AA Health Plan for Active Emps: STD Option (*Non*Grandfathered) Covg Period: 01/01/2016-12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: EE, Spouse, Children|PlanType:POS**

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 1-800-447-2000. This summary provides you information about the **Standard Option**. Should discrepancies exist between this summary and the SPD, the SPD governs.

Important Questions	Answers		Why this Matters:
What is the overall deductible? (calendar year)	**IN NTWK** **$800 Indiv** **$2,400 Fam**	**OUT NTWK** **$3,000 Indiv** **$9,000 Fam**	You must pay all the costs up to **deductible** amount before this plan begins to pay for covered services you use. Check your SPD to see when **deductible** starts over (Jan 1st). See the chart on page 2 for how much you pay for covered services after you meet **deductible.** In-network preventive care is not subject to **deductible**
Are there other specific deductibles ?	**NO other deductibles for specific services**		N/A
Is there an out-of-pocket limit on my expenses? (calendar year)	**IN NTWK** **$2,000 Indiv** **$5,000 Fam**	**OUT NTWK** **$6,000 Indiv** **$15,000 Fam**	Out-of-pocket limit is the most you could pay during a coverage period (calendar year) for your share of cost of covered services. This limit helps you plan for health care expenses. **Annual deductible DOES NOT count toward annual out-of-pocket limits. However co-payments DO count toward the out-of-pocket limit.**
What is not included in the out–of–pocket limit?	**Contributions, balance-billed charges, deductibles, precertification failure penalties & care this plan won't cover**		Even though you pay these expenses, they DO NOT count toward the out-of-pocket limit. Also, you continue to pay all co-payments up to the federal out-of-pocket limits of $6,850 (Individual) and $13,700 (Family), even if you have already satisfied your annual out-of-pocket limit for this Medical Benefit Option.
Any annual limit on what the plan pays?	**NO overall limit on what the plan pays**		N/A
Does this plan use a network of providers?	**YES**		If you use an in-network doctor or other health care **provider**, this plan will pay some/all of costs of covered services. Be aware, your **in-network** doctor/hospital may use out-of-network **providers** for some services. Plans use the term **in-network** or preferred **providers** for those in-network. See the chart 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 pg 5. See your SPD for more information about **excluded expenses**.

- **Co-payments** are fixed dollar amounts (for example, $30) 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	Your cost if you use an In-network Provider	Your cost if you use an 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	$30	40%	*In-network not subject to deductible* *Out-of-network pays after deductible met*
	Specialist visit	20%	40%	Pays after deductible met
	Other practitioner office visit	20%	40%	*Pays after deductible met*
	Preventive care/screening/immunization	No charge	40%	In-network not subject to deductible *Out-of-network pays after deductible met*
If you have a test	Diagnostic test(x-ray, lab work) at hospital	20%	40%	Pays after deductible met
	Imaging(CT/PET scans, MRIs) at hospital	20%	40%	*Pays after deductible met*
	Diagnostic test(x-ray, lab work) at dr's office or non-hospital lab/imaging center	No charge	40%	Out-of-network pays after deductible met
	Imaging (CT/PET scans, MRIs) at dr's office or non-hospital imaging center	No charge	40%	*Out-of-network pays after deductible met*
If you need drugs to treat your illness or condition: *Other limitations may apply*— **More information about prescription drug coverage is at my.aa.com or www.express-scripts.com** *Continued on next page*	**Generic Rx:** Long-term Rx must be filled via Mail Order or at Safeway or at CVS starting with 4th fill, else you pay 50%; see www.express-scripts.com Retail (30-day supply) Mail Order (90-day supply) **$ amts referenced are min and max you pay per Rx**	**RETAIL** 20% ($10/$40) **MAIL ORDER** 20% ($5/$80)	**RETAIL** 20% ($10/$40) based on Express Scripts discounted price **MAIL ORDER** Not covered	Not subject to deductible, but does count toward out-of-pocket limit *Some Rx require Prior Auth*
	Preferred brand Rx (*Formulary*): Long-term Rx must be filled via Mail Order or at Safeway or at CVS starting with 4th fill, else you pay 50%; see www.express-scripts.com Retail (30-day supply)	**RETAIL** 30% ($30/$100)	**RETAIL** 30% ($30/$100) Paid based on Express Scripts discounted price	Not subject to deductible but does count toward out-of-pocket limit *If you select a preferred brand drug when generic is available, you pay 20% plus cost difference between generic and preferred brand or non-preferred brand*

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition: *Other limitations may apply*— **More information about prescription drug coverage is at my.aa.com or www.express-scripts.com**	Mail Order (90-day supply) **$ amounts referenced are min and max you pay per Rx**	**MAIL ORDER** 30% ($60/$200)	**MAIL ORDER** Not covered	Some Rx require Prior Auth *Certain brand Rx are not covered, check Express Scripts website*
	Non-preferred brand Rx (*NonFormulary*): Long-term Rx must be filled via Mail Order or at Safeway or at CVS starting with 4th fill, else you pay 50%; see www.express-scripts.com Retail (30-day supply) Mail Order (90-day supply) **$ amounts referenced are min and max you pay per Rx**	**RETAIL** 50% ($45/150) **MAIL ORDER** 50% ($90/$300)	**RETAIL** 50% ($45/$150); Paid based on Express Scripts' discounted price **MAIL ORDER** Not covered	Not subject to the deductible, but does count toward your out-of-pocket limit *If you select a non-preferred brand drug when generic is available, you pay 20% plus the cost difference between generic and non-preferred brand* Some Rx require Prior Auth *Certain brand Rx are not covered, check with Express Scripts website*
	Specialty Rx RETAIL (30-day supply) Some Long-term Rx must be filled via Accredo or at Safeway or at CVS starting with 4th fill, otherwise you pay 50%; see www.express-scripts.com **$ amounts referenced are min and max you pay per Rx**	*Preferred Brand:* 30%($30/$100) *Non-Preferred Brand:* 50%($45/$150)	Not covered	Not subject to deductible, but does count toward your out-of-pocket limit *If you select a preferred or non-preferred brand drug when generic is available, you pay 20% plus the cost difference between generic and preferred or non-preferred brand* You must obtain specialty Rx from a network retail pharmacy or Accredo *Certain brand Rx are not covered, check Express Scripts website* Some Rx require Prior Auth
	Specialty Rx MAIL ORDER (90-day supply) **$ amounts referenced are min and max you pay per Rx**	*Preferred Brand:* 30% ($60/$200) *Non-Preferred Brand:* 50% ($90/$300)	Not covered	*Not subject to deductible, but does count toward your out-of-pocket limit* If you select a preferred or non-preferred brand drug when generic is available, you pay 20% plus cost difference between generic and preferred or non-preferred brand *You must obtain specialty Rx from Accredo* Certain brand Rx are not covered, so Check Express Scripts website

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20%	40%	Pays after deductible met
	Physician/surgeon fees	20%	40%	*Pays after deductible met*
If you need immediate medical attention	Emergency room services	$100 copay, plus 20% on full allowed amount of the bill	$100 copay, plus 20% on full allowed amount of the bill	$100 copay counts toward deductible or out-of-pocket limit *Co-insurance pays after deductible met, and does count toward out-of-pocket limit*
	Emergency medical transportation	20%	40%	Pays after deductible met
	Urgent care (e.g. "anytime" walk-in clinics)	20%	40%	*Pays after deductible met*
If you have a hospital stay	Facility fee (e.g., hospital room, ancillary charges)	20%	40%	Pays after deductible met *Inpatient requires precertification*
	Physician/surgeon fee	20%	40%	Pays after deductible met
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	PCP or Specialist-no charge; all other services-20%	40%	*PCP not subject to deductible and does count toward out-of-pocket limit* Others—pays after deductible met
	Mental/Behavioral health inpatient services	20%	40%	*Pays after deductible met* Inpatient requires precertification
	Substance use disorder outpatient services	PCP or Specialist-no charge; all other services-20%	40%	*PCP not subject to deductible and does count toward out-of-pocket limit* Others—pays after deductible met
	Substance use disorder inpatient services	20%	40%	*Pays after deductible met* Inpatient requires precertification
If you, spouse/DP, or dependent daughter is pregnant	Routine prenatal care	No charge	40%	*Pays after deductible met*
	Delivery, all inpatient services, postnatal care	20%	40%	Pays after deductible met *Inpatient requires precertification*
If you need help recovering or have other special health needs	Home health care	20%	40%	Pays after deductible met
	Rehabilitation services	20%	40%	*Pays after deductible met*
	Habilitation services	Not covered	Not covered	Some services this plan doesn't cover are listed on pg 5. See SPD for facts about **excluded expenses**
	Skilled nursing care up to 60 days per illness	20%	40%	*Pays after deductible met*
	Durable medical equipment	20%	40%	Pays after deductible met
	Hospice services	20%	40%	*Pays after deductible met*

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam, eyeglasses/contact lenses	Not covered	Not covered	Paid under Vision Benefit, IF you elected it
	Dental check up	Not covered	Not covered	*Paid under Dental Benefit IF you elected it*

Excluded Services & Other Covered Services:

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

- Cosmetic surgery and treatment
- Long term care
- Dental care unless for TMJD, accidental injury, or fracture/dislocation of jaw
- Routine eye care
- Habilitation service
- Routine foot care

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

- Acupuncture
- Infertility medications ($15,000 maximum limit for life of patient's participation in the Plan)
- Bariatric surgery (limit one procedure for life of patient's participation in the Plan)
- Certain TMJD treatments
- Hearing aids ($3500 per aid, original and replacement, paid once every 36 months)
- Gender Reassignment Benefits
- Chiropractic care
- Home health care
- Virtual doctor's visits

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 this 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 1-800-447-2000. You may also contact your state insurance department, the U.S. Dept. of Labor, Employee Benefits Security Administration, at 1-866-444-3272, / www.dol.gov/ebsa , or the U.S. Dept. of Health & Human Services at 1-877-267-2323 x61565, / 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:

- American Airlines, Inc. HR Services, at 1-800-447-2000 (or chat with HR Services at my.aa.com)
- U.S. Dept of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
- Additionally, your state consumer assistance program (if applicable for your state) can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and at http://cciio.cms.gov/programs/consumer/capgrants/index.html
- American Airlines, Inc. Benefits Compliance at 1-800-967-1412 (or via facsimile at 1-800-967-6335, or via email at albert.garcia@aa.com)

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?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides.**

Health Reimbursement Account (HRA)

If you (or your spouse/DP) participate in the WebMD wellness program and earn wellness rewards, we will place those reward funds in your Aon Hewitt Your Spending Accounts (YSA) HRA. You can then use those funds to help pay for health-related items not paid by your medical, dental, and vision coverage, (deductibles, out-of-pocket amounts, etc.) **However, you can access these funds only up to the amount actually deposited into this account, and you must have depleted the funds in your HCFSA before you can access the funds in this account.**

Health Care Flexible Spending Account (HCFSA)

Through payroll deductions throughout the year, you can set aside pre-tax funds that go into your YSA 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 entire amount of your elected YSA HCFSA account is available for your and your family's use. **For 2016, the maximum amount you can deposit into your HCFSA is $2,550. Examples of HCFSA eligible expenses are shown on the following chart. For a complete list of reimbursable expenses, see your SPD.**

Examples of HCFSA-Reimbursable Expenses (medical, dental, and vision)					
Acupuncture	Hospital services	Dental anesthesia/sedation	Eyeglasses	Hearing devices	Contraceptives (retail)
Blood tests	Insulin	Cleanings more than twice a year	Contact lenses	Wheelchairs	Dental nightguard
Chiropractor	Lab tests	Balance billing expenses	Ophthalmologist fees	Vision therapy	Podiatrist

Language Access Services:

If you need translation of this document, help is available:

SPANISH (Español): Para obtener asistencia en Español, llame al [800-447-2000]

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [800-447-2000]

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 [800-447-2000]

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [800-447-2000].]

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** $4,660
- **Patient pays** $2,880

Sample care costs:

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

Patient pays:

Deductibles	$800
Co-pays	$60
Co-insurance	$1,120
Limits or exclusions*	$900
Total	**$2,880**

***Newborn's expenses not covered under mother's benefits, & are paid only if newborn is added to employee's medical coverage.**
****In-network preventive care paid at 100%**

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

- **Amount owed to providers:** $4,100
- **Plan pays** $2,364
- **Patient pays** $1,736

Sample care costs:

Prescriptions (10@$150ea)	$1,500
Medical Equipment and Supplies	$1,300
OfficeVisits/Procedures(10@$73ea)	$730
Education (physical fitness classes)*	$290
Laboratory tests	$140
Vaccines, other preventive**	$140
Total	**$4,100**

Patient pays:

Deductibles	$800
Co-pays	$400
Co-insurance	$246
Limits or exclusions*	$290
Total	**$1,736**

***Educational services excluded from covg**
****In-network preventive care paid at 100%**

Note: This assumes participation in our Health Condition Management Program. If you have diabetes and do not participate in this program, your costs may be higher. For more information about this program, please contact WebMD at 1-888-383-8740.

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.
- The patient's inpatient hospitalization was precertified through the network/claim administrator.

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.