AA Health Plan for Active Emps:VALUE 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: 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) (formerly, the Employee Benefits Guide (EBG)) at my.aa.com, or by calling 1-800-447-2000. This summary provides information about the Value 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 $350 Indiv $1050 Fam	OUT NTWK $1,550 Indiv $4,650 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 chart on pg 2 for how much you pay for covered services after you meet the deductible. In-network preventive care, some prescriptions, physicians' visits not subject to 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 chart on pg 2 for other costs for services this plan covers.
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 costs 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 and co-insurance DO count toward the out-of-pocket limit.
What is not included in the out-of-pocket limit?	Contributions, deductibles, balance-billed charges, precertification failure penalties & care this plan won't cover		Even though you pay these expenses, they DO NOT count toward out-of-pocket limit. Also, you continue to pay all co-payments, even if you have already satisfied your annual out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	NO		Chart on pg 2 describes any limits on what the plan pays for *specific* covered services such as office visits.
Does this plan use a network of providers?	YES		If you use in-network doctor or other health care provider, this plan will pay some or all costs of covered services. Be aware, your in-network doctor/hospital may use out-of-network providers for some services. This coverage uses the term in-network or preferred, for those in-network. Chart on pg 2 shows 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 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, $20) 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 $1000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.

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.

- 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 injury or illness	$20	40%	*In-network not subject to deductible, and does count toward out-of-pocket limit* In-network preventive paid at 100% *Out-of-network pays after deductible met, and does count toward out-of-pocket limit*
	Specialist visit	$40	40%	
	Other practitioner office visit	$40	40%	
	Preventive care/screening/immunization	No charge	40%	
If you have a test	Diagnostic test (xray, 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 (xray, lab work), if non hospital-based (e.g., dr's office, imaging ctr)	No charge	40%	Out-of-network pays after deductible met
	Imaging (CT/PET scans, MRIs, if non hospital-based (e.g., dr's office, imaging ctr)	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 info about prescription drug coverage 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) $ amts are min and max you pay per Rx	RETAIL 20% ($10/$40) MAIL ORDER 20% ($5/$80)	RETAIL $10 Paid based on Express Scripts' discounted price MAIL ORDER Not covered	Co-insurance not subject to deductible and applies to out-of-pocket limit *Co-payment counts toward out-of-pocket limit* Out-of-network mail order Rx is not covered *Some Rx require Prior Auth*
	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%; 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 30% ($20/$75) MAIL ORDER 30% ($40/$150)	RETAIL 30% ($20/$75) Paid based on Express Scripts discounted price MAIL ORDER Not covered	*Not subject to deductible and counts toward out-of-pocket limit* Some Rx require Prior Auth *If you select preferred brand drug when a generic's available, you pay retail generic 30% (mail order generic 20%) plus cost difference between generic and preferred brand* Certain brand Rx are 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. *Other limitations may apply—* More info about prescription drug coverage 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%; see www.express-scripts.com Retail (30-day supply) Mail Order (90-day supply) $ amts are min and max you pay per Rx	RETAIL 50% ($35/$90) MAIL ORDER 50% ($70/$180)	RETAIL 50% ($35/$90); Paid based on Express Script's discounted price MAIL ORDER Not covered	*Not subject to deductible and counts toward out-of-pocket limit* Some Rx require Prior Auth *If you select non-preferred brand drug when generic's available, you pay retail generic 30% (mail order generic 20%) plus cost difference between generic and non-preferred brand)* Certain brand Rx are not covered, check Express Scripts website
	Specialty Rx RETAIL: 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 Retail (30-day supply) $ amts are min and max you pay per Rx	*Preferred Brand:* 30%($20/$75) *Non-Preferred Brand:* 50%($35/$90)	Not covered	*Not subject to the deductible and counts toward out-of-pocket limit* Co-payment counts toward out-of-pocket limit *You must fill these specialty Rx from an in-network retail pharmacy or Accredo* Certain brand Rx are not covered, check Express Scripts website
	Specialty Rx MAIL ORDER: Mail Order from Accredo or at Safeway or at CVS; else you pay 50% (90-day supply) See www.express-scripts.com $ amts are min and max you pay per Rx	*Preferred Brand* 30% ($40/$150) *Non-Preferred Brand* 50% ($70/$180)	Not covered	Not subject to deductible and counts toward out-of-pocket limit *You must fill these 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%	40%	*Pays after deductible met*
	Physician/surgeon fees	20%	40%	Pays after deductible met
If you need immediate medical attention *cont'd*	Emergency room services	$100 co-payment plus 20% allowed on full billed amount	$100 co-payment plus 20% allowed on full billed amount	$100 co-payment counts toward out-of-pocket *Co-insurance 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 you need immediate medical attention *cont'd*	Emergency medical transportation	No charge	No charge	Not subject to deductible
	Urgent care (e.g., "anytime" walk-in clinics) including visit, lab, xray, other testing/treatment)	$40	40%	*Co-insurance pays after deductible met* Co-payment does count toward out-of-pocket limit
If you have a hospital stay	Facility fee (e.g., hospital room, ancillary	20%	40%	*Pays after deductible met*
	Physician/surgeon fee	20%	40%	*Pays after deductible met*
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	20%	40%	*Pays after deductible met* Inpatient requires precertification
	Mental/Behavioral health outpatient services	PCP-$20 Specialist-$40 other providers-20%	40%	*In-network PCP & Specialist visits not subject to deductible* Co-payment does count toward out-of-pocket limit *Other expenses, pay after deductible met*
	Substance use disorder outpatient services	PCP-$20; Specialist-$40; other providers-20%	40%	In-network PCP & Specialist visits not subject to deductible *Co-payment does count toward out-of-pocket limit*
	Substance use disorder inpatient services	20%	40%	Pays after deductible met *Inpatient requires precertification*
If you, your spouse/DP, or your dependent daughter is pregnant	Routine prenatal care	No charge	40%	Out-of-network pays after deductible met
	Delivery and postnatal care (dr's fee only)	$150 co-payment	40%	*Co-payment does count toward out-of-pocket*
	All inpatient hospital services, anesthesia, lab, x-ray, etc.	20%	40%	*Pays after deductible met* Inpatient requires precertification
If you need help recovering or have other special health needs *Continued on next page*	Home health care	20%	40%	*Pays after deductible met*
	Rehabilitation services	20%	40%	Pays after deductible met
	Habilitation services	Not covered	Not covered	*The plan does not cover this service, see excluded expenses*
	Skilled nursing care up to 60 days per illness	20%	40%	Pays after deductible met

other special health needs, *cont'd*	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, 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 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 the patient's participation in the Plan)
- Bariatric surgery (limit one procedure for the life of the patient's participation in the Plan)
- Certain TMJD treatments
- Hearing aids ($3500 per aid, original and replacement, paid once every 36 months)
- 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 and 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 on my.aa.com)
- American Airlines, Inc. Benefits Compliance at 1-817-967-1412 (via facsimile at 1-817-967-6335) 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 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) (formerly referred to as Health Incentive Account (HIA)

If you (or your spouse/DP) participate in the WebMD wellness program and earn wellness rewards, we will place those reward funds in your HRA account with Aon Hewitt's Your Savings Account (YSA). You can use the funds to pay for health-related items not paid by your medical, dental or vision 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. Any unused funds in your Health Incentive Account (HIA) will be transferred to your 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 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 2016, the maximum amount you can deposit into your HCFSA is $2,550.

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** $5380
- **Patient pays** $2160

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	$350
Co-pays	$40
Co-insurance	$870
Limits or exclusions*This charge is not covered, so patient pays 100%	$900
Total	$2,160

*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 100%

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

- **Amount owed to providers:** $4,100
- **Plan pays** $2,570
- **Patient pays** $1,530

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	$350
Co-pays	$400
Co-insurance	$490
Limits or exclusions*	$290
Total	$1,530

* Educational services excluded
**In-network preventive care 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.