





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 <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 have not yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers Doctor on Demand Telehealth visits, prescription drugs and home health care 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> ?	\$1,500/Individual \$3,000/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> ?	Contributions, <a href="#">copayments</a> for certain services, <a href="#">balance-billing</a> charges, penalties for non-compliance, and excluded expenses 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> .
Will you pay less if you use a <a href="#">network provider</a> ?	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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	YES	The <a href="#">plan</a> treats <a href="#">providers</a> the same in determining payment for the same services. You may receive a bill from the <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ) based on <a href="#">usual, reasonable and customary charges</a> . For <a href="#">prescription drugs</a> you have the choice of using <a href="#">in-network</a> or <a href="#">out-of-network providers</a> . You can access <a href="#">network provider listings</a> by visiting <a href="#">my.aa.com</a> 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).
What is the overall <a href="#">deductible</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	10% coinsurance	<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 cost share that are contingent on the services provided. See the SPD for details.</li> </ul>
	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"> <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)	10% coinsurance	
If you need drugs to treat your illness or condition  More information about <a href="http://www.express-scripts.com">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	<ul style="list-style-type: none"> <li>• Certain brand name prescription drugs are not covered, check with Express Scripts at <a href="http://www.express-scripts.com">www.express-scripts.com</a></li> <li>• Prescription drugs are not subject to the deductible</li> <li>• You must use an in-network pharmacy, out-of-network prescription drugs are not covered</li> <li>• 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</li> <li>• Covers up to 34-day supply (retail prescription drug); 35-90 day supply (mail order prescription drug)</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, unless physician indicates on the script "dispense as written"</li> <li>• Maintenance medications are required to be filled through mail order after the 3<sup>rd</sup> fill</li> <li>• Other limitations may apply, see the SPD for details</li> </ul>
		<b>MAIL ORDER</b> \$30 copayment per fill	
	Preferred brand drugs	<b>RETAIL</b> \$30 copayment per fill	
Non-preferred brand drugs	<b>MAIL ORDER</b> \$60 copayment per fill	<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)	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	

 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 have a hospital stay	Facility fee (e.g., hospital room)	10% <b>coinsurance</b>	• Inpatient requires precertification; if not precertified, you pay \$250 penalty
	Physician/surgeon fees	10% <b>coinsurance</b>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% <b>coinsurance</b>	None
	Inpatient services	10% <b>coinsurance</b>	• Inpatient requires precertification; if not precertified, you pay \$250 penalty
	Employee Assistance Program (EAP)	4 visits, per issue, No cost to you	• You must use EAP network providers, see SPD for details
If you are pregnant	Office visits	10% <b>coinsurance</b>	None
	Childbirth/delivery professional services	10% <b>coinsurance</b>	
	Childbirth/delivery facility services	10% <b>coinsurance</b>	• Inpatient requires precertification; if not precertified, you pay \$250 penalty
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>	10% <b>coinsurance</b>	• Maximum benefit of 40 visits annually for physical therapy and occupational therapy combined • Maximum benefit of 20 visits annually for speech therapy • All <b>rehabilitation</b> and <b>habilitation</b> visits count toward your <b>rehabilitation</b> visit limit
	<a href="#">Habilitation services</a>	10% <b>coinsurance</b>	
	<a href="#">Skilled nursing care</a>	10% <b>coinsurance</b>	• Maximum benefit of 60 days annually
	<a href="#">Durable medical equipment</a>	1st \$500, no cost to you Then 10% <b>coinsurance</b> after <b>deductible</b>	• <b>Preauthorization</b> required after \$500 has been paid
	<a href="#">Hospice services</a>	No cost to you after <b>deductible</b>	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"><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 diagnostic testing to determine the cause of infertility and prescription drug 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 plan document.)

- |   |   |   |
|---|---|---|
| <ul style="list-style-type: none"><li>• Acupuncture (if prescribed for rehabilitation purposes)</li></ul> | <ul style="list-style-type: none"><li>• Bariatric Surgery (limits apply, see SPD)</li><li>• Chiropractic Care (limits apply, see SPD)</li></ul> | <ul style="list-style-type: none"><li>• Dental care (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: 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](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: 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.**

### 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

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*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:**

<a href="#">Specialist</a> office visits (routine prenatal)	\$500
Childbirth/Delivery Professional Services	\$2,000
Childbirth/Delivery Facility Services	\$7,500
<a href="#">Diagnostic tests</a> (ultrasounds, blood work)	\$1,300
<a href="#">Specialist</a> visit (anesthesia)	\$1,500

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

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

<i>Cost Sharing</i>	
Deductibles	\$225
Copayments	\$0
Coinsurance	\$1,258
<i>What isn't covered</i>	
Limits or exclusions	N/A
<b>The total Peg would pay is</b>	<b>\$1,483</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) **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:**

<a href="#">Specialist</a> hospital visits	\$300
Primary Care physician (PCP) office visits (including disease education)	\$1,000
Hospital (facility)	\$3,000
<a href="#">Diagnostic tests</a> (blood work)	\$2,000
<a href="#">Prescription drugs</a>	\$1,000
Durable medical equipment (glucose meter)	\$100

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

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

<i>Cost Sharing</i>	
Deductibles	\$225
Copayments	\$120
Coinsurance	\$408
<i>What isn't covered</i>	
Limits or exclusions	N/A
<b>The total Joe would pay is</b>	<b>\$753</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) **10%**
- Hospital (facility) **10%**
- Crutches **10%**
- X-ray at doctor's office **10%**
- Physical Therapy **10%**

**This EXAMPLE event includes services like:**

<a href="#">Specialist</a> (set fracture and follow-up)	\$600
Emergency room (including medical supplies)	\$500
<a href="#">Diagnostic test</a> (x-ray)	\$100
Durable medical equipment (crutches)	\$50
Rehabilitation services (physical therapy)	\$650

**Total Example Cost \$1,900**

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

<i>Cost Sharing</i>	
Deductibles	\$225
Copayments	\$0
Coinsurance	\$163
<i>What isn't covered</i>	
Limits or exclusions	N/A
<b>The total Mia would pay is</b>	<b>\$388</b>

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