

December 2006
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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 Notice and Summary of Material Modifications describes the changes that affect your benefit plans, and updates your summary plan descriptions. This Summary of Material Modifications, together with the Employee Benefits Guide, 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, 2007, unless otherwise stated elsewhere in this document.**

- These changes apply to the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 501, EIN #13-1502798 referred to herein as the “Plan”).

Eagle Group Life and Health Benefits Plan

- Under “Health Maintenance Organizations (HMOs)” (page 6), first sentence in the third paragraph is revised as follows:

HMOs are offered only in Puerto Rico, and St. Thomas and St. Croix USVI.

- Under “Employees Married to Other Employees” (page 11) the first paragraph of this section is deleted and replaced as follows:

If both you and your spouse are Company employees you have a choice to be covered as single employee or enrolled as dependent under your spouse’s plan. If you decide to be covered under you 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.

- Under “Spouse on leave of absence:” (page 11) last paragraph of this section is deleted and replaced as follows:

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

- Under “Life Events” the first bullet of the second Life Event listed (page 29) is revised as follows:

<i>If...</i>	<i>Then, You Can...</i>
<i>You or your spouse becomes pregnant</i>	Contact: UHC at 800-592-3048 before the 16 th week of pregnancy, if you are covered by the Out-of-Area, Minimum Coverage, PPO-Deductible or PPO-Copay Options

- Under “Life Events”, “Benefit Coverages Not Affected by Life Events” (page 34), the second sentence in the last paragraph titled “Medical Options” is revised as follows:

However, if you are enrolled in either the PPO-Copay, PPO-Deductible, Minimum Coverage, or Out-of-Area Options when you relocate, 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 our new location.

- Under “Medical Benefits”, “Overview” (page 36), the third paragraph, is revised as follows:

Employee residing in Puerto Rico, St. Thomas and St. Croix, USVI will have the choice between HMOS and the Out-of-Area Coverage options. All other employees will be eligible to participate in either the Out-of-Area Coverage Plan, or have a choice between the PPO-Deductible, the PPO-Copay, or Minimum Coverage Options. 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, specialist, hospitals and pharmacies for our members. If you live within a PPO service area you have a choice of either, the PPO-Deductible Option, 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 “Medical Benefits”, “Overview” (page 36), the first sentence in the fourth paragraph, is revised as follows:

Under the Out-of-Area Coverage you will receive the PPO in-network level of coverage.

- Under “Medical Benefits”, “Key Features of the Medical Options” , “Family annual deductible” (page 37), this paragraph is revised as follows:

Under the Out-of-Area Coverage, PPO-Deductible and Minimum Coverage Options, once the family annual deductible has been satisfied, all member 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.

- Under “Medical Benefits”, “Key Features of the Medical Options” , “Annual out-of-pocket maximum” (page 37), the second bullet in this paragraph is revised as follows:
 - For network services under the PPO-Deductible, PPO-Copay and Minimum Coverage Options, coinsurance amounts for hospital-based services apply to the annual network out-of-pocket maximum.
- Under “Medical Benefits”, “Key Features of the Medical Options” , “Prescription drug benefits” (page 38), the first sentence of the second paragraph is revised as follows:

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).

Eliminate \$3,500 restoration to the maximum medical benefit

- Under “Key Features of the Medical Options” under “Lifetime medical maximum benefit” (page 38), the third and fourth sentence of the first paragraph

Effective January 1 of each year, part of your Lifetime Medical Maximum benefit is automatically restored. The amount restored is \$3,500, or the amount necessary to restore your full \$5,000,000, whichever is less.

are deleted in their entirety.

- Under “Maximum Medical Benefit” (page 39), the second paragraph

Effective January 1 of each year, part of your Lifetime Medical Maximum benefit is automatically restored. The amount restored is \$3,500, or the amount necessary to restore your full \$5,000,000, whichever is less.

is deleted in its entirety.

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

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 service under the PPO-Deductible, PPO-Copay or Minimum Coverage Options, you must satisfy any individual annual deductibles before the options pays benefits for Eligible Expenses.

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.

Provider Networks for the Medical Benefit Options

- Under “Benefits at a Glance”, “Out-of-Area Coverage, Minimum Coverage and PPO Deductible Options” (page 5) the second sentence in the second paragraph is revised as follows:

When you use a network provider under the PPO-Deductible Option and the Minimum Coverage Option, you receive a higher level of benefits.

- Under “Benefits at a Glance” (page 6) the following section is added immediately following “PPO-Copay Option” section, before the last sentence on this section “To see comparison of your benefits under the Medical Options, see page 40”:

Provider Networks for the Medical Options

The Medical Benefit Option you select determines the provider network you access. UnitedHealthcare. When you access UnitedHealthcare’s website, your ID and password enables UnitedHealthcare to know which Medical Benefit Option you’ve elected, and to select the appropriate provider network for your elected Medical Benefit Option—thus, you will have access to the provider network corresponding to your medical coverage. The following chart references the specific provider network and network usage requirements for each of the self-funded Medical Options:

Medical Benefit Option	Type of Network Provider	Voluntary Choice of In vs. Out of Network?	Benefit Level Reduction for Out of Network?
Out-of-Area Coverage	UnitedHealthcare Options	Yes	Not Applicable

Option	PPO Network		
Minimum Coverage Option	UnitedHealthcare Choice Plus Network	Yes	Yes, from 80% / 20% to 60% / 40%
PPO-Deductible Option	UnitedHealthcare Choice Plus Network	Yes	Yes, from 80% / 20% to 60% / 40%
PPO-Copay Option	UnitedHealthcare Choice Plus Network	Yes	Yes, from 80% / 20% to 60% / 40%

Choice Plus provider network for participants in Maine, Massachusetts, and New Hampshire: UnitedHealthcare has introduced the Harvard Pilgrim healthcare provider network to its Choice Plus network participants residing in Maine, Massachusetts, and New Hampshire. Participants residing in these three states and who elect coverage that utilizes the Choice Plus network, will have access to the Harvard Pilgrim network for services rendered in these three states. If these participants access medical care outside Maine, Massachusetts, and New Hampshire, they will access the Choice Plus network.

- Under “Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options”, “How the medical Options Work” (page 48), the first paragraph is revised as follows:

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 “Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options”, “How the medical Options Work” (page 48), the third sentence of the second paragraph is revised as follows:

When you use a network provider under the Out-of-Area Coverage Option, you save and the company saves.

- Under “Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options”, “How the medical Options Work” (page 48), the third paragraph is revised as follows:

After meeting the annual deductible under the Out-of-Area Coverage and in-network under the PPO-Deductible and Minimum Coverage Options, the plans pays 80% of most eligible expenses up to usual and prevailing fee limits for most medically necessary services. Your coinsurance is 20%. When using non-network provider under the PPO-Deductible and Minimum Coverage Options, the plan pays 60% of most eligible expenses up to usual and prevailing fee limits 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. Outpatient mental health care is covered at 50% and does not count toward the annual out-of-pocket maximum.

- Under “Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options”, “How the medical Options Work” (page 48), a new paragraph is added under the third paragraph as follows:

Under the PPO Deductible and Minimum Coverage Options, you may decide whether to use in-network or out-of-network providers each and ever 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 UnitedHealthcare for approval to visit an out-of-network specialist. Provided you have obtained approval from UnitedHealthcare, 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.

Introduce Out-of-Network deductibles under the Minimum Coverage Option

- Under “Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options”, “Special provisions”, “Deductibles” (page 48), the third sentence in this paragraph is revised as follows:

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.

Individual Annual Out-of-Pocket Maximum under the Out-of-Area, Minimum Coverage and PPO-Deductible Options

- Under “Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options”, “Special Provisions”, bellow “Deductibles” (page 48), a paragraph is added as follows:

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.

Add preventive care coverage to the Minimum Coverage, PPO Deductible and Out-of-Area Options

- Under “Special Provisions” section “Preventive Care” (page 49) each bullet reads as follows (see December 15, 2005 SMM):
 - Under the Minimum Coverage and PPO Deductible Options, in-network preventive care will be covered at 80%, without having to meet the annual deductible. (See Medical Benefits Options Comparison Table for details).
 - Under the Out-of-Area Coverage Option preventive care will be covered at 80% in-network or out-of-network, without having to meet the annual deductible. (See Medical Benefits Options Comparison Table for details).
- Under “Covered Expenses”, “Preventive Care” (page 62), this paragraph is revised as follows:

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.

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

- Under “Special Provisions” section “Hospital out-of-pocket maximum” (page 52), the first sentence in this paragraph is revised as follows:

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 \$150 annual copayment.

Bariatric – surgeries covered in-network only

- Under “Covered Expenses”, below “Assistant Surgeon” (page 58), add a section as follows:

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

- Under “Excluded Expenses”, below “Alternative and/or Complementary medicine” (page 70), add a section as follows:

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

Eliminate Plan Coverage for Sexual Performance Medications, Devices, and/or Treatment

- Under “Excluded Expenses” below “Sex changes” (page 72) a bullet is added as follows:
 - 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.

Introduce generic coinsurance and minimum copayments under the prescription drug benefit

- Under “Retail Drug Coverage” (page 66) the second paragraph is deleted in its entirety and replaced with the following paragraph and chart:

Under the Retail Prescription Drug Option, you may order up to a 30-day supply of any medically-necessary covered prescription, including psychotherapeutics. If cost of the drug is less than the minimum then participant pays the cost of the drug.

Retail Prescription Drug	Coverage:
Generic	20% coinsurance, with \$10 Minimum and \$50 Maximum per prescription/refill
Brand Drug (no generic available)	30% coinsurance, with \$20 Minimum and \$100 Maximum per prescription/refill
Brand Drug (if generic available)	50% coinsurance, with \$20 Minimum and no Maximum per prescription/refill

- Under “Mail Service Prescription Drug Option” (page 68) the second paragraph is revised as follows:

Under the Mail Service Prescription Drug Option, you may order up to a 90-day supply of your prescription drug (but no more than the number of days prescribed by your physician). You pay a coinsurance (with no annual deductible) for each prescription or refill.

- Under “Mail Service Prescription Drug Option” (page 68) the two bullets are deleted in their entirety and replaced with the following chart:

Mail Service Prescription Drug	Coverage:
Generic	20% coinsurance, with \$20 Minimum and \$125 Maximum per prescription/refill
Brand Drug (no generic available)	30% coinsurance, with \$40 Minimum and \$250 Maximum per prescription/refill
Brand Drug (if generic available)	50% coinsurance, with \$40 Minimum and no Maximum per prescription/refill

- Under “Continuation of Coverage” (page 81) this section is deleted in its entirety and replaced with the following

Continuation of Coverage

Overview

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 (see page 5) available through CONEXIS, the COBRA administrator. CONEXIS 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, HCFSA Benefit and the Supplemental Medical Plan) 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 Benefit
- Vision Insurance Benefit
- Supplemental Medical Plan
- 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 dependents¹, including future changes.

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, Vision Insurance Benefits, and Supplemental Medical. 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.

COBRA Continuation

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.

¹ Although a Domestic Partner and his/her children do not have rights to COBRA Continuation of Coverage under existing federal law, AMR currently offers them the opportunity to continue health coverages that would be lost when certain events occur, however this may change. The current voluntary extension of COBRA Continuation of Coverage to Domestic Partners does not apply to the Supplemental Medical Plan and is not available under COBRA to surviving Domestic Partners.

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 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 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 (CONEXIS) 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 Domestic Partner relationship ends²
- You become entitled to (enrolled in) Medicare benefits
- Loss of eligibility because the dependent, including children of a covered 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 Domestic Partner's death¹

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.

Eligibility for Extended Continuation of Medical Coverage for Qualifying Pilots

Eligibility

You are eligible to elect Extended Continuation of Medical 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.

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 CONEXIS, 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 Domestic Partner relationship¹, your entitlement to or enrollment in Medicare, a dependent reaching the limiting age for coverage, or your Domestic Partner's death³), 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 Employee Services at 800-447-2000 to process the change. For example, in the event of your death, your supervisor or a dependent must call HR Employee Services to make the appropriate notification. If the Qualifying Event is also a Life Event that involves your Domestic Partner, you must call HR Employee Services to process the change.

³ Your 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 Domestic Partner relationship, your partner's child's loss of eligibility under the Plan, or the death of your Domestic Partner or yourself.

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.

Enrolling in COBRA Continuation of Coverage

Following notification of any of Qualifying Event (see page 82), HR Employee Services will advise CONEXIS, 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 CONEXIS 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 CONEXIS' 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 CONEXIS.

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 CONEXIS 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 CONEXIS at 877-902-9207 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

Please note: The Pilot who elects Extended Continuation of Medical Coverage will not be able to process Life Events.

If you elect COBRA Continuation of Coverage for yourself and later marry or *declare a 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 CONEXIS, the COBRA administrator, at 877-902-9207, *within 60 days* of the marriage, 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 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 CONEXIS 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 CONEXIS at 877-902-9207.

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 CONEXIS 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 CONEXIS and sent to **CONEXIS, P.O. Box 14225, Orange, CA 92863-1225**.

Solicitation For, Enrollment In, and Payment For, Extended Continuation of Medical Coverage for Qualifying Pilots

CONEXIS, the COBRA administrator, will mail a COBRA expiration notice to your home address (or to the address you provide CONEXIS) 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 CONEXIS 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 CONEXIS 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 CONEXIS and sent to **CONEXIS, P.O. Box 14225, Orange, CA 92863-1225**.

If you have questions regarding Extended Continuation of Medical Coverage, contact CONEXIS at 877-902-9207.

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 for COBRA Continuation of Coverage* on page 5).
- 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* on page 16.

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

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 Employees Obligations

In order to protect you and your family's rights, you should keep both CONEXIS and the Company informed of any changes in the addresses of your family members.

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. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

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 CONEXIS (see *Contact Information* on page 1).

Certificate of Coverage

If you lose your coverage (or when you notify Employee 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.

Changes to the Spectera Vision Insurance Benefit

- Under "Vision Benefits" (page114), the first paragraph is revised as follows:

The Company offers a Vision Discount Program and the Spectera Vision Insurance Benefit (optional). When you enroll in any of the medical plans, you are automatically registered as a member of the Vision Discount Program, which is offered through EyeMed. Also, all employees have the option of purchasing more comprehensive vision coverage through Spectera, which provides coverage for eyeglass lenses, frames, contact lenses, and sundry items.
- Under "Vision Benefits", "Spectera Vision Insurance Benefits", "Spectera Vision Insurance Network Provider Benefits" (page115), the "Covered Services / You Pay..." chart is deleted and replaced with the following:

Covered Services	You Pay . . .
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)

VPAI coverage for children

- Under "Accident Insurance Benefit", "Overview", (page 122), third bullet after "VPAI coverage also includes the following features" is revised as follows:
 - 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 benefit amount
Spouse and Children	Spouse: 60% of benefit amount Each child: 15% of benefit amount
Children only	Each child: 25% of benefit amount

Enhancements to Accidental Death and Dismemberment Insurance Benefit (AD&D)

- Under “Accident Insurance Benefit”, “Special AD&D Benefit Features” (page 123), the following paragraph is inserted immediately preceding “Child care benefit”:

Air bag benefit: If a participant is involved in a motor vehicle accident and his/her safety airbag is deployed as a result of such accident, the participant will receive a benefit equivalent to 10% of his/her principal sum benefit, up to a maximum of \$10,000.

- Under “Accident Insurance Benefit”, “Special AD&D Benefit Features” “Counseling and bereavement benefits” (page 124), the second sentence’s reference to “\$50 per session” is deleted and replaced with the following:

. . .at a maximum of \$100 per session. . . .

- Under “Accident Insurance Benefit”, “Special AD&D Benefit Features” (page 124), the following paragraph is inserted immediately following “Double benefit for dismemberment of children”:

Home/Vehicle modification benefit: If, as the result of an accident, the participant’s covered injury(ies) require use 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.

- Under “Accident Insurance Benefit”, “Special AD&D Benefit Features” (page 125), the following paragraph is inserted immediately preceding “Seat belt benefit”:

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.

- Under “Accident Insurance Benefit”, “Special AD&D Benefit Features” (page 125), the following two paragraph is inserted immediately following “Spouse retraining benefit”:

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.

- Under “Flexible Spending Account”, “Receiving Reimbursement”, (page 151) add three bullets before the first paragraph as follows:

You might receive reimbursement from your HCFSAs through 3 different methods:

- File your claims by mail directly with UnitedHealthcare, and UnitedHealthcare will mail your reimbursement check to you (or will deposit the reimbursement amount into your bank account, if you have elected to receive reimbursement via direct deposit)

- Use the automatic rollover feature – certain expenses will be submitted to UnitedHealthcare automatically, and UnitedHealthcare will mail your reimbursement check to you (or will deposit the reimbursement amount into your bank account, if you have elected to receive reimbursement via direct deposit)
- Use your UnitedHealthcare Consumer Account Card to pay the service provider directly from your HCFSA at the time you receive the service or product
- Under “Flexible Spending Account”, “Receiving Reimbursement”, “Automatic Reimbursement Feature” or “Automatic Rollover Feature” (page 152) at the end of first paragraph add a sentence as follows:

UnitedHealthcare 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).

- Under “Flexible Spending Account”, “Receiving Reimbursement”, “Automatic Reimbursement Feature” or “Automatic Rollover Feature” (page 152) add a second paragraph as follows:

The Automatic Rollover Feature is automatically activated for all participants on January 1 of each year. However, there may be situations where you cannot or do not wish to use this feature.

- Under “Flexible Spending Account”, “Receiving Reimbursement”, “Automatic Reimbursement Feature” or “Automatic Rollover Feature” (page 152) under “You should stop the Automatic Rollover Feature if:” a third bullet is added as follows:

- You cover dependents under your health care benefits as the result of a Qualified Medical Child Support Order.

- Under “Flexible Spending Account”, before “Filing Claims”, under section entitled “Using the UnitedHealthcare Consumer Card” (page 152) add three paragraphs before the chart as follows (see December 15, 2005 SMM):

Effective January 1, 2005, all FSA enrollees began receiving the UnitedHealthcare Consumer Account Card – this is different than your regular medical ID card. This Consumer Account Card (also referred to as the “FSA Card”) carries information about your FSA account(s) (both your HCFSA and your DDFSA, if applicable), including your account balance(s). Your FSA Card can be used at any provider, pharmacy, mail order pharmacy, or other medical provider that accepts MasterCard to pay for certain FSA-eligible expenses at the time and point of service. When you receive your FSA Card, you must activate it (similar to activating a credit card – instructions for activation are on the card). Each year that you participate in an HCFSA, your existing FSA card will be updated with your selected HCFSA amount, and you need not reactivate your card unless you are issued a new card (keep in mind that any newly issued/reissued card must be activated after January 1, and you must wait three business days after activating the card before you may use it). After you have activated your FSA Card, each year that you participate in an HCFSA, your FSA Card will be updated (“reloaded”) with your selected HCFSA amount, and will be ready for use on January 1 of the year to which your election applies.

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 Card to the provider. The doctor’s office will bill a charge for your \$20 PCP or \$35 Specialist copayment, and run this charge against your FSA Card – the FSA 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 are not required to use the FSA Card if you prefer to use the automatic rollover feature or file your claims manually. Keep in mind however, that when you use the FSA Card, the provider of service must bill/run the charge to your FSA Card as credit card, since the FSA Card cannot be assigned a PIN (Personal Identification Number) that is required for debit card transactions.

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 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 Card, which are subject to automatic rollover, and which must be submitted manually to the FSA administrator:

END OF SUMMARY OF MATERIAL MODIFICATIONS

CLARIFICATIONS TO THE EMPLOYEE BENEFITS GUIDE FOR AMERICAN EAGLE AIRLINES EMPLOYEES

This document serves as notice to American Eagle Airlines, Inc. active and Leave-of-Absence employee of clarifications to the summary plan description—the American Eagle Employee Benefits Guide (“EBG”). These clarifications, together with the EBG, make up the official plan documents and summary plan descriptions. **Please read this notice carefully, and place this notice with your summary plan description(s) (the Summary Plan Descriptions are contained in your EBG).**

These clarifications apply to the following plans:

Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 501, EIN #13-1502798; referred to herein as the “Plan”)

Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 503, EIN #13-1502798; referred to herein as “SMP”)

American Airlines, Inc. Long Term Disability Plan (Plan 509, EIN #13-1502798; herein referred to as “LTD”)

- Under “Eligibility”, under “Eligibility During Leaves of Absence and Disability” (pages 13), this subsection is deleted in its entirety and replaced with the following subsection:

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 Employee 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. Register your Life Event and benefit elections of Jetnet, and it will display for you a confirmation statement reflecting your choices, the monthly cost of benefits, etc. If you have not received HR Employee Services’ letter within 10 days of being placed on a leave, contact HR Employee Services immediately, so that you may continue your benefits while on leave.

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 Plan, Optional Short Term Disability Insurance Benefits, Contributory Term Life Insurance Benefit).

With respect to your reactivating your Contributory 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)

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 Employee Policy Guide, located under Policies and Procedures on Jetnet, or consult with your supervisor.

- Under “Life Events” (page 28), under “You get married or declare a Domestic Partner”, in the bullet describing Supplemental Medical Plan coverage, the following parenthetical statement is added to the end of the existing sentence, as follows:

(you must enroll yourself and/or your new spouse/Domestic Partner within 60 days of your marriage/declaration; otherwise, you cannot enroll in/add your spouse/Domestic Partner to the Supplemental Medical Plan).

- Under “Life Events” (page 29), under “You divorce or legally separate, or your Domestic Partner relationship ends”, the bullet entitled, “Medical and Dental Options and Vision Insurance Benefit” is revised to reflect the following:

Stop coverage for your spouse. Add coverage for yourself and/or your eligible dependents (dependent coverage may be subject to QMCSO—see page 74-75). You cannot change benefit options at this time.

- Under “Special Provisions” below “Deductibles” (page 52), a paragraph is added as follows:

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.

- Under “Covered Expenses” (page 57), the entry entitled, “Acupuncture” is deleted in its entirety and replaced with the following:

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).

- Under “Supplemental Medical Plan”, under “Eligibility”, “Active Employees” (page 88), the following parenthetical statement is added at the end of the second bullet:

(you must enroll yourself and/or your new spouse/Domestic Partner within 60 days of your marriage/declaration; otherwise, you cannot enroll in/add your spouse/Domestic Partner to the Supplemental Medical Plan).

- Under “Supplemental Medical Plan”, “Enrollment” (page 90), the following parenthetical statement is added to the end of the first sentence in the first paragraph:

(you must enroll yourself and/or your new spouse/Domestic Partner within 60 days of your marriage/declaration; otherwise, you cannot enroll in/add your spouse/Domestic Partner to the Supplemental Medical Plan).

- Under “Supplemental Medical Plan, “Enrollment” (page 90), the following statement is added to the end of the third sentence in the second paragraph:

. . . otherwise, you cannot enroll in/add your spouse/Domestic Partner to the Supplemental Medical Plan.

- Under “Dental Benefits”, under “Covered Expenses” (page 111), the subsection entitled “Periodontal treatment” is clarified as follows:

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.

- Under “Vision Benefits”, “How the Spectera Vision Insurance Benefit Works” (page 114), the third paragraph is deleted and replaced with the following:

ID cards are not necessary under the Spectera Vision Insurance Benefit—the “unique ID number” you need to access your Spectera 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.

- Under “Spectera Vision Insurance Benefits”, (page 114), the first paragraph is revised as follows:

If you use a network provider, the Spectera Vision Insurance Benefit covers the following services, with the benefit available every 12 months based on the last date of service, for each covered member. (The insurance also offers access to discounted laser eye surgery procedures).

- Under “Disability Benefits”, “Optional Short Term Disability Insurance Benefit”, “Exclusions and Limitations” (page 138), the following is added as the tenth bullet under the Exclusions and Limitations:

- **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).

- Under “Dependent Day Care Flexible Spending Account”, “Receiving Reimbursement”, under “Using the UnitedHealthcare Consumer Account Card” (page 156), the last sentence in the first paragraph is deleted in its entirety and replaced with the following:

Each year that you participate in an DDFSA, your existing FSA card will be updated with your selected DDFSA amount, and you need not reactivate your card unless you are issued a new card (keep in mind that any newly issued/reissued card must be activated after January 1, and you must wait three business days after activating the card before you may use it).

- Under “Flexible Spending Accounts”, “Dependent Day Care Flexible Spending Account”, “Filing Claims” (page 156), in the second paragraph, after the first sentence a sentence is added as follows:

Claims not postmarked by June 15 are ineligible for reimbursement.

- Under “Flexible Spending Accounts”, “Health Care FSAs”, “Receiving Reimbursement”, the chart added on the SMM effective date 01/01/06 (pages 7-8) is deleted in its entirety and replaced with the following chart:

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
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 (for a dental provider in the UHC network)	Yes	Yes	No
Coinsurance and Deductibles (for a dental provider in both the MetLife PDP network and the UHC network)	Yes	Yes	No
Coinsurance and Deductibles (for a dental provider in only the MetLife PDP network)	No	Yes	No
Vision Expenses			
Copayments	Yes	Yes	No
Coinsurance and Deductibles (for a Spectera or UHC network provider)	No	Yes	No
Eligible Over-the-Counter Drugs (OTC) purchased Retail or Online			
Walgreens — in store purchases only	Yes	No	No
Drugstore.com — online only	Yes	No	No
Any Other FSA-Eligible Expenses Not Filed with your Health Coverages	No	No	Yes
Dependent Day Care			
Some providers — check locally	Yes	No	No

- Under the Glossary, under the definition for “Proof of Good Health, Statement of Health” (page 194), the third bullet in the definition (regarding the addition of Supplemental Medical Plan) is deleted in its entirety.

END OF CLARIFICATIONS TO THE EMPLOYEE BENEFITS GUIDE

ANNUAL BENEFITS NOTICE UNDER THE WOMEN'S CANCER RIGHTS ACT

In compliance with the Women's Cancer Rights Act, this annual notice provides you with information about the coverages available to participants and their eligible dependents under the 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 lymphadenomas; 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.

END OF ANNUAL BENEFITS NOTICE UNDER THE WOMEN'S CANCER RIGHTS ACT

SMM for 2007, American Eagle Airlines EBG, 120406

2007 American Eagle Medical Plan Comparison Chart

2007 Plan Features

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	In-Network Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay	Out-of-Network Minimum Coverage
DEDUCTIBLES / MAXIMUMS						
Individual Annual Deductible	\$250	\$250	None	\$1,000	\$500	\$2,000
Family Annual Deductible	\$750	\$750	None	\$2,000	Not Applicable	\$4,000
Individual Annual Out-of-Pocket Maximum*	\$2,000	\$2,000	\$2,000	\$3,000	\$4,000	\$5,000
Individual Lifetime Medical Maximum	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
PREVENTIVE CARE						
Annual Routine Physical Exam	20% coinsurance without deductible waived	20% coinsurance without deductible waived	\$20 copayment*	20% coinsurance without deductible waived	Not Covered	Not Covered
Pap Test	20% coinsurance without deductible waived	20% coinsurance without deductible waived	No cost if part of office visit 20% coinsurance if in at a outpatient hospital	20% coinsurance without deductible waived	Not Covered	Not Covered
Screening Mammogram according to age guidelines, (Age 35 thru 39- one every 1-2 years. Age 40 thru 49 as recommended by physician. Age 50 and beyond- once every year)	20% coinsurance without deductible waived	20% coinsurance without deductible waived	No cost if part of office visit 20% coinsurance if in at a outpatient hospital	20% coinsurance without deductible waived	Not Covered	Not Covered
PSA screening and colorectal screening (according to age guidelines - routine coverage begins at age 50)	20% coinsurance without deductible waived	20% coinsurance without deductible waived	No cost if part of office visit 20% coinsurance if in at a outpatient hospital	20% coinsurance without deductible waived	Not Covered	Not Covered
Well Child office visits and immunizations (Birth to age 18, initial hospitalization, all immunizations. Up to 7 well child visits, birth to age 2)	20% coinsurance without deductible waived	20% coinsurance without deductible waived	\$20 copayment*	20% coinsurance without deductible waived	Not Covered	Not Covered
MEDICAL SERVICES						
Primary Care Physician's Office Visit	20% coinsurance	20% coinsurance	\$20 copayment*	20% coinsurance	40% coinsurance	40% coinsurance
Specialist Office Visit	20% coinsurance	20% coinsurance	\$35 copayment*	20% coinsurance	40% coinsurance	40% coinsurance
Gynecological Care Visit	20% coinsurance if medically necessary (preventive care not covered)	20% coinsurance after satisfying annual deductible	\$20 copayment* (for preventive visits) \$35 copayment* (if not a preventive diagnosis)	20% coinsurance if medically necessary (preventive care not covered)	40% coinsurance if medically necessary (preventive care not covered)	40% coinsurance if medically necessary (preventive care not covered)
Diagnostic Mammogram	20% coinsurance (if medically necessary)	20% coinsurance (if medically necessary)	20% coinsurance (if medically necessary)	20% coinsurance (if medically necessary)	40% coinsurance (if medically necessary)	40% coinsurance (if medically necessary)
Pregnancy - Physician Services	20% coinsurance	20% coinsurance	\$35 copayment* per visit \$350 max copayment per pregnancy (includes prenatal/postnatal/delivery)	20% coinsurance	40% coinsurance	40% coinsurance
PSA and colorectal diagnostic exam (according to age guidelines - routine coverage begins at age 50) Diagnostic	20% coinsurance (if medically necessary)	20% coinsurance (if medically necessary)	20% coinsurance (if medically necessary)	20% coinsurance (if medically necessary)	40% coinsurance (if medically necessary)	40% coinsurance (if medically necessary)
Second Surgical Opinion	20% coinsurance	20% coinsurance	\$20 copay PCP \$35 copay Specialist	20% coinsurance	40% coinsurance	40% coinsurance
Urgent Care Center Visit	20% coinsurance	20% coinsurance	\$25 copayment*	20% coinsurance	40% coinsurance	40% coinsurance
Chiropractic Care Visit	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)	\$35 copayment* (max of 20 visits per year in-network and out-of-network combined)	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)	40% coinsurance (max of 20 visits per year in-network and out-of-network combined)	40% coinsurance (max of 20 visits per year in-network and out-of-network combined)
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance	20% coinsurance	\$35 copayment* per visit (max copayment of \$350 per person per year)	20% coinsurance	40% coinsurance	40% coinsurance
Allergy Care	20% coinsurance	20% coinsurance	\$35 copayment* per visit (max copayment of \$350 per person per year)	20% coinsurance	40% coinsurance	40% coinsurance

2007 American Eagle Medical Plan Comparison Chart

2007 Plan Features

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	In-Network Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay	Out-of-Network Minimum Coverage
Diagnostic X-ray and Lab	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital. No cost if performed in physician's office or a network laboratory/radiology center	20% coinsurance	40% coinsurance	40% coinsurance
OUTPATIENT SERVICES						
Outpatient Surgery in Physician's Office	20% coinsurance	20% coinsurance	\$20 copay PCP \$35 copay Specialist	20% coinsurance	40% coinsurance	40% coinsurance
Outpatient Surgery in a Hospital or Free Standing Surgical Facility	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Pre-admission Testing	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
HOSPITAL SERVICES						
Inpatient Room and Board, including intensive care unit or special care unit	20% coinsurance	20% coinsurance	\$150 copayment* per year, plus 20% coinsurance for all other hospital based services	20% coinsurance	40% coinsurance	40% coinsurance
Ancillary services (including x-rays, pathology, operating room, and supplies)	20% coinsurance	20% coinsurance	20% coinsurance for all hospital based services	20% coinsurance	40% coinsurance	40% coinsurance
Newborn Nursery Care (Considered under the baby's coverage, not the mother's. You must add the baby on-line via Jetnet within 60 days or these charges will not be covered.)	20% coinsurance (separate calendar year deductible applies to baby)	20% coinsurance (separate calendar year deductible applies to baby)	20% coinsurance for all hospital based services (hospital admission copayment of \$150 does not apply to baby)	20% coinsurance (separate calendar year deductible applies to baby)	40% coinsurance (separate calendar year deductible applies to baby)	40% coinsurance (separate calendar year deductible applies to baby)
Inpatient Physician Services, Surgery, Anesthesia, and Medically Necessary Assistant Surgeon	20% coinsurance	20% coinsurance	20% coinsurance for inpatient hospital services	20% coinsurance	40% coinsurance	40% coinsurance
Blood Transfusion	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital. No cost if performed in physician's office	20% coinsurance	40% coinsurance	40% coinsurance
Organ Transplant	20% coinsurance	20% coinsurance	20% coinsurance for inpatient hospital services	20% coinsurance	40% coinsurance	40% coinsurance
Emergency Ambulance	20% coinsurance	20% coinsurance	No Cost	20% coinsurance	40% coinsurance	40% coinsurance
Emergency Room (hospital) Visit	20% coinsurance	20% coinsurance	\$75 copayment* (Waived if admitted to the hospital) plus 20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
OUT-OF-HOSPITAL CARE						
Convalescent and Skilled Nursing facility, following hospitalization	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	40% coinsurance (max of 60 days per year in-network and out-of-network combined)	40% coinsurance (max of 60 days per year in-network and out-of-network combined)
Home Health Care Visit	20% coinsurance	20% coinsurance	\$20 copayment	20% coinsurance	40% coinsurance	40% coinsurance
Hospice Care	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital; \$20 copayment per day if home care	20% coinsurance	40% coinsurance	40% coinsurance
OTHER SERVICES						
Tubal Ligation or Vasectomy (reversals are not covered)	20% coinsurance	20% coinsurance	\$20 copay PCP \$35 copay Specialist 20% coinsurance in hospital or freestanding surgical center	20% coinsurance	40% coinsurance	40% coinsurance

2007 American Eagle Medical Plan Comparison Chart

2007 Plan Features

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	In-Network Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay	Out-of-Network Minimum Coverage
Infertility Treatment	Not Covered	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	40% coinsurance
Kidney Dialysis (if the dialysis continues more than 12 months, participants must apply for Medicare)	20% coinsurance	20% coinsurance	No cost if performed in a physician's office; 20% coinsurance if performed in a hospital or dialysis center	20% coinsurance	40% coinsurance	40% coinsurance
Supplies, Equipment, and Durable Medical Equipment (DME)	20% coinsurance	20% coinsurance	20% coinsurance for items rented or purchased from an in-network provider	20% coinsurance	40% coinsurance	40% coinsurance
MENTAL HEALTH AND CHEMICAL DEPENDENCY						
Inpatient Mental Health Care	20% coinsurance (max of 30 days per year and Lifetime max of 60 days)	20% coinsurance (max of 30 days per year and Lifetime max of 60 days)	20% coinsurance for all hospital based services	20% coinsurance (max of 30 days per year and Lifetime max of 60 days)	40% coinsurance (max of 30 days per year and Lifetime max of 60 days)	40% coinsurance (max of 30 days per year and Lifetime max of 60 days)
Alternative Mental Health Center	50%** (max of 30 days per year)	50%** (max of 30 days per year)	20% coinsurance for all hospital based services	50%** (max of 30 days per year)	50%** (max of 30 days per year)	50%** (max of 30 days per year)
Outpatient Mental Health Care Visit	50%** (up to max of 60 visits per year in-network and out-of-network combined)	50%** (up to max of 60 visits per year in-network and out-of-network combined)	\$35 copayment	50%** (up to max of 60 visits per year in-network and out-of-network combined)	50%** (up to max of 60 visits per year in-network and out-of-network combined)	50%** (up to max of 60 visits per year in-network and out-of-network combined)
Marriage Counseling	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Detoxification (considered a medical condition)	20% coinsurance	20% coinsurance	20% coinsurance for all hospital based services	20% coinsurance	40% coinsurance	40% coinsurance
Chemical Dependency*** Inpatient Rehabilitation	20% coinsurance if approved by EAP (max \$5,000 benefit)	20% coinsurance if approved by EAP (max \$5,000 benefit)	20% coinsurance for all hospital based services if approved by EAP	20% coinsurance if approved by EAP (max \$5,000 benefit)	40% coinsurance if approved by EAP (max \$5,000 benefit)	40% coinsurance if approved by EAP (max \$5,000 benefit)
Chemical Dependency*** Outpatient Rehabilitation	50%** if approved by EAP	50%** if approved by EAP	\$35 copayment* per visit if approved by EAP (max copayment of \$350 per person per year)	50%** if approved by EAP	50%** if approved by EAP	50%** if approved by EAP
PRESCRIPTION MEDICATIONS						
Retail Pharmacy* (up to a 30 day supply)	Retail Card Program Generic: 20% (\$10 Min/\$50 Max) Brand: (no generic available) 30% (\$20 Min/\$100 Max) Brand: (if generic available) 50% (\$20 Min/No-Max)	Retail Card Program Generic: 20% (\$10 Min/\$50 Max) Brand: (no generic available) 30% (\$20 Min/\$100 Max) Brand: (if generic available) 50% (\$20 Min/No-Max)	Retail Card Program Generic: 20% (\$10 Min/\$50 Max) Brand: (no generic available) 30% (\$20 Min/\$100 Max) Brand: (if generic available) 50% (\$20 Min/No-Max)	Retail Card Program Generic: 20% (\$10 Min/\$50 Max) Brand: (no generic available) 30% (\$20 Min/\$100 Max) Brand: (if generic available) 50% (\$20 Min/No-Max)	Medco Health will reimburse the amount the drug would have cost at a network pharmacy (less copayment amount)	Medco Health will reimburse the amount the drug would have cost at a network pharmacy (less copayment amount)
Mail Service Pharmacy* (up to a 90 day supply)	Generic: 20% (\$20 Min/\$125 Max) Brand: (no generic available) 30% (\$40 Min/\$250 Max) Brand: (if generic available) 50% (\$40 Min/No-Max)	Generic: 20% (\$20 Min/\$125 Max) Brand: (no generic available) 30% (\$40 Min/\$250 Max) Brand: (if generic available) 50% (\$40 Min/No-Max)	Generic: 20% (\$20 Min/\$125 Max) Brand: (no generic available) 30% (\$40 Min/\$250 Max) Brand: (if generic available) 50% (\$40 Min/No-Max)	Generic: 20% (\$20 Min/\$125 Max) Brand: (no generic available) 30% (\$40 Min/\$250 Max) Brand: (if generic available) 50% (\$40 Min/No-Max)	Not Applicable	Not Applicable

2007 American Eagle Medical Plan Comparison Chart

2007 Plan Features

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	In-Network Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay	Out-of-Network Minimum Coverage
Oral Contraceptives (available only thru mail service)	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered	Not Covered
Over-The-Counter Medication	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
OTHER INFORMATION						
CheckFirst (predetermination of benefits via 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	Call United HealthCare for a form at 1-800-592-3048, complete, and mail

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

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

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

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