





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:
What is the overall <u>deductible</u> ?	\$450/Individual \$900/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. <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 some items and services even if you have not yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers Telehealth visits with preferred provider, prescription drugs and <u>home health care</u> before you meet your <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	NO	You do not have to meet any other <u>deductible</u> for specific services.
What is the <u>out-of-pocket limit</u> for this plan ?	\$3,000/Individual \$6,000/Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. The <u>out-of-pocket limit</u> includes the <u>deductible</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> ?	Contributions, <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	The plan treats <u>providers</u> the same in determining payment for the same services. 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>) based on <u>usual, reasonable and customary charges</u> . For <u>prescription drugs</u> you have the choice of using <u>in-network</u> or <u>out-of-network providers</u> . You can access <u>network provider listings</u> 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	Network Provider	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit (including telehealth)	20% <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 the services provided. See the SPD for details.
	Specialist visit (including telehealth)	20% <u>coinsurance</u>	
	Preventive care/screening/immunization	20% <u>coinsurance</u>	
	Other medical practitioner (e.g., chiropractor)	20% <u>coinsurance</u>	
	Telehealth visits with preferred provider	\$20 <u>copayment</u>	
If you have a test	Diagnostic test (x-ray, labs)	20% <u>coinsurance</u>	<ul style="list-style-type: none"> The amount you pay may be different depending on how/where your care was provided. See the SPD for complete details.
	Imaging (CT, PET, MRIs)	20% <u>coinsurance</u>	
If you need prescription drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic drugs	RETAIL \$15 <u>copayment</u> per fill	<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, <u>out-of-network prescription drugs</u> are not covered 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 drug</u>); 35-90 day supply (mail order <u>prescription drug</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
		MAIL ORDER \$30 <u>copayment</u> per fill	
	Preferred brand drugs	RETAIL \$30 <u>copayment</u> per fill	
Non-preferred brand drugs	MAIL ORDER \$60 <u>copayment</u> per fill		
	RETAIL \$50 <u>copayment</u> per fill		
If you have outpatient surgery	Facility fee (e.g., freestanding day surgicenter, doctor's surgical suite)	MAIL ORDER \$100 <u>copayment</u> per fill	None
		20% <u>coinsurance</u>	
	Physician/surgeon fees	20% <u>coinsurance</u>	
	Emergency room care	20% <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	Network Provider	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	
	<u>Urgent care</u>	20% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	• Inpatient requires precertification; if not precertified, you pay \$250 penalty
	Physician/surgeon fees	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	• Inpatient requires precertification; if not precertified, you pay \$250 penalty
	Employee Assistance Program (EAP)	4 visits, per issue at no cost to you	• You must use EAP <u>network providers</u> . See the SPD for details.
If you are pregnant	Office visits	20% <u>coinsurance</u>	
	Childbirth/delivery professional services	20% <u>coinsurance</u>	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	• Inpatient requires precertification; if not precertified, you pay \$250 penalty
If you need help recovering or have other special health needs	<u>Home health care</u>	No cost to you	• Maximum benefit of 100 visits annually
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	• Maximum benefit of 40 visits annually for physical therapy and occupational therapy combined
	<u>Habilitation services</u>	20% <u>coinsurance</u>	• Maximum benefit of 20 visits annually for speech therapy
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	• All <u>rehabilitation</u> and <u>habilitation</u> visits count toward your <u>rehabilitation</u> visit limit
	<u>Durable medical equipment</u>	1 st \$500, no cost to you, then 20% <u>coinsurance</u> after <u>deductible</u>	• <u>Preauthorization</u> required after \$500 has been paid
	<u>Hospice services</u>	No cost to you after annual deductible	None
If your child needs dental or eye care	Children's eye exam		
	Children's glasses	Not covered	None
	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">• Acupuncture• Cosmetic Surgery• Dental Care (except for treatment and surgery of the mouth necessitated by accident and is started prior to one year after the accident) | <ul style="list-style-type: none">• Glasses• Hearing Aids• Infertility treatments (except <u>diagnostic testing</u> to determine the cause of infertility and <u>prescription drug</u> to treat infertility)• Long-term Care | <ul style="list-style-type: none">• Routine eye care (Adult)• Routine Foot Care (except for procedures associated with diabetic treatment)• Weight loss programs |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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">• Acupuncture (if prescribed for <u>rehabilitation</u> purposes) | <ul style="list-style-type: none">• Bariatric Surgery (limits apply, see SPD)• Chiropractic Care (limits apply, see SPD) | <ul style="list-style-type: none">• 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 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** \$450
- **Specialist** (routine prenatal office visits) 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	\$0
Coinsurance	\$2,470
<i>What isn't covered</i>	
Limits or exclusions	N/A
The total Peg would pay is	\$2,920

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) 20%
- PCP office visits (4 visits) 20%
- Hospital (facility) 20%
- **Diagnostic tests** at PCP's office \$0
- **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	\$120
Coinsurance	\$770
<i>What isn't covered</i>	
Limits or exclusions	N/A
The total Joe would pay is	\$1,340

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 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	\$450
Copayments	\$0
Coinsurance	\$280
<i>What isn't covered</i>	
Limits or exclusions	N/A
The total Mia would pay is	\$730

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