





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:
What is the overall <u>deductible</u> ?	\$225/Individual \$450/Family	You must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <a href="#">plan</a> 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 <a href="#">plan</a> 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 don't have to meet any other <u>deductible</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <a href="#">plan</a> ?	\$1,500/Individual \$3,000/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> ?	<u>Contributions</u> , <u>copayments</u> for certain services, <u>balance-billing</u> charges, penalties for non-compliance, and excluded expenses this <a href="#">plan</a> 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 <a href="#">plan</a> 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 <a href="#">plan</a> pays ( <u>balance billing</u> ) based on <u>usual, reasonable and customary</u> charges. For <u>prescription drugs</u> you have the choice of using <u>in-network</u> or <u>out-of-network</u> providers. You can access <u>network provider</u> listings 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 <u>referral</u> to see a <u>specialist</u> ?	NO	You can see the <u>specialist</u> you choose without permission from this <a href="#">plan</a> .

 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 telemedicine)	10% <a href="#">coinsurance</a>	<ul style="list-style-type: none"> <li>Other medical provider (e.g., chiropractor) coverage is limited to a maximum of 20 visits annually</li> <li>There may be other levels of <a href="#">cost share</a> that are contingent on the services provided. See the SPD for details.</li> </ul>
	Specialist visit (including telemedicine)	10% <a href="#">coinsurance</a>	
	Preventive care/screening/immunization	10% <a href="#">coinsurance</a>	
	Other medical practitioner (e.g., chiropractor)	10% <a href="#">coinsurance</a>	
	Telehealth visits with preferred provider	\$20 <a href="#">copayment</a>	
If you have a test	Diagnostic test (x-ray, labs)	10% <a href="#">coinsurance</a>	<ul style="list-style-type: none"> <li>The amount you pay may be different depending on how/where your care was provided. See the SPD for complete details.</li> </ul>
	Imaging (CT, PET, MRIs)	10% <a href="#">coinsurance</a>	
If you need prescription drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs	<b>RETAIL</b> \$15 <a href="#">copayment</a> per fill	<ul style="list-style-type: none"> <li>Certain brand name <a href="#">prescription drugs</a> are not covered, check with CVS Caremark at <a href="http://www.caremark.com">www.caremark.com</a></li> <li><a href="#">Prescription drugs</a> are not subject to the <a href="#">deductible</a></li> <li>You must use an <a href="#">in-network</a> pharmacy, <a href="#">out-of-network prescription drugs</a> are not covered</li> <li>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</li> <li>Covers up to 34-day supply (retail <a href="#">prescription drug</a>); 35-90 day supply (mail order <a href="#">prescription drug</a>)</li> <li>If you select a preferred or non-preferred brand drug when a generic is available, you pay <a href="#">copayment</a> plus the cost difference between generic and preferred or non-preferred brand, unless physician indicates on the script "dispense as written"</li> <li>Maintenance medications are required to be filled through mail order after the 3<sup>rd</sup> fill</li> <li>Other limitations may apply, see the SPD for details</li> </ul>
		<b>MAIL ORDER</b> \$30 <a href="#">copayment</a> per fill	
	Preferred brand drugs	<b>RETAIL</b> \$30 <a href="#">copayment</a> per fill	
<b>MAIL ORDER</b> \$60 <a href="#">copayment</a> per fill			
Non-preferred brand drugs	<b>RETAIL</b> \$50 <a href="#">copayment</a> per fill		
	<b>MAIL ORDER</b> \$100 <a href="#">copayment</a> per fill		
If you have outpatient surgery	Facility fee (e.g., freestanding day surgicenter, doctor's surgical suite)	10% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	None
If you need	Emergency room care	10% <a href="#">coinsurance</a>	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
immediate medical attention	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	
	<u>Urgent care</u>	10% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	• Inpatient requires precertification; if not precertified, you pay \$250 penalty
	Physician/surgeon fees	10% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% <u>coinsurance</u>	None
	Inpatient services	10% <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 SPD for details
If you are pregnant	Office visits	10% <u>coinsurance</u>	None
	Childbirth/delivery professional services	10% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <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>	10% <u>coinsurance</u>	• Maximum benefit of 40 visits annually for physical therapy and occupational therapy combined
	<u>Habilitation services</u>	10% <u>coinsurance</u>	• Maximum benefit of 20 visits annually for speech therapy
	<u>Skilled nursing care</u>	10% <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>	1st \$500, no cost to you Then 10% <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 <u>deductible</u>	None
If your child needs dental or eye care	Children's eye exam	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](#).)

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic Surgery</li><li>• Dental Care (except for treatment and surgery of the mouth necessitated by accident and is started prior to one year after the accident)</li></ul> | <ul style="list-style-type: none"><li>• Glasses</li><li>• Hearing Aids</li><li>• Infertility treatments (except <u>diagnostic testing</u> to determine the cause of infertility and <u>prescription drug</u> to treat infertility)</li><li>• Long-term Care</li></ul> | <ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Routine Foot Care (except for procedures associated with diabetic treatment)</li><li>• Weight loss programs</li></ul> |
|---|---|--|

### 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"><li>• Acupuncture (if prescribed for <u>rehabilitation</u> purposes)</li></ul> | <ul style="list-style-type: none"><li>• Bariatric Surgery (limits apply, see SPD)</li><li>• Chiropractic Care (limits apply, see SPD)</li></ul> | <ul style="list-style-type: none"><li>• Dental care (limits apply, see SPD)</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 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.*

**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](#) \$225
- [Specialist](#) (routine prenatal office visits) 10%
- Hospital (facility) 10%
- Anesthesiologist 10%
- [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>	
<a href="#">Deductibles</a>	\$225
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,258
<i>What isn't covered</i>	
Limits or exclusions	N/A
<b>The total Peg would pay is</b>	<b>\$1,483</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 [deductible](#) \$225
- [Specialist](#) (hospital visits) 10%
- PCP office visits (4 visits) 10%
- Hospital (facility) 10%
- [Diagnostic tests](#) at PCP's office \$0
- [Prescription drugs](#) (generic) \$15
- [Glucose Meter](#) 10%

**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>	
<a href="#">Deductibles</a>	\$225
<a href="#">Copayments</a>	\$120
<a href="#">Coinsurance</a>	\$408
<i>What isn't covered</i>	
Limits or exclusions	N/A
<b>The total Joe would pay is</b>	<b>\$753</b>

**Mia's Simple Fracture**

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

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

- The plan's overall [deductible](#) \$225
- [Specialist](#) (setting fracture, casting) 10%
- Hospital (facility) 10%
- Crutches 10%
- X-ray at doctor's office 10%
- Physical Therapy 10%

**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>	
<a href="#">Deductibles</a>	\$225
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$163
<i>What isn't covered</i>	
Limits or exclusions	N/A
<b>The total Mia would pay is</b>	<b>\$388</b>

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