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

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Covg for: EE, Spouse/DP, Children| Plan Type: HDHP**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan Summary Plan Description (SPD) at my.aa.com , or by calling 1-800-447-2000. This summary provides information about the Core 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 $2,000 Indiv $4,000 Fam	OUT NTWK $4,000 Indiv $8,000 Fam	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 starting on page 2 for how much you pay for covered services after you meet the deductible. In-network preventive care, and preventive prescriptions are not subject to the deductible.
Are there other deductibles for specific services?	NO		There are no other specific deductibles. 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? (calendar year)	YES: IN NTWK $4,000 Indiv $8,000 Fam*	YES: OUT NTWK $12,000 Indiv $24,000 Fam	The out-of-pocket limit is the most you could pay during a coverage period (calendar year) for your share of the cost of covered services. This limit helps you plan for health care expenses. The annual deductible and co-insurance amounts DO count toward the annual out-of-pocket limits. *No one person has to meet more than $6850 of the Family in-network out-of-pocket limit for the calendar year.
What is not included in the out–of–pocket limit?	Contributions, balance-billed charges, precertification failure penalties, or care this plan won't cover		Even though you pay these expenses, they DO NOT 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, you can access network provider listings via my.aa.com and click on your network/claim administrator, or call 800-447-2000		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 or preferred for providers in this 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 page 4. See your SPD for additional information about excluded services.

- 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 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 for injury/illness	20%	40%	*Pays after deductible met*
	Specialist visit for injury/illness	20%	40%	Pays after deductible met
	Other provider office visit for injury/illness	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, at hospital or dr's office	Diagnostic test (x-ray, lab work)	20%	40%	Pays after deductible met
	Imaging (CT/PET scans, MRIs)	20%	40%	*Pays after deductible met*
If you need drugs to treat your illness or condition and get them from EXPRESS SCRIPTS NETWORK RETAIL PHARMCY: *Other limitations may apply*—More info about prescription drug coverage is at my.aa.com or www.express-scripts.com	*Generic Rx, 30-day supply RETAIL:* 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	20%	40% Paid based on Express Scripts discounted price	*Pays after deductible met* Certain preventive Rx not subject to deductible *Some Rx require Prior Auth*
	Brand Name Rx 30-day supply RETAIL: Long-term Rx must be filled via Mail Order or at Safeway or at CVS starting with the 4th fill, else you pay 50%; see www.express-scripts.com	20%	40% Paid based on Express Scripts discounted price	Pays after deductible met *Certain preventive Rx not subject to deductible* Some Rx require Prior Auth *Certain brand Rx not covered, check Express Scripts website*
	Specialty Rx, 30-day supply, RETAIL GENERIC AND BRAND: Both generic and brand Rx; some Long-term Rx must be filled via Accredo or at Safeway or at CVS starting with 4th fill, else you pay 50%; see www.express-scripts.com	20%	40% Paid based on Express Scripts discounted price	Pays after deductible met *Some Rx require Prior Auth* You must fill specialty Rx at network retail pharmacy or Accredo (by mail) *Certain brand Rx not covered, 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 need drugs to treat your illness or condition and get them from EXPRESS SCRIPTS BY MAIL ORDER: *Other limitations may apply*—More info about prescription drug coverage at www.my.aa.com or www.express-scripts.com	*Generic Rx, 90-day supply MAIL ORDER:* Long-term Rx must be filled via Mail Order, or at Safeway, or at CVS starting with the 4th fill, else you pay 50%; see www.express-scripts.com	20%	Not covered	Pays after deductible met *Certain preventive Rx not subject to deductible* Some Rx require Prior Auth *Certain brand Rx not covered, check Express Scripts website*
	Brand Name Rx 90-day supply MAIL ORDER: Long-term Rx must be filled via Mail Order, or at Safeway, or at CVS starting with the 4th fill, else you pay 50%; see www.express-scripts.com	20%	Not covered	Pays after deductible met *Certain preventive Rx not subject to deductible* Some Rx require Prior Auth *Certain brand Rx not covered, check Express Scripts website*
	Specialty Rx, 30-day supply MAIL ORDER: Both generic and brand Rx; Some Long-term Rx must be filled via Accredo or at Safeway or at CVS starting with 4th fill, else you pay 50%; see www.express-scripts.com	20%	Not covered	Pays after deductible met *Some Rx require Prior Auth* You must fill specialty Rx via Accredo *Certain brand Rx not covered, check Express Scripts website*
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	20%	40%	Pays after deductible met
	Emergency medical transportation	20%	40%	*Pays after deductible met*
	Urgent care	20%	40%	Pays after deductible met
If you have a hospital stay	Facility fee (e.g., hospital room)	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	20%	40%	Pays after deductible met
	Mental/Behavioral health inpatient services	20%	40%	*Pays after deductible met* Inpatient requires precertification
	Substance use disorder outpatient services	20%	40%	*Pays after deductible met*
	Substance use disorder inpatient services	20%	40%	Pays after deductible met *Inpatient requires precertification*

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, your spouse/DP, or your dependent daughter are pregnant	Routine prenatal care	No charge	40%	Out-of-network pays after deductible met
	Delivery and 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 the deductible met*
	Rehabilitation services (Physical, occupational, speech therapies)	20%	40%	Pays after deductible met
	Habilitation services	Not covered	Not covered	*Plan does not cover this, see this pg 4 and SPD for more info on excluded services*
	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 service	20%	40%	Pays after deductible met
If your child needs dental or eye care	Eye exam and/or, 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 fractures/dislocation of jaw
- Routine eye care
- Habilitation services
- Routine foot care

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

- Acupuncture
- Infertility medications ($15,000 maximum limit for life of patient's participation in the Plan)
- Collection and cryopreservation of human female ova ("egg freezing") and in-vitro fertilization (maximum $25,000 limit for life of patient's participation in the Plan)
- Certain TMJD treatments
- Diagnostic mammograms (100% after deductible if in doctor's office or non-hospital facility)
- Hearing aids ($3500 per aid, original and replacement, paid once every 36 months)
- Gender Reassignment Benefits
- Bariatric surgery (limit one procedure for life of patient's participation in the Plan)
- Chiropractic care
- Home health care
- Diagnostic colonoscopies (100% after deductible if in doctor's office or non-hospital facility)
- Applied Behavioral Analysis for treatment of autism spectrum disorder
- 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 contributions 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 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 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:

- American Airlines, Inc. HR Services, at 1-800-447-2000 (or chat with HR Services at 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.

Health Savings Accounts

The Core Option is made to work with a Health Savings Account (HSA) that you establish with Aon Hewitt's Your Spending Account (YSA, via pre-tax payroll deductions) or with your bank or other financial institution (post-tax). You can deposit funds into this account to help pay for medical, prescription, dental, and/or vision expenses—items such as charges used to meet the annual deductible, co-insurance, other out-of-pocket expenses, etc. Additionally, 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 HSA. The chart on page 6 gives some examples of HSA-covered expenses. For complete information, please refer to your SPD. Keep in mind that you can have access to the funds in your HSA only up to the amount you've actually deposited into your HSA. Maximum federally–defined HSA contributions for 2016 are $3,350 for employee only, $6,750 for employee + family.

Limited Purpose Flexible Spending Account (LPFSA)

You can also establish a Limited Purpose Health Care Flexible Spending Account (LPFSA) to help pay medical, dental, vision services and supplies that are not paid by the Medical Benefit, Dental Benefit and/or Vision Insurance Benefit. This includes items such as deductibles, co-insurance, and other out-of-pocket expenses. Through YSA, you deposit pre-tax dollars into the LPFSA (via payroll deduction), and these dollars can reimburse you for the portion of medical, dental, and vision expenses that you'd be responsible for paying. As soon as you make your first contribution through payroll deduction each year, the entire amount of your elected YSA LPFSA account is available for your and your family's use. For 2016, the maximum amount you can deposit into your LPFSA is $2,550.
Some examples of covered expenses are listed below:

Examples of Covered HSA Expenses (medical, dental, vision)		Examples of Covered LPFSA Expenses (dental & vision only)	
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
Dental expenses	Vision expenses	Orthodontia expenses	Protective eyewear

This is not a complete list of covered expenses. Please consult your SPD for a complete list of covered and non-covered services, and for information on how the LPFSA works.

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** $3,860
- **Patient pays** $3,680

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	$2,000
Co-pays	$0
Co-insurance	$780
Limits or exclusions* This charge is not covered, so patient pays 100%	$900
Total	$3,680

*Newborn's expense not covered under mother's benefits, & is 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** $1,504
- **Patient pays** $2,596

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	$2,000
Co-pays	$0
Co-insurance	$306
Limits or exclusions*This charge is not covered, so patient pays 100%	$290
Total	$2,596

*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.