# UMR: AMERICAN AIRLINES: PPO 90 Option



**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, visit my.aa.com or by calling 1-833-346-3929. 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 my.aa.com or call 1-833-346-3929 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | $225 person / $450 family In-network<br>$450 person / $900 family Out-of-network | Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. |
| **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?** | $1,500 person / $3,000 family In-network<br>$3,000 person / $6,000 family Out-of-network | 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out–of–pocket limit?** | Copayments for medical services, penalties, 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 my.aa.com or call 1-833-346-3929 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 |
|---|---|---|---|---|
| | | In-network (You will pay the least) | Out-of-network (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 | $25 Copay per visit; Deductible Waived | 30% Coinsurance | None |
| | Specialist visit | $40 Copay per visit; Deductible Waived | 30% Coinsurance | None |
| | Preventive care/screening/ immunization | No charge; Deductible Waived | Not covered | 1 Maximum exam per calendar year from age 5; You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge; Deductible Waived Office setting & lab Outpatient setting; 10% Coinsurance x-rays Outpatient setting | 30% Coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | No charge; Deductible Waived Office setting; 10% Coinsurance Outpatient setting | 30% Coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network (You will pay the least) | Out-of-network (You will pay the most) | |
| **If you need drugs to treat your illness or condition.**<br><br>More information about prescription drug coverage is available at www.caremark.com. | Generic drugs (Tier 1) | $15 Copay | Not covered | Prescription drugs are not subject to the deductible.<br>Some prescriptions require preauthorization. Other limitations may apply, see SPD.<br><br>Benefits shown are for Retail 30 day supply.<br><br>Specialty Drugs must be filled at CVS Specialty Pharmacy. Specialty Drugs on the PrudentRx Drug List are $0 for enrolled members. Please reference SPD. |
| | Preferred brand drugs (Tier 2) | $30 Copay | Not covered | |
| | Non-preferred brand drugs (Tier 3) | $50 Copay | Not covered | |
| | Specialty drugs (Tier 4) | Specialty drugs follow the generic, preferred and non-preferred copays listed above. | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% Coinsurance | 30% Coinsurance | None |
| | Physician/surgeon fees | 10% Coinsurance | 30% Coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $100 Copay per visit; Deductible Waived | $100 Copay per visit; Deductible Waived | Copay may be waived if admitted |
| | Emergency medical transportation | 10% Coinsurance | 10% Coinsurance | In-network deductible applies to Out-of-network benefits True ER |
| | Urgent care | $40 Copay per visit; Deductible Waived | 30% Coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network (You will pay the least) | Out-of-network (You will pay the most) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% Coinsurance | 30% Coinsurance | Preauthorization is required. |
| | Physician/surgeon fees | 10% Coinsurance | 30% Coinsurance | |
| **If you have mental health, behavioral health, or substance abuse services** | Outpatient services | $25 Copay per visit; Deductible Waived Office visits; 10% Coinsurance other outpatient services | 30% Coinsurance | Preauthorization is required for Partial hospitalization. |
| | Inpatient services | 10% Coinsurance | 30% Coinsurance | Preauthorization is required. |
| **If you are pregnant** | Office visits | $25 Copay per visit; Deductible Waived for initial visit; 10% Coinsurance all other visits | 30% Coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 10% Coinsurance | 30% Coinsurance | |
| | Childbirth/delivery facility services | 10% Coinsurance | 30% Coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network (You will pay the least) | Out-of-network (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | No charge; Deductible Waived | Not covered | 100 Maximum visits per calendar year combined with Private-duty nursing; Preauthorization is required. |
| | Rehabilitation services | $40 Copay per visit; Deductible Waived | 30% Coinsurance | None |
| | Habilitation services | $40 Copay per visit; Deductible Waived | 30% Coinsurance | Habilitation services for Learning Disabilities are not covered. |
| | Skilled nursing care | 10% Coinsurance | 30% Coinsurance | 60 Maximum days per calendar year; Preauthorization is required. |
| | Durable medical equipment | No charge; Deductible Waived up to $500 per calendar year, then 10% Coinsurance | 30% Coinsurance | 1 Maximum replacement every three years; Preauthorization is required for DME in excess of $500. |
| | Hospice service | No charge; Deductible Waived | Not covered | Preauthorization is required. |
| **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 (This is not a complete list. Please see your plan document.)**

- Cosmetic surgery & treatment (elective)
- Dental care, except treatment of accidental injury
- Experimental, investigational, unproven care
- Massage therapy
- Routine eye care
- Complimentary/Alternative medicine
- Drugs not approved by the FDA
- Non-emergency care outside the USA
- Routine foot care
- Long term care
- Certain types of infertility care
- Educational services
- Custodial care
- Non-medically necessary services/supplies
- Weight loss programs unless for morbid obesity

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

- Acupuncture
- Chiropractic care (limits apply)
- Collection/cryopreservation of human female ova ("egg freezing") and in-vitro fertilization (limits apply)
- Gender Reassignment Benefits (limits apply)
- Infertility medications (limits apply)
- Applied Behavioral Analysis (ABA) therapy
- Clinical Trials (limits apply)
- Diagnostic colonoscopies (100% in doctor's office on non-hospital facility)
- Hearing aids, (limits apply)
- Private duty nursing if medically necessary
- Temporomandibular Joint Disease (TMJD) treatment (limits apply)
- Bariatric surgery (limits apply)
- Diagnostic mammograms (100% in doctor's office or non-hospital facility)
- Home health care (limits apply)
- Reconstructive surgery to repair accidental injury or removal of diseased tissue
- Telehealth visits with preferred provider
- Joint and spine surgeries (limits apply)

**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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. 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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

**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.

**Does this plan Meet the Minimum Value Standard?** **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 1-877-558-1608.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-558-1608.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-558-1608.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-558-1608.

***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)

| | |
|---|---|
| **The plan's overall deductible** | **$225** |
| **Specialist copayment** | **$40** |
| **Hospital (facility) coinsurance** | **10%** |
| **Other coinsurance** | **10%** |

**This EXAMPLE event includes services like:**
Specialist office visits *(pre-natal 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 | $225 |
| Copayments | $25 |
| Coinsurance | $1,000 |
| *What isn't covered* | |
| Limits or exclusions | $70 |
| **The total Peg would pay is** | **$1,320** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$225** |
| **Specialist copayment** | **$40** |
| **Hospital (facility) coinsurance** | **10%** |
| **Other coinsurance** | **10%** |

**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* | $225 |
| Copayments | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $4,300 |
| **The total Joe would pay is** | **$4,725** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$225** |
| **Specialist copayment** | **$40** |
| **Hospital (facility) coinsurance** | **10%** |
| **Other coinsurance** | **10%** |

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

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $225 |
| Copayments | $300 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| **The total Mia would pay is** | **$635** |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: my.aa.com or call 1-833-346-3929.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"" row above.

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