



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 \$3,000/Family	\$4,000/Individual \$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 and 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 \$8,000/Family (includes deductible)	\$12,000/Individual \$24,000/Family (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 .



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 (including telehealth)	20% coinsurance	40% coinsurance	None
	Specialist visit (including telehealth)	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			



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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)	
<p>If you need prescription drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.express-scripts.com</p>	Generic drugs	RETAIL 20% <u>coinsurance</u> per fill	RETAIL 40% <u>coinsurance</u> per fill, but will be reimbursed based on the Express-Scripts discounted price	<ul style="list-style-type: none"> • Certain preventive <u>prescription drugs</u> are not subject to <u>deductible</u> • Certain brand name <u>prescriptions</u> are not covered, check with Express Scripts at www.express-scripts.com • Some <u>prescription drugs</u> require <u>preauthorization</u> • If you fill the same <u>prescription</u> 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% <u>coinsurance</u> plus the cost difference between the generic and preferred or non-preferred brand • Up to a 30-day supply can be filled through an Express Scripts <u>network</u> pharmacy for <u>in-network</u> benefits • Up to a 90-day supply are only available through Express Scripts mail order or from CVS or Safeway-owned pharmacies for <u>in-network</u> benefits • Other limitations may apply, see SPD
	Preferred brand name drugs			
	Non-Preferred brand name drugs	MAIL ORDER 20% <u>coinsurance</u> per fill	MAIL ORDER Not covered	
	Specialty drugs	20% <u>coinsurance</u> per fill	Not covered	<ul style="list-style-type: none"> • The same limitations for generic, preferred, and non-preferred drugs above apply to <u>Specialty drugs</u> • <u>Specialty drugs</u> must be purchased from Accredo Health • <u>Specialty drugs</u> 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% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	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)	
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	•40% <u>coinsurance</u> for non-emergency <u>out-of-network</u>
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Urgent care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	•Inpatient requires precertification; failure to precertify, you pay \$250 penalty
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services for mental health, substance abuse	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Outpatient services for family therapy or couples therapy			
	Inpatient services for mental health, substance abuse			
	Employee Assistance Program (EAP)	4 visits per issue, no cost to you 5+ visits, 20% <u>coinsurance</u>	Not covered	<ul style="list-style-type: none"> •Maximum of 1st 4 visits per issue. •The EAP <u>network</u> of <u>providers</u> may be different than the <u>network</u> of your network/claim administrators; check with your network/claim administrator's <u>provider network</u> to ensure the EAP <u>provider</u> participates in both <u>networks</u>. •See SPD for details
If you are pregnant (you, your spouse/DP, or dependent daughter)	Office, routine prenatal care	No cost to you	40% <u>coinsurance</u>	None
	Birth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Birth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	•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% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Rehabilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Habilitation services	Not covered	Not covered	• <u>Habilitation services</u> are not covered, see SPD
	Skilled nursing care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	•Maximum benefit is 60 days per illness or injury



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)	
	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			

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) | •Complimentary/Alternative medicine | •Certain types of infertility care (see SPD) |
| •Dental care, except treatment of accidental injury | •Drugs not approved by the FDA | •Educational services |
| •Experimental, investigational, unproven care | •Non-emergency care outside the USA | •Custodial care |
| •Massage therapy | •Routine foot care | •Non-medically necessary services/supplies |
| •Routine eye care | •Long term care | •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 | •Applied Behavioral Analysis (ABA) therapy | •Bariatric surgery (limits apply, see SPD) |
| •Chiropractic care (limits apply, see SPD) | •Clinical Trials (limits apply, see SPD) | •Diagnostic mammograms (100% after deductible in doctor's office or non-hospital facility) |
| •Collection/cryopreservation of human female ova ("egg freezing") and in-vitro fertilization (limits apply, see SPD) | •Diagnostic colonoscopies (100% after deductible in doctor's office on non-hospital facility) | • Home health care (limits apply, see SPD) |
| •Gender Reassignment Benefits (limits apply, see SPD) | •Hearing aids, (limits apply, see SPD) | • Reconstructive surgery to repair accidental injury or removal of diseased tissue |
| •Infertility medications (limits apply, see SPD) | •Private duty nursing if medically necessary | •Telehealth visits (Doctor on Demand) |
| | •Temporomandibular Joint Disease (TMJD) treatment (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: 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 ability to enroll in a Health Savings Account (HSA) administered by Smart-Choice. Contributions to your HSA can be made via pre-tax payroll deductions or directly with UMB, your bank or other financial institution on a post-tax basis. You can use the HSA to pay for eligible medical, [prescription](#), dental, and/or vision expenses—including your annual [deductible](#), [coinsurance](#), [out-of-pocket](#) expenses such as over-the-counter items including feminine hygiene products and pain relievers. The chart on page 6 provides some examples of HSA-covered expenses. For complete information, please refer to the SPD. **Maximum federally-defined HSA contributions for 2021 are \$3,600 for employee only, \$7,200 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 an LPFSA through Smart-Choice which can be used to help pay **dental** and **vision** services only, such as [deductibles](#), [coinsurance](#), and other [out-of-pocket](#) expenses until you meet your medical deductible. Once you have met your medical deductible, the LPFSA becomes a full Health Care Flexible Spending Account, meaning you can use the funds to help pay for eligible medical and prescription expenses for the remainder of the plan year. Contributions to your LPFSA will be taken pre-tax 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 enroll in an LPFSA, the entire elected amount is available to you and your eligible dependents on January 1. **For 2021, the maximum amount you can deposit into your LPFSA is \$2,750.**

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)	
<ul style="list-style-type: none"> •Acupuncture •Blood tests •Chiropractor •Contraceptives (retail) •Diagnostic devices •Hearing devices •Dental expenses 	<ul style="list-style-type: none"> •Hospital Services •Insulin •Lab tests •Prescriptions •Nursing care •Wheelchairs •Vision expenses 	<ul style="list-style-type: none"> •Dental services (when these are not covered under a medical plan) •Charges with balance billings •Drugs and their administration •Extra set of dentures/appliances •Replacement of lost/stolen dentures •Orthodontia expenses 	<ul style="list-style-type: none"> •Eyeglasses •Contact Lenses •Ophthalmologist fees •Guide dog •Special education services for blind •Vision therapy •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, kwijjigo 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)

Managing Joe's type 2 Diabetes
(a year of routine [in-network](#) care of a well-controlled condition)

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

PEG'S COVERAGE IS EMPLOYEE-ONLY

JOE'S COVERAGE IS EMPLOYEE-ONLY

MIA'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%

- 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%

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

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

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 \$12,800

Total Example Cost \$7,400

Total Example Cost \$1,900

In this example, Peg would pay:

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

In this example, Joe would pay:

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

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$80
<i>What isn't covered</i>	
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.