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?	**$850/Individual** **$2,550/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**	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/. Preventive care, prescriptions and outpatient behavioral health / substance abuse are not subject to deductible / coinsurance.
Are there other deductibles for specific services?	**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)	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, 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**	If you are enrolled in OUT-OF-AREA coverage, it is because either there are not enough network providers, or there are no network providers where you reside. However, there may be instances in which you receive services from a network provider. Network providers are limited to what they can charge you for their services. For further information, consult the SPD. You can access 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.

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 Your Cost	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit	20% coinsurance	None
	Specialist visit	20% coinsurance	None
	Doctor on Demand Telehealth visit	$20 copayment	None
	Preventive care/screening/ immunization	No cost to you	•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	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 performed in a physician's office or non-hospital facility	•Charges apply if performed in a hospital
	Imaging (CT, PET,MRI) scans		
If you need prescription drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com Continued on next page	Generic drugs	**RETAIL** Up to a 30-day supply, 20% coinsurance ($10 min/$40 max per fill) Up to a 90-day supply, 20% coinsurance ($5 min/$80 max per fill) **MAIL ORDER** Up to 90-day supply, 20% coinsurance ($5 min/$80 max per fill)	•Certain brand name prescription drugs are not covered, check with Express Scripts at www.express-scripts.com •Prescription drugs are not subject to the deductible •If you fill the same prescription drug 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 prescription drugs require preauthorization •Up to a 30-day supply can be filled through an Express Scripts network pharmacy for in-network benefits •Up to 90-day prescription drugs fills are only available through Express Scripts mail order or from CVS or Safeway-owned pharmacies for in-network benefits •Prescription drugs filled at an out-of-network pharmacy may be subject to different coinsurance amounts •Other limitations may apply, see SPD
	Preferred brand drugs	**RETAIL** Up to a 30-day supply, 30% coinsurance ($30 min/$100 max per fill) Up to a 90-day supply, 30% coinsurance ($60 min/$200 max per fill) **MAIL ORDER** Up to a 90-day supply, 30% coinsurance ($60 min/$200 max per fill)	

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 Your Cost	Limitations, Exceptions, & Other Important Information
	Non-preferred brand drugs	**RETAIL** Up to a 30-day supply, 50% coinsurance ($45 min/$150 max per fill) Up to a 90-day supply, 50% coinsurance ($90 min/$300 max per fill) **MAIL ORDER** Up to a 90-day supply, 50% coinsurance ($90 min/$300 max per fill)	
	Specialty drugs	**RETAIL GENERIC** Not covered **MAIL ORDER GENERIC** Up to 90-day supply, 20% coinsurance ($5 min/$80 max per fill) **RETAIL PREFERRED BRAND** Not covered **MAIL ORDER PREFERRED BRAND** Up to a 90-day supply, 30% coinsurance ($60 min/$200 max per fill) **RETAIL NON-PREFERRED BRAND** Not covered **MAIL ORDER NON-PREFERRED BRAND** Up to a 90-day supply, 50% coinsurance ($90 min/$300 max per fill)	•The same limitations for generic, preferred, and non-preferred drugs above apply to Specialty drugs •Specialty drugs must be purchased from Accredo Health Specialty drugs are NOT available in a 90-day supply 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 Your Cost	Limitations, Exceptions, & Other Important Information
	Specialty drugs (Continued)		
If you have outpatient surgery	Facility fee (e.g., freestanding day surgicenter, doctor's office)	20% coinsurance	None
	Physician/surgeon fees	20% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	None
	Urgent care	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	•Inpatient requires precertification; failure to precertify, you pay $250 penalty
	Physician/surgeon fees	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services for mental health, substance abuse Outpatient services for family therapy or couples therapy	No cost to you	•No cost for PCP or Specialists visits •20% coinsurance for other outpatient services
	Inpatient services for mental health, substance abuse	20% coinsurance	None
	Employee Assistance Program (EAP)	1st 4 visits, no cost to you 5+ visits, No cost to you	•Maximum of 1st 4 visits per issue. •The EAP network of providers may be different than the network of your network/claim administrators •See SPD for details.
If you are pregnant (you, your spouse, or dependent daughter)	Office, routine prenatal care	No cost to you	•Non-routine prenatal care subject to deductible and coinsurance
	Birth/delivery professional services	No cost to you	None
	Birth/delivery facility services	No cost to you	•Inpatient must have precertification; failure to precertify, you

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 Your Cost	Limitations, Exceptions, & Other Important Information
			pay $250 penalty
If you need help recovering or have other special health needs	Home health care	20% coinsurance	•Limits apply, see SPD.
	Rehabilitation services	20% coinsurance	None
	Habilitation services	Not covered	•This plan does not cover this service, see SPD
	Skilled nursing care	20% coinsurance	•Maximum benefit is 60 days per illness or injury
	Durable medical equipment	20% coinsurance	•Dollar and quantity limits may apply, see SPD
	Hospice services	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	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 isn't 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 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 do not have Minimum Essential Coverage for a month, you will 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.**

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:

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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 pric 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 cos ote these coverage examples are based on self-only coverage.

(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
What isn't covered	
Limits or exclusions	N/A
The total Peg would pay is	**$2,850**

(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)**	**20%**
■ **PCP office visits (4 visits)**	**20%**
■ **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	$500
Primary Care physician (PCP) office visits (including disease education)	$1,200
Hospital (facility)	$3,600
Diagnostic tests (blood work)	$1,000
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	$0
Coinsurance	$1,510
What isn't covered	
Limits or exclusions	N/A
The total Joe would pay is	**$2,360**

(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	$0
Coinsurance	$190
What isn't covered	
Limits or exclusions	N/A
The total Mia would pay is	**$1,040**

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