

# American Airlines/US Airways: Employee Assistance Program Covg Period: 01/01/17–12/31/17

## Summary of Benefits and Coverage: What this Program Covers & What it Costs Coverage for: Employees + Family | Plan Type: EAP



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the **Summary Plan Description (SPD)** at [my.aa.com](http://my.aa.com) or by calling 1-888-860-6178. You can view the Uniform Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov). If a discrepancy exists between the SBC and the SPD, the SPD governs.

Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	\$0	See the chart starting on page 2 for your costs for services this program covers.
Are there other <b>deductibles</b> for specific services?	No	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this program covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	No	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the <b>out-of-pocket limit</b> ?	This plan has no <b>out-of-pocket limit</b> .	Not applicable because there's no <b>out-of-pocket limit</b> on your expenses.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the program will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. Only counselors affiliated with the EAP will be available to you at no cost. Call 1-800-363-7190 or visit <a href="http://www.liveandworkwell.com">www.liveandworkwell.com</a> (access code "American") for a list of providers.	If you use an in-network doctor or other health care <b>provider</b> , this program will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Programs use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this program pays different kinds of <b>providers</b> .
Do I need a referral to see a <b>specialist</b> ?	No	You can see the <b>specialist</b> you choose without permission from this program.
Are there services this plan doesn't cover?	Yes	Some of the services this program doesn't cover are listed on page 4. See your SPD for additional information about <b>excluded services</b> .

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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	Not Covered	Not Covered	Not Covered
	Specialist visit	Not Covered	Not Covered	Not Covered
	Other practitioner office visit	Not Covered	Not Covered	Not Covered
	Preventive care/screening/immunization	Not Covered	Not Covered	Not Covered
If you have a test	Diagnostic test (x-ray, blood work)	Not Covered	Not Covered	Not Covered
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	Not Covered
If you need drugs to treat your illness or condition  More information about <b>prescription drug coverage</b> is available at N/A.	Generic drugs	Not Covered	Not Covered	Not Covered
	Preferred brand drugs	Not Covered	Not Covered	Not Covered
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered
	Specialty drugs	Not Covered	Not Covered	Not Covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	Not Covered
	Physician/surgeon fees	Not Covered	Not Covered	Not Covered
If you need	Emergency room services	Not Covered	Not Covered	Not Covered

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Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
<b>immediate medical attention</b>	Emergency medical transportation	Not Covered	Not Covered	Not Covered
	Urgent care	Not Covered	Not Covered	Not Covered
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not Covered	Not Covered	Not Covered
	Physician/surgeon fee	Not Covered	Not Covered	Not Covered
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	No charge	Not Covered	Limited to 4 sessions. Only counselors affiliated with the EAP will be available to you at no cost.
	Mental/Behavioral health inpatient services	Not Covered	Not Covered	Not Covered
	Substance use disorder outpatient services	No charge	Not Covered	Limited to 4 sessions. Only counselors affiliated with the EAP will be available to you at no cost.
	Substance use disorder inpatient services	Not Covered	Not Covered	Not Covered
<b>If you are pregnant</b>	Prenatal and postnatal care	Not Covered	Not Covered	Not Covered
	Delivery and all inpatient services	Not Covered	Not Covered	Not Covered
<b>If you need help recovering or have other special health needs</b>	Home health care	Not Covered	Not Covered	Not Covered
	Rehabilitation services	Not Covered	Not Covered	Not Covered
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Not Covered	Not Covered	Not Covered
	Durable medical equipment	Not Covered	Not Covered	Not Covered
	Hospice service	Not Covered	Not Covered	Not Covered
<b>If your child needs dental or eye care</b>	Eye exam	Not Covered	Not Covered	Not Covered
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	Not Covered

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## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your SPD for other excluded services.)

- |  |   |  |
|--|---|--|
| • Acupuncture                              | • Hospitalization   | • Prenatal, post-natal and newborn delivery services |
| • Bariatric surgery                        | • Infertility treatment   | • Private-duty nursing                               |
| • Chiropractic care                        | • Inpatient mental health, behavioral or substance abuse services | • Routine eye care (Adult)                           |
| • Cosmetic surgery                         | • Long term care  | • Routine foot care                                  |
| • Drugs to treat your illness or condition | • Non-emergency care when traveling outside the U.S.              | • Tests  |
| • Dental care                              | • Outpatient surgery  | • Weight loss programs                               |
| • Emergency and urgent care services       |   | • Visits to a provider's office or clinic            |
| • Hearing aids                             |   |  |

### Other Covered Services (This isn't a complete list. Check your SPD for other covered services and your costs for these services.)

- |                                    |                                    |
|------------------------------------|------------------------------------|
| • Behavioral/psychological testing | • Counseling/psychological therapy |
|------------------------------------|------------------------------------|

## Your Rights to Continue Coverage

If you lose coverage under the program, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the program. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the program at 1-888-860-6178. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the claims administrator at (*see page 5*):

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OptumHealth Behavioral Solutions  
Appeals for US Airways, Inc. and for American Airlines, Inc.  
P.O. Box 30755  
Salt Lake City, UT 84130-0755  
1-800-363-7190  
[www.liveandworkwell.com](http://www.liveandworkwell.com) (access code “American”)

You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This program, on its own, does not provide minimum essential coverage.**

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This program, on its own, does not meet the minimum value standard for the benefits it provides.**

### Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-363-7190.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-363-7190.

CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-363-7190.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-363-7190.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this program. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Program pays \$0
- Patient pays \$7,540  
(This condition is not covered by Employee Assistance Program, so patient pays 100%)

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	N/A
Co-payments	N/A
Co-insurance	N/A
Limits or exclusions	N/A
<b>Total:</b>	<b>\$7,540</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Program pays \$0
- Patient pays \$5,400  
(This condition is not covered by the Employee Assistance Program, so patient pays 100%)

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$4,100</b>

#### Patient pays:

Deductibles	N/A
Co-payments	N/A
Co-insurance	N/A
Limits or exclusions	N/A
<b>Total</b>	<b>\$4,100</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- ***This is a limited benefit program for mental health and/or substance abuse treatment only***

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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