# US Airways, Inc. Health Plan: Out-of-Area 100 Option

**Coverage Period: 01/01/2017 – 12/31/2017**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** Individual/Family | **Plan Type:** Indemnity

**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 or by calling 1-888-860-6178. If a discrepancy exists between the SBC and the SPD, the SPD governs.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$225** INDIVIDUAL<br>**$450** FAMILY | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your SPD to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. **Deductible doesn't apply to co-payments and home health care.** |
| **Are there other deductibles for specific services?** | No | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | **$225** INDIVIDUAL<br>**$450** FAMILY | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. Includes deductibles and coinsurance but not copayments. |
| **What is not included in the out–of–pocket limit?** | Premiums, copayments, balance-billed charges, penalties for non-compliance, pharmacy claims, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | No | This plan treats **providers** the same in determining payment for the same services. |
| **Do I need a referral to see a specialist?** | No | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes | Some of the services this plan doesn't cover are listed on page 5. See your SPD for additional information about **excluded services**. |

- **Co-payments** (co-pays) 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**.)
- Your cost sharing does not depend on whether a provider is in a **network**.

| Common Medical Event | Services You May Need | Your Cost If You Use any Provider | Limitations & Exceptions |
|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | No Charge | Pays only after deductible met. |
| | Specialist visit | No Charge | Pays only after deductible met. |
| | Other medical practitioner office visit (e.g., chiropractor) | No Charge | Coverage is limited to maximum 20 visits annually. |
| | Preventive care/screening/immunization | No Charge | There may be other levels of cost share that are contingent on what services are provided. See the Schedule of Out-of-Area Program Benefits section of the SPD for complete details. |
| | "Doctor on Demand" Telehealth visit | No Charge | ----------none---------- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge after deductible is met | The amount you pay may be different depending on how/where your care was provided. See the Schedule of Out-of-Area Program Benefits section of the SPD for complete details. |
| | Imaging (CT/PET scans, MRIs) | No Charge after deductible is met | The amount you pay may be different depending on how/where your care was provided. See the Schedule of Out-of-Area Program Benefits section of the SPD for complete details. |

| Common Medical Event | Services You May Need | Your Cost If You Use any Provider | Limitations & Exceptions |
|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.express-scripts.com | Generic drugs | $15 retail/$30 mail order | Deductible does not apply.<br>You must use an in-network pharmacy.<br>Covers up to 34 day supply (retail Rx); 35-90 day supply (mail order Rx). |
| | Preferred brand drugs | $30 retail/$60 mail order | Deductible does not apply.<br>You must use an in-network pharmacy.<br>If you request a brand drug when a generic drug is available, you will pay the cost difference between the brand and generic drugs in addition to the generic co-payment. |
| | Non-preferred brand drugs | $50 retail/$100 mail order | Deductible does not apply.<br>You must use an in-network pharmacy.<br>If you request a brand drug when a generic drug is available, you will pay the cost difference between the brand and generic drugs in addition to the generic co-payment. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No Charge | Pays only after deductible met. |
| | Physician/surgeon fees | No Charge | Pays only after deductible met. |
| **If you need immediate medical attention** | Emergency room services | No Charge | Pays only after deductible met. |
| | Emergency medical transportation | No Charge | Pays only after deductible met. |
| | Urgent care | No Charge | Pays only after deductible met. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Charge | Pays only after deductible met. |
| | Physician/surgeon fee | No Charge | Pays only after deductible met. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | No Charge | Pays only after deductible met. |
| | Mental/Behavioral health inpatient services | No Charge | Pays only after deductible met. |
| | Substance use disorder outpatient services | No Charge | Pays only after deductible met. |
| | Substance use disorder inpatient services | No Charge | Pays only after deductible met. |
| **If you are pregnant** | Prenatal and postnatal care | No Charge | Pays only after deductible met. |
| | Delivery and all inpatient services | No Charge | Pays only after deductible met. |

| Common Medical Event | Services You May Need | Your Cost If You Use any Provider | Limitations & Exceptions |
|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | No Charge | Deductible does not apply.<br>Coverage is limited to maximum 100 visits annually. |
| | Rehabilitation services | No Charge after deductible is met | Coverage is limited to maximum 40 visits annually for physical and occupational combined therapy; maximum 20 visits annually for speech therapy. |
| | Habilitation services | No Charge after deductible is met | All rehabilitation and habilitation visits count toward your rehabilitation visit limit. |
| | Skilled nursing care | No Charge after deductible is met | Coverage is limited to maximum 60 days annually. |
| | Durable medical equipment | 1st $500 no charge; then 100% covered after deductible is met | Precertification required after $500 has been met. |
| | Hospice service | No Charge | Pays only after deductible met. |
| **If your child needs dental or eye care** | Eye exam | Not Covered | ——————none—————— |
| | Glasses | Not Covered | ——————none—————— |
| | Dental check-up | Not Covered | ——————none—————— |

## 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
- Cosmetic surgery
- Dental care (except for dental treatment and oral surgery related to the mouth that is required as the result of an accident and started prior to a year after the accident)
- Glasses
- Hearing aids
- Infertility treatment (except diagnostic testing to determine the cause of infertility and prescription medication to treat infertility)
- Long-term care
- Routine eye care
- Routine foot care (except for procedures associated with diabetic treatment)
- Weight loss programs

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

- Bariatric surgery (one procedure for the life of the patient's participation in the Plan)
- Chiropractic care (20 visit annual max.)

## Your Rights to Continue Coverage:

If you lose coverage under the plan, 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 plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-860-6178, 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.

## 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 (listed on your member ID card) at:

| | | |
|---|---|---|
| Blue Cross and Blue Shield of Texas | UnitedHealthcare | Express-Scripts, Inc. |
| ATTN: Appeals for US Airways, Inc. | National Appeals Center | Appeals for US Airways, Inc. |
| PO BOX 833874 | PO BOX 30432 | PO BOX 66588 |
| Richardson, TX 75083-3874 | Salt Lake City, UT 84130-0432 | St. Louis, MO 63166-6588 |
| Telephone: 1-800-441-9188 | Telephone: 1-800-520-0811 | Telephone: 1-800-753-2851 |

## 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 health coverage does 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 health coverage does meet the minimum value standard for the benefits it provides.**

## Health Reimbursement Account (HRA) (formerly known as Health US Account (HUSA))

If you (or your spouse/DP) participate in the WebMD Wellness program and earn wellness rewards, we will place those reward funds in your YSA (Your Spending Account) 2017 HRA. Any remaining unused funds in your HUSA will automatically be transferred to your 2017 HRA. You can use the funds to

pay for health-related items not paid by your medical, dental, or vision (deductibles, out-of-pocket amounts, etc.) You must use all the funds in your HCFSA before you can access the funds in this HRA. Also, you can access these funds only up to the amounts actually deposited into the HRA.

## Health Care Flexible Spending Account (HCFSA)

From payroll deductions throughout the year, you can set aside pre-tax funds that go into your YSA (Your Spending Account) HCFSA. These funds may be used to reimburse you for health-related expenses such as deductibles, out-of-pocket amounts, etc. As soon as you make your first contribution through payroll deduction each year, the full amount of your elected HCFSA account is available for use. **For 2017, the maximum amount you can deposit into your HCFSA is $2,550.**

## Language Access Services:

Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.
若需要中文协助，请拨打您会员卡上的电话号码
Dine k'ehji shich'i' hadoodzih ninizingo, bee neehozin biniiye nanitinigii number bikaa'igii bich'i' hodiilnih
Para sa tulong sa Tagalog, tawagan ang numero sa iyong ID card.

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

## 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 plan. 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
- **Plan pays** $7,115
- **Patient pays** $425

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions (4 @ $50 each) | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $225 |
| Co-payments | $200 |
| Co-insurance | $0 |
| Limits or exclusions | $0 |
| **Total** | **$425** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,190
- **Patient pays** $1,210

**Sample care costs:**

| | |
|---|---|
| Prescriptions (50 @ $58 each) | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits (7 @ $100 each) | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles (met previously) | $0 |
| Co-payments | $910 |
| Co-insurance | $0 |
| Limits or exclusions | $300 |
| **Total** | **$1,210** |

# 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.

## 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.