



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](http://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 <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Does not apply	You don't have to meet <a href="#">deductibles</a> for specific services, but a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	Yes. Major Medical coverage - <b>\$50</b> Individual / <b>\$150</b> Family. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For medical, hospital and prescription drug services provided by <a href="#">in-network providers</a> - <b>\$5,000</b> Individual / <b>\$10,000</b> Family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing charges</a> , health care this <a href="#">plan</a> doesn't cover, payments for non essential benefits, <a href="#">out of network coinsurance</a> / <a href="#">copayments</a> , and penalties for failure to obtain <a href="#">precertification</a> for services.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.ssspr.com">www.ssspr.com</a> or call 1-800-981-3241 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

For more information about limitations and exceptions, see the [plan](#) or policy document at [www.ssspr.com](http://www.ssspr.com)

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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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$10 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	-----none-----
	<a href="#">Specialist/</a> subspecialist visit	\$15 <a href="#">copay</a> / <a href="#">specialist</a> visit \$15 <a href="#">copay</a> / subspecialist visit	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	-----none-----
	<a href="#">Preventive care/screening</a> /immunization	No charge for preventive services according to the Federal Law No charge for other immunizations No charge for the immunization for respiratory syncytial virus.	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	Immunization for respiratory syncytial virus requires <a href="#">precertification</a> . You may have to pay for non-preventive services. Ask your provider if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	25% <a href="#">coinsurance</a> / x-ray and blood work 10% <a href="#">coinsurance</a> / other diagnostic tests	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	Pet scan and PET CT, up to one (1) per year, per member, subject to <a href="#">precertification</a> .

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)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.ssspr.com">www.ssspr.com</a>.</p>	Generic drugs	\$2 <a href="#">copay</a> / \$6 <a href="#">copay</a> mail order	<p>Prescription drug coverage outside the Primary Network in Puerto Rico:</p> <p>Generic drug – 10% minimum \$5 copay</p> <p>Brand drug – 20% minimum \$10 copay</p> <p>New drug – 20% minimum \$10 copay</p>	<p>The following rules apply:</p> <ul style="list-style-type: none"> <li>• Generic drugs as first option.</li> <li>• Up to 30-day (retail) supply and 90-day supply or mail order for some maintenance drugs.</li> <li>• Mail order is not available for <a href="#">specialty drugs</a> or drugs for chemotherapy.</li> <li>• Some medications require <a href="#">precertification</a> from the <a href="#">plan</a>.</li> </ul>
	Brand drugs	20% minimum \$4 <a href="#">copay</a> / \$12 <a href="#">copay</a> mail order	<p>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 <a href="#">copayment</a> or <a href="#">coinsurance</a>.</p>	
	<a href="#">Specialty drugs</a>	20% minimum \$50 maximum \$100 <a href="#">copay</a>		
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	No charge / visit	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	-----none-----
	Physician / surgeon fees	No Charge	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	-----none-----
<p><b>If you need immediate medical attention</b></p>	<a href="#">Emergency room care</a>	\$50 <a href="#">copay</a> / illness visit No charge / accident visit	\$50 <a href="#">copay</a> / illness visit No charge / accident visit	No charge if recommended by <i>Teleconsulta</i> . <a href="#">Coinsurance</a> may apply for non-routine <a href="#">diagnostic tests</a> .

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)	
	<a href="#">Emergency medical transportation</a>	Up to \$70 / occurrence	Up to \$70 / occurrence	You pay for the services and the <a href="#">plan</a> will reimbursement the submitted charges.
	<a href="#">Urgent care</a>	See emergency room services	See emergency room services	<a href="#">Coinsurance</a> may apply for non-routine <a href="#">diagnostic tests</a> other than x-rays.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$150 <a href="#">copay</a> / admission	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	Services rendered outside of Puerto Rico will be covered up to 40 visits per year.
	Physician/surgeon fees	No charge, except for lithotripsy and invasive cardiovascular test	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	Lithotripsy requires <a href="#">precertification</a> .
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$5 <a href="#">copay</a> / group therapy \$15 <a href="#">copay</a> / psychiatrist or psychologist visit \$10 <a href="#">copay</a> / collateral visit	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	-----none-----
	Inpatient services	\$150 <a href="#">copay</a> / admission \$50 <a href="#">copay</a> / partial admission	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	-----none-----
<b>If you are pregnant</b>	Office visits	\$10 <a href="#">copay</a>	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	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% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	
	Childbirth/delivery facility services	\$150 <a href="#">copay</a>	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	

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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	25% <a href="#">coinsurance</a>	Covered by reimbursement or assignment of benefits, subject to a 25% <a href="#">coinsurance</a>	Up to 40 visits per policy year for physical, occupational and speech therapies. Requires <a href="#">precertification</a> .
	<a href="#">Rehabilitation services</a>	\$5 <a href="#">copay</a> / physical therapies	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	Up to 40 physical therapies per contract year, per member. Chiropractor are covered under the Major Medical coverage.
	<a href="#">Habilitation services</a>	See Rehabilitation services.	See Rehabilitation services.	See Rehabilitation services.
	<a href="#">Skilled nursing care</a>	No charge	Covered by reimbursement or assignment of benefits	Up to 120 days per year, per member. Services rendered outside of Puerto Rico will be covered up to 40 visits per year, per member. Requires <a href="#">precertification</a> .
	<a href="#">Durable medical equipment</a>	25% <a href="#">coinsurance</a>	Covered by reimbursement or assignment of benefits, subject to a 25% <a href="#">coinsurance</a>	Requires <a href="#">precertification</a> .
	<a href="#">Hospice service</a>	Covered through Case Management, subject to be a <a href="#">precertification</a> .	Not covered	-----none-----
<b>If your child needs dental or eye care</b>	Children's eye exam	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	Up to one (1) refraction exam per member, per year.
	Children's glasses	Covered by reimbursement or assignment of benefits	Covered by reimbursement or assignment of benefits	Covered under the Major Medical coverage up to \$100 every two years for glasses and contact lenses. This benefit does not apply to the <a href="#">out-of-pocket limit</a> .
	Children's dental check-up	No charge	Not covered	Covered through Dental coverage. Up to one (1) dental check-up every six (6) months.

## 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
- 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 pre-certification
- Chiropractic care (covered through Major Medical coverage)
- Dental care
- Hearing aids (covered through Major Medical coverage)
- Infertility treatment (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](http://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](http://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](http://www.dol.gov/ebsa/healthreform), or visit [www.ssspr.com](http://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, kwijigo 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.

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### 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](#) \$15
- [Hospital \(facility\) copayment](#) \$150
- Other [coinsurance](#) 25%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$600</b>

**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](#) \$15
- [Hospital \(facility\) copayment](#) \$150
- Other [coinsurance](#) 25%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$50
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,050</b>

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

- The plan's overall [deductible](#) \$0
- [Specialist copayment](#) \$15
- [Hospital \(facility\) copayment](#) \$150
- Other [coinsurance](#) 25%

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$50
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$430</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services