TRIPLE-S SALUD BlueCross BlueShield of Puerto Rico : **American Airlines**

Coverage for: Ind/Ind + 1/Fam | **Plan Type:** PPO

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 , you can access **www.ssspr.com** or call (787) 774-6060. 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 **1-800-981-3241** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Does not apply	You don't have to meet deductibles for specific services, but a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. Major Medical coverage - **$100** Individual / **$300** Family. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For medical, hospital and prescription drug services provided by in-network providers - **$6,350** Individual / **$12,700** Family. Major Medical coverage - **$1,000** Individual / **$3,000** 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, 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, payments for non essential benefits, out of network coinsurance / copayments, and penalties for failure to obtain precertification for services.	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 **www.ssspr.com** or call **1-800-981-3241 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 copay / visit	20% coinsurance, covered by reimbursement after annual deductible	----------none----------
	Specialist/ subspecialist visit	$20 copay / specialist visit $20 copay / subspecialist visit	20% coinsurance, covered by reimbursement after annual deductible	----------none----------
	Preventive care/screening /immunization	No charge for preventive services according to the Federal Law No charge for other immunizations 20% coinsurance for the immunization for respiratory syncytial virus.	20% coinsurance, covered by reimbursement after annual deductible	Immunization for respiratory syncytial virus requires precertification. You may have to pay for non-preventive services. 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)	30% coinsurance	20% coinsurance, covered by reimbursement after annual deductible	----------none----------
	Imaging (CT/PET scans, MRIs)	30% coinsurance	20% coinsurance, covered by reimbursement after annual deductible	Pet scan and PET CT, up to one (1) per year, per member, subject to precertification. MRI and CT, up to one (1) per anatomical region, per year, per member.
If you need drugs to treat your illness or condition More information about prescription drug coverage is	Preferred Generic drugs	$10 copay / $20 copay mail order	Prescription drug coverage - covered in United States or its territories by reimbursement to the members up to 75% of Triple-S Salud established fees, less the applicable drug copayment or coinsurance.	The following rules apply: • Generic drugs as first option. • Up to 30 (retail) and 90 (mail order) day supply for maintenance drugs. • Mail order is not available for specialty drugs or drugs for chemotherapy.
	Non-Preferred Generic drugs	$10 copay / $20 copay mail order		

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)	
available at www.ssspr.com.	Preferred Brand drugs	$25 copay / $50 copay mail order		• Some medications require precertification from the plan and the use of step therapy.
	Non-Preferred Brand Drugs	$25 copay / $50 copay mail order		
	Preferred Specialty drugs	20% maximum $200		
	Non-Preferred Specialty drugs	20% maximum $200		
	Drugs for chemotherapy	No Charge		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copay / visit	20% coinsurance, covered by reimbursement after annual deductible	----------none----------
	Physician / surgeon fees	No Charge	20% coinsurance, covered by reimbursement after annual deductible	----------none----------
If you need immediate medical attention	Emergency room care	$75 copay / visit	$75 copay / visit	No charge if recommended by *Teleconsulta*. Coinsurance may apply for non-routine diagnostic tests.
	Emergency medical transportation	Up to $80 / occurrence	Up to $80 / occurrence	You pay for the services and the plan will reimbursement the submitted charges.
	Urgent care	See emergency room services	See emergency room services	Coinsurance may apply for non-routine diagnostic tests other than x-rays.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay / admission	20% coinsurance, covered by reimbursement after annual deductible	----------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)	
	Physician/surgeon fees	No charge, except for lithotripsy and invasive cardiovascular test	20% coinsurance, covered by reimbursement after annual deductible	Lithotripsy requires precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 copay / group therapy $20 copay / visit (includes collaterals)	20% coinsurance, covered by reimbursement after annual deductible	----------none----------
	Inpatient services	$100 copay / admission $50 copay / partial admission	20% coinsurance, covered by reimbursement after annual deductible	----------none----------
If you are pregnant	Office visits	$20 copay	20% coinsurance, covered by reimbursement after annual deductible	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No charge	20% coinsurance, covered by reimbursement after annual deductible	
	Childbirth/delivery facility services	$100 copay	20% coinsurance, covered by reimbursement after annual deductible	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	Covered by reimbursement or assignment of benefits, subject to a 25% coinsurance	Up to 40 visits per policy year for physical, occupational and speech therapies. Requires precertification.
	Rehabilitation services	No charge / physical therapies it	20% coinsurance, covered by reimbursement after annual deductible	Physical therapies with no limits. Chiropractor are covered under the Major Medical coverage
	Habilitation services	See Rehabilitation services.	See Rehabilitation services.	See Rehabilitation services.
	Skilled nursing care	No charge	Covered by reimbursement or assignment of benefits	Up to 120 days per year, per member. Requires precertification.
	Durable medical equipment	25% coinsurance	Covered by reimbursement or assignment of benefits, subject to a 25% coinsurance	Requires precertification.
	Hospice service	Covered through Case Management, subject to be a precertification.	Not covered	----------none----------
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance, covered by reimbursement after annual deductible	Up to one (1) refraction exam per member, per year.
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	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.)

- Cosmetic surgery
- Dental care
- Glasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

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

- Acupuncture (covered through Triple-S Natural)
- Bariatric surgery subject to precertification
- Chiropractic care (covered through Major Medical coverage)
- Hearing aids (covered through Major Medical coverage)
- Routine eye care
- Routine foot care

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 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage. For more information about the individual insurance coverage, visit www.ssspr.com or call 787-774-6060 or toll free 1-800-981-3241.

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or visit www.ssspr.com or call 787-774-6060 or toll free 1-800-981-3241.

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 **787-774-6060** or toll free **1-800-981-3241**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **787-774-6060** or toll free **1-800-981-3241**.

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 **787-774-6060** or toll free **1-800-981-3241**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **787-774-6060** or toll free **1-800-981-3241**.

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	$0
Specialist copayment	$20
Hospital (facility) copayment	$100
Other coinsurance	30%

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	$100
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$500**

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	$20
Hospital (facility) copayment	$100
Other coinsurance	30%

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	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900**

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$100
Other coinsurance	30%

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	$100
Copayments	$300
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$470**