




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 <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 \$4,500/Family	\$3,000/Individual \$9,000/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 deductible?	YES	NO	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="#">In-network 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> . <a href="#">Out-of-network preventive care</a> , <a href="#">prescriptions</a> and outpatient behavioral health / substance abuse are subject to <a href="#">deductible</a> / <a href="#">coinsurance</a> .
Are there other deductibles for specific services?	NO	NO	There are no other <a href="#">deductibles</a> for specific services.
What is the out-of-pocket limit for this plan?	\$4,500/Individual \$9,000/Family (includes <a href="#">deductible</a> )	\$9,000/Individual \$18,000/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 out-of-pocket limit?	<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 network provider?	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 you may receive a bill from the <a href="#">provider</a> for the difference between the <a href="#">provider's charge</a> and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). You can access <a href="#">in-network provider listings</a> 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 referral to see a specialist?	NO		You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

\*For more information about limitations and exceptions, see the [plan](#) document and SPD at [my.aa.com](http://my.aa.com).

 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)	
<b>If you visit a health care provider's office or clinic</b>	<u>Primary care</u> visit (including telemedicine)	\$25 <u>copayment</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit (including telemedicine)	\$45 <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
<b>If you have a test at a hospital facility</b>	<u>Diagnostic test</u> (x-ray, labs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT, PET, MRI) scans			
<b>If you have a test at the doctor's office</b>	<u>Diagnostic test</u> (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			
<b>If you need <u>prescription drugs</u> to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com">www.caremark.com</a>  Continued on next page	Generic drugs	<b><u>RETAIL</u></b> Up to a 30-day supply 20% <u>coinsurance</u> (\$10 min/\$40 max per fill)  Up to a 90-day supply 20% <u>coinsurance</u> (\$5 min/\$80 max per fill)  <b><u>MAIL ORDER</u></b> Up to 90-day supply 20% <u>coinsurance</u> (\$5 min/\$80 max per fill)	<b><u>RETAIL</u></b> Up to a 30-day supply 20% <u>coinsurance</u> (\$10 min/\$40 max per fill) but will be reimbursed based on the CVS Caremark discounted price  <b><u>MAIL ORDER</u></b> Not covered	<ul style="list-style-type: none"> <li>•Certain brand name <u>prescriptions</u> are not covered, check with CVS Caremark at <a href="http://www.caremark.com">www.caremark.com</a></li> <li>•<u>Prescriptions</u> are not subject to the <u>deductible</u></li> <li>•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</li> <li>•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</li> <li>•Some <u>prescriptions</u> require <u>preauthorization</u></li> <li>•Up to a 30-day supply can be filled through an CVS Caremark <u>network</u> pharmacy for <u>in-network</u> benefits</li> </ul>

	Preferred brand drugs	<p><b><u>RETAIL</u></b> Up to a 30-day supply 30% <u>coinsurance</u> (\$30 min/\$100 max per fill)</p> <p>Up to a 90-day supply 30% <u>coinsurance</u> (\$60 min/\$200 max per fill)</p> <p><b><u>MAIL ORDER</u></b> Up to a 90-day supply 30% <u>coinsurance</u> (\$60 min/\$200 max per fill)</p>	<p><b><u>RETAIL</u></b> Up to 30-day supply 30% <u>coinsurance</u> (\$30 min/\$100 max per fill) but will be reimbursed based on the CVS Caremark discounted price</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 CVS Caremark mail order or from 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 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>	<p><b><u>RETAIL</u></b> Up to a 30-day supply 50% <u>coinsurance</u> (\$45 min/\$150 max per fill) but will be reimbursed based on the CVS Caremark discounted price</p> <p><b><u>MAIL ORDER</u></b> Not covered</p>	
	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></p>	Not covered	<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 CVS Specialty Pharmacy 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 (Continued)	Up to a 90-day supply 30% <u>coinsurance</u> (\$60 min/\$200 max per fill)  <b><u>RETAIL NON-PREFERRED BRAND</u></b> Not covered  <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)		
<b>If you have outpatient surgery</b>	Facility fee (e.g., freestanding day surgicenter, doctor's office)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	•\$25 copay if done in a primary care provider's office
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	•\$25 copay if done in a primary care provider's office
<b>If you need immediate medical attention</b>	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"> <li>•\$200 <u>copayment</u> paid before <u>deductible</u> and <u>coinsurance</u> applies</li> <li>•\$200 <u>copayment</u> is waived if you're admitted to hospital</li> <li>•\$200 <u>copayment</u>, plus 40% <u>coinsurance</u> for non-emergency <u>out-of-network</u></li> </ul>
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	• <u>In-network deductible</u> applies
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	•Inpatient requires precertification for out-of-network hospitalization; failure to pre-authorization, you pay \$250 penalty
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services for mental health, substance abuse	No cost to you	40% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>•No cost for PCP or Specialists visits</li> <li>•20% <u>coinsurance</u> for other outpatient services</li> </ul>
	Outpatient services for family therapy or couples therapy			
	Inpatient services for mental health, substance abuse	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

	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/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.</li> </ul>
<b>If you are pregnant (you, your spouse, or dependent daughter)</b>	Office, routine prenatal care	No cost to you	40% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>Non-routine prenatal care, see SPD for details.</li> </ul>
	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>	<ul style="list-style-type: none"> <li>Inpatient must have precertification for delivery stays over 48 hours for a normal delivery and 96 hours for a c-section; failure to precertify, you pay \$250 penalty – Penalty only applies to OON</li> </ul>
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>Limits apply, see SPD</li> </ul>
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Habilitation services</u>	Not covered	Not covered	<ul style="list-style-type: none"> <li>The <u>plan</u> does not cover this service, see SPD</li> </ul>
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>Maximum benefit is 60 days per illness or injury</li> </ul>
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>Dollar and quantity limits may apply, see SPD</li> </ul>
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<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> </ul>
	Children's glasses			<ul style="list-style-type: none"> <li>Paid under Dental Benefit if you elected it</li> </ul>
	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"><li>•Cosmetic surgery &amp; treatment (elective)</li><li>•Dental care, except treatment of accidental injury</li><li>•Experimental, investigational, unproven care</li><li>•Massage therapy</li><li>•Routine eye care</li></ul> | <ul style="list-style-type: none"><li>•Complimentary/Alternative medicine</li><li>•Drugs not approved by the FDA</li><li>•Non-emergency care outside the USA</li><li>•Routine foot care</li><li>•Long term care</li></ul> | <ul style="list-style-type: none"><li>•Certain types of infertility care (see SPD)</li><li>•Educational services</li><li>•Custodial care</li><li>•Non-medically necessary services/supplies</li><li>•Weight loss programs unless for morbid obesity</li></ul> |
|---|---|---|

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

- |   |   |   |
|---|---|---|
| <ul style="list-style-type: none"><li>•Acupuncture</li><li>•Chiropractic care (limits apply, see SPD)</li><li>•Collection/cryopreservation of human female ova (“egg freezing”) and in-vitro fertilization (limits apply, see SPD)</li><li>•Gender Reassignment Benefits (limits apply, see SPD)</li><li>•Infertility medications (limits apply, see SPD)</li></ul> | <ul style="list-style-type: none"><li>•Applied Behavioral Analysis (ABA) therapy</li><li>•Clinical Trials (limits apply, see SPD)</li><li>•Diagnostic colonoscopies (100% in doctor’s office on non-hospital facility)</li><li>•Hearing aids, (limits apply, see SPD)</li><li>•Private duty nursing if <u>medically necessary</u></li><li>•Temporomandibular Joint Disease (TMJD) treatment (limits apply, see SPD)</li></ul> | <ul style="list-style-type: none"><li>•Bariatric surgery (limits apply, see SPD)</li><li>•Diagnostic mammograms (100% in doctor’s office or non-hospital facility)</li><li>•<u>Home health care</u> (limits apply, see SPD)</li><li>•<u>Reconstructive surgery</u> to repair accidental injury or removal of diseased tissue</li><li>•Telehealth visits with a preferred provider</li></ul> |
|---|---|---|

**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 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

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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 a hospital delivery)

**PEG'S COVERAGE IS EMPLOYEE-ONLY**

■ The plan's overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> (routine prenatal office visits)	\$0
■ <u>Specialist</u> (delivery, postnatal care)	20%
■ Hospital (facility)	20%
■ Anesthesiologist	20%
■ <u>Diagnostic tests</u> 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	\$1,500
Copayments	\$0
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	N/A
<b>The total Peg would pay is</b>	<b>\$3,500</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 plan's overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> (2 hospital visits)	\$45
■ PCP office visits (4 visits)	\$25
■ Hospital (facility)	20%
■ <u>Diagnostic tests</u> at PCP's office	\$0
■ <u>Prescription drugs</u> (generic)	20%
■ Glucose Meter	20%

**This EXAMPLE event includes services like:**

<i>Specialist hospital visits</i>	\$90
<i>Primary Care physician (PCP) office visits (including disease education)</i>	\$100
<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	\$1,500
Copayments	\$190
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	N/A
<b>The total Joe would pay is</b>	<b>\$2,290</b>

**Mia's Simple Fracture**

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

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

■ The plan's overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> (setting fracture, casting)	\$45
■ 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:**

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$45
Coinsurance	\$170
<i>What isn't covered</i>	
Limits or exclusions	N/A
<b>The total Mia would pay is</b>	<b>\$1,120</b>

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