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

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

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

Eagle Group Life and Health Benefits Plan

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

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

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

Establish a new contact number for UnitedHealthcare

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

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

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

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

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

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

Increase deductible amounts in the PPO-Deductible Option

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

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

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

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

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

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

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

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

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

Increase maximum member coinsurance amounts in the Prescription Drug Benefit

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

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

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

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

Changes to the Medical Benefit Options Comparison table

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

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

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

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

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

- *TriCare Supplement Insurance*

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

TriCare Supplement Insurance Option

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

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

- *TriCare Supplement Insurance Option*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TriCare Supplement Insurance Option

For those employees who are eligible for TriCare medical coverage,

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

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

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

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

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

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

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

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

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

TriCare Supplement Insurance Option

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

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

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

Portability of the TriCare Supplement Insurance

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

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

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

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

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

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

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

TriCare Supplement Insurance Option

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medicare Part D for Non Retiree Participants with Medicare

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

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

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

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

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

"Services not covered by Medicare include prescription drugs."

is deleted.

2 ½ Month Carryover of Unused Flexible Spending Account Funds

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

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

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

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

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

"June 15"

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

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

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

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

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

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

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

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

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

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

2 ½ Month Carryover of Unused HCFSA Funds

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

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

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

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

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

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

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

2 ½ Month Carryover of Unused DDFSA Funds

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

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

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

Method of Contribution Payment for Employees on Leaves of Absence

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

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

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

Restatement of the Employee Benefits Management Structure

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Return to Work Program

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

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

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

Family Care Incentive

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

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

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

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

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

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

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

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

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

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

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

Benefits from Other Sources

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

END OF SUMMARY OF MATERIAL MODIFICATIONS

ANNUAL BENEFITS NOTICE UNDER THE WOMEN'S CANCER RIGHTS ACT

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

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

These plans provide coverage for reconstructive surgery, as follows:

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

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

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

2006 American Eagle Medical Plan Comparison Chart

2006 Plan Features

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

2006 American Eagle Medical Plan Comparison Chart

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance	20% coinsurance	$30 copayment* per visit (max copayment of $300 per person per year)	20% coinsurance	40% coinsurance
Allergy Care	20% coinsurance	20% coinsurance	$30 copayment* per visit (max copayment of $300 per person per year)	20% coinsurance	40% coinsurance
Diagnostic X-ray and Lab	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital. No cost if performed in physician's office or a network laboratory/radiology center	20% coinsurance	40% coinsurance
OUTPATIENT SERVICES					
Outpatient Surgery in Physician's Office	20% coinsurance	20% coinsurance	$20 copay PCP $30 copay Specialist	20% coinsurance	40% coinsurance
Outpatient Surgery in a Hospital or Free Standing Surgical Facility	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance
Pre-admission Testing	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance
HOSPITAL SERVICES					
Inpatient Room and Board, including intensive care unit or special care unit	20% coinsurance	20% coinsurance	$150 copayment* per year, plus 20% coinsurance for all other hospital based services+E58	20% coinsurance	40% coinsurance
Ancillary services (including x-rays, pathology, operating room, and supplies)	20% coinsurance	20% coinsurance	20% coinsurance for all hospital based services	20% coinsurance	40% coinsurance
Newborn Nursery Care (Considered under the baby's coverage, not the mother's. You must add the baby on-line via Jetnet within 60 days or these charges will not be covered.)	20% coinsurance (separate calendar year deductible applies to baby)	20% coinsurance (separate calendar year deductible applies to baby)	20% coinsurance for all hospital based services (hospital admission copayment of $150 does not apply to baby)	20% coinsurance (separate calendar year deductible applies to baby)	40% coinsurance (separate calendar year deductible applies to baby)
Inpatient Physician Services, Surgery, Anesthesia, and Medically Necessary Assistant Surgeon	20% coinsurance	20% coinsurance	20% coinsurance for inpatient hospital services	20% coinsurance	40% coinsurance
Blood Transfusion	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital. No cost if performed in physician's office	20% coinsurance	40% coinsurance
Organ Transplant	20% coinsurance	20% coinsurance	20% coinsurance for inpatient hospital services	20% coinsurance	40% coinsurance
Emergency Ambulance	20% coinsurance	20% coinsurance	No Cost	20% coinsurance	40% coinsurance
Emergency Room (hospital) Visit	20% coinsurance	20% coinsurance	$75 copayment* Waived if admitted to the hospital	20% coinsurance	40% coinsurance

2006 American Eagle Medical Plan Comparison Chart

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

2006 American Eagle Medical Plan Comparison Chart

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

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

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

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