



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:
	IN-NETWORK	OUT-OF-NETWORK	
What is the overall <a href="#">deductible</a> ?	\$0/Individual \$0/Family	No Out-of-Network coverage other than emergency services. In-Network benefits apply.	This <a href="#">plan</a> will begin paying immediately and there is no <a href="#">deductible</a> . Only <a href="#">copayments</a> and <a href="#">coinsurance</a> will be required until the <a href="#">out-of-pocket limit</a> is met.
Are there services covered before you meet your <a href="#">deductible</a> ?	YES	YES	This <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</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> . In-network <a href="#">preventive care</a> and <a href="#">prescriptions</a> are not subject <a href="#">copayments</a> . No <a href="#">Out-of-network</a> <a href="#">preventive care</a> / <a href="#">prescriptions</a> are covered.
Are there other <a href="#">deductibles</a> for specific services?	NO	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> ?	\$3,500/Individual \$7,000/Family	No Out-of-Network coverage other than Emergent/Urgent & In-Network benefits apply.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. <a href="#">Copayment</a> , and <a href="#">coinsurance</a> amounts DO count toward your <a href="#">out-of-pocket limit</a> . In families of 2 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="#">Balance-billing</a> charges, 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> . This includes out of network services that are not an emergency.
Will you pay less if you use a <a href="#">network provider</a> ?	YES		This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , as these services are not covered unless a true emergency so you will pay the full cost. You can access <a href="#">in-network provider</a> listings by visiting <a href="http://dfwconnectedcare.com">dfwconnectedcare.com</a> , or call 1-888-860-6178.
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> as long as they are in-network.



There is no deductible to be met for coinsurance to apply.

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 <u>provider's</u> office or clinic	<u>Primary care</u> visit (including telehealth)	\$15 <u>copayment</u>	Not covered	None
	<u>Specialist</u> visit (including telehealth)	\$50 <u>copayment</u>	Not covered	None
	Doctor on Demand Telehealth visit	\$10 <u>copayment</u>	Not covered	None
	<u>Preventive care/screening/immunization</u>	No cost to you	Not covered	•Charges will apply for services and tests which fall outside USPSTF guidelines
If you have a test at a hospital facility	<u>Diagnostic test</u> (x-ray, labs)	\$50 <u>copayment</u>	Not covered	None
	Imaging (CT, PET, MRI) scans	\$400 <u>copayment</u>		
If you have a test at the doctor's office	<u>Diagnostic test</u> (x-ray, labs)	No cost to you	Not covered	•Charges apply if performed in a hospital
	Imaging (CT, PET, MRI) scans	\$100 <u>copayment</u>		
<p>If you need <u>prescription drugs</u> to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a></p> <p>Continued on next page</p>	Generic drugs	<p><b>RETAIL</b> Up to a 30-day supply \$20 <u>copayment</u></p> <p>Up to a 90-day supply \$40 <u>copayment</u></p> <p><b>MAIL ORDER</b> Up to a 90-day supply \$40 <u>copayment</u></p>	<p><b>RETAIL</b> Not covered</p> <p><b>MAIL ORDER</b> Not covered</p>	<ul style="list-style-type: none"> <li>•You will pay the cost of the prescription drug if it is less than the copayment</li> <li>•Certain brand name <u>prescription drugs</u> are not covered, check with Express Scripts at <a href="http://www.express-scripts.com">www.express-scripts.com</a></li> <li>•<u>Prescription drugs</u> do not have a <u>deductible</u></li> <li>•If you fill the same <u>prescription drugs</u> in a 30-day supply quantity or less 3 times, you will pay 175% of the copayment 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 the <u>copayment</u> plus the cost difference between generic and preferred or non-preferred brand</li> <li>•Some <u>prescription drugs</u> require <u>preauthorization</u></li> <li>•Up to a 30-day supply can be filled through an Express Scripts <u>network</u> pharmacy for <u>in-network</u> benefits</li> </ul>



There is no deductible to be met for coinsurance to apply.

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)	
	Preferred brand drugs	<p><b><u>RETAIL</u></b> Up to a 30-day supply \$50 <u>copayment</u></p> <p>Up to a 90-day supply \$100 <u>copayment</u></p> <p><b><u>MAIL ORDER</u></b> Up to a 90-day supply \$100 <u>copayment</u></p>	<p><b><u>RETAIL</u></b> Not covered</p> <p><b><u>MAIL ORDER</u></b> Not covered</p>	<ul style="list-style-type: none"> <li>• Up to 90-day <u>prescription</u> fills are only available through Express Scripts mail order or from a Baylor, CVS, or Safeway-owned pharmacies for <u>in-network</u> benefits</li> <li>• Other limitations may apply, see SPD</li> </ul>
	Non-preferred brand drugs	<p><b><u>RETAIL</u></b> Up to a 30-day supply \$100 <u>copayment</u></p> <p>Up to a 90-day \$200 <u>copayment</u></p> <p><b><u>MAIL ORDER</u></b> Up to a 90-day supply \$200 <u>copayment</u></p>	<p><b><u>RETAIL</u></b> Not covered</p> <p><b><u>MAIL ORDER</u></b> Not covered</p>	
	Specialty drugs	<p><b><u>RETAIL GENERIC</u></b> Up to a 30-day supply \$20 <u>copayment</u></p> <p><b><u>MAIL ORDER GENERIC</u></b> Up to 90-day supply \$40 <u>copayment</u></p>	Not covered	



There is no **deductible** to be met for **coinsurance** to apply.

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 (Continued)	<p><b><u>RETAIL PREFERRED BRAND</u></b> Up to a 30-day supply \$50 <u>copayment</u></p> <p><b><u>MAIL ORDER PREFERRED BRAND</u></b> Up to 90-day supply \$100 <u>copayment</u></p> <p><b><u>RETAIL NON PREFERRED BRAND</u></b> Up to a 30-day supply \$100 <u>copayment</u></p> <p><b><u>MAIL ORDER NON-PREFERRED BRAND</u></b> Up to a 90-day supply \$200 <u>copayment</u></p>		
If you have outpatient surgery	Facility fee (e.g., freestanding day surgicenter)	\$300 <u>copayment</u>	Not covered	• Outpatient surgery completed in a doctor's office will only have the Physician/surgeon fees and no facility fee
	Physician/surgeon fees	\$50 <u>copayment</u>	Not covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$300 <u>copayment</u>	\$300 <u>copayment</u>	<ul style="list-style-type: none"> <li>• \$300 <u>copayment</u> is waived if you're admitted to hospital</li> <li>• \$300 <u>copayment</u>, plus 40% <u>coinsurance</u> for non-emergency</li> </ul>
	<a href="#">Emergency medical transportation</a>	No cost to you	No cost to you	None
	<a href="#">Urgent care</a>	\$75 <u>copayment</u>	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copayment</u> per day	Not covered	<ul style="list-style-type: none"> <li>• Inpatient requires precertification</li> <li>• \$1,500 maximum per stay</li> </ul>



There is no **deductible** to be met for **coinsurance** to apply.

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)	
	Physician/surgeon fees	\$50 <u>copayment</u>	Not covered	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services for mental health, substance abuse	\$15 or \$50 <u>copayment</u>	Not covered	<ul style="list-style-type: none"> <li>•If PCP office visit, PCP copayment would apply</li> <li>•If <u>Specialist</u> office visit, <u>Specialist copayment</u> would apply</li> </ul>
	Outpatient services for family therapy or couples therapy			
	Inpatient services for mental health, substance abuse	\$500 <u>copayment</u> per day	Not covered	<ul style="list-style-type: none"> <li>•Inpatient requires precertification</li> <li>•\$1,500 maximum per stay</li> </ul>
	Employee Assistance Program (EAP)	4 visits per issue, no cost to you	Not covered	<ul style="list-style-type: none"> <li>•The EAP <u>network</u> of <u>providers</u> may be different than the <u>network</u> of your network administrators; check with your network administrator's <u>provider network</u> to ensure the EAP <u>provider</u> participates in both <u>networks</u>. See SPD for details.</li> </ul>
<b>If you are pregnant (you, your spouse, or dependent daughter)</b>	Office, routine prenatal care	\$0 <u>copayment</u>	Not covered	<ul style="list-style-type: none"> <li>•Non-routine prenatal care see SPD for details.</li> </ul>
	Birth/delivery professional services	\$50 <u>copayment</u>	Not covered	None
	Birth/delivery facility services	\$500 <u>copayment</u> per day	Not covered	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$50 <u>copayment</u> per day	Not covered	<ul style="list-style-type: none"> <li>•Maximum of 40 services</li> <li>•\$500 maximum per episode</li> </ul>
	<a href="#">Rehabilitation services</a>	\$50 <u>copayment</u> per visit	Not covered	<ul style="list-style-type: none"> <li>•\$500 maximum per injury/illness</li> </ul>
	<a href="#">Habilitation services</a>	Not covered	Not covered	<ul style="list-style-type: none"> <li>•This <u>plan</u> does not cover this service, see SPD</li> </ul>
	<a href="#">Skilled nursing care</a>	\$50 <u>copayment</u> per day	Not covered	<ul style="list-style-type: none"> <li>•Maximum benefit is 60 days per illness or injury</li> <li>•\$500 maximum per injury</li> <li>•Within 15 days of hospitalization</li> </ul>
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	Not covered	<ul style="list-style-type: none"> <li>•Dollar and quantity limits may apply, see SPD</li> </ul>
	<a href="#">Hospice services</a>	\$50 copayment per day	Not covered	<ul style="list-style-type: none"> <li>•\$500 maximum per episode</li> </ul>
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered by Medical	Not covered by Medical	<ul style="list-style-type: none"> <li>•Paid under Vision Benefit, if you elected it</li> <li>•Paid under Dental Benefit, if you elected it</li> </ul>
	Children's glasses			
	Children's dental check-up			

## Excluded Services & Other Covered Services:

### Services Your [plan](#) Generally Does NOT Cover (This is not 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 of the network
- 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)
- 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)
- 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 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)**

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, [copayments](#), [coinsurance](#), and [out-of-pocket](#) expenses such as over-the-counter items like 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 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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**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 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](#) \$0
- [Specialist](#) (routine prenatal office visits) \$0
- [Specialist](#) (delivery, postnatal care) \$50
- Hospital (facility – 3 days) \$500 per day
- Anesthesiologist \$50
- [Diagnostic tests](#) at doctor's office \$0

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) (2 hospital visits) \$50
- [PCP](#) office visits (4 visits) \$15
- Hospital (facility – 2, 2 day stays) \$500 per day
- [Diagnostic tests](#) at [PCP's](#) office \$0
- [Prescription drugs](#) (generic – 1 90 day) \$40
- [Glucose Meter](#) 20%

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) (2 visits - setting/casting) \$50
- Hospital (facility) \$300
- Crutches 20%
- X-ray at doctor's office \$0
- [Physical Therapy](#) (6 visits) \$50

**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

**This EXAMPLE event includes services like:**

- [Specialist](#) hospital visits \$300
- [Primary Care physician \(PCP\)](#) office visits (including disease education) \$1,000
- Hospital (facility) \$10,000
- [Diagnostic tests](#) (blood work) \$2,000
- [Prescription drugs](#) \$1,000
- [Durable medical equipment](#) (glucose meter) \$100

**This EXAMPLE event includes services like:**

- [Specialist](#) (set fracture and follow-up) \$600
- [Emergency room](#) (including medical supplies) \$1500
- [Diagnostic test](#) (x-ray) \$100
- [Durable medical equipment](#) (crutches) \$50
- [Rehabilitation services](#) (physical therapy) \$1150

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

**Total Example Cost \$14,400**

**Total Example Cost \$3,400**

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

<u>Cost Sharing</u>	
Deductibles	\$0
Copayments	\$1,600
Coinsurance	\$0

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

<u>Cost Sharing</u>	
Deductibles	\$0
Copayments	\$2,320
Coinsurance	\$20

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

<u>Cost Sharing</u>	
Deductibles	\$0
Copayments	\$700
Coinsurance	\$10

**What isn't covered**

Limits or exclusions	N/A
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**What isn't covered**

Limits or exclusions	N/A
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**What isn't covered**

Limits or exclusions	N/A
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**The total Peg would pay is \$1,600**

**The total Joe would pay is \$2,340**

**The total Mia would pay is \$710**

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