



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 <https://www.healthcare.gov/sbc-glossary> or call 1-888-860-6178 to request a copy.

| Important Questions | Answers | | Why This Matters: |
|--|---|---------------------------------------|--|
| | <u>In Network</u> | <u>Out-of-Network</u> | |
| What is the overall <u>deductible</u> ? | \$450/Individual \$900/Family | \$900/Individual \$1,800/Family | You must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> . <u>Copayments</u> do not apply toward the <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u> ? | YES | | This plan covers most items and services even if you haven't yet met the <u>deductible</u> amount, but a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers Doctor on Demand Telehealth visits, <u>prescription drugs</u> and <u>home health care</u> before you meet your <u>deductible</u> . |
| Are there other <u>deductibles</u> for specific services? | NO | | You don't have to meet any other <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this plan ? | \$3,000 Individual \$6,000 Family | \$6,000 Individual \$12,000 Family | The <u>out-of-pocket limit</u> is the most you could pay in a year for your share of the covered services. It includes <u>deductibles</u> and <u>coinsurance</u> , but it does not include <u>copayments</u> . |
| What is not included in the <u>out-of-pocket limit</u> ? | <u>Contributions</u> , <u>copayments</u> for certain services, <u>balance-billing</u> charges, penalties for non-compliance, and excluded expenses this plan does not cover | | Even though you pay these expenses, they do not count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u> ? | YES | | This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network . You will pay the most if you use an <u>out-of-network provider</u> , as you may receive a bill from the <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays (<u>balance billing</u>). You can access <u>network provider</u> 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 <u>referral</u> to see a <u>specialist</u> ? | NO | | You can see the <u>specialist</u> you choose without permission from this plan . |



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 telemedicine) | \$25 <u>copayment</u> | 40% <u>coinsurance</u> | None |
| | Specialist visit (including telemedicine) | \$40 <u>copayment</u> | 40% <u>coinsurance</u> | None |
| | Other medical practitioner visit (e.g., chiropractor) | \$40 <u>copayment</u> | 40% <u>coinsurance</u> | <ul style="list-style-type: none"> •Other medical provider (e.g., chiropractor) coverage is limited to a maximum of 20 visits annually •There may be other levels of <u>cost share</u> that are contingent on what services are provided. See the SPD for complete details. |
| | Preventive care/screening/immunization | \$25 <u>copayment</u> | Not covered | <ul style="list-style-type: none"> •There may be other levels of <u>cost share</u> that are contingent on what services are provided. See the SPD for complete details. |
| | Doctor on Demand Telehealth visit | \$20 <u>copayment</u> | Not covered | None |
| If you have a test | Diagnostic test (x-ray, labs) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | <ul style="list-style-type: none"> •There may be other levels of <u>cost share</u> that depend on how or where your care was provided. See the SPD for complete details. |
| | Imaging (CT, PET, MRIs) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |



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 prescription drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com | Generic drugs | RETAIL \$15 <u>copayment</u> per fill MAIL ORDER \$30 <u>copayment</u> per fill | Not covered | <ul style="list-style-type: none"> • Certain brand name <u>prescription drugs</u> are not covered, check with CVS Caremark at www.caremark.com • <u>Prescription drugs</u> are not subject to the <u>deductible</u> • You must use an <u>in-network</u> pharmacy • 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 • Covers up to 34-day supply (retail <u>prescription drugs</u>); 35-90 day supply (mail order <u>prescription drugs</u>) • If you select a preferred or non-preferred brand drug when a generic is available, you pay <u>copayment</u> plus the cost difference between generic and preferred or non-preferred brand, unless physician indicates on the script “dispense as written” • Maintenance medications are required to be filled through mail order after the 3rd fill • Other limitations may apply, see the SPD for details |
| | Preferred brand drugs | RETAIL \$30 <u>copayment</u> per fill MAIL ORDER \$60 <u>copayment</u> per fill | Not covered | |
| | Non-preferred brand drugs | RETAIL \$50 <u>copayment</u> per fill MAIL ORDER \$100 <u>copayment</u> per fill | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., freestanding day surgicenter, doctor’s surgical suite) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| If you need immediate medical attention | Emergency room care | \$100 <u>copayment</u> | \$100 <u>copayment</u> | • <u>Copayment</u> is waived if admitted to the hospital |
| | Emergency medical transportation | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| | Urgent care | \$40 <u>copayment</u> | 40% <u>coinsurance</u> | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | • Inpatient requires <u>preauthorization</u> ; otherwise, \$250 penalty will apply |
| | 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 mental health, behavioral health, or substance abuse services | Outpatient services | \$25 copayment | 40% coinsurance | None |
| | Inpatient services | 20% coinsurance | 40% coinsurance | |
| | Employee Assistance Program (EAP) | 4 visits, per issue at no cost to you | Not covered | •The EAP network of providers may be different than the network of your network/claim administrators; check with your network/claim administrator's provider network to ensure the EAP provider participates in both networks . See SPD for details. |
| If you are pregnant | Prenatal and postnatal care | 20% coinsurance | 40% coinsurance | •\$25 copayment for the initial visit |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | None |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | •Precertification is required. Failure to precertify, you pay \$250 penalty |
| If you need help recovering or have other special health needs | Home health care | No cost to you | Not covered | •Coverage maximum is 100 visits annually |
| | Rehabilitation services | \$40 copayment | 40% coinsurance | •Coverage maximums are for in-network and out-of-network visits combined |
| | Habilitation services | \$40 copayment | 40% coinsurance | •Coverage maximum is 40 visits annually for physical and occupational therapy combined |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | •Coverage maximum is 20 visits for speech therapy |
| | Durable medical equipment | 1 st \$500, no cost to you Then, 20% coinsurance | 40% coinsurance | • Preauthorization required after \$500 has been paid |
| | Hospice services | No cost to you after deductible | Not covered | None |
| If your child needs dental or eye care | Children's eye exam | Not covered | 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](#).)

- | | | |
|--|---|---|
| •Acupuncture | •Infertility treatment (except diagnostic testing to determine the cause of infertility and prescription drug to treat infertility) | •Weight loss programs |
| •Cosmetic Surgery | | •Routine eye care (Adult) |
| •Dental care (except for dental treatment and oral | | •Routine Foot Care (except for procedures |

| | | |
|--|---------------------------|--|
| surgery related to the mouth that is required resulting from an accident and started prior to a year after the accident) | •Glasses •Hearing aids | associated with diabetic treatment) •Long-term care |
|--|---------------------------|--|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

| | | |
|---|--|--------------------------------------|
| •Acupuncture (if prescribed for <u>rehabilitation</u> purposes) | •Bariatric surgery (limits apply, see SPD) •Chiropractic care (limits apply, see SPD) | •Dental care (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 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](#), [copayments](#), [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 is available to you and your eligible dependents on January 1. **For 2022, 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

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](#) **\$450**
- [Specialist](#) (routine prenatal office visits) **\$25 copay, then 20%**
- Hospital (facility) **20%**
- Anesthesiologist **20%**
- [Diagnostic tests](#) 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$450 |
| Copayments | \$25 |
| Coinsurance | \$2,470 |
| <i>What isn't covered</i> | |
| Limits or exclusions | N/A |
| The total Peg would pay is | \$2,945 |

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](#) **\$450**
- [Specialist](#) (hospital visits) **\$40**
- PCP office visits (4 visits) **\$25**
- Hospital (facility) **20%**
- [Diagnostic tests](#) at PCP's office **20%**
- [Prescription drugs](#) (generic) **\$15**
- Glucose Meter **20%**

This EXAMPLE event includes services like:

| | |
|---|---------|
| <i>Specialist hospital visits</i> | \$300 |
| <i>Primary Care physician (PCP) office visits (including disease education)</i> | \$1,000 |
| <i>Hospital (facility)</i> | \$3,000 |
| <i>Diagnostic tests (blood work)</i> | \$2,000 |
| <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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$450 |
| Copayments | \$260 |
| Coinsurance | \$510 |
| <i>What isn't covered</i> | |
| Limits or exclusions | N/A |
| The total Joe would pay is | \$1,220 |

Mia's Simple Fracture

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

MIA'S COVERAGE IS EMPLOYEE-ONLY

- The plan's overall [deductible](#) **\$450**
- [Specialist](#) (setting fracture, casting) **20%**
- Hospital (facility) **20%**
- Crutches **20%**
- X-ray at doctor's office **20%**
- Physical Therapy **\$40**

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$450 |
| Copayments | \$500 |
| Coinsurance | \$50 |
| <i>What isn't covered</i> | |
| Limits or exclusions | N/A |
| The total Mia would pay is | \$1,000 |

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