



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?	No.	You do not have to pay deductibles for specific services.
What is the out-of-pocket limit for this plan ?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out-of-pocket limit ?	This plan has no out-of-pocket limit .	Not applicable because there's no out-of-pocket limit on your expenses.
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	\$5 copay / visit	Covered by reimbursement only when the specialty is not available in the list of network providers	-----none-----
	Specialist/ subspecialist visit	\$10 copay / specialist visit \$10 copay / subspecialist visit	Covered by reimbursement only when the specialty is not available in the list of network providers	-----none-----
	Preventive care/screening /immunization	25% coinsurance for diagnostic tests No charge for immunizations 20% coinsurance for the respiratory syncytial virus immunization	Covered by reimbursement only when the specialty is not available in the list of network providers	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	Covered by reimbursement only when the specialty is not available in the list of network providers	-----none-----
	Imaging (CT/PET scans, MRIs)	25% coinsurance	Covered by reimbursement only when the specialty is not available in the list of network providers	Pet Scan and PET CT, subject to precertification .
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ssspr.com .	Preferred Generic drugs	\$5 copay / \$10 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-day (retail) supply and 90-day supply or mail order for some maintenance drugs. • Mail order is not available for specialty drugs or drugs for chemotherapy.
	Non-Preferred Generic drugs	\$5 copay / \$10 copay mail order		
	Preferred Brand drugs	\$10 copay / \$20 copay mail order		
	Non-Preferred Brand 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)	
	Preferred Specialty drugs	25% coinsurance minimum \$15		Some medications require precertification from the plan.
	Non-Preferred Specialty drugs	25% coinsurance minimum \$15		
	Drugs for chemotherapy	No Charge		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 copay / visit	Covered by reimbursement only when the specialty is not available in the list of network providers	-----none-----
	Physician / surgeon fees	No Charge	Covered by reimbursement only when the specialty is not available in the list of network providers	-----none-----
If you need immediate medical attention	Emergency room care	\$50 copay / visit	\$50 copay / visit	\$25 copay if recommended by <i>Teleconsulta</i> . Coinsurance may apply for non-routine diagnostic tests other than x-rays.
	Emergency medical transportation	Up to \$80 / occurrence	Up to \$80 / occurrence	Covered by reimbursement
	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)	\$50 copay / admission	Covered by reimbursement only when the specialty is not available in the list of network providers	-----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	Covered by reimbursement only when the specialty is not available in the list of network providers	Lithotripsy requires precertification .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 copay / group therapy \$10 copay / visit (includes collaterals)	Covered by reimbursement only when the specialty is not available in the list of network providers	-----none-----
	Inpatient services	\$50 copay / admission \$50 copay / partial admission	Covered by reimbursement only when the specialty is not available in the list of network providers	-----none-----
If you are pregnant	Office visits	\$10 copay	Covered by reimbursement only when the specialty is not available in the list of network providers	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	Covered by reimbursement only when the specialty is not available in the list of network providers	
	Childbirth/delivery facility services	\$50 copay / admission	Covered by reimbursement only when the specialty is not available in the list of network providers	
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 services	\$7 copay / physical therapies and chiropractor's manipulations \$7 copay / chiropractor visit	Covered by reimbursement only when the specialty is not available in the list of network providers	Up to 20 occupational therapies, combined with speech therapy, per policy year, per member.
	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	25% coinsurance	Covered by reimbursement only when the specialty is not available in the list of network providers	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
- 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): Dinekehgo 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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well – controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0
■ Specialist copayment	\$10	■ Specialist copayment	\$10	■ Specialist copayment	\$10
■ Hospital (facility) copayment	\$50	■ Hospital (facility) copayment	\$50	■ Hospital (facility) copayment	\$50
■ Other coinsurance	25%	■ Other coinsurance	25%	■ Other coinsurance	25%
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$60	Copayments	\$300	Copayments	\$300
Coinsurance	\$400	Coinsurance	\$200	Coinsurance	\$90
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$0	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$460	The total Joe would pay is	\$500	The total Mia would pay is	\$390

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