

**SUMMARY OF MATERIAL MODIFICATIONS FOR HEALTH AND
WELFARE BENEFIT PLANS SPONSORED BY
AMERICAN AIRLINES, INC.**

December 15, 2007

This document serves as notice to American Eagle Airlines, Inc. active and Leave-of-Absence employees of changes to the Company sponsored health and welfare benefit plans listed below. This Summary of Material Modifications describes the changes that affect your benefit plans and updates your summary plan descriptions. This Summary of Material Modifications, together with the Employee Benefits Guide, makes up the official plan documents and Summary Plan Descriptions. **Please read this notice carefully, and place this notice with your Summary Plan Description(s) (the Summary Plan Descriptions are contained in the Employee Benefit Guide (“EBG”)). These changes are effective January 1, 2008, 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”).

Changes to the Medical Options’ Prescription Drug Coverage (page 66) under “Prescription Drug Benefits,” “Retail Drug Coverage,” replace second paragraph with the following:

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

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

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

Contact Medco at (800) 988-4125 to determine if the brand-name drug you are taking is on the formulary list. You can also locate this information at www.medco.com.

Drug Type	Retail Prescriptions	Mail Order Prescriptions
Generic Drug	You pay 20%, with a minimum of \$10 and a maximum of \$50 per prescription	You pay 20% for a 90-day supply, with a minimum of \$25 and a maximum of \$125 per prescription
Formulary Brand Drug	You pay 30%, with a minimum of \$25 and a maximum of \$75 per prescription	You pay 30% for a 90-day supply, with a minimum of \$60 and a maximum of \$185 per prescription
Non-Formulary Brand Drug	You pay 50%, with a minimum of \$40 and a maximum of \$100 per prescription	You pay 50% for a 90-day supply, with a minimum of \$100 and a maximum of \$250 per prescription

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

On page 68 under “Mail Service Prescription Drug Option,” replace the second paragraph with the following:

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

Drug Type	If you use a retail pharmacy for your initial Rx purchase and two refill Rx purchases . . .	If you use a retail pharmacy for refills of maintenance medication beyond the two-refill limit . . .
Generic Drug	You pay 20%, with a minimum of \$10 and a maximum of \$50 per prescription	You pay 40%, with a minimum of \$10 and an unlimited maximum per refill
Formulary Brand Drug	You pay 30%, with a minimum of \$25 and a maximum of \$75 per prescription	You pay 50%, with a minimum of \$25 and an unlimited maximum per refill
Non-Formulary Brand Drug	You pay 50%, with a minimum of \$40 and a maximum of \$100 per prescription	You pay 75%, with a minimum of \$40 and an unlimited maximum per refill

Contribution Rate Change for TriCare Supplement in the section “Addition of TriCare Supplement Insurance Option as a Medical Benefit Option for Active and Leave of Absence Employees,” “TriCare Supplement Insurance Option” (page 2) of the SMM effective 1/1/06, the following paragraph should be added at the end of that section:

In compliance with federal law, effective January 1, 2008, American Airlines will no longer provide any employer subsidy for employees who elect the TriCare

Supplement Option. Premiums for this option must be 100 percent employee-paid.

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 employees of clarifications to the summary plan description – the American Eagle Employee Benefits Guide (“EBG”). These clarifications, together with the EBG, make up the official plan documents and Summary Plan Descriptions. **Please read this notice carefully, and place this notice with your Summary Plan Description(s) (the Summary Plan Descriptions are contained in your EBG).**

These clarifications apply to:

- Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 501, EIN #13-1502798; referred to herein as the “Plan”)
- Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 503, EIN #13-1502798; referred to herein as the “SMP”)

In “Life Events,” “Benefit Coverages Not Affected by Life Events” (page 34 of EBG and page 1 of SMM effective 1/1/07), the second sentence in the last paragraph titled “Medical Options” is revised as follows:

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, Minimum Coverage, Out-of-Area Option 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.

In “COBRA Continuation of Coverage for Your Dependents Only – Qualifying Events” (on page 6 of the SMM effective 1/1/07 and on page 81 of the EBG), it should read:

- You are eligible to elect Extended Continuation of Coverage when you:*
- *Retire as an American Eagle Pilot at the FAA mandated retirement age. (Pilots retiring prior to the FAA mandated retirement age are not eligible for Extended Continuation of Medical Coverage).*
 - *Elect and maintain Medical coverage under COBRA Continuation of Coverage for the maximum continuation period when first eligible at the time of retirement.*

Dependents will not be eligible for Extended Continuation of Coverage.

In "COBRA Continuation of Coverage for Your Dependents Only – Qualifying Events" (on page 6 of the SMM effective 1/1/07 and on page 81 of the EBG), the second bullet should read:

- *Your Domestic Partner relationship ends'*

In "Flexible Spending Accounts," "Health Care FSA," "Receiving Reimbursement" the chart added in the SMM effective 1/1/06 (pages 7-8) is deleted in its entirety and replaced with the following chart:

Type of Expense	Can You Use FSA Consumer Account Card?	Can You Use Automatic Rollover?	Must You File FSA Claims Manually?
Medical Expenses – PPO Copay Option			
Co-payments, deductibles, co-insurance at a UHC network provider	Yes	Yes	No
Deductibles and co-insurance at an out-of-network (or non-UHC) provider	No	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			
Deductibles and co-insurance at a UHC network provider	Yes	Yes	No
Deductibles and co-insurance at an out-of-network (or non-UHC) provider	No	Yes	No
Retail Prescription Drugs	No	Yes	No
Mail Order Prescription Drugs (Medco by Mail)	Yes	Yes	No
Medical Expenses – HMOs			
Co-payments	Yes	No	No
Co-insurance and deductibles	No*	No	Yes
Dental Expenses, including Orthodontia			
Co-insurance and deductibles	No*	Yes	No
Vision Expenses			

Type of Expense	Can You Use FSA Consumer Account Card?	Can You Use Automatic Rollover?	Must You File FSA Claims Manually?
Co-payments, deductibles, co-insurance at a Spectera or UHC network provider	Yes	Yes	No
Vision expenses incurred with an out-of-network provider or if you are not enrolled in the Spectera Vision Plan	No	No	Yes
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 Expenses not filed with your AMR Health Coverages	No	No	Yes
Dependent Day Care			
Some providers – check locally	Yes	No	No

* The Consumer Account Card (CAC) is designed to work for any United Healthcare (UHC) provider since it is set up through UHC. If your HMO doctor or health care provider is in the UHC network, your card may work for these expenses as well. Likewise, if your dentist is in the UHC network (not the MetLife dental network used by the AMR health plan), your card may work for FSA-eligible dental expenses as well. To see if your dentist is a participating UHC dentist, go to <http://www.myuhcdental.com> and search for Dental Options PPO or check with your dentist. PLEASE NOTE: This is not the MetLife dental network for the AMR dental plan. This is only an option that may allow you to use your CAC at the dentist, but it may be out of network under your MetLife dental plan.

In "Benefits at a Glance," "Supplemental Medical Plan" (page 6), the following paragraph replaces the third paragraph:

If you elect coverage under the Supplemental Medical Plan, there are three circumstances under which this Plan would pay a benefit:

- *When you or your covered spouse exhausts your maximum medical benefit under your selected Medical Benefit Option (for active employees) or Retiree Medical Benefit under the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (collectively, "Company-sponsored Medical Benefit Option(s)"), or*
- *If you are the surviving spouse of an active or retired employee who dies while you are both covered under this Plan and you have*

exhausted your maximum medical benefits under your selected Company-sponsored Medical Benefit Option, or

- *If a surviving spouse continues coverage under the Supplemental Medical Plan once coverage under one of the Company-sponsored Medical Benefit Options ends (for any reason other than failure to pay contributions).*

In "Eligibility," "Dependent Eligibility" (page 14), the following clarifications apply:

The first bullet of that page or 4th bullet of that section should read as follows:

- *Unmarried child age 19 through 22, if the child is registered as a full-time student at a school/educational institution in a program of study leading to a degree or certification (proof of continuing eligibility will be required from time to time) and either*
 - *The child maintains legal residence with you and is wholly dependent on you for maintenance and support, or*
 - *You are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.*

If, for medical reasons, the child is required to reduce or terminate his or her studies, coverage will be continued for up to nine months. The child must be under a physician's care, and statements must be provided from the attending physician and school/educational institution to UnitedHealthcare. After nine months, coverage will end unless the child returns to school/educational institution full time or meets the definition of an incapacitated child. If you are enrolled in an HMO, you must contact your individual HMO to determine eligibility requirements and when coverage will be terminated.

In "New Employee Enrollment" (page 19), the text box should be clarified as follows:

Proof of good health is required if you wish to enroll in the above coverages later (if/when you are eligible) or to increase life insurance coverage levels. You must submit (postmarked) a completed, dated, and signed proof of health (a Statement of Health form to add or increase Life Insurance coverage or an Enrollment Form for OSTD coverage) within 30 days after your enrollment deadline. If your statement of health is not

postmarked within 30 days after the close of annual enrollment, your application for these coverages will not be considered, and you must wait until the next annual enrollment (or your next qualifying Life Event) to apply for any of these coverages.

In "Enrollment," "Making Changes During the Year," "Life Events" (page 33), the following additions should be made to the list of qualified events that allow participants to make changes to their benefit elections outside the annual enrollment period:

If . . .	Then, You Can . . .
<p>Benefit coverages are significantly improved, lowered or lessened by the Company <i>(Plan Administrator/Sponsor will determine whether or not a change is "significant")</i></p>	<ul style="list-style-type: none"> • Make changes to the applicable benefit coverages: The Company will notify you of the allowable benefit changes, the time limits for making election changes and how to make changes at that time.
<p>You are subject to a court order resulting from a divorce, legal separation, annulment, guardianship or change in legal custody (including a QMSCO) that requires you to provide health care coverage for a child</p>	<ul style="list-style-type: none"> • Medical and Dental Options and Vision Insurance Benefit: Start or add coverage for the dependent(s) and yourself. You cannot change benefit options at this time.
<p>You, your spouse or your dependent enroll in Medicare or Medicaid</p>	<ul style="list-style-type: none"> • Medical and Dental Options and Vision Insurance Benefit: Stop coverage for the applicable person. You cannot change benefit options at this time. • Supplemental Medical Plan: Stop coverage for you or your spouse.

In "Medical Benefit Options," "Additional Rules," "Coordination of Benefits/Other Plans" (page 78), add the following bullet to the list of other plans:

- *Other individual insurance policies*

In "Medical Benefit Options," "Additional Rules/Coordination with Medicare/Benefits for Individuals Who Are Entitled to Medicare" (page 80), the following paragraph replaces the current second paragraph:

The AMR Corporation plan is the primary payer – in other words, your claims go to the AMR Corporation plan first – if you are currently working for a participating AMR Corporation subsidiary.

If you become eligible for Medicare due to you (or your dependent) having end-stage renal disease, then AMR Corporation is the primary payer for the first 30 months of Medicare entitlement due to end-stage renal disease. At the end of the 30-month period, Medicare will become the primary payer.

If you become eligible for Medicare due to becoming eligible for Social Security disability and if your coverage under this plan is due to the current employment status of the employee, then this plan (the AMR Corporation plan) pays primary.

If you are covered by both Tricare and an AMR group health plan, the AMR plan pays primary. If you participate in the Tricare Supplement Option and Tricare, then Medicare is secondary.

In "Medical Benefit Options," "Additional Rules," "Coordination with Medicare" (page 80), the following clarification applies to the section titled "Benefits for Disabled Individuals:"

The Medicare-eligible person must apply for Medicare Parts A, B and D (or Parts C and D), whichever is applicable.

In "Medical Coverage," under "Continuation of Coverage," all references to "Extended Continuation of Coverage" (pages 81-84) should read "Extended Continuation of Medical Coverage".

In "How to Elect COBRA Continuation of Coverage," under "Solicitation Following a Qualifying Event" (page 82), the first sentence in that paragraph should read:

In the event of a Qualifying Event (as shown above as for your dependents only) (divorce, legal separation, the end of a Domestic partner relationship, your entitlement to or enrollment in Medicare, a dependent reaching the limiting age of coverage, or your Domestic Partner's death,) you must notify the Company by processing a Life Event change within 60 days of the event.

In "Medical Benefit Options," "Additional Rules," "Continuation of Coverage" (page 87), the following paragraphs should be added at the end of the "Certificate of Coverage" section:

HIPAA Certificate of Creditable 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 creditable coverage showing how long you had been covered under the Plan. This document will provide the proof of coverage you may need to reduce any subsequent medical plan's pre-existing medical condition limitation period that might otherwise apply to you. If you elect COBRA continuation coverage, when that coverage ends, you will receive another certificate of coverage within the 24 months after your coverage has ended. You may also request a certificate of creditable coverage within the 24 months after your coverage has ended.

To request a certificate of creditable coverage, contact HR Employee Services (see Contact Information on page 1), either by phone or by email, or by mail and ask for a HIPAA certificate of creditable coverage.

In "Supplemental Medical Plan," "Overview" (page 88), the following paragraph replaces the second paragraph:

If you elect coverage under the Supplemental Medical Plan, there are three circumstances under which this Plan would pay a benefit:

- When you or your covered spouse exhausts your maximum medical benefit under your selected Medical Benefit Option (for active employees) or Retiree Medical Benefit under the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (collectively, "Company-sponsored Medical Benefit Option(s)"), or*
- If you are the surviving spouse¹ of an active or retired employee who dies while you are both covered under this Plan and you have exhausted your maximum medical benefits under your selected Company-sponsored Medical Benefit Option, or*
- If a surviving spouse continues coverage under the Supplemental Medical Plan once coverage under one of the Company-sponsored Medical Benefit Options ends (for any reason other than failure to pay contributions)..*

In "Supplemental Medical Plan," under "Eligibility" (page 89), the following paragraph replaces the paragraph at the top of the page:

You and your spouse may join the Supplemental Medical Plan only when:

- *You are first eligible for benefits*
- *You both are enrolled in one of the Company-sponsored Medical Benefit Options*
- *You later marry or declare a Domestic Partner, after you are first eligible for benefits.*

In "Supplemental Medical Plan," under "Eligibility" (page 90), the following sentence should be added to the end of the paragraph at the top of page 90:

If interested in COBRA, contact Employee Services at 1-800-447-2000.

In "Life and Accident Insurance Benefits," "Spouse and Child Term Life Insurance Benefit" (page 120), the following sentence replaces the one immediately following the first chart:

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

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

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

In "Optional Short Term Disability (OSTD) Insurance Benefit," "Filing a Claim (page 137)," the following paragraph replaces the first paragraph in this section:

If your disability (as defined in this insurance benefit) continues for eight or more days, you should file your disability claim

immediately. Do not wait until your sick pay is used up; file by the eighth day of your disability. The sooner you file, the sooner your claim can begin processing. However, the latest you can file your claim is six (6) months after your disability began. If you are covered under a state-mandated short-term disability plan, and the state requires you to file sooner, the state's filing deadline overrides the Company's deadline. If you file your disability claim beyond the six (6) month deadline (or the state-mandated deadline, if sooner), your claim will not be accepted, and you will not be eligible for benefits.

In "Long Term Disability Plan," "Duration of Benefits" (page 141), the chart showing duration of benefits should be replaced with the following chart:

Age at Which Disability Begins	Maximum Duration of Benefits
Under age 60 or the day you turn age 60	To age 65
After your 60th birthday	5 years

In "Plan Administration," "Claims," "Appealing a Denial" (pages 169-172), the following clarifications apply:

The following sentence should be added to the second paragraph on page 169: For urgent care claims, only Second Level Appeals are required – no First Level Appeals are necessary.

Delete the third bullet on page 170 regarding urgent care claims

The following sentence should be added to the fourth bullet on page 170: For disability claims, this process may also be referred to as a First Level Review.

The third bullet on page 171 should read: For urgent care claims, within the 72-hour time period allotted for completion of your appeal.

In "Glossary" (page 192), the following clarification applies:

Under "Medical necessity or medically necessary", the third paragraph should read as follows: A service or supply for an illness or injury must meet the above conditions to be considered medically necessary. A service is not considered

medically necessary if it is educational, experimental, or unproven in nature.

In "Glossary" (page 194), the following clarification applies:

Under "Proof of Good Health, Statement of Good Health," the text should read as follows:

Some benefit plans require you to provide "proof of good health" when you enroll for coverage at a later date (if you do not enroll when you are first eligible), or when you increase levels of coverage. Proof of good health (via a Statement of Health for Life Insurance and an Enrollment Form for OSTD and LTD Insurance) is a form you must complete and return to the appropriate benefit Plan Administrator when you:

- *Increase levels of Life Insurance*
- *Add Long Term Disability Plan or Optional Short Term Disability Insurance Benefit (for work groups that offer this Plan and/or benefit), or*
- *Add Supplemental Medical Plan coverage if you marry or declare a Domestic Partner (and are part of a work group that offers this coverage).*

Coverage amounts will not increase nor will you be enrolled in these coverages until the Plan Administrator approves your proof of good health.

If a death or accident occurs before your enrollment for coverage or increase in coverage is processed, the amount of Life Insurance and Accidental Death and Dismemberment coverage that will be payable is your current amount of coverage or default coverage (if you have not enrolled following your eligibility).

You may obtain a Statement of Health or Enrollment Form from MetLife for each benefit plan or online through Jetnet under the Forms menu.

In "Glossary" (page 196), the following clarification applies:

Under "School", the term should be changed to "School/
Educational Institution."

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*.

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