





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:
What is the overall deductible ?	\$225/Individual \$450/Family	You must pay all of the costs from providers up to the deductible amount before this plan begins to pay for covered services. Copayments do not apply toward the deductible .
Are there services covered before you meet your deductible ?	YES	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers Doctor on Demand Telehealth visits, prescription drugs and home health care before you meet your deductible .
Are there other deductibles for specific services?	NO	You don't have to meet any other deductible for specific services.
What is the out-of-pocket limit for this plan ?	\$1,500/Individual \$3,000/Family	The out-of-pocket limit is the most you could pay in a year for covered services. The out-of-pocket limit includes the deductible and coinsurance , but it does not include copayments .
What is not included in the out-of-pocket limit ?	Contributions , copayments for certain services, balance-billing charges, penalties for non-compliance, and health care this plan does not cover.	Even though you pay these expenses, they don't 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.
Will you pay less if you use a network provider ?	YES	The plan treats providers the same in determining payment for the same services. For prescription drugs you have the choice of using in-network or out-of-network providers .
Do I need a referral to see a specialist ?	NO	You can see the specialist you choose without permission from this plan .

 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	10% coinsurance	<ul style="list-style-type: none"> • Other medical provider (e.g., chiropractor) coverage is limited to a maximum of 20 visits annually • There may be other levels of cost share that are contingent on the services provided. See the SPD for complete details.
	Specialist visit	10% coinsurance	
	Preventive care/screening/immunization	10% coinsurance	
	Other medical practitioner (e.g., chiropractor)	10% coinsurance	
	Doctor on Demand Telehealth visit	\$20 copayment	
If you have a test	Diagnostic test (x-ray, labs)	10% coinsurance	<ul style="list-style-type: none"> • The amount you pay may be different depending on how/where your care was provided. See the SPD for complete details.
	Imaging (CT, PET, MRIs)	10% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	RETAIL \$15 copayment per fill MAIL ORDER \$30 copayment per fill	<ul style="list-style-type: none"> • Out-of-network prescription drugs are not covered • Prescriptions are not subject to the deductible • Certain brand name prescriptions are not covered, check with Express Scripts at www.express-scripts.com • You must use an in-network pharmacy • Covers up to 34-day supply (retail prescription); 35-90 day supply (mail order prescription) • 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 • Other limitations may apply, see SPD
	Preferred brand drugs	RETAIL \$30 copayment per fill MAIL ORDER \$60 copayment per fill	
	Non-preferred brand drugs	RETAIL \$50 copayment per fill MAIL ORDER \$100 copayment per fill	
If you have outpatient surgery	Facility fee (e.g., freestanding day surgicenter, doctor's surgical suite)	10% coinsurance	None
	Physician/surgeon fees	10% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	None
	Emergency medical transportation	10% coinsurance	
	Urgent care	10% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	<ul style="list-style-type: none"> • Inpatient requires precertification; if not precertified, you pay \$250 penalty
	Physician/surgeon fees	10% coinsurance	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% coinsurance	None
	Inpatient services	10% coinsurance	• Inpatient requires precertification; if not precertified, you pay \$250 penalty
	Employee Assistance Program (EAP)	1st 4 visits, no cost to you	• Maximum of 1st 4 visits per issue • You must use EAP network providers
If you are pregnant	Office visits	10% coinsurance	None
	Childbirth/delivery professional services	10% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	
If you need help recovering or have other special health needs	Home health care	No cost to you	• Maximum benefit of 100 visits annually
	Rehabilitation services	10% coinsurance	• Maximum benefit of 40 visits annually for physical therapy and occupational therapy combined
	Habilitation services	10% coinsurance	• Maximum benefit of 20 visits annually for speech therapy • All rehabilitation and habilitation visits count toward your rehabilitation visit limit
	Skilled nursing care	10% coinsurance	• Maximum benefit of 60 days annually
	Durable medical equipment	1st \$500, no cost to you Then 10% coinsurance after deductible met	• Preauthorization required after \$500 has been paid
	Hospice services	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic Surgery • Dental Care (except for treatment and surgery of the mouth necessitated by accident and is started prior to one year after the accident) 	<ul style="list-style-type: none"> • Glasses • Hearing Aids • Infertility treatments (except <u>diagnostic testing</u> to determine the cause of infertility and <u>prescription drug</u> to treat infertility) • Long-term Care 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Routine Foot Care (except for procedures associated with diabetic treatment) • Weight loss programs

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 (if prescribed for <u>rehabilitation</u> purposes) 	<ul style="list-style-type: none"> • Chiropractic Care (limits apply, see SPD) 	<ul style="list-style-type: none"> • Bariatric Surgery (limits apply, see SPD)

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, or the US Department of Health and Human Services at 1-877-267-2323 extension 61565, or 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 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 nd 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

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](#) \$225
- [Specialist](#) (routine prenatal office visits) 10%
- Hospital (facility) 10%
- Anesthesiologist 10%
- [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>	
<u>Deductibles</u>	\$225
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,258
<i>What isn't covered</i>	
Limits or exclusions	N/A
The total Peg would pay is	\$1,483

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) 10%
- PCP office visits (4 visits) 10%
- Hospital (facility) 10%
- [Diagnostic tests](#) at PCP's office \$0
- [Prescription drugs](#) (generic) \$15
- Glucose Meter 10%

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>	
<u>Deductibles</u>	\$225
<u>Copayments</u>	\$150
<u>Coinsurance</u>	\$618
<i>What isn't covered</i>	
Limits or exclusions	N/A
The total Joe would pay is	\$993

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) 10%
- Hospital (facility) 10%
- Crutches 10%
- X-ray at doctor's office 10%
- Physical Therapy 10%

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>	
<u>Deductibles</u>	\$225
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$168
<i>What isn't covered</i>	
Limits or exclusions	N/A
The total Mia would pay is	\$393

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