



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 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 - \$100 Individual / \$300 Family. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.
What is the <b>out-of-pocket limit</b> 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 <b>out-of-pocket limit</b> 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 and upfront deductibles, copayments and coinsurance for the purchase of medicines.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Will you pay less if you use a <b>network providers</b> ?	Yes. See <a href="http://www.ssspr.com">www.ssspr.com</a> or call 1-800-981-3241 for a list of <b>network providers</b> .	This <b>plan</b> uses a provider <b>network</b> . You will pay less if you use a <b>provider</b> in the plan's <b>network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the provider's charge and what your <b>plan</b> pays (balance billing). Be aware, your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services.
Do you need a referral to see a <b>specialist</b> ?	No.	You can see the <b>specialist</b> you choose without a <b>referral</b> .



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 provider's office or clinic</b>	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-----
	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 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.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	30% coinsurance diagnostic test 25% coinsurance x-ray, blood work	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 pre-certification. MRI and CT, up to one (1) per anatomical region, per year, per member. Mammography with magnetic resonance requires plan 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)	
<b>If you need drugs to treat your illness or condition</b>  More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.ssspr.com">www.ssspr.com</a> .	Generic drugs	\$5 copay /\$10 copay Mail order or Flex 90	Not covered	The following rules apply: <ul style="list-style-type: none"> <li>• Generic drugs as first option.</li> <li>• Up to 30 (retail) and 90 (Mail Order or Flex 90) day supply for maintenance drugs.</li> <li>• Mail Order is not available for specialty drugs or drugs for chemotherapy.</li> <li>• Some medications require precertification from the plan and the use of step therapy.</li> </ul>
	Brand drugs	\$20 copay /\$40 copay Mail Order or Flex 90		
	Specialty drugs	30% coinsurance		
	Drugs for chemotherapy	10% coinsurance		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$100 copay / visit	Not covered	-----none-----
	Physician/surgeon fees	No Charge	Not covered	-----none-----
<b>If you need immediate medical attention</b>	Emergency room services/ Urgent care	\$75 copay / illness or accident visit	\$75 copay / illness or accident visit	\$35 copay if recommended by <i>Teleconsulta</i> . Coinsurance may apply for non-routine diagnostic tests.
	Emergency medical transportation	Up to \$80 / occurrence	Up to \$80 / occurrence	Covered by reimbursement
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Level 1: \$100 copay / admission Level 2: \$200 copay / admission Level 3: \$450 copay / admission	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)	
	Physician/surgeon fee	No charge, except for lithotripsy and invasive cardiovascular test	Not covered	Lithotripsy requires pre-certification.
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$7 copay / group therapy \$15 copay / visit (includes collaterals)	Not covered	-----none-----
	Mental/Behavioral health inpatient services	Level 1: \$100 copay / admission Level 2: \$200 copay / admission Level 3: \$450 copay / admission \$50 copay / partial admission	Not covered	-----none-----
	Substance use disorder outpatient services	\$7 copay / group therapy \$15 copay / visit (includes collaterals)	Not covered	-----none-----
	Substance use disorder inpatient services	Level 1: \$100 copay / admission Level 2: \$200 copay / admission Level 3: \$450 copay / admission \$50 copay / partial admission	Not covered	-----none-----
<b>If you are pregnant</b>	Prenatal and postnatal care	No charge / preventive annual visit \$15 copay / routine care visit	Not covered	Shared costs do not apply for shared services. 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	Level 1: \$100 copay / admission Level 2: \$200 copay / admission Level 3: \$450 copay / admission	Not covered	

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>	Home health care	25% coinsurance	Not covered	Up to 40 visits per policy year for physical, occupational and speech therapies. Requires precertification.
	Rehabilitation / Habilitation services	\$7 copay / physical therapy \$7 copay /chiropractors manipulations	Not covered	Up to 20 physical therapies, chiropractor manipulations, occupational and speech therapies combined per policy year, per member.
	Skilled nursing care	No charge	Not covered	Up to 120 days per year, per member. Requires pre-certification.
	Durable medical equipment	25% coinsurance up to a maximum of \$5,000, afterwards 60% coinsurance apply	Not covered	Requires pre-certification.
	Hospice service	No charge	Not covered	Covered under the Individual Case Management Program subject to the established requisites.
<b>If your child needs dental or eye care</b>	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 <b>out-of-pocket limit.</b>
	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
- 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 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, 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 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) coinsurance **\$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>\$12,035</b>
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**In this examples, patient pays:**

Cost Sharing	
Deductibles	\$0
Copayments	\$465
Coinsurance	\$418
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$943</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) coinsurance **\$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)

<b>Total Example Cost</b>	<b>\$6,155</b>
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**In this examples, patient pays:**

Cost Sharing	
Deductibles	\$0
Copayments	\$420
Coinsurance	\$770
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,245</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) coinsurance **\$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>\$1,558</b>
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**In this examples, patient pays:**

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

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