Coverage Period: 01/01/2026-12/31/2026
Coverage for: Individual/Family | **Plan Type: PPO**
American Airlines, Inc. PPO Plan: PPO 80 Option

UnitedHealthcare

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.comor call 1-800 447-2000. 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.healthcare.gov/sbc-glossary or call 1-800-213-5755 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $450 Individual / $900 Family Out-of-Network: $900 Individual / $1,800 Family per calendar year.	Generally, you must pay all of 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, primary care services with copay, and prescription drugs 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?	Network: $3,000 Individual / $6,000 Family Out-of-Network: $6,000 Individual / $12,000 Family per calendar year	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?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain prior authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-800-213-5755 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	$25 copay/visit; deductible does not apply	40% coinsurance	For virtual visit, in-network $20 copay per visit by a Designated Virtual Network Provider; deductible does not apply. No virtual visit coverage for out-of-network. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply.
	Specialist visit	$40 copay/visit; deductible does not apply	40% coinsurance	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply.
	Preventive care/screening/ immunization	$25 copay/visit; deductible does not apply	Not covered	No coverage out-of-network except for annual pap smear and mammogram.
If you have a test	Diagnostic test (x-ray, blood work)	Office: No Charge Free Standing: No charges (labs); 20% coinsurance (x-ray) Hospital: 20% coinsurance	40% coinsurance	Prior authorization required out-of-network for certain services or $250 penalty applies.
	Imaging (CT/PET scans, MRIs)	Office: No Charge Free Standing/Hospital: 20% coinsurance	40% coinsurance	None

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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic Drugs (Tier 1)	Retail: $15 copay Mail Order: $30 copay Deductible does not apply	Not covered	Benefits shown are for Retail up to a 34-day supply and Mail-Order up to a 90-day supply. Some prescriptions require prior authorization. Other limitations may apply, see SPD, "Your Prescription Drug Benefit" chapter Specialty Drugs must be filled at CVS Specialty Pharmacy. Specialty Drugs on the PrudentRx Drug List are $0 for enrolled members. Please reference SPD, "Your Prescription Drug Benefit" chapter.
	Preferred brand drugs (Tier 2)	Retail: $30 copay Mail Order: $60 copay Deductible does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	Retail: $50 copay Mail Order: $100 copay Deductible does not apply	Not covered	
	Specialty drugs (Tier 4)	Specialty Drugs follow the generic, preferred and non-preferred copay listed above; deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Prior authorization required out-of-network or $250 penalty applies.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Copay is waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$40 copay/visit	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Prior authorization required out-of-network or $250 penalty applies.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

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 copay/office visit; deductible does not apply; 20% coinsurance for partial hospitalization, intensive outpatient treatment, and ABA therapy	40% coinsurance	Prior authorization required for certain services out-of-network or $250 penalty applies.
	Inpatient services	20% coinsurance	40% coinsurance	Prior authorization required out-of-network for inpatient facility or $250 penalty applies.
If you are pregnant	Office visits	$25 copay/initial visit only, deductible does not apply After initial visit, 20% coinsurance	40% coinsurance	Prior authorization required out-of-network for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean or $250 penalty applies. Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance or deductible 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	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Limited to 100 visits per calendar year.
	Rehabilitation services	$40 copay/visit; deductible does not apply	40% coinsurance	Occupational and Physical Therapy are limited to 40 visits each per calendar year. Speech therapy is limited to 20 visits per calendar year.
	Habilitation services	$40 copay/visit; deductible does not apply	40% coinsurance	Habilitation services are provided, and limits are combined with Rehabilitation Services above. Habilitation services for Learning Disabilities are not covered.

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)	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 60 days per illness or injury per calendar year. Confinement must occur within 15 days of release from hospital. Prior authorization required out-of-network or $250 penalty applies.
	Durable medical equipment	No charge up to $500 per calendar year, then 20% coinsurance	40% coinsurance	Prior authorization required out-of-network for DME over $500 or $250 penalty applies.
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Child routine vision exam is not covered
	Children's glasses	Not covered	Not covered	Child glasses are not covered
	Children's dental check-up	Not covered	Not covered	Child dental check-up is not covered

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
- Children's glasses
- Children's dental check-up
- Cosmetic surgery
- Dental Care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) Children's eye exam
- 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.)

- Bariatric Surgery – limited to one surgery per lifetime
- Chiropractic care – limited to 20 visits per calendar year
- 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 https://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 on how 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: 1-800-213-5755 or visit www.welcometouhc.com or the Employee Benefits Security Administration at 1-866-444-3272 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.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-213-5755.

Traditional Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-213-5755.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-213-5755.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-213-5755 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-213-5755.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-213-5755.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-213-5755.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-213-5755.

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**	**$450**
■ **Specialist copayment**	**$40**
■ **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:

Cost Sharing	
Deductibles	$450
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,920**

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

■ **The plan's overall deductible**	**$450**
■ **Specialist copayment**	**$40**
■ **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:

Cost Sharing	
Deductibles	$100
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

■ **The plan's overall deductible**	**$450**
■ **Specialist copayment**	**$40**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

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	$450
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,050**