizations
- Have a structured program utilizing individual treatment plans with specific attainable goals and objectives appropriate both to the patient and the program's treatment format.

Psychiatric day treatment facility

An institution licensed and operated as set forth in the laws that apply to hospitals, which:

- Is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons, either by or under the supervision of a physician
- Maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided
- Is licensed as a psychiatric hospital
- Requires that every patient be under the care of a physician
- Provides 24-hour nursing service.

The term psychiatric hospital does not include an institution, or that part of an institution, used mainly for the following:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial care
- Educational care

Regular employee

An employee hired for work that is expected to be continuous in nature. Work may be full-time, part-time, depending on the business needs of the organization or the terms of the applicable labor agreement. A regular employee is eligible for the benefits and privileges that apply to his/her workgroup or as outlined in his/her applicable labor agreement.

Reliable evidence

Reliable evidence includes:

- Published reports and articles in the authoritative peer reviewed medical and scientific literature (including, but not limited to: AMA Drug Evaluation, American Hospital Formulary Service Drug Information, U.S. Pharmacopoeia Dispensing Information, and National Institutes of Health)
- Written protocols used by the treating facility studying substantially the same drug, device, medical treatment, or procedure
- Written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Reliable evidence does not include articles published only on the internet.

Residential treatment center

A facility that offers 24-hour residential programs that are usually short-term in nature and provide intensive supervision and highly structured activities through a written individual treatment plan to persons undergoing an acute demonstrable psychiatric crisis of moderate to severe proportions. The center must be licensed by the state as a psychiatric residential treatment center and accredited by the Joint Commission on the Accreditation of Health Care Organizations.

Restorative and rehabilitative care

Care that is expected to result in an improvement in the patient's condition and restore reasonable function. After improvement ceases, care is considered to be maintenance and is no longer covered.

School/Educational Institution

An educational institution, including a vocational or technical school, if the student is enrolled:

- In a program leading to a degree or certificate
- On a full-time basis (generally 12 credit hours at colleges and universities).

Secondary Surgical Procedure

A surgical procedure performed at the same time as the primary surgical procedure, which is medically necessary but was not included in the primary diagnosis.

Special Dependent

A foster child or child for whom you are the legal guardian.

Summary Plan Description

In our efforts to provide you with full multi-media access to benefits information, American Eagle Airlines, Inc., has created online versions of the Summary Plan Descriptions for our benefit plans and they are included in this Guide. The Summary Plan Descriptions also the formal legal plan documents. If there is any discrepancy between the online version and the official hard copy of this Guide, then the official hard copy, plus official notices of plan changes/updates will govern.

Subrogation

Third-party Recovery (Applies to OSTD Insurance Benefit)

Recovery amounts that you receive for loss of income as a result of claims filed against a third party by judgment, settlement, or otherwise, including future earnings. Such recovery amount may be an offset to your OSTD benefit.

Urgent Care

Care required because of an illness or injury that is serious and requires prompt medical attention, but is not life threatening. Examples of situations that require urgent care include high fevers, flu, cuts that may require stitches, and sprains.

Unproven Service, Supply or Treatment

Any medical or dental service, supply, or treatment that has not been proven both safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications, or has not been proven both safe and effective by Reliable Evidence.

See the definition of "Reliable evidence" on page 212.

Usual and prevailing fee limits

The maximum amount that the Plan will consider as an eligible expense for medical or dental services and supplies. The following are the primary factors considered when determining if a charge is within the usual and prevailing fee limits:

- The range and complexity of the services provided
- The typical charges in the geographic area where the service or supply is rendered/provided and other geographic areas with similar medical cost experience.

The Plan Administrator utilizes a database of charge information about healthcare procedures and services, and this database is reviewed, managed, and monitored by FairHealth. Information about FairHealth and its work on this database is available at www.fairhealthus.org. Information from this FairHealth database is utilized by American Eagle's medical administrators in determining the eligible expense for services provided by out-of-network, non-contracting providers.

The usual and prevailing fee limits can also be impacted by number of services or procedures you receive during one medical treatment. Under the Plan, when the claims processor reviews a claim for usual and prevailing fees, it looks at all of the services and procedures billed. Related services and procedures performed at the same time can often be included in a single, more comprehensive procedure code. Coding individual services and procedures by providers (called "coding fragmentation" or "unbundling") usually results in higher physician charges than if coded and billed on a more appropriate combined basis. In such cases, the Plan will pay for the services as a group under a comprehensive procedure code, not individually.

Archives

Prior versions of your Employee Benefits Guide (EBG) are available at http://www.aacareers.com/ebg/archive.