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?	**$1,600/Individual** **$4,800/Family**	**$3,000/Individual** **$9,000/Family**	Except for preventive services and copayments, each member 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 member's deductible applies toward the family deductible. Once the family deductible is met, the plan will begin to pay for those members who have not reached their individual deductibles.
Are there services covered before you meet your deductible?	**YES**	**NO**	This plan covers certain preventive services without cost-sharing and before you meet your deductible. Covered preventive services are listed at https://www.healthcare.gov/coverage/preventive-care-benefits/. In-network preventive care, prescriptions and outpatient behavioral health / substance abuse are not subject to deductible / coinsurance. Out-of-network preventive care, prescriptions and outpatient behavioral health / substance abuse are subject to deductible / coinsurance.
Are there other deductibles for specific services?	**NO**	**NO**	There are no other deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$4,500/Individual** **$9,000/Family** (includes deductible)	**$9,000/Individual** **$18,000/Family** (includes deductible)	The out-of-pocket limit is the most you could pay in a year for covered services. Deductible, copayment, and coinsurance amounts DO count toward your out-of-pocket limit. In families of 3 or more members, if family out-of-pocket limit is met cumulatively, expenses are payable at 100% for all family members even if the individual out-of-pocket limits haven't been met by each member.
What is not included in the out-of-pocket limit?	Contributions, balance-billing charges, penalties for non-compliance, and excluded expenses this plan does not cover.		Even though you pay for these expenses, they DO NOT count toward your 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 in-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 a referral.

*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	40% coinsurance	None
	Specialist visit (including telemedicine)	$45 copayment	40% coinsurance	None
	Telehealth visits with preferred provider	$20 copayment	Not applicable	None
	Preventive care/screening/ immunization	No cost to you	40% coinsurance	• Charges will apply for services and tests which fall outside USPSTF guidelines
If you have a test at a hospital facility	Diagnostic test (x-ray, labs)	20% coinsurance	40% coinsurance	None
	Imaging (CT, PET, MRI) scans			
If you have a test at the doctor's office	Diagnostic test (x-ray, labs)	No cost to you if performed in a physician's office or non-hospital facility	40% coinsurance	• Charges apply if performed in a hospital
	Imaging (CT, PET, MRI) scans			
If you need prescription drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com Continued on next page	Generic drugs	**RETAIL** Up to a 30-day supply 20% coinsurance ($10 min/$40 max per fill) Up to a 90-day supply 20% coinsurance ($5 min/$80 max per fill) **MAIL ORDER** Up to 90-day supply 20% coinsurance ($5 min/$80 max per fill)	**RETAIL** Up to a 30-day supply 20% coinsurance ($10 min/$40 max per fill) but will be reimbursed based on the CVS Caremark discounted price **MAIL ORDER** Not covered	• Certain brand name prescriptions are not covered, check with CVS Caremark at www.caremark.com • Prescriptions are not subject to the deductible • 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 • If you select a preferred or non-preferred brand drug when a generic is available, you pay 20% coinsurance plus the cost difference between generic and preferred or non-preferred brand • Some prescriptions require preauthorization • Up to a 30-day supply can be filled through an CVS Caremark network pharmacy for in-network benefits

	Preferred brand drugs	**RETAIL** Up to a 30-day supply 30% coinsurance ($30 min/$100 max per fill) Up to a 90-day supply 30% coinsurance ($60 min/$200 max per fill) **MAIL ORDER** Up to a 90-day supply 30% coinsurance ($60 min/$200 max per fill)	**RETAIL** Up to 30-day supply 30% coinsurance ($30 min/$100 max per fill) but will be reimbursed based on the CVS Caremark discounted price **MAIL ORDER** Not covered	• Up to 90-day prescription fills are only available through CVS Caremark mail order or from CVS or Safeway-owned pharmacies for in-network benefits • Other limitations may apply, see SPD
	Non-preferred brand drugs	**RETAIL** Up to a 30-day supply 50% coinsurance ($45 min/$150 max per fill) Up to a 90-day supply 50% coinsurance ($90 min/$300 max per fill) **MAIL ORDER** Up to a 90-day supply 50% coinsurance ($90 min/$300 max per fill)	**RETAIL** Up to a 30-day supply 50% coinsurance ($45 min/$150 max per fill) but will be reimbursed based on the CVS Caremark discounted price **MAIL ORDER** Not covered	
	Specialty drugs	**RETAIL GENERIC** Not covered **MAIL ORDER GENERIC** Up to 90-day supply 20% coinsurance ($5 min/$80 max per fill) **RETAIL PREFERRED BRAND** Not covered **MAIL ORDER PREFERRED BRAND**	Not covered	• The same limitations for generic, preferred, and non-preferred drugs above apply to Specialty drugs • Specialty drugs must be purchased from CVS Specialty Pharmacy Health • Specialty drugs are NOT available in a 90-day supply when certain clinical rules or quantity restrictions apply

	Specialty drugs (Continued)	Up to a 90-day supply 30% coinsurance ($60 min/$200 max per fill) **RETAIL NON-PREFERRED BRAND** Not covered **MAIL ORDER NON-PREFERRED BRAND** Up to a 90-day supply 50% coinsurance ($90 min/$300 max per fill)		
If you have outpatient surgery	Facility fee (e.g., freestanding day surgicenter, doctor's office)	20% coinsurance	40% coinsurance	• $25 copay if done in a primary care provider's office
	Physician/surgeon fees	20% coinsurance	40% coinsurance	• $25 copay if done in a primary care provider's office
If you need immediate medical attention	Emergency room care	$200 copayment, plus 20% coinsurance	$200 copayment, plus 20% coinsurance	• $200 copayment paid before deductible and coinsurance applies • $200 copayment is waived if you're admitted to hospital • $200 copayment, plus 40% coinsurance for non-emergency out-of-network
	Emergency medical transportation	20% coinsurance	20% coinsurance	• In-network deductible applies
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	• Inpatient requires precertification for out-of-network hospitalization; failure to pre-authorization, you pay $250 penalty
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services for mental health, substance abuse	No cost to you	40% coinsurance	• No cost for PCP or Specialists visits • 20% coinsurance for other outpatient services
	Outpatient services for family therapy or couples therapy			
	Inpatient services for mental health, substance abuse	20% coinsurance	40% coinsurance	None

	Employee Assistance Program (EAP)	4 visits per issue, 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 (you, your spouse, or dependent daughter)	Office, routine prenatal care	No cost to you	40% coinsurance	• Non-routine prenatal care, see SPD for details.
	Birth/delivery professional services	20% coinsurance	40% coinsurance	None
	Birth/delivery facility services	20% coinsurance	40% coinsurance	• Inpatient must have precertification for delivery stays over 48 hours for a normal delivery and 96 hours for a c-section; failure to precertify, you pay $250 penalty – Penalty only applies to OON
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	• Limits apply, see SPD
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	Not covered	Not covered	• The plan does not cover this service, see SPD
	Skilled nursing care	20% coinsurance	40% coinsurance	• Maximum benefit is 60 days per illness or injury
	Durable medical equipment	20% coinsurance	40% coinsurance	• Dollar and quantity limits may apply, see SPD
	Hospice services	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered by Medical	Not covered by Medical	• Paid under Vision Benefit if you elected it
	Children's glasses			
	Children's dental check-up			• Paid under Dental Benefit if you elected it

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 (see SPD)
- 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, see SPD)
- Collection/cryopreservation of human female ova ("egg freezing") and in-vitro fertilization (limits apply, see SPD)
- Gender Reassignment Benefits (limits apply, see SPD)
- Infertility medications (limits apply, see SPD)
- Applied Behavioral Analysis (ABA) therapy
- Clinical Trials (limits apply, see SPD)
- Diagnostic colonoscopies (100% in doctor's office on non-hospital facility)
- Hearing aids, (limits apply, see SPD)
- Private duty nursing if medically necessary
- Temporomandibular Joint Disease (TMJD) treatment (limits apply, see SPD)
- Bariatric surgery (limits apply, see SPD)
- Diagnostic mammograms (100% in doctor's office or non-hospital facility)
- Home health care (limits apply, see SPD)
- Reconstructive surgery to repair accidental injury or removal of diseased tissue
- Telehealth visits with a preferred provider
- 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 of 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, co-payments and co-insurance) 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	**$1,600**
Specialist (routine prenatal office visits)	**$0**
Specialist (delivery, postnatal care)	**20%**
Hospital (facility)	**20%**
Anesthesiologist	**20%**
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	$1,600
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	N/A
The total Peg would pay is	**$3,600**

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	**$1,600**
Specialist (2 hospital visits)	**$45**
PCP office visits (4 visits)	**$25**
Hospital (facility)	**20%**
Diagnostic tests at PCP's office	**$0**
Prescription drugs (generic)	**20%**
Glucose Meter	**20%**

This EXAMPLE event includes services like:

Specialist hospital visits	$90
Primary Care physician (PCP) office visits (including disease education)	$100
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	$1,600
Copayments	$190
Coinsurance	$600
What isn't covered	
Limits or exclusions	N/A
The total Joe would pay is	**$2,390**

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

MIA'S COVERAGE IS EMPLOYEE-ONLY

The plan's overall deductible	**$1,600**
Specialist (setting fracture, casting)	**$45**
Hospital (facility)	**20%**
Crutches	**20%**
X-ray at doctor's office	**$0**
Physical Therapy	**20%**

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	$1,600
Copayments	$45
Coinsurance	$170
What isn't covered	
Limits or exclusions	N/A
The total Mia would pay is	**$1,220**

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