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 at https://www.healthcare.gov/sbc-glossary or call **1-800-981-3241**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart of common events below for the costs of the services covered by this plan.
Are there services covered before you meet your deductible?	Does not apply	This plan does not have an overall **deductible**.
Are there other deductibles for specific services?	Yes. Major Medical coverage - **$50** Individual / **$150** 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 - **$5,000** Individual / **$10,000** Family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. If you have other family members under this plan, the maximum out-of-pocket per family must be completed.
What is not included in the out-of-pocket limit?	Premiums, payments for non-essential benefits, payments for services not covered, services provided by non-network providers.	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 providers?	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	$10 copay / visit	20% coinsurance, covered by reimbursement after annual deductible	----------none----------
	Specialist visit	$15 copay / specialist $15 copay / subspecialist	20% coinsurance, covered by reimbursement after annual deductible	----------none----------
	Other practitioner office visit	$10 copay / podiatrist, optometrist and audiologist	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 No charge for the immunization for respiratory syncytial virus.	20% coinsurance, covered by reimbursement after annual deductible	Immunization for respiratory syncytial virus requires pre-certification. You may have to pay for non-preventive services. Consult your doctor if the services you need are preventive. Then check how much your plan will pay for services.
If you have a test	Diagnostic tests (x-ray, blood work)	25% coinsurance /x-ray and blood work 10% coinsurance / other diagnostic tests	20% coinsurance, covered by reimbursement after annual deductible	----------none----------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance, covered by reimbursement after annual deductible	Pet scan and PET CT, up to one (1) per year, per member, subject to pre-certification.

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.ssspr.com.	Generic drug	$2 copay /$6 copay mail order	Prescription drug coverage outside the Primary Network in Puerto Rico: Generic drug – 10% minimum $5 copay Brand drug – 20% minimum $10 copay New drug – 20% minimum $10 copay 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 co-payment or co-insurance.	The following rules apply: • Generic drugs as first option. • Up to 30 (retail) and 90 (mail order) day supply for maintenance drugs. • Some medications require precertification from the plan and the use of step therapy. • Mail order is not available for specialty drugs.
	Brand drug	20% minimum $4 copay /$12 copay mail order		
	New drugs	20% minimum $4 copay /$12 copay mail order		
	Specialty drug	20% minimum $50 maximum $100 copay		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge / 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 services/ Urgent care	$50 copay / illness visit No charge / accident visit	$50 copay / illness visit No charge / accident visit	Nothing if recommended by *Teleconsulta*. Coinsurance may apply for non-routine diagnostic tests.
	Emergency medical transportation	Up to $70 / occurrence	Up to $70 / occurrence	Covered by reimbursement
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 copay / admission	20% coinsurance, covered by reimbursement after annual deductible	Services rendered outside of Puerto Rico will be covered up to 40 visits per year

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 fee	No charge, except for lithotripsy and invasive cardiovascular test	20% coinsurance, covered by reimbursement after annual deductible	Lithotripsy requires pre-certification.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$5 copay / group therapy $15 copay / psychiatrist or psychologist visit $10 copay / collateral visit	20% coinsurance, covered by reimbursement after annual deductible	----------none----------
	Mental/Behavioral health inpatient services	$150 copay / admission $50 copay / partial admission	20% coinsurance, covered by reimbursement after annual deductible	----------none----------
	Substance use disorder outpatient services	$5 copay / group therapy $15 copay / psychiatrist or psychologist visit $10 copay / collateral visit	20% coinsurance, covered by reimbursement after annual deductible	----------none----------
	Substance use disorder inpatient services	$150 copay / admission $50 copay / partial admission	20% coinsurance, covered by reimbursement after annual deductible	----------none----------
If you are pregnant	Prenatal and postnatal care	No charge / preventive annual visit $10 copay / routine care visit	20% coinsurance, covered by reimbursement after annual deductible	Depending on the type of service a coinsurance, copayment or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC.
	Delivery and all inpatient services	$150 copay / admission	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.

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)	
	Rehabilitation / Habilitation services	$5 copay / physical therapies	20% coinsurance, covered by reimbursement after annual deductible	Up to 20 physical therapies per policy year.
	Skilled nursing care	No charge	20% coinsurance, covered by reimbursement after annual deductible	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 pre-certification.
	Durable medical equipment	25% coinsurance	Covered by reimbursement or assignment of benefits, subject to a 25% coinsurance.	Requires pre-certification.
	Hospice service	No charge	Not covered	Covered under the Individual Case Management Program subject to the established requisites.
If your child needs dental or eye care	Eye exam	10% coinsurance	20% coinsurance, covered by reimbursement after annual deductible	Up to one (1) refraction exam per member, per year.
	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 2 years for glasses and contact lenses. This benefit does not apply to the **out-of-pocket limit.**
	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 Does NOT Cover (This is not a complete list. Check your policy or plan document for 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 (This is not a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture (covered through Major Medical coverage) • 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. 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 Coverage 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 Coverage 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 individual insurance coverage.

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 page.

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)

Total Example Cost	**$12,035**

In this examples, patient pays:

Cost Sharing	
Deductibles	$0
Copayments	$465
Coinsurance	$418
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$943**

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)
Diagnostics tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	**$6,155**

In this examples, patient pays:

Cost Sharing	
Deductibles	$0
Copayments	$420
Coinsurance	$770
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,245**

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)

Total Example Cost	**$1,558**

In this examples, patient pays:

Cost Sharing	
Deductibles	$0
Copayments	$463
Coinsurance	$21
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$484**

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 us.*Note: This plan has other deductibles for specific services included in this coverage example. See are there other deductibles for specific services?" row above.

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