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 deductible?	**$225/Individual** **$450/Family**	**$450/Individual** **$900/Family**	You must pay all of the costs from providers up to the deductible 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 deductible. Copayments do not apply toward the deductible.
Are there services covered before you meet your deductible?	**YES**		This plan covers some items and services even if you haven't yet met the deductible amount, but a copayment or coinsurance may apply. For example, this plan covers Telehealth visits with a preferred provider, prescription drugs and home health care before you meet your deductible.
Are there other deductibles for specific services?	**NO**		You don't have to meet any other deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$1,500** Individual **$3,000** Family	**$3,000** Individual **$6,000** Family	The out-of-pocket limit is the most you could pay in a year for your share of the covered services. It includes deductibles and coinsurance, but it does not include copayments.
What is not included in the out-of-pocket limit?	Contributions, copayments for certain services, balance-billing 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 out–of–pocket limit.
Will you pay less if you use a network provider?	**YES**		This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, as you may receive a bill from the provider for the difference between the provider's charge and what your plan pays (balance billing). You can access network provider 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 referral to see a specialist?	**NO**		You can see the specialist you choose without permission from this plan.

*For more information about limitations and exceptions, see the plan document and SPD at 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)	
If you visit a health care provider's office or clinic	Primary care visit (Including telemedicine)	$25 copayment	30% coinsurance	None
	Specialist visit (including telemedicine)	$40 copayment	30% coinsurance	None
	Other medical practitioner visit (e.g., chiropractor)	$40 copayment	30% coinsurance	• Other medical provider (e.g., chiropractor) coverage is limited to a maximum of 20 visits annually. • There may be other levels of cost share that are contingent on what services are provided. See the SPD for complete details.
	Preventive care/screening/ immunization	$25 copayment	Not covered	There may be other levels of cost share that are contingent on what services are provided. See the SPD for complete details.
	Telehealth visits with preferred provider	$20 copayment	Not covered	None
If you have a test	Diagnostic test (x-ray, labs)	10% coinsurance	30% coinsurance	There may be other levels of cost share that depend on how or where your care was provided. See the SPD for complete details.
	Imaging (CT, PET, MRIs)	10% coinsurance	30% coinsurance	

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 copayment per fill **MAIL ORDER** $30 copayment per fill	Not covered	• Certain brand name prescription drugs are not covered, check with CVS Caremark at www.caremark.com • Prescription drugs are not subject to the deductible • You must use an in-network 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 prescription drugs); 35-90 day supply (mail order prescription drugs) • If you select a preferred or non-preferred brand drug when a generic is available, you pay copayment 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 copayment per fill **MAIL ORDER** $60 copayment per fill	Not covered	
	Non-preferred brand drugs	**RETAIL** $50 copayment per fill **MAIL ORDER** $100 copayment per fill	Not covered	
If you have outpatient surgery	Facility fee (e.g., freestanding day surgicenter, doctor's surgical suite)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copayment	$100 copayment	Copayment is waived if admitted to the hospital
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$40 copayment	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Inpatient requires preauthorization; otherwise, $250 penalty will apply
	Physician/surgeon fees	10% coinsurance	30% coinsurance	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	30% coinsurance	None
	Inpatient services	10% coinsurance	30% 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	10% coinsurance	30% coinsurance	$25 copayment for the initial visit
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	30% 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	30% coinsurance	• Coverage maximums are for in-network and out-of-network visits combined. • Coverage maximum is 40 visits annually for physical and occupational therapy combined. • Coverage maximum is 20 visits for speech therapy
	Habilitation services	$40 copayment	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	Coverage maximum is 60 days annually, for both in-network and out-of-network facilities combined
	Durable medical equipment	1st $500, no cost to you Then, 10% coinsurance after deductible	30% coinsurance	Preauthorization required after $500 has been paid
	Hospice services	No cost 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
- Cosmetic Surgery
- Dental care (except for dental treatment and oral surgery related to the mouth that is required resulting from an accident and started prior to a year after the accident)
- Infertility treatment (except diagnostic testing to determine the cause of infertility and prescription drug to treat infertility)
- Glasses
- Hearing aids
- Weight loss programs
- Routine eye care (Adult)
- Routine Foot Care (except for procedures 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 rehabilitation purposes)
- Bariatric surgery (limits apply, see SPD)
- Chiropractic care (limits apply, see SPD)
- Dental care (limits apply, see SPD)
- Joint and spine surgeries (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 2024, the maximum amount you can deposit into your HCFSA is $3,050.**

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, kwiijigo 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, copayments and coinsurance) 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)	**$25 copay, then 10%**
Hospital (facility)	**10%**
Anesthesiologist	**10%**
Diagnostic tests at doctor's office	**$0**

This EXAMPLE event includes services like:

Specialist office visits (routine prenatal)	$500
Childbirth/Delivery Professional Services	$2,000
Childbirth/Delivery Facility Services	$7,500
Diagnostic tests (ultrasounds, blood work)	$1,300
Specialist visit (anesthesia)	$1,500

Total Example Cost $12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$225
Copayments	$25
Coinsurance	$1,235
What isn't covered	
Limits or exclusions	N/A

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)	**$40**
PCP office visits (4 visits)	**$25**
Hospital (facility)	**10%**
Diagnostic tests at PCP's office	**10%**
Prescription drugs (generic)	**$15**
Glucose Meter	**10%**

This EXAMPLE event includes services like:

Specialist hospital visits	$300
Primary Care physician (PCP) office visits (including disease education)	$1,000
Hospital (facility)	$3,000
Diagnostic tests (blood work)	$2,000
Prescription drugs	$1,000
Durable medical equipment (glucose meter)	$100

Total Example Cost $7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$225
Copayments	$260
Coinsurance	$278
What isn't covered	
Limits or exclusions	N/A

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	**$40**

This EXAMPLE event includes services like:

Specialist (set fracture and follow-up)	$600
Emergency room (including medical supplies)	$500
Diagnostic test (x-ray)	$100
Durable medical equipment (crutches)	$50
Rehabilitation services (physical therapy)	$650

Total Example Cost $1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$225
Copayments	$500
Coinsurance	$48
What isn't covered	
Limits or exclusions	N/A

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

The total Peg would pay is	**$1,485**	**The total Joe would pay is**	**$763**	**The total Mia would pay is**	**$773**