



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](http://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](http://my.aa.com), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), [www.cciio.cms.gov](http://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> ?	\$850/Individual \$2,550/Family	Except for <a href="#">preventive services</a> and <a href="#">copayments</a> , each member 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. If you have other family members on the <a href="#">plan</a> , each member's <a href="#">deductible</a> applies toward the family <a href="#">deductible</a> . Once the family <a href="#">deductible</a> is met, the <a href="#">plan</a> will begin to pay for those members who have not reached their individual <a href="#">deductibles</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	YES	This <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . Covered <a href="#">preventive services</a> are listed at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . <a href="#">Preventive care</a> , <a href="#">prescriptions</a> and outpatient behavioral health / substance abuse are not subject to <a href="#">deductible</a> / <a href="#">coinsurance</a> .
Are there other <a href="#">deductibles</a> for specific services?	NO	There are no other <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$2,850/Individual \$7,550/Family  (includes <a href="#">deductible</a> )	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. <a href="#">Deductible</a> , <a href="#">copayment</a> , and <a href="#">coinsurance</a> amounts DO count toward your <a href="#">out-of-pocket limit</a> . In families of 3 or more members, if family <a href="#">out-of-pocket limit</a> is met cumulatively, expenses are payable at 100% for all family members even if the individual <a href="#">out-of-pocket limits</a> haven't been met by each member.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Contributions</a> , <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 for these expenses, they DO NOT count toward your <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	YES	If you are enrolled in OUT-OF-AREA coverage, it is because either there are not enough <a href="#">network providers</a> , or there are no <a href="#">network providers</a> where you reside. However, there may be instances in which you receive services from a <a href="#">network provider</a> . <a href="#">Network providers</a> are limited to what they can charge you for their services. For further information, consult the SPD. You can access <a href="#">network provider</a> listings by visiting <a href="http://my.aa.com">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).
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	NO	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</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	What You Will Pay	Limitations, Exceptions, & Other Important Information
		Your Cost	
<b>If you visit a health care provider's office or clinic</b>	<a href="#">Primary care</a> visit (Including Telehealth)	20% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit (Including Telehealth)	20% <a href="#">coinsurance</a>	None
	Doctor on Demand Telehealth visit	\$20 <a href="#">copayment</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No cost to you	Charges will apply for services and tests which fall outside USPSTF guidelines
<b>If you have a test at a hospital facility</b>	Diagnostic test (x-ray, labs)	20% <a href="#">coinsurance</a>	None
	Imaging (CT, PET, MRI) scans		
<b>If you have a test at the doctor's office</b>	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		
<b>If you need <a href="#">prescription drugs</a> to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	<b>RETAIL</b> Up to a 30-day supply, 20% <a href="#">coinsurance</a> (\$10 min/\$40 max per fill)  Up to a 90-day supply, 20% <a href="#">coinsurance</a> (\$5 min/\$80 max per fill)	<ul style="list-style-type: none"> <li>• Certain brand name <a href="#">prescription drugs</a> are not covered, check with Express Scripts at <a href="http://www.express-scripts.com">www.express-scripts.com</a></li> <li>• <a href="#">Prescription drugs</a> are not subject to the <a href="#">deductible</a></li> <li>• If you fill the same <a href="#">prescription drug</a> in a 30-day supply quantity or less 3 times, you will pay 50% more on the 4th and consecutive fills</li> <li>• If you select a preferred or non-preferred brand drug when a generic is available, you pay 20% <a href="#">coinsurance</a> plus the cost difference between generic and preferred or non-preferred brand</li> <li>• Some <a href="#">prescription drugs</a> require <a href="#">preauthorization</a></li> <li>• Up to a 30-day supply can be filled through an Express Scripts <a href="#">network</a> pharmacy for <a href="#">in-network</a> benefits</li> <li>• Up to 90-day <a href="#">prescription drugs</a> fills are only available through Express Scripts mail order or from CVS or Safeway-owned pharmacies for <a href="#">in-network</a> benefits</li> <li>• <a href="#">Prescription drugs</a> filled at an <a href="#">out-of-network</a> pharmacy may be subject to different <a href="#">coinsurance</a> amounts</li> <li>• Other limitations may apply, see SPD</li> </ul>
		<b>MAIL ORDER</b> Up to 90-day supply, 20% <a href="#">coinsurance</a> (\$5 min/\$80 max per fill)	
Continued on next page	Preferred brand drugs	<b>RETAIL</b> Up to a 30-day supply, 30% <a href="#">coinsurance</a> (\$30 min/\$100 max per fill)	
		Up to a 90-day supply, 30% <a href="#">coinsurance</a> (\$60 min/\$200 max per fill)	
		<b>MAIL ORDER</b> Up to a 90-day supply, 30% <a href="#">coinsurance</a> (\$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	Limitations, Exceptions, & Other Important Information
		Your Cost	
	Non-preferred brand drugs	<p><b><u>RETAIL</u></b> Up to a 30-day supply, 50% <u>coinsurance</u> (\$45 min/\$150 max per fill)</p> <p>Up to a 90-day supply, 50% <u>coinsurance</u> (\$90 min/\$300 max per fill)</p> <p><b><u>MAIL ORDER</u></b> Up to a 90-day supply, 50% <u>coinsurance</u> (\$90 min/\$300 max per fill)</p>	<ul style="list-style-type: none"> <li>• The same limitations for generic, preferred, and non-preferred drugs above apply to <u>Specialty drugs</u></li> <li>• <u>Specialty drugs</u> must be purchased from Accredo Health</li> <li>• <u>Specialty drugs</u> are NOT available in a 90-day supply when certain clinical rules or quantity restrictions apply</li> </ul>
	Specialty drugs	<p><b><u>RETAIL GENERIC</u></b> Not covered</p> <p><b><u>MAIL ORDER GENERIC</u></b> Up to 90-day supply, 20% <u>coinsurance</u> (\$5 min/\$80 max per fill)</p> <p><b><u>RETAIL PREFERRED BRAND</u></b> Not covered</p> <p><b><u>MAIL ORDER PREFERRED BRAND</u></b> Up to a 90-day supply, 30% <u>coinsurance</u> (\$60 min/\$200 max per fill)</p> <p><b><u>RETAIL NON-PREFERRED BRAND</u></b> Not covered</p> <p><b><u>MAIL ORDER NON-PREFERRED BRAND</u></b> Up to a 90-day supply, 50% <u>coinsurance</u> (\$90 min/\$300 max per fill)</p>	



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
		Your Cost	
	Specialty drugs (Continued)		
If you have outpatient surgery	Facility fee (e.g., freestanding day surgicenter, doctor's office)	20% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	• Inpatient requires precertification; failure to precertify, you pay \$250 penalty
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services for mental health, substance abuse	No cost to you	• No cost for PCP or Specialists visits • 20% coinsurance for other outpatient services
	Outpatient services for family therapy or couples therapy		
	Inpatient services for mental health, substance abuse	20% <a href="#">coinsurance</a>	None
	Employee Assistance Program (EAP)	4 visits per issue, no cost to you	• The EAP <a href="#">network</a> of <a href="#">providers</a> may be different than the <a href="#">network</a> 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 <a href="#">deductible</a> and <a href="#">coinsurance</a>
	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 pay \$250 penalty



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
		Your Cost	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	•Limits apply, see SPD.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Habilitation services</a>	Not covered	•This <a href="#">plan</a> does not cover this service, see SPD
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	•Maximum benefit is 60 days per illness or injury
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	•Dollar and quantity limits may apply, see SPD
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	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](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 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)**

You have the option to elect an HCFSA through Smart-Choice which can be used to pay for eligible medical, prescription, dental, and/or vision expenses including [deductibles](#), [coinsurance](#), [out-of-pocket](#) expenses, and over-the-counter items such as feminine hygiene products and pain relievers. Contributions to your HCFSA will be taken pre-tax via payroll deductions. If you enroll in an HCFSA, the entire elected amount of is available to you and your eligible dependents on January 1. **For 2021, the maximum amount you can deposit into your HCFSA is \$2,750.**

**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, kwijigo holne' 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.*

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**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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$850
■ <a href="#">Specialist</a> (routine prenatal office visits)	\$0
■ <a href="#">Specialist</a> (delivery, postnatal care)	20%
■ Hospital (facility)	20%
■ Anesthesiologist	20%
■ <a href="#">Diagnostic tests</a> at doctor's office	\$0

This EXAMPLE event includes services like:

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

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

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$850
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	N/A
<b>The total Peg would pay is</b>	<b>\$2,850</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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$850
■ <a href="#">Specialist</a> (2 hospital visits)	20%
■ PCP office visits (4 visits)	20%
■ Hospital (facility)	20%
■ <a href="#">Diagnostic tests</a> at PCP's office	\$0
■ <a href="#">Prescription drugs</a> (generic)	20%
■ Glucose Meter	20%

This EXAMPLE event includes services like:

<i>Specialist hospital visits</i>	\$500
<i>Primary Care physician (PCP) office visits (including disease education)</i>	\$1,200
<i>Hospital (facility)</i>	\$3,600
<i>Diagnostic tests (blood work)</i>	\$1,000
<i>Prescription drugs</i>	\$1,000
<i>Durable medical equipment (glucose meter)</i>	\$100

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

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$850
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,110
<i>What isn't covered</i>	
Limits or exclusions	N/A
<b>The total Joe would pay is</b>	<b>\$1,960</b>

### Mia's Simple Fracture

([in-network](#) [emergency room](#) visit and follow up care)

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$850
■ <a href="#">Specialist</a> (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:

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

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

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$850
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$190
<i>What isn't covered</i>	
Limits or exclusions	N/A
<b>The total Mia would pay is</b>	<b>\$1,040</b>

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