



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:
	IN-NETWORK	OUT-OF-NETWORK	
What is the overall <u>deductible</u> ?	\$400/Individual \$1,200/Family	\$1,550/Individual \$4,650/Family	Except for <u>preventive services</u> and <u>copayments</u> , each member must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each member's <u>deductible</u> applies toward the family <u>deductible</u> . Once the family <u>deductible</u> is met, the <u>plan</u> will begin to pay for those members who have not reached their individual <u>deductibles</u> .
Are there services covered before you meet your <u>deductible</u> ?	YES	YES	This <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . Covered <u>preventive services</u> are listed at https://www.healthcare.gov/coverage/preventive-care-benefits/ . <u>In-network preventive care</u> / <u>prescriptions</u> are not subject to <u>deductible</u> / <u>coinsurance</u> . <u>Out-of-network preventive care</u> and <u>prescriptions</u> are subject to <u>deductible</u> / <u>coinsurance</u> .
Are there other <u>deductibles</u> for specific services?	NO	NO	There are no other <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$2,400/Individual \$6,200/Family (includes <u>deductible</u>)	\$7,550/Individual \$19,650/Family (includes <u>deductible</u>)	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. <u>Deductible</u> , <u>copayment</u> , and <u>coinsurance</u> amounts DO count toward your <u>out-of-pocket limit</u> . In families of 3 or more members, if family <u>out-of-pocket limit</u> is met cumulatively, expenses are payable at 100% for all family members even if the individual <u>out-of-pocket limits</u> haven't been met by each member.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Contributions</u> , <u>balance-billing</u> charges, penalties for non-compliance, and excluded expenses this <u>plan</u> does not cover.		Even though you pay for these expenses, they DO NOT count toward your <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	YES		This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . 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 charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). You can access <u>in-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 a <u>referral</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 visit a health care provider's office or clinic	<u>Primary care</u> visit (including telemedicine)	\$25 <u>copayment</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit (including telemedicine)	\$60 <u>copayment</u>	40% <u>coinsurance</u>	None
	Telehealth visits with preferred provider	\$20 <u>copayment</u>	Not applicable	None
	<u>Preventive care/screening/immunization</u>	No cost to you	40% <u>coinsurance</u>	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% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT, PET, MRI) scans			
If you have a test at the doctor's office	Diagnostic test (x-ray, labs)	No cost to you if performed in a physician's office or non-hospital facility	40% coinsurance	Charges apply if performed in a hospital
	Imaging (CT, PET, MRI) scans			



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)	
<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 www.caremark.com</p> <p>Continued on next page</p>	Generic drugs	<p><u>RETAIL</u> Up to a 30-day supply 20% <u>coinsurance</u> (\$10 min/\$40 max per fill)</p> <p>Up to a 90-day supply 20% <u>coinsurance</u> (\$5 min/\$80 max per fill)</p> <p><u>MAIL ORDER</u> Up to 90-day supply 20% <u>coinsurance</u> (\$5 min/\$80 max per fill)</p>	<p><u>RETAIL</u> Up to a 30-day supply 20% <u>coinsurance</u> (\$10 min/\$40 max per fill) but will be reimbursed based on the Express Scripts discounted price</p> <p><u>MAIL ORDER</u> Not covered</p>	<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> • If you fill the same <u>prescription drugs</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 generic and preferred or non-preferred brand • Some <u>prescription drugs</u> require <u>preauthorization</u> • Up to a 30-day supply can be filled through a CVS Caremark <u>network</u> pharmacy for <u>in-network</u> benefits • Up to 90-day <u>prescription</u> fills are only available through CVS Caremark mail order or from CVS or Safeway-owned pharmacies for <u>in-network</u> benefits • Other limitations may apply, see SPD
	Preferred brand drugs	<p><u>RETAIL</u> Up to a 30-day supply 30% <u>coinsurance</u> (\$20 min/\$75 max per fill)</p> <p>Up to a 90-day supply 30% <u>coinsurance</u> (\$40 min/\$150 max per fill)</p> <p><u>MAIL ORDER</u> Up to a 90-day supply 30% <u>coinsurance</u> (\$40 min/\$150 max per fill)</p>	<p><u>RETAIL</u> Up to 30-day supply 30% <u>coinsurance</u> (\$20 min/\$75 max per fill) but will be reimbursed based on the CVS Caremark discounted price</p> <p><u>MAIL ORDER</u> Not covered</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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs	<p><u>RETAIL</u> Up to a 30-day supply 50% <u>coinsurance</u> (\$35 min/\$90 max per fill)</p> <p>Up to a 90-day supply 50% <u>coinsurance</u> (\$70 min/\$180 max per fill)</p> <p><u>MAIL ORDER</u> Up to a 90-day supply 50% <u>coinsurance</u> (\$70 min/\$180 max per fill)</p>	<p><u>RETAIL</u> Up to a 30-day supply 50% <u>coinsurance</u> (\$35 min/\$90 max per fill) but will be reimbursed based on the CVS Caremark discounted price</p> <p><u>MAIL ORDER</u> Not covered</p>	
	Specialty drugs	<p><u>RETAIL GENERIC</u> Not covered</p> <p><u>MAIL ORDER GENERIC</u> Up to 90-day supply 20% <u>coinsurance</u> (\$5 min/\$80 max per fill)</p> <p><u>RETAIL PREFERRED BRAND</u> Not covered</p> <p><u>MAIL ORDER PREFERRED BRAND</u> Up to a 90-day supply 30% <u>coinsurance</u> (\$40 min/\$150 max per fill)</p> <p><u>RETAIL NON-PREFERRED BRAND</u> Not covered</p>	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 CVS Specialty Pharmacy •<u>Specialty drugs</u> are NOT available in a 90-day supply when certain clinical rules or quantity restrictions apply



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)	
	Specialty drugs (Continued)	MAIL ORDER NON-PREFERRED BRAND Up to a 90-day supply 50% <u>coinsurance</u> (\$70 min/\$180 max per fill)		
If you have outpatient surgery	Facility fee (e.g., freestanding day surgicenter, doctor's office)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<ul style="list-style-type: none"> No cost to you if done in a doctor's office
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<ul style="list-style-type: none"> \$25 if done in primary care provider's office \$60 if done in specialist's office
If you need immediate medical attention	Emergency room care	\$200 <u>copayment</u> , plus 20% <u>coinsurance</u>	\$200 <u>copayment</u> , plus 20% <u>coinsurance</u>	<ul style="list-style-type: none"> \$200 <u>copayment</u> paid before <u>deductible</u> and <u>coinsurance</u> applies \$200 <u>copayment</u> is waived if you're admitted to hospital \$200 <u>copayment</u>, plus 40% <u>coinsurance</u> for non-emergency <u>out-of-network</u>
	<u>Emergency medical transportation</u>	No cost to you	No cost to you	None
	<u>Urgent care</u>	\$100 <u>copayment</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>	<ul style="list-style-type: none"> Inpatient requires precertification; failure to pre-certify, 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	\$60 <u>copayment</u>	40% <u>coinsurance</u>	<ul style="list-style-type: none"> If PCP office visit, PCP copayment would apply If <u>Specialist</u> office visit, <u>Specialist copayment</u> would apply
	Outpatient services for family therapy or couples therapy			
	Inpatient services for mental health, substance abuse	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)	
	Employee Assistance Program (EAP)	4 visits per issue, no cost to you	Not covered	<ul style="list-style-type: none"> 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, or dependent daughter)	Office, routine prenatal care	No cost to you	40% <u>coinsurance</u>	<ul style="list-style-type: none"> Non-routine prenatal care see SPD for details.
	Birth/delivery professional services	\$150 <u>copayment</u>	40% <u>coinsurance</u>	None
	Birth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<ul style="list-style-type: none"> Inpatient must have precertification; failure to pre-certify, you pay \$250 penalty
If you need help recovering or have other special health needs	<u>Home health care</u>	No cost to you	40% <u>coinsurance</u>	<ul style="list-style-type: none"> No cost to you for <u>in-network</u> benefit when approved by your network/claims administrator. Limits apply, see SPD.
	<u>Rehabilitation services</u>	\$60 <u>copayment</u>	40% <u>coinsurance</u>	None
	<u>Habilitation services</u>	Not covered	Not covered	<ul style="list-style-type: none"> This <u>plan</u> does not cover this service, see SPD
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<ul style="list-style-type: none"> Maximum benefit is 60 days per illness or injury
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<ul style="list-style-type: none"> Dollar and quantity limits may apply, see SPD
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	Not covered by Medical	Not covered by Medical	<ul style="list-style-type: none"> Paid under Vision Benefit if you elected it
	Children's glasses			<ul style="list-style-type: none"> Paid under Dental Benefit if you elected it
	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.)

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> Cosmetic surgery & treatment (elective) Dental care, except treatment of accidental injury Experimental, investigational, unproven care Massage therapy Routine eye care | <ul style="list-style-type: none"> Complimentary/Alternative medicine Drugs not approved by the FDA Non-emergency care outside the USA Routine foot care Long term care | <ul style="list-style-type: none"> 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.)

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> Acupuncture | <ul style="list-style-type: none"> Applied Behavioral Analysis (ABA) therapy | <ul style="list-style-type: none"> Bariatric surgery (limits apply, see SPD) |
|---|---|---|

- 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)
- Clinical Trials (limits apply, see SPD)
- Diagnostic colonoscopies (100% 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)
- Diagnostic mammograms (100% 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 with preferred provider

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 of is available to you and your eligible dependents on January 1. **For 2023, the maximum amount you can deposit into your HCFSA is \$2,850.**

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	\$400
■ Specialist (routine prenatal office visits)	\$0
■ Specialist (delivery, postnatal care)	\$150
■ 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	\$400
Copayments	\$150
Coinsurance	\$1,720

What isn't covered

Limits or exclusions N/A

The total Peg would pay is **\$2,270**

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	\$400
■ Specialist (2 hospital visits)	\$60
■ PCP office visits (4 visits)	\$25
■ Hospital (facility)	20%
■ Diagnostic tests at PCP's office	\$0
■ Prescription drugs (generic)	20%
■ 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	\$400
Copayments	\$220
Coinsurance	\$740

What isn't covered

Limits or exclusions N/A

The total Joe would pay is **\$1,360**

Mia's Simple Fracture

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

MIA'S COVERAGE IS EMPLOYEE-ONLY

■ The plan's overall deductible	\$400
■ Specialist (setting fracture, casting)	\$60
■ Hospital (facility)	20%
■ Crutches	20%
■ X-ray at doctor's office	\$0
■ Physical Therapy (4 visits)	\$45

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	\$400
Copayments	\$180
Coinsurance	\$50

What isn't covered

Limits or exclusions N/A

The total Mia would pay is **\$630**