



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?	\$1,650 person / \$4,950 family In-network \$3,000 person / \$9,000 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. 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?	\$4,700 person / \$9,400 family In-network \$9,000 person / \$18,000 family Out-of-network (includes deductible)	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?	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	40% Coinsurance	None
	Specialist visit	\$45 Copay per visit; Deductible Waived	40% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	40% Coinsurance	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 & Independent facilities; 20% Coinsurance Outpatient setting	40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge; Deductible Waived Office setting & Independent facilities; 20% Coinsurance Outpatient setting	40% Coinsurance	Preauthorization is required.

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. More information about prescription drug coverage is available at www.caremark.com .	Generic drugs (Tier 1)	20% (\$10min, \$40max)	Same as in network, reimbursed based on CVS discounted price	Prescription drugs are not subject to the deductible. Some prescriptions require preauthorization. Other limitations may apply, see SPD. Benefits shown are for Retail 30 day supply. 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% (\$30min, \$100max)	Same as in network, reimbursed based on CVS discounted price	
	Non-preferred brand drugs (Tier 3)	50% (\$45min, \$150max)	Same as in network, reimbursed based on CVS discounted price	
	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)	20% Coinsurance	40% Coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you need immediate medical attention	Emergency room care	\$200 Copay per visit; 20% Coinsurance	\$200 Copay per visit; 20% Coinsurance True ER; \$200 Copay per visit; 40% Coinsurance Non-true ER	In-network deductible applies to Out-of-network benefits True ER; Copay may be waived if admitted
	Emergency medical transportation	20% Coinsurance	20% Coinsurance True ER; 40% Coinsurance Non-true ER	In-network deductible applies to Out-of-network benefits True ER; Preauthorization is required for Non-emergent Air ambulance.
	Urgent care	20% Coinsurance	40% 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)	20% Coinsurance	40% Coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by \$250 of the total cost of the service for Out-of-network only.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	No charge; Deductible Waived Office visits; 20% Coinsurance other outpatient services	40% Coinsurance	Preauthorization is required for Partial hospitalization & Intensive treatment.
	Inpatient services	20% Coinsurance	40% Coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by \$250 of the total cost of the service for Out-of-network only.
If you are pregnant	Office visits	No charge; Deductible Waived	40% 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	20% Coinsurance	40% Coinsurance	
	Childbirth/delivery facility services	20% Coinsurance	40% 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	20% Coinsurance	40% Coinsurance	40 Maximum visits per calendar year; Preauthorization is required.
	Rehabilitation services	20% Coinsurance	40% Coinsurance	Preauthorization is required after 12 visits. Habilitation services for Learning Disabilities are not covered.
	Habilitation services	20% Coinsurance	40% Coinsurance	
	Skilled nursing care	20% Coinsurance	40% Coinsurance	60 Maximum days per disability; Preauthorization is required. If you don't get preauthorization , benefits could be reduced by \$250 of the total cost of the service for Out-of-network only.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	Preauthorization is required for DME in excess of 1,000.
	Hospice service	20% Coinsurance	40% Coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by \$250 of the total cost of the service for Out-of-network only.
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.)

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

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|--|---|--|
| • Acupuncture | • Applied Behavioral Analysis (ABA) therapy | • Bariatric surgery (limits apply) |
| • Chiropractic care (limits apply) | • Clinical Trials (limits apply) | • Diagnostic mammograms (100% in doctor's office or non-hospital facility) |
| • Collection/cryopreservation of human female ova ("egg freezing") and in-vitro fertilization (limits apply) | • Diagnostic colonoscopies (100% in doctor's office on non-hospital facility) | • Home health care (limits apply) |
| • Gender Reassignment Benefits (limits apply) | • Hearing aids, (limits apply) | • Reconstructive surgery to repair accidental injury or removal of diseased tissue |
| • Infertility medications (limits apply) | • Private duty nursing if medically necessary | • Telehealth visits with preferred provider |
| | • Temporomandibular Joint Disease (TMJD) treatment (limits apply) | • 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](http://cciio.cms.gov/programs/consumer/capgrants/index.html) 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, kwijigo 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](#) \$1,600
- [Specialist copayment](#) \$45
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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:

<i>Cost Sharing</i>	
Deductibles	\$1,600
Copayments	\$0
Coinsurance	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$3,370

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

- The [plan's](#) overall [deductible](#) \$1,600
- [Specialist copayment](#) \$45
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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:

<i>Cost Sharing</i>	
Deductibles*	\$200
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
The total Joe would pay is	\$4,700

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

- The [plan's](#) overall [deductible](#) \$1,600
- [Specialist copayment](#) \$45
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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:

<i>Cost Sharing</i>	
Deductibles*	\$1,600
Copayments	\$200
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$2,010

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.