



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. If a discrepancy exists between this SBC and the [plan](#) provisions, the [plan](#) provisions govern.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, view the Summary Plan Description (SPD) at my.aa.com or contact us at 1-888-860-6178. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at my.aa.com, www.dol.gov/ebsa/healthreform, www.cciio.cms.gov, <https://www.healthcare.gov/sbc-glossary> or call 1-888-860-6178 to request a copy.

Important Questions	Answers		Why This Matters:
	IN-NETWORK	OUT-OF-NETWORK	
What is the overall deductible ?	\$850/Individual \$2,550/Family	\$3,000/Individual \$9,000/Family	Except for preventive services and copayments , each member must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each member's deductible applies toward the family deductible . Once the family deductible is met, the plan will begin to pay for those members who have not reached their individual deductibles .
Are there services covered before you meet your deductible ?	YES	NO	This plan covers certain preventive services without cost-sharing and before you meet your deductible . Covered preventive services are listed at https://www.healthcare.gov/coverage/preventive-care-benefits/ . In-network preventive care / prescriptions are not subject to deductible / coinsurance . Out-of-network preventive care / prescriptions are subject to deductible / coinsurance .
Are there other deductibles for specific services?	NO	NO	There are no other deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$2,850/Individual \$7,550/Family (includes deductible)	\$9,000/Individual \$24,000/Family (includes deductible)	The out-of-pocket limit is the most you could pay in a year for covered services. Deductible , copayment , and coinsurance amounts DO count toward your out-of-pocket limit . In families of 3 or more members, if family out-of-pocket limit is met cumulatively, expenses are payable at 100% for all family members even if the individual out-of-pocket limits haven't been met by each member.
What is not included in the out-of-pocket limit ?	Contributions, balance billing charges, precertification failure penalties, or health care this plan will not cover		Even though you pay for these expenses, they DO NOT count toward your out-of-pocket limit .
Will you pay less if you use a network provider ?	YES		This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , as you may receive a bill from the provider for the difference between the provider's charge and what your plan pays (balance billing). You can access in-network provider listings by visiting my.aa.com and click on your respective network/claim administrator, or call 1-877-235-9258 (Blue Cross Blue Shield of Texas) OR 1-800-955-8095 (United Healthcare).
Do you need a referral to see a specialist ?	NO		You can see the specialist you choose without a referral .



All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit	\$30 copayment	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Doctor on Demand Telehealth visit	\$20 copayment	Not applicable	None
	Preventive care/screening/immunization	No cost to you	40% coinsurance	•Charges will apply for services and tests which fall outside USPSTF guidelines
If you have a test at a hospital facility	Diagnostic test (x-ray, labs)	20% coinsurance	40% coinsurance	None
	Imaging (CT, PET, MRI) scans			
If you have a test at the doctor's office	Diagnostic test (x-ray, labs)	No cost to you if part of an office visit	40% coinsurance	•Charges apply if performed by an inpatient facility
	Imaging (CT, PET, MRI) scans			
<p>If you need prescription drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.express-scripts.com</p> <p>Continued on next page</p>	Generic drugs	<p>RETAIL Up to a 30-day supply 20% coinsurance (\$10 min/\$40 max per fill)</p> <p>Up to a 90-day supply 20% coinsurance (\$5 min/\$80 max per fill)</p> <p>MAIL ORDER Up to 90-day supply 20% coinsurance (\$5 min/\$80 max per fill)</p>	<p>RETAIL Up to a 30-day supply 20% coinsurance (\$10 min/\$40 max per fill) but will be reimbursed based on the Express Scripts discounted price</p> <p>MAIL ORDER Not covered</p>	<ul style="list-style-type: none"> •Certain brand name prescriptions are not covered, check with Express Scripts at www.express-scripts.com •Prescriptions are not subject to the deductible •If you fill the same prescription in a 30-day supply quantity or less 3 times, you will pay 50% more on the 4th and consecutive fills •If you select a preferred or non-preferred brand drug when a generic is available, you pay 20% coinsurance plus the cost difference between generic and preferred or non-preferred brand •Some prescriptions require preauthorization



All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Preferred brand drugs	<p><u>RETAIL</u> Up to a 30-day supply 30% <u>coinsurance</u> (\$30 min/\$100 max per fill)</p> <p>Up to a 90-day supply 30% <u>coinsurance</u> (\$60 min/\$200 max per fill)</p> <p><u>MAIL ORDER</u> Up to a 90-day supply 30% <u>coinsurance</u> (\$60 min/\$200 max per fill)</p>	<p><u>RETAIL</u> Up to 30-day supply 30% <u>coinsurance</u> (\$30 min/\$100 max per fill) but will be reimbursed based on the Express Scripts discounted price</p> <p><u>MAIL ORDER</u> Not covered</p>	<ul style="list-style-type: none"> •Up to a 30-day supply can be filled through an Express Scripts <u>network</u> pharmacy for <u>in-network</u> benefits •Up to 90-day <u>prescription</u> fills are only available through Express Scripts mail order or from CVS or Safeway-owned pharmacies for <u>in-network</u> benefits •Other limitations may apply, see SPD
	Non-preferred brand drugs	<p><u>RETAIL</u> Up to a 30-day supply 50% <u>coinsurance</u> (\$45 min/\$150 max per fill)</p> <p>Up to a 90-day supply 50% <u>coinsurance</u> (\$90 min/\$300 max per fill)</p> <p><u>MAIL ORDER</u> Up to a 90-day supply 50% <u>coinsurance</u> (\$90 min/\$300 max per fill)</p>	<p><u>RETAIL</u> Up to a 30-day supply 50% <u>coinsurance</u> (\$45 min/\$150 max per fill) but will be reimbursed based on the Express Scripts discounted price</p> <p><u>MAIL ORDER</u> Not covered</p>	
	Specialty drugs	<p><u>RETAIL GENERIC</u> Up to a 30-day supply 20% <u>coinsurance</u> (\$10 min/\$40 max per fill)</p> <p>Up to a 90-day supply 20% <u>coinsurance</u> (\$5 min/\$80 max per fill)</p>	<p><u>RETAIL GENERIC</u> Up to a 30-day supply 20% <u>coinsurance</u> (\$10 min/\$40 max per fill), but will be reimbursed based on the Express Scripts discounted price</p>	



All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	<p><u>MAIL ORDER GENERIC</u> Up to 90-day supply 20% coinsurance (\$5 min/\$80 max per fill)</p> <p><u>RETAIL PREFERRED BRAND</u> Up to a 30-day supply 30% coinsurance (\$30 min/\$100 max per fill)</p> <p>Up to a 90-day supply 30% coinsurance (\$60 min/\$200 max per fill)</p> <p><u>MAIL ORDER PREFERRED BRAND</u> Up to a 90-day supply 30% coinsurance (\$60 min/\$200 max per fill)</p> <p><u>RETAIL NON PREFERRED BRAND</u> Up to a 30-day supply 50% coinsurance (\$45 min/\$150 max per fill)</p> <p>Up to a 90-day supply 50% coinsurance (\$90 min/\$300 max per fill)</p> <p><u>MAIL ORDER NON-PREFERRED BRAND</u> Up to a 90-day supply 50% coinsurance (\$90 min/\$300 max per fill)</p>	<p><u>MAIL ORDER GENERIC</u> Not covered</p> <p><u>RETAIL PREFERRED BRAND</u> Up to 30-day supply 30% coinsurance (\$30 min/\$100 max per fill) but will be reimbursed based on Express Scripts discounted price</p> <p><u>MAIL ORDER PREFERRED BRAND</u> Not covered</p> <p><u>RETAIL NON PREFERRED BRAND</u> Up to a 30-day supply 50% coinsurance (\$45 min/\$150 max per fill) but will be reimbursed based on the Express Scripts discounted price</p> <p><u>MAIL ORDER NON-PREFERRED</u> Not covered</p>	supply quantities when certain clinical rules or quantity restrictions apply



All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., freestanding day surgicenter, doctor's office)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	\$100 copayment , plus 20% coinsurance	\$100 copayment , plus 20% coinsurance	<ul style="list-style-type: none"> •\$100 copayment paid before deductible and coinsurance applies •\$100 copayment is waived if you're admitted to hospital •\$100 copayment, plus 40% coinsurance for non-emergency out-of-network
	Emergency medical transportation	20% coinsurance	20% coinsurance	• In-network deductible applies
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	•Inpatient requires precertification; failure to precertify, you pay \$250 penalty
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services for mental health, substance abuse	20% coinsurance	40% coinsurance	None
	Outpatient services for family therapy or couples therapy			
	Inpatient services for mental health, substance abuse			
	Employee Assistance Program (EAP)	1 st 4 visits, per issue, no cost to you	Not covered	•The EAP network of providers may be different than the network of your network/claim administrators; check with your network/claim administrator's provider network to ensure the EAP provider participates in both networks .
If you are pregnant (you, your spouse, or dependent daughter)	Office, routine prenatal care	No cost to you	40% coinsurance	•Non-routine prenatal care subject to deductible and coinsurance .
	Birth/delivery professional services	20% coinsurance	40% coinsurance	None
	Birth/delivery facility services	20% coinsurance	40% coinsurance	•Inpatient must have precertification; failure to precertify, you pay \$250 penalty



All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	•Limits apply, see SPD.
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	Not covered	Not covered	•This plan does not cover this service, see SPD
	Skilled nursing care	20% coinsurance	40% coinsurance	•Maximum benefit is 60 days per illness or injury
	Durable medical equipment	20% coinsurance	40% coinsurance	•Dollar and quantity limits may apply, see SPD
	Hospice services	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered by Medical	Not covered by Medical	•Paid under Vision Benefit, if you elected it
	Children's glasses			
	Children's dental check-up			•Paid under Dental Benefit, if you elected it

Excluded Services & Other Covered Services:

Services Your plan Generally Does NOT Cover (Check your SPD or my.aa.com for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> •Cosmetic surgery & treatment (elective) •Dental care, except treatment of accidental injury •Experimental, investigational, unproven care •Massage therapy •Routine eye care 	<ul style="list-style-type: none"> •Complimentary/Alternative medicine •Drugs not approved by the FDA •Non-emergency care outside the USA •Routine foot care •Long term care 	<ul style="list-style-type: none"> •Certain types of infertility care (see SPD) •Educational services •Custodial care •Non-medically necessary services/supplies •Weight loss programs unless for morbid obesity

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> •Acupuncture •Chiropractic care (limits apply, see SPD) •Collection/cryopreservation of human female ova ("egg freezing") and in-vitro fertilization (limits apply, see SPD) •Gender Reassignment Benefits (limits apply, see SPD) •Infertility medications (limits apply, see SPD) 	<ul style="list-style-type: none"> •Applied Behavioral Analysis (ABA) therapy •Clinical Trials (limits apply, see SPD) •Diagnostic colonoscopies (100% after deductible in doctor's office on non-hospital facility) •Hearing aids, (limits apply, see SPD) •Private duty nursing if medically necessary •Temporomandibular Joint Disease (TMJD) treatment (limits apply, see SPD) 	<ul style="list-style-type: none"> •Bariatric surgery (limits apply, see SPD) •Diagnostic mammograms (100% after deductible in doctor's office or non-hospital facility) •Home health care (limits apply, see SPD) •Reconstructive surgery to repair accidental injury or removal of diseased tissue •Telehealth visits (Doctor on Demand)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: US Department of Labor Employee Benefits Security Administration (1-866-444-EBSA [3272]) or American Airlines Benefits Service Center at 1-888-860-6178. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: American Airlines, Inc. Benefits Service Center at 1-888-860-6178, American Airlines, Inc. Benefits Compliance/Appeals at 1-817-967-1412, or the US Department of Labor at 1-866-487-2365.

Does this plan provide Minimum Essential Coverage? YES

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? YES

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

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. If you elected the HCFSA, beginning January 1, the full amount of your elected HCFSA account is available for use. **For 2018, the maximum amount you can deposit into your HCFSA is \$2,600.**

Health Reimbursement Account (HRA)

If you or your spouse participate in the WebMD Wellness Program and earn Wellness Rewards, American will place those reward funds in your HRA account with Alight's Your Savings Account (YSA). You can use the funds to pay for eligible health related items from your medical, [prescription](#), dental, or vision coverage ([deductibles](#), [out-of-pocket](#) amounts, etc.) **You can access these funds only up to the amounts actually deposited into the HRA.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-860-6178

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-860-6178

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-860-6178

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-860-6178

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [co-payments](#) and [co-insurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of [in-network](#) pre-natal care and a hospital delivery)

PEG'S COVERAGE IS EMPLOYEE-ONLY

■ The plan's overall deductible	\$850
■ Specialist (routine prenatal office visits)	\$0
■ Specialist (delivery, postnatal care)	20%
■ Hospital (facility)	20%
■ Anesthesiologist	20%
■ Diagnostic tests at doctor's office	\$0

This EXAMPLE event includes services like:

Specialist office visits (routine prenatal)	\$500
Childbirth/Delivery Professional Services	\$2,000
Childbirth/Delivery Facility Services	\$7,500
Diagnostic tests (ultrasounds, blood work)	\$1,300
Specialist visit (anesthesia)	\$1,500

Total Example Cost \$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$850
Copayments	\$0
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	N/A
The total Peg would pay is	\$2,850

Managing Joe's type 2 Diabetes

(a year of routine [in-network](#) care of a well-controlled condition)

JOE'S COVERAGE IS EMPLOYEE-ONLY

■ The plan's overall deductible	\$850
■ Specialist (2 hospital visits)	40%
■ PCP office visits (4 visits)	\$30
■ Hospital (facility)	20%
■ Diagnostic tests at PCP's office	\$0
■ Prescription drugs (generic)	20%
■ Glucose Meter	20%

This EXAMPLE event includes services like:

Specialist hospital visits	\$300
Primary Care physician (PCP) office visits (including disease education)	\$1,000
Hospital (facility)	\$3,000
Diagnostic tests (blood work)	\$2,000
Prescription drugs	\$1,000
Durable medical equipment (glucose meter)	\$100

Total Example Cost \$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$850
Copayments	\$120
Coinsurance	\$710
<i>What isn't covered</i>	
Limits or exclusions	N/A
The total Joe would pay is	\$1,680

Mia's Simple Fracture

([in-network](#) [emergency room](#) visit and follow up care)

MIA'S COVERAGE IS EMPLOYEE-ONLY

■ The plan's overall deductible	\$850
■ Specialist (setting fracture, casting)	20%
■ Hospital (facility)	20%
■ Crutches	20%
■ X-ray at doctor's office	\$0
■ Physical Therapy	20%

This EXAMPLE event includes services like:

Specialist (set fracture and follow-up)	\$600
Emergency room (including medical supplies)	\$500
Diagnostic test (x-ray)	\$100
Durable medical equipment (crutches)	\$50
Rehabilitation services (physical therapy)	\$650

Total Example Cost \$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$850
Copayments	\$100
Coinsurance	\$170
<i>What isn't covered</i>	
Limits or exclusions	N/A
The total Mia would pay is	\$1,120

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.