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?	**$0/Individual** **$0/Family**	**No Out-of-Network coverage other than emergency services. In-Network benefits apply.**	This plan will begin paying immediately and there is no deductible. Only copayments and coinsurance will be required until the out-of-pocket limit is met.
Are there services covered before you meet your deductible?	**YES**	**YES**	This plan covers certain preventive services without cost-sharing. Covered preventive services are listed at https://www.healthcare.gov/coverage/preventive-care-benefits/. In-network preventive care / prescriptions are not subject copayments. No Out-of-network preventive care / prescriptions are covered.
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?	**$3,500/Individual** **$7,000/Family**	**No Out-of-Network coverage other than Emergent/Urgent & In-Network benefits apply.**	The out-of-pocket limit is the most you could pay in a year for covered services. Copayment, and coinsurance amounts DO count toward your out-of-pocket limit. In families of 2 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?	Balance-billing charges, and excluded expenses this plan does not cover.		Even though you pay for these expenses, they DO NOT count toward your out-of-pocket limit. This includes out of network services that are not an emergency.
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 these services are not covered unless a true emergency so you will pay the full cost. You can access in-network provider listings by visiting dfwconnectedcare.com, or call 1-888-860-6178.
Do you need a referral to see a specialist?	**NO**		You can see the specialist you choose without a referral as long as they are in-network.

*For more information about limitations and exceptions, see the plan document and SPD at my.aa.com.

There is no **deductible** **to be met for** **coinsurance** to apply.

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	$15 copayment	Not covered	None
	Specialist visit	$50 copayment	Not covered	None
	Doctor on Demand Telehealth visit	$10 copayment	Not covered	None
	Preventive care/screening/ immunization	No cost to you	Not covered	•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)	$50 copayment	Not covered	None
	Imaging (CT, PET, MRI) scans	$400 copayment		
If you have a test at the doctor's office	Diagnostic test (x-ray, labs)	No cost to you	Not covered	•Charges apply if performed in a hospital
	Imaging (CT, PET,MRI) scans	$100 copayment		
If you need prescription drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	**RETAIL** Up to a 30-day supply $20 copayment Up to a 90-day supply $40 copayment **MAIL ORDER** Up to a 90-day supply $40 copayment	**RETAIL** Not covered **MAIL ORDER** Not covered	•You will pay the cost of the prescription drug if it is less than the copayment •Certain brand name prescription drugs are not covered, check with Express Scripts at www.express-scripts.com •Prescription drugs do not have a deductible •If you fill the same prescription drugs in a 30-day supply quantity or less 3 times, you will pay 175% of the copayment on the 4th and consecutive fills •If you select a preferred or non-preferred brand drug when a generic is available, you pay the copayment plus the cost difference between generic and preferred or non-preferred brand •Some prescription drugs require preauthorization •Up to a 30-day supply can be filled through an Express Scripts network pharmacy for in-network benefits

Continued on next page

There is no **deductible** **to be met for** **coinsurance** to apply.

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	**RETAIL** Up to a 30-day supply $50 copayment Up to a 90-day supply $100 copayment **MAIL ORDER** Up to a 90-day supply $100 copayment	**RETAIL** Not covered **MAIL ORDER** Not covered	•Up to 90-day prescription fills are only available through Express Scripts mail order or from a Baylor, CVS, or Safeway-owned pharmacies for in-network benefits •Other limitations may apply, see SPD
	Non-preferred brand drugs	**RETAIL** Up to a 30-day supply $100 copayment Up to a 90-day $200 copayment **MAIL ORDER** Up to a 90-day supply $200 copayment	**RETAIL** Not covered **MAIL ORDER** Not covered	
	Specialty drugs	**RETAIL GENERIC** Up to a 30-day supply $20 copayment **MAIL ORDER GENERIC** Up to 90-day supply $40 copayment	Not covered	•The same limitations for generic, preferred, and non-preferred drugs above apply to Specialty drugs •Specialty drugs purchased in quantities greater than a 30-day supply must be purchased from Accredo Health or from a Baylor, CVS or a Safeway-owned pharmacy •Specialty drugs are NOT available in 90-day supply quantities when certain clinical rules or quantity restrictions apply

There is no **deductible to be met for coinsurance** to apply.

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 (Continued)	**RETAIL PREFERRED BRAND** Up to a 30-day supply $50 copayment **MAIL ORDER PREFERRED BRAND** Up to 90-day supply $100 copayment **RETAIL NON PREFERRED BRAND** Up to a 30-day supply $100 copayment **MAIL ORDER NON-PREFERRED BRAND** Up to a 90-day supply $200 copayment		
If you have outpatient surgery	Facility fee (e.g., freestanding day surgicenter)	$300 copayment	Not covered	•Outpatient surgery completed in a doctor's office will only have the Physician/surgeon fees and no facility fee
	Physician/surgeon fees	$50 copayment	Not covered	None
If you need immediate medical attention	Emergency room care	$300 copayment	$300 copayment	•$300 copayment is waived if you're admitted to hospital •$300 copayment, plus 40% coinsurance for non-emergency
	Emergency medical transportation	No cost to you	No cost to you	None
	Urgent care	$75 copayment	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment per day	Not covered	•Inpatient requires precertification •$1,500 maximum per stay

There is no **deductible to be met for coinsurance** to apply.

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)	
	Physician/surgeon fees	$50 copayment	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services for mental health, substance abuse	$15 or $50 copayment	Not covered	•If PCP office visit, PCP copayment would apply •If Specialist office visit, Specialist copayment would apply
	Outpatient services for family therapy or couples therapy			
	Inpatient services for mental health, substance abuse	$500 copayment per day	Not covered	•Inpatient requires precertification •$1,500 maximum per stay
	Employee Assistance Program (EAP)	4 visits per issue, no cost to you	Not covered	•The EAP network of providers may be different than the network of your network administrators; check with your network administrator's provider network to ensure the EAP provider participates in both networks. See SPD for details.
If you are pregnant (you, your spouse, or dependent daughter)	Office, routine prenatal care	$0 copayment	Not covered	•Non-routine prenatal care see SPD for details.
	Birth/delivery professional services	$50 copayment	Not covered	None
	Birth/delivery facility services	$500 copayment per day	Not covered	None
If you need help recovering or have other special health needs	Home health care	$50 copayment	Not covered	
	Rehabilitation services	$50 copayment	Not covered	•$500 maximum per injury/illness
	Habilitation services	Not covered	Not covered	•This plan does not cover this service, see SPD
	Skilled nursing care	$50 copayment	Not covered	•Maximum benefit is 60 days per illness or injury •$500 maximum per injury
	Durable medical equipment	20% coinsurance	Not covered	•Dollar and quantity limits may apply, see SPD
	Hospice services	$50 copayment	Not covered	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 (This is not a complete list. Please see your plan document.)

- Cosmetic surgery & treatment (elective)
- Dental care, except treatment of accidental injury
- Experimental, investigational, unproven care
- Massage therapy
- Routine eye care
- Complimentary/Alternative medicine
- Drugs not approved by the FDA
- Non-emergency care outside of the network
- Routine foot care
- Long term care
- 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.)

- 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)
- Applied Behavioral Analysis (ABA) therapy
- Clinical Trials (limits apply, see SPD)
- Hearing aids, (limits apply, see SPD)
- Private duty nursing if medically necessary
- Temporomandibular Joint Disease (TMJD) treatment (limits apply, see SPD)
- Bariatric surgery (limits apply, see SPD)
- 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, 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 Smart-Choice 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 2020, the maximum amount you can deposit into your HCFSA is $2,700.**

Health Reimbursement Account (HRA)

If you or your spouse participate in the Wellness Program and earn Wellness Rewards, American will place those reward funds in your HRA account with Alight's Smart-Choice. You can use the funds to pay for eligible health related items from your medical, prescription drugs, 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, kwiijigo 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 hospital delivery)

PEG'S COVERAGE IS EMPLOYEE-ONLY

The plan's overall deductible	$0
Specialist (routine prenatal office visits)	$0
Specialist (delivery, postnatal care)	$50
Hospital (facility)	$1,500
Anesthesiologist	$50
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	$0
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	N/A
The total Peg would pay is	**$1,600**

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	$0
Specialist (2 hospital visits)	$100
PCP office visits (4 visits)	$60
Hospital (facility – 2, 2 day stays)	$2,000
Diagnostic tests at PCP's office	$0
Prescription drugs (generic)	$160
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)	$10,000
Diagnostic tests (blood work)	$2,000
Prescription drugs	$1,000
Durable medical equipment (glucose meter)	$100
Total Example Cost	**$14,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,340
Coinsurance	$20
What isn't covered	
Limits or exclusions	N/A
The total Joe would pay is	**$2,360**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

MIA'S COVERAGE IS EMPLOYEE-ONLY

The plan's overall deductible	$0
Specialist (setting fracture, casting)	$100
Hospital (facility)	$300
Crutches	20%
X-ray at doctor's office	$0
Physical Therapy (6 visits)	$300

This EXAMPLE event includes services like:

Specialist (set fracture and follow-up)	$600
Emergency room (including medical supplies)	$1500
Diagnostic test (x-ray)	$100
Durable medical equipment (crutches)	$50
Rehabilitation services (physical therapy)	$1150
Total Example Cost	**$3,400**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$10
What isn't covered	
Limits or exclusions	N/A
The total Mia would pay is	**$710**

The plan would be responsible for the other costs of these EXAMPLE covered services.