AA Health Plan for Active Emps: OOA Option (*Non*Grandfathered) Covg Period: 01/01/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: EE, Spouse, Children|PlanType: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)** (formerly, the Employee Benefits Guide (EBG) at my.aa.com or by calling 1-800-447-2000. This summary provides information about the **Out of Area 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)	**Individual $850**	**Family $2,550**	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 (Jan 1st). See the chart on pg 2 for how much you pay for covered services after you meet the **deductible**. In network preventive care is not subject to the **deductible**.
Are other specific deductibles?	**NO**	**NO**	**N/A**
Is there an out-of-pocket limit on my expenses? (calendar year)	**Individual $2,000**	**Family $5,000**	Out-of-pocket limit is the most you could pay during a coverage period (calendar year) for your share of costs of covered services. This limit helps you plan for health care expenses. **Annual deductible DOES NOT count toward out-of-pocket limit. However, co-payments DO count toward your 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.
Is there any annual limit on what the plan pays?	**NO**		N/A
Does this plan use a network of providers?	**NO**		If you are enrolled in OUT-OF-AREA coverage, it is because there are not any network providers where you reside. However, there may be instances in which you receive services from a network provider. For further information reference the SPD for your workgroup.
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 services this plan doesn't cover are listed on pg 5. See your SPD for additional 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	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20%	*Pays after deductible met*
	Specialist visit	20%	Pays after deductible met
	Other practitioner office visit	20%	*Pays after deductible met*
	Preventive care/screening/immunization	No charge	Not subject to deductible
	"Doctor on Demand" Telehealth visit	$20	Not subject to deductible
If you have a test	Diagnostic test (xray, lab work) at hospital	20%	*Pays after deductible met*
	Imaging (CT, PET scans, MRIs) at hospital	20%	Pays after deductible met
	Diagnostic test (xray, lab work) at dr's office/non-hospital imaging center	No charge	*Pays after deductible met*
	Imaging (CT, PET scans, MRIs) at dr's office/non-hospital imaging center	No charge	Pays after deductible met
If you need drugs to treat your illness or condition… More information about prescription drug coverage is at my.aa.com , or www.express-scripts.com	**Generic Rx:** Long-term Rx must be filled via Mail Order or at Safeway or at CVS starting with 4th fill; else, you pay 50%; see www.express-scripts.com Retail (30-day supply) Mail Order (90-day supply) **$ amounts referenced are min and max you will pay per Rx**	**RETAIL** 20% ($10/$40) **MAIL ORDER** 20% ($5/$80)	*Not subject to deductible, but does count toward out-of-pocket limit* Some Rx require Prior Auth
Cont'd on next page	**Preferred brand** *(Formulary)* **Rx:** Long-term Rx must be filled via Mail Order or at Safeway or at CVS starting with 4th fill; else, you pay 50% Retail (30-day supply) Mail Order (90-day supply) **$ amounts referenced are min and max you pay per Rx**	**RETAIL** 30% ($30/$100) **MAIL ORDER** 30% ($60/$200)	*Not subject to deductible; counts toward out-of-pocket limit* Some Rx require Prior Auth *If you select formulary brand drug when generic's available, you pay generic 20% plus cost difference between generic/formulary* Certain brand Rx are not covered, check Express Scripts website

Common Medical Event	Services You May Need	Your cost	Limitations & Exceptions
If you need drugs to treat your illness or condition… More information about prescription drug coverage is at my.aa.com , or www.express-scripts.com	**Non-preferred brand (*Non-Formulary*) Rx:** Long-term Rx must be filled via Mail Order or at Safeway or at CVS starting with 4th fill; else, you pay 50% 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/$300)	*Not subject to deductible* Some Rx require Prior Auth *If you select non-formulary brand drug when generic's available, you pay generic 20% plus cost difference between generic/ non-formulary* Certain brand Rx are not covered, check Express Scripts website
	Specialty Rx RETAIL: (30-day supply) Some Long-term Rx must be filled via Accredo or at Safeway or at CVS starting with 4th fill, otherwise you pay 50%; see www.express-scripts.com **$ amounts referenced are min and max you will pay per Rx**	*Formulary Brand:* 30% ($30/$100) *NonFormulary Brand:* 50% ($45/$150)	*Not subject to deductible* Some Rx require Prior Auth *You must obtain specialty Rx from a network retail pharmacy or Accredo* Certain brand Rx are not covered, check Express Scripts website
	Specialty Rx MAIL ORDER: (90-day supply) **$ amounts referenced are min and max you pay per Rx**	*Formulary Brand:* 30% ($60/$200) *NonFormulary Brand:* 50% ($90/$300)	*Not subject to deductible* Some Rx require Prior Auth *You must obtain specialty Rx from Accredo* Certain brand Rx are not covered, check Express Scripts website
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20%	*Pays after deductible met*
	Physician/surgeon fees	20%	Pays after deductible met
If you need immediate medical attention	Emergency room services	$100 co-payment, plus 20% co-insurance on full allowed amount of the bill	*Pays after deductible met* $100 co-payment counts toward deductible or out-of-pocket limit
	Emergency medical transportation	20%	Pays after deductible met
	Urgent care	20%	*Pays after deductible met*
If you have a hospital stay	Facility fee (e.g., hospital room, ancillary charges)	20%	Pays after deductible met *Inpatient requires precertification*
	Physician/surgeon fee	20%	Pays after deductible met

Common Medical Event	Services You May Need	Your cost	Limitations & Exceptions
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%	*Pays after deductible met*
	Mental/Behavioral health inpatient services	20%	Pays after deductible met *Inpatient requires precertification*
	Substance use disorder outpatient services	PCP or Specialist-no charge; all other services-20%	Pays after deductible met
	Substance use disorder inpatient services	20%	*Pays after deductible met* Inpatient requires precertification
If you, your spouse, or dependent daughter are pregnant	Routine prenatal care	No charge	*Pays after deductible met*
	Delivery, all inpatient services, and postnatal care	20%	Pays after deductible met *Inpatient requires precertification*
If you need help recovering or have other special health needs	Home health care	20%	Pays only after deductible is met
	Rehabilitation services	20%	*Pays only after deductible is met*
	Habilitation services	Not covered, you pay 100%	Some services the plan does not cover are listed on pg 5. See EBG for info on **excluded expenses**.
	Skilled nursing care up to 60 days per illness	20%	*Pays only after deductible is met*
	Durable medical equipment	20%	Pays only after deductible is met
	Hospice service	20%	*Pays only after deductible is met*
If your child needs dental or eye care	Eye exam, eyeglasses / contact lenses	Not covered	Paid by Vision Benefit IF you elected it
	Dental check-up	Not covered	*Paid by Dental Benefit IF you elected it*

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
- Gender reassignment surgery and treatment
- Dental care unless for TMJD, accidental injury, or fracture/dislocation of jaw
- Routine eye care
- Habilitation services
- Routine foot care

Common Medical Event	Services You May Need	Your cost	Limitations & Exceptions

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

- Acupuncture
- Hearing aids($3500 per aid, original and replacement, paid once every 36 months)
- Evaluation, testing, treatment of autism spectrum disorders
- Bariatric surgery (limit one procedure for the life of the patient's participation in the Plan)
- Certain TMJD treatments
- Infertility medications ($15,000 maximum limit for life of patient's participation in the Plan)
- Infertility testing and treatment
- Chiropractic care
- Home health care
- Telehealth 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, or www.dol.gov/ebsa , or the U.S. Dept of Health & 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:

- American Airlines, Inc. HR Services at 1-800-447-2000 (or chat with HR Services **my.aa.com**)
- American Airlines, Inc. Benefits Compliance at 1-800-967-1412 (or via facsimile at 817-967-6335, or via email at albert.garcia@aa.com)
- U.S. Department 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 .

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 plan or policy 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.**

Questions: Call 1-800-447-2000 or visit us at **my.aa.com** . If you aren't clear about any of the bolded terms used in this form, see Glossary. You can view Glossary at **my.aa.com** , **www.dol.gov/ebsa/healthreform** , **www.cciio.cms.gov** ,or call 1-800-447-2000 for a copy.

Health Reimbursement Account

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, such as 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, co-payments, co-insurance, services and supplies covered but not paid by your medical, dental, and vision coverage, and even some health-related expenses your medical, dental, and vision coverage does not cover (such as amounts exceeding usual and prevailing amounts, experimental/investigational treatment, costs for a service animal, etc.). As soon as you make your first contribution to your YSA HCFSA through payroll deduction each year, the entire amount of your elected HCFSA account is available for your and your family's use. **For 2017, the maximum amount you can deposit into your HCFSA is $2550.** 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
Blood tests	Insulin	Cleanings more than twice a year	Contact Lenses
Chiropractor	Lab tests	Charges with balance billings	Ophthalmologist fees
Contraceptives (retail)	Prescriptions	Drugs and their administration	Guide dog
Diagnostic devices	Nursing care	Extra set of dentures/appliances	Special education services for blind
Hearing devices	Wheelchairs	Replacement of lost/stolen dentures	Vision therapy

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** $4,740
- **Patient pays** $2,870

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	$850
Co-pays	$0
Co-insurance	$1,120
Limits or exclusions*	$900
Total	**$2,870**

***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** $2,314
- **Patient pays** $1,786

Sample care costs:

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

Patient pays:

Deductibles	$850
Co-pays	$0
Co-insurance	$646
Limits or exclusions*	$290
Total	**$1,786**

***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 by 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.