TRIPLE-S SALUD BlueCross BlueShield of Puerto Rico : **PEARSON, INC.**

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 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 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 - **$2,000** Individual / **$6,000** 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 preauthorization 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	$10 copay / visit	Not covered	----------none----------
	Specialist visit	$15 copay / specialist visit $20 copay / subspecialist visit	Not covered	----------none----------
	Other practitioner office visit	$15 copay / podiatrist, optometrist, and audiologist visit $7 copay / chiropractor visit	Not covered	----------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)	
	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.	Not covered	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)	25% coinsurance x-ray, blood work 30% coinsurance / diagnostic test	Not covered	----------none----------
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	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. Mammography with magnetic resonance requires plan precertification.
If you need drugs to treat your illness or condition More information about prescription drug coverage is	Preferred Generic drugs	$5 copay / $10 copay mail order	Not covered	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	$5 copay / $10 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	$20 copay / $40 copay mail order		• Some medications require precertification from the plan and the use of step therapy.
	Non Preferred Brand Drugs	$20 copay / $40 copay mail order		
	Preferred Specialty drugs	30% coinsurance		
	Non Preferred Specialty drugs	30% coinsurance		
	Drugs for chemotherapy	10% coinsurance		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay / visit	Not covered	----------none----------
	Physician / surgeon fees	No Charge	Not covered	----------none----------
If you need immediate medical attention	Emergency room services	$75 copay / visit	$75 copay / visit	$35 copay if recommended by *Teleconsulta*. Coinsurance may apply for non-routine diagnostic tests.

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)	
	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	See emergency room services
If you have a hospital stay	Facility fee (e.g., hospital room)	Level 1: $100 copay / admission Level 2: $200 copay / admission Level 3: $450 copay / admission	Not covered	----------none----------
	Physician/surgeon fee	No charge, except for lithotripsy and invasive cardiovascular test	Not covered	Lithotripsy requires precertification.
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$7 copay / group therapy $15 copay / visit (includes collaterals)	Not covered	----------none----------
	Inpatient services	Level 1: $100 copay / admission Level 2: $200 copay / admission Level 3: $450 copay / admission $50 copay / partial admission	Not covered	----------none----------
If you are pregnant	Office visits	$15 copay	Not covered	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	Not covered	
	Childbirth/delivery facility services	Level 1: $100 copay / admission Level 2: $200 copay / admission Level 3: $450 copay / admission	Not covered	
If you need help recovering or have	Home health care	25% coinsurance	Not covered	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)	
other special health needs	Rehabilitation services	$7 copay / physical therapies and chiropractor's manipulations	Not covered	Up to 20 physical therapies, chiropractor manipulations, occupational and speech therapies combined per policy year, per member.
	Habilitation services	See Rehabilitation services.	See Rehabilitation services.	See Rehabilitation services.
	Skilled nursing care	No charge	Not covered	Up to 120 days per year, per member. Requires precertification.
	Durable medical equipment	25% coinsurance up to a maximum of $5,000, afterwards 60% coinsurance apply	Not covered	Requires precertification.
	Hospice service	Covered through Case Management, subject to be a precertification.	Not covered	----------none----------
If your child needs dental or eye care	Eye exam	No charge	Not covered	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	The benefit for insureds up to age 21 will be provided only through the contracted network. For insured over 21 years of age the benefit is covered up to $100 per policy year. 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
- Infertility treatment
- 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 Triple-S Natural)
- Bariatric surgery subject to pre-certification
- Chiropractic care
- Dental care
- Glasses
- 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 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.

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)

Total Example Cost	**$12,035**

In this example, 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 example, 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 example, 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: Department of Education and Disease management at Triple-S Salud. The toll-free phone number is 866-788-6770 or 787-793-8383, extensions 3106 or 3154.