**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?** | **$1,500/Individual**<br>**$3,000/Family** | **$4,000/Individual**<br>**$8,000/Family** | Except for preventive services, 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, the overall family deductible must be met before the 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?** | **$4,000/Individual**<br>**$8,000/Family**<br>(includes deductible) | **$12,000/Individual**<br>**$24,000/Family**<br>(includes deductible) | The out-of-pocket limit is the most you could pay in a year for covered services. Deductible and coinsurance amounts DO count toward your out-of-pocket limit. If you have other family members in the plan, the overall family out-of-pocket limit must be met. 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 individual out-of-pocket limits haven't been met by each member. No one covered person will pay more than $6,850 of the family out-of-pocket limit. |
| **What is not included in the out-of-pocket limit?** | Contributions, copayments for certain services, balance-billing charges, penalties for non-compliance, 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. |
| **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 1-800-826-9781 (UMR). |
| **Do you need a referral to see a specialist?** | **NO** | | You can see the specialist you choose without a referral. |

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

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 | 20% coinsurance | 40% coinsurance | None |
| | Specialist visit | 20% coinsurance | 40% coinsurance | None |
| | Doctor on Demand Telehealth visit | 20% coinsurance | 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) | 20% coinsurance | 40% coinsurance | None |
| | Imaging (CT, PET,MRI) scans | | | |
| **If you need prescription drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.express-scripts.com | Generic drugs<br><br>Preferred brand name drugs<br><br>Non-Preferred brand name drugs | **RETAIL**<br>20% coinsurance per fill<br><br>**MAIL ORDER**<br>20% coinsurance per fill | **RETAIL**<br>40% coinsurance per fill, but will be reimbursed based on the Express-Scripts discounted price<br><br>**MAIL ORDER**<br>Not covered | •Certain preventive prescription drugs are not subject to deductible<br>•Certain brand name prescriptions are not covered, check with Express Scripts at www.express-scripts.com<br>•Some prescription drugs require preauthorization<br>•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<br>•If you select a preferred or non-preferred brand drug when a generic is available, you pay 20% coinsurance plus the cost difference between the generic and preferred or non-preferred brand<br>•Up to a 30-day supply can be filled through an Express Scripts network pharmacy for in-network benefits<br>•Up to a 90-day supply are only available through Express Scripts mail order or from CVS or Safeway-owned pharmacies for in-network benefits<br>•Other limitations may apply, see SPD |

Continued on next page

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 | 20% coinsurance per fill | Not covered | •The same limitations for generic, preferred, and non-preferred drugs above apply to Specialty drugs<br>•Specialty drugs must be purchased from Accredo Health<br>•Specialty drugs are NOT available in a 90-day supply when certain clinical rules or quantity restrictions apply |
| **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 | 20% coinsurance | 20% coinsurance | •40% coinsurance for non-emergency out-of-network |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None |
| | 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) | 1st 4 visits, no cost to you<br>5+ visits, 20% coinsurance | Not covered | •Maximum of 1st 4 visits per issue.<br>•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.<br>•See SPD for details |
| **If you are pregnant** | Office, routine prenatal care | No cost to you | 40% 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 | 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) | |
| (you, your spouse/DP, or dependent daughter) | Birth/delivery professional services | 20% coinsurance | 40% coinsurance | None |
| | Birth/delivery facility services | 20% coinsurance | 40% coinsurance | •Inpatient requires precertification; failure to precertify, you pay $250 penalty |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 40% coinsurance | None |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | None |
| | Habilitation services | Not covered | Not covered | •Habilitation services are not covered, 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 policy or plan document for more information and a list of any other excluded services.)**

- •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 the USA
- •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)
- •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)
- •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, 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 Savings Accounts (HSA)**

The Core Option offers you the option to enroll in a Health Savings Account (HSA) administered by Alight's Smart-Choice, via pre-tax payroll deductions with UMB only or post-tax with UMB or your bank or other financial institution. You can deposit funds into this account to help pay for medical, prescription, dental, and/or vision expenses—items such as charges used to meet the annual deductible, coinsurance, other out-of-pocket expenses, etc. **Maximum federally-defined HSA contributions for 2020 are $3,550 for employee only, $7,100 for employee + family (if you're over age 55, you may contribute an additional $1,000 to your HSA).**

**Limited Purpose Flexible Spending Account (LPFSA)**

You also have the option to elect a Limited Purpose Health Care Flexible Spending Account (LPFSA) through Alight's Smart-Choice via pre-tax payroll deductions to help pay dental and vision services only, such as deductibles, coinsurance, and other out-of-pocket expenses. Through YSA, you deposit pre-tax dollars into the LPFSA via payroll deductions, and these dollars can reimburse you for the portion of dental and vision expenses that you would be responsible for paying. If you elected a LPFSA, beginning January 1, the entire amount of your elected YSA LPFSA account is available for your and your family's use. **For 2020, the maximum amount you can deposit into your LPFSA is $2,700.**

Some examples of covered expenses are listed below.

| Examples of Covered HSA Expenses (medical, dental, and vision) | | Examples of Covered LPFSA Expenses (dental and vision only) | |
|---|---|---|---|
| •Acupuncture | •Hospital Services | •Dental services (when these are not covered under a medical plan) | •Eyeglasses |
| •Blood tests | •Insulin | •Charges with balance billings | •Contact Lenses |
| •Chiropractor | •Lab tests | •Drugs and their administration | •Ophthalmologist fees |
| •Contraceptives (retail) | •Prescriptions | •Extra set of dentures/appliances | •Guide dog |
| •Diagnostic devices | •Nursing care | •Replacement of lost/stolen dentures | •Special education services for blind |
| •Hearing devices | •Wheelchairs | •Orthodontia expenses | •Vision therapy |
| •Dental expenses | •Vision expenses | | •Protective eyewear |

**This is not a complete list of covered expenses.** Please consult the SPD for a complete list of covered and non-covered services, and for information on how the HSA and LPFSA work.

**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 a hospital delivery)

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

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist (routine prenatal office visits) | $0 |
| Hospital (facility) | 20% |
| Routine lab services at Specialist office | 20% |

**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 and blood work)* | *$1,300* |
| *Specialist visit (anesthesia)* | *$1,500* |

**Total Example Cost** **$12,800**

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Copayments | $0 |
| Coinsurance | $2,160 |
| *What isn't covered* | |
| Limits or exclusions | N/A |
| **The total Peg would pay is** | **$3,660** |

### 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 | $1,500 |
| PCP office visits | 20% |
| Specialist (hospital/office visits) | 20% |
| Hospital (facility) | 20% |
| Diagnostic tests | 20% |
| Prescription drugs (generic) | 20% |

**This EXAMPLE event includes services like:**

| | |
|---|---|
| *Primary care physician office visits (including disease education)* | *$400* |
| *Specialist office visits* | *$300* |
| *Hospital (facility)* | *$5,000* |
| *Diagnostic tests (labs at doctor's office)* | *$150* |
| *Prescription drugs* | *$1,250* |
| *Durable medical equipment (glucose meter)* | *$300* |

**Total Example Cost** **$7,400**

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Copayments | $0 |
| Coinsurance | $1,180 |
| *What isn't covered* | |
| Limits or exclusions | N/A |
| **The total Joe would pay is** | **$2,680** |

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

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

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist | 20% |
| Hospital (facility) | 20% |
| Crutches | 20% |
| Physical Therapy | 20% |

**This EXAMPLE event includes services like:**

| | |
|---|---|
| *Emergency room care (including medical supplies)* | *$500* |
| *Specialist (set fracture and follow-up)* | *$600* |
| *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 | $1,500 |
| Copayments | $0 |
| Coinsurance | $80 |
| *What isn't covered* | |
| Limits or exclusions | N/A |
| **The total Mia would pay is** | **$1,580** |

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