US Airways, Inc. Health Plan: PPO 80/60 Option

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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

Coverage for: Individual/Family | **Plan Type:** PPO

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?	**IN NTWK** **$450** Individual **$900** Family	**OUT NTWK** **$900** Individual **$1800** 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**. **The 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?	**IN NTWK** **$3000** Individual **$6000** Family	**OUT NTWK** **$6000** Individual **$12,000** 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, balance-billed charges, co-payments, 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?	Yes. See my.aa.com **or call 1-866-860-6178** for a list of in-network providers.		If you use an in-network doctor or other health care **provider**, this plan 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
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**.

Questions: Call 1-888-860-6178 or visit us at my.aa.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call **1-888-860-6178** to request a copy.

- **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**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	In-Network Provider	Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay	40% co-insurance	----------none----------
	Specialist visit	$40 co-pay	40% co-insurance	----------none----------
	Other medical practitioner office visit (e.g., chiropractor)	$40 co-pay	Not Covered	Coverage is limited to 20 visits annual max.
	Preventive care/screening/immunization	$25 co-pay	Not Covered	There may be other levels of cost share that are contingent on what services are provided. See the Schedule of PPO Plan Benefits section of the SPD for a complete explanation.
	"Doctor on Demand" Telehealth visit	$20 co-pay	Not Covered	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	The amount you pay may be different depending on how or where your care was provided. See the Schedule of PPO Plan Benefits section of the SPD for complete details.
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	The amount you pay may be different depending on how or where your care was provided. See the Schedule of PPO Plan Benefits section of the SPD for complete details.

Common Medical Event	Services You May Need	In-Network Provider	Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$15 retail/$30 mail order	Not Covered	Covers up to 34 day supply (retail prescription); 35-90 day supply (mail order prescription).
	Preferred brand drugs	$30 retail/$60 mail order	Not Covered	If you request a brand drug when a generic drug is available, you will pay the difference in cost between the brand and generic drug in addition to the generic co-pay.
	Non-preferred brand drugs	$50 retail/$100 mail order	Not Covered	If you request a brand drug when a generic drug is available, you will pay the difference in cost between the brand and generic drug in addition to the generic co-pay.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	——————none——————
	Physician/surgeon fees	20% co-insurance	40% co-insurance	——————none——————
If you need immediate medical attention	Emergency room services	$100 co-payment	$100 co-payment	Co-payment waived if admitted.
	Emergency medical transportation	20% co-insurance	20% co-insurance	——————none——————
	Urgent care	$40 co-payment	40% co-insurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Notification required for inpatient out-of-network or $250 penalty applies.
	Physician/surgeon fee	20% co-insurance	40% co-insurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 co-payment	40% co-insurance	——————none——————
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	——————none——————
	Substance use disorder outpatient services	$25 co-payment	40% co-insurance	——————none——————
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	——————none——————
If you are pregnant	Prenatal and postnatal care	$25 Global Maternity co-payment	40% co-insurance	Additional out-of-pocket costs may apply. See the Schedule of PPO Plan Benefits section of the SPD.
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	——————none——————

Common Medical Event	Services You May Need	In-Network Provider	Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Coverage is limited to 100 visits annual max.
	Rehabilitation services	$40 co-payment	40% co-insurance	Coverage is limited to 40 visits annual max. physical and occupational combined therapy, 20 visits annual max speech therapy. Combined in-network and out-of-network.
	Habilitation services	$40 co-payment	40% co-insurance	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	20% co-insurance	40% co-insurance	Coverage is limited to 60 days annual max. combined in-network and out-of-network.
	Durable medical equipment	First $500 No Charge, then 20% co-insurance	40% co-insurance	Precertification required after $500 met. Co-insurance after deductible met.
	Hospice service	No Charge after deductible is met	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	——————none——————
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

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.
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

Questions: Call 1-888-860-6178 or visit us at my.aa.com.
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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
- 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)
- Routine eye care
- Routine foot care (except for procedures associated with diabetic treatment)
- Weight loss programs
- Long-term care

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. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 funds in your HUSA will automatically transfer to your 2017 HRA. You can use the funds to pay for health-related items not paid by your medical/prescription coverage, (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** $5,945
- **Patient pays** $1,595

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	$450
Co-payments	$225
Co-insurance	$920
Limits or exclusions	$0
Total	**$1,595**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,790
- **Patient pays** $1,610

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
Total	**$5,400**

Patient pays:

Deductibles (met previously)	$0
Co-payments	$1,030
Co-insurance	$280
Limits or exclusions	$300
Total	**$1,610**

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.

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.