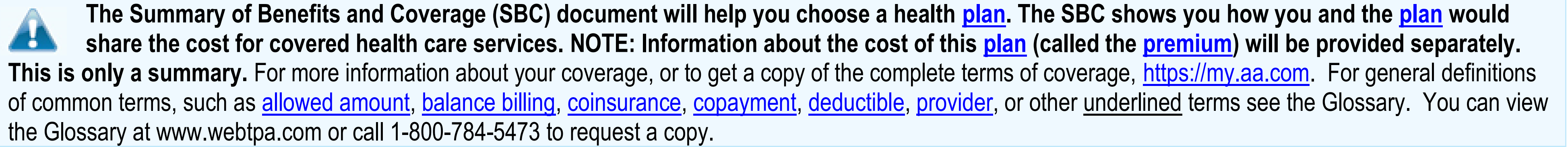
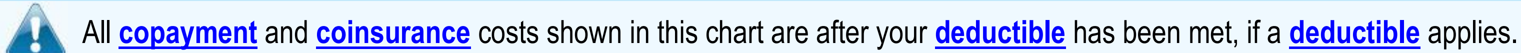


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://my.aa.com. 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 www.webtpa.com or call 1-800-784-5473 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0/Individual or $0/family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes, because there is no deductible on this plan.	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 certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,500 individual / $7,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out–of–pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://dfwconnectedcare.com or call 1-800-784-5473 for a list of network providers.	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, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.


All copayment and 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 to treat an injury or illness	$15 copayment	Not Covered	Includes lab/basic x-ray, injections, and in office surgery. $10 copayment for telehealth office visit provided by Doctor on Demand.
	Specialist visit	$50 copayment	Not Covered	Includes lab/basic x-ray, injections, and in office surgery.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	**PCP:** $15 copayment **Specialist:** $50 copayment	Not Covered	None
	Imaging (CT/PET scans, MRIs)	**Hospital:** $400 copayment **Freestanding Facility:** $100 copayment	Not Covered	Preauthorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	**Retail:** 30-day supply $20 copayment **Mail Order:** Up to 90-day supply $40 copayment	Not Covered	• You will pay the cost of the prescription drug if it is less than the copayment/coinsurance. • Certain brand name prescription drugs are not covered, check with CVS Caremark at www.caremark.com. • Prescription drugs do not have a deductible. • If you fill the same prescription drugs in a 30-day supply quantity or less 3 times, you will pay 175% of the copayment or 100% of the drug cost, whichever is lesser, on the 4th consecutive fill. • If you select a preferred or non-preferred brand drug when a generic is available,
	Preferred brand drugs	**Retail:** 30-day supply 30% coinsurance ($30 min/$100 max) **Mail Order:** Up to 90-day supply 30% coinsurance ($60 min/$200 max)	Not Covered	
	Non-preferred brand drugs	**Retail:** 30-day supply 50% coinsurance ($45 min/$150 max) **Mail Order:** Up to 90-day supply 50% coinsurance ($90 min/$300 max)	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at https://my.aa.com.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Specialty drugs	**Generic: 30-day supply** $20 copayment **/ 90-day supply** $40 copayment **Preferred Brand: 30-day supply** 30% coinsurance ($30 min/$100 max) / **90-day supply** 30% coinsurance ($60 min/$200 max) **Non-Preferred Brand: 30-day supply** 50% coinsurance ($45 min/$150 max) / **90-day supply** 50% coinsurance ($90 min/$300 max)	Not Covered	you pay the copayment plus the cost difference between the generic and preferred or non-preferred brand. • Some prescription drugs require pre-authorization. • Up to a 30-day supply can be filled through a CVS Caremark network pharmacy for network benefits. • Up to 90-day prescription fills are only available through CVS Caremark mail order or from Baylor, CVS, Costco, Kroger, or Safeway-owned pharmacies for network benefits. • Specialty drugs on the PrudentRx list are $0 for participating members. • **Specialty drugs must be purchased from CVS Specialty pharmacy** Other limitations may apply, see SPD.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copayment	Not Covered	Preauthorization is required.
	Physician/surgeon fees	**Surgery in office by PCP:** $15 copayment **All others:** $50 copayment	Not Covered	One copayment per provider per day. Preauthorization is required for outpatient surgeries not done in a physician office setting.
If you need immediate medical attention	Emergency room care	**True Emergency:** $300 copayment **Non-Emergency:** $300 copayment then 40% coinsurance	**True Emergency:** $300 copayment **Non-Emergency:** $300 copayment then 40% coinsurance	Waived if admitted. Preauthorization is required for Emergency care over 48 hours.
	Emergency medical transportation	No Charge	No Charge	Applies to ground and air ambulance. Preauthorization is required for non-emergency air ambulance.

* For more information about limitations and exceptions, see the plan or policy document at https://my.aa.com.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Urgent care	$75 copayment OR $15 copayment at select BS&W locations	Not Covered	Includes lab/basic x-ray and other charges made by the Urgent Care Clinic.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment per day	Not Covered	Member responsibility is up to $1,500 max per stay. Preauthorization is required.
	Physician/surgeon fees	$50 copayment	Not Covered	Preauthorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**PCP:** $15 copayment **Specialist:** $50 copayment	Not Covered	One copayment per provider per day. Preauthorization is required for certain outpatient services.
	Inpatient services	$500 copayment per day	Not Covered	Member responsibility is up to $1,500 max per stay. Preauthorization is required.
If you are pregnant	Office visits	No Charge	Not Covered	• Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment, coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). • Doulas covered 100% up to $2,000 per birth; member must pay upfront and submit a claim for reimbursement. Only certified through DONA International and Nation Black Doulas Association are covered. • Midwife, plan pays at 100% for global fees and delivery fees. • Birthing Centers inpatient $500 copayment, $1,500 maximum; outpatient $300 copayment. • Dependent pregnancy is covered.
	Childbirth/delivery professional services	$50 copayment	Not Covered	
	Childbirth/delivery facility services	$500 copayment per day	Not Covered	
If you need help recovering or have other special health	Home health care	$50 copayment	Not Covered	Member responsibility up to $500 maximum per episode, 40 maximum per services per year. Preauthorization is required.

* For more information about limitations and exceptions, see the plan or policy document at https://my.aa.com.

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)	
needs	Rehabilitation services	$50 copayment	Not Covered	Member responsibility up to $500 maximum per episode. Preauthorization is required after 12 visits or 30 days from initial visit in in duration, whichever is less.
	Habilitation services	**PCP:** $15 copayment/ **Specialist:** $50 copayment	Not Covered	• ABA Therapy (subject to SPD terms) • No limit for Speech, Physical, or Occupational therapy as it relates to autism. • Speech/Occupational/Physical therapy: Restorative and Rehabilitative Care and treatment for Loss or Impairment of Speech/Occupational/Physical functionality due to an illness, injury, or surgery. If the loss or impairment is caused by a congenital anomaly, surgery to correct the anomaly must be performed before the therapy. Maintenance treatments (once your maximum therapeutic benefit has been reached) are not covered. • Preauthorization required after initial 12 visits or 30 days in duration; whichever is less.
	Skilled nursing care	$50 copayment	Not Covered	Member responsibility up to $500 maximum per stay, 60 days per injury or illness. Must be within 15 days of hospitalization. Preauthorization is required.
	Durable medical equipment	20% coinsurance	Not Covered	Preauthorization is required for DME with a purchase price greater than $1,000 or $1,000 cumulative rental.
	Hospice services	$50 copayment	Not Covered	Member responsibility up to $500 max per episode. Preauthorization is required.

* For more information about limitations and exceptions, see the plan or policy document at https://my.aa.com.

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 your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)

- Cosmetic Surgery
- Dental Care (Adult)
- Non-Emergency Care When Traveling Outside The U.S.A.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Private Duty Nursing

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform. 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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

* For more information about limitations and exceptions, see the plan or policy document at https://my.aa.com.

Does this plan meet 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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 800-784-5473.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-784-5473.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 800-784-5473.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-784-5473.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at https://my.aa.com.

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)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **$500**
- **Other copayment** **$15**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,260**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **$500**
- **Other copayment** **$15**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$1,800
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2020**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **$500**
- **Other copayment** **$15**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$800
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$850**

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