





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](http://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](http://my.aa.com), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), [www.cciio.cms.gov](http://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:
What is the overall <a href="#">deductible</a> ?	\$225/Individual \$450/Family	You must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for covered services. <a href="#">Copayments</a> do not apply toward the <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	YES	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan covers Doctor on Demand Telehealth visits, prescription drugs and <a href="#">home health care</a> before you meet your <a href="#">deductible</a> .
Are there other <a href="#">deductibles</a> for specific services?	NO	You don't have to meet any other <a href="#">deductible</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$225/Individual \$450/Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. The <a href="#">out-of-pocket limit</a> includes the <a href="#">deductible</a> and <a href="#">coinsurance</a> , but it does not include <a href="#">copayments</a> .
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Contributions</a> , <a href="#">copayments</a> for certain services, <a href="#">balance-billing</a> charges, penalties for non-compliance, and health care this <a href="#">plan</a> does not cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Is there an overall annual limit on what the <a href="#">plan</a> pays?	NO	The chart starting on page 2 describes any limits on what the <a href="#">plan</a> will pay for specific covered services, such as office visits.
Will you pay less if you use a <a href="#">network provider</a> ?	YES	The <a href="#">plan</a> treats <a href="#">providers</a> the same in determining payment for the same services. For <a href="#">prescription drugs</a> you have the choice of using <a href="#">in-network</a> or <a href="#">out-of-network</a> <a href="#">providers</a> .
Do I need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	NO	You can see the <a href="#">specialist</a> you choose without permission from this <a href="#">plan</a> .

 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	Network Provider	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit	No cost to you	<ul style="list-style-type: none"> <li>Other medical provider (e.g., chiropractor) coverage is limited to a maximum of 20 visits annually</li> <li>There may be other levels of <u>cost share</u> that are contingent on the services provided. See the SPD for complete details.</li> </ul>
	Specialist visit	No cost to you	
	Preventive care/screening/immunization	No cost to you	
	Other medical practitioner (e.g., chiropractor)	No cost to you	
	Doctor on Demand Telehealth visit	\$20 copayment	
If you have a test	Diagnostic test (x-ray, labs)	No cost to you	<ul style="list-style-type: none"> <li>The amount you pay may be different depending on how/where your care was provided. See the SPD for complete details.</li> </ul>
	Imaging (CT, PET, MRIs)	No cost to you	
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	<b>RETAIL</b> \$15 copayment per fill <b>MAIL ORDER</b> \$30 copayment per fill	<ul style="list-style-type: none"> <li><b>Out-of-network prescription drugs are not covered</b></li> <li>Prescriptions are not subject to the deductible</li> <li>Certain brand name prescriptions are not covered, check with Express Scripts at <a href="http://www.express-scripts.com">www.express-scripts.com</a></li> <li>You must use an in-network pharmacy</li> <li>Covers up to 34-day supply (retail prescription); 35-90 day supply (mail order prescription)</li> <li>If you select a preferred or non-preferred brand drug when a generic is available, you pay copayment plus the cost difference between generic and preferred or non-preferred brand</li> <li>Other limitations may apply, see SPD</li> </ul>
	Preferred brand drugs	<b>RETAIL</b> \$30 copayment per fill <b>MAIL ORDER</b> \$60 copayment per fill	
	Non-preferred brand drugs	<b>RETAIL</b> \$50 copayment per fill <b>MAIL ORDER</b> \$100 copayment per fill	
If you have outpatient surgery	Facility fee (e.g., freestanding day surgicenter, doctor's surgical suite)	No cost to you	None
	Physician/surgeon fees	No cost to you	None
If you need immediate medical attention	Emergency room care	No cost to you	None
	Emergency medical transportation	No cost to you	None
	Urgent care	No cost to you	
If you have a hospital stay	Facility fee (e.g., hospital room)	No cost to you	<ul style="list-style-type: none"> <li>Inpatient requires precertification; if not precertified, you pay \$250 penalty</li> </ul>
	Physician/surgeon fees	No cost to you	None

 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	Network Provider	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% <a href="#">coinsurance</a>	None
	Inpatient services	No cost to you	• Inpatient requires precertification; failure to precertify, you pay \$250 penalty
	Employee Assistance Program (EAP)	1 <sup>st</sup> 4 visits, no cost to you	• Maximum of 1st 4 visits per issue • You must use EAP <a href="#">network providers</a>
If you are pregnant	Office visits	No cost to you	None
	Childbirth/delivery professional services	No cost to you	
	Childbirth/delivery facility services	No cost to you	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No cost to you	• Maximum benefit of 100 visits annually
	<a href="#">Rehabilitation services</a>	No cost to you	• Maximum benefit of 40 visits annually for physical therapy and occupational therapy combined
	<a href="#">Habilitation services</a>	No cost to you	• Maximum benefit of 20 visits annually for speech therapy • All <a href="#">rehabilitation</a> and <a href="#">habilitation</a> visits count toward your <a href="#">rehabilitation</a> visit limit
	<a href="#">Skilled nursing care</a>	No cost to you	• Maximum benefit of 60 days annually
	<a href="#">Durable medical equipment</a>	1 <sup>st</sup> \$500, no cost to you Then no cost to you after <a href="#">deductible</a> met	• <a href="#">Preauthorization</a> required after \$500 has been paid
	<a href="#">Hospice services</a>	No cost to you after annual deductible	None
If your child needs dental or eye care	Children's eye exam	Not covered	None
	Children's glasses		
	Children's dental check-up		

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic Surgery</li> <li>• Dental Care (except for treatment and surgery of the mouth necessitated by accident and is started prior to one year after the accident)</li> </ul>	<ul style="list-style-type: none"> <li>• Glasses</li> <li>• Hearing Aids</li> <li>• Infertility treatments (except <u>diagnostic testing</u> to determine the cause of infertility and <u>prescription drug</u> to treat infertility)</li> <li>• Long-term Care</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine Foot Care (except for procedures associated with diabetic treatment)</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture (if prescribed for <u>rehabilitation</u> purposes)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care (limits apply, see SPD)</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric Surgery (limits apply, see SPD)</li> </ul>

**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: American Airlines, Inc. Benefits Service Center at 1-888-860-6178, [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the US Department of Health and Human Services at 1-877-267-2323 extension 61565, or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://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:

Blue Cross Blue Shield of Texas	United Healthcare	Express Scripts	American Airlines, Inc. Benefits Compliance and Appeals	American Airlines, Inc. Benefits Service Center
ATTN: Appeals for US Airways	National Appeals Center	Appeals for US Airways	Urgent Pharmacy and 2 <sup>nd</sup> Level Pharmacy Appeals	Benefit Appeals
PO BOX 833874	PO BOX 30432	PO BOX 66588	PO BOX 619616, MD 5134-HDQ1	PO BOX 564103
Richardson, TX 75083-3874	Salt Lake City, UT 84130-0432	St. Louis, MO 63166-6588	DFW Airport, TX 75261-9616	Charlotte, NC 28256-1884
1-800-411-9188	1-800-520-0811	1-800-753-2851	1-817-967-1412	1-847-554-1884

**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 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 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.**

### 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.**

### 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

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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**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](#) \$225
- [Specialist](#) (routine prenatal office visits) \$0
- Hospital (facility) \$0
- Anesthesiologist \$0
- [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:**

<u>Cost Sharing</u>	
<a href="#">Deductibles</a>	\$225
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$10
<i>What isn't covered</i>	
Limits or exclusions	N/A
<b>The total Peg would pay is</b>	<b>\$225</b>

**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](#) \$225
- [Specialist](#) (hospital visits) \$0
- PCP office visits (4 visits) \$0
- Hospital (facility) \$0
- [Diagnostic tests](#) at PCP's office \$0
- [Prescription drugs](#) (generic) \$15
- Glucose Meter \$0

**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:**

<u>Cost Sharing</u>	
<a href="#">Deductibles</a>	\$225
<a href="#">Copayments</a>	\$150
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	N/A
<b>The total Joe would pay is</b>	<b>\$375</b>

**Mia's Simple Fracture**

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

**MIA'S COVERAGE IS EMPLOYEE-ONLY**

- The [plan's](#) overall [deductible](#) \$225
- [Specialist](#) (setting fracture, casting) \$0
- Hospital (facility) \$0
- Crutches \$0
- X-ray at doctor's office \$0
- Physical Therapy \$0

**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:**

<u>Cost Sharing</u>	
<a href="#">Deductibles</a>	\$225
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	N/A
<b>The total Mia would pay is</b>	<b>\$225</b>

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