



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?	No.	You do not have to pay <a href="#">deductibles</a> for specific 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>\$6,350 Individual / \$12,700 Family.</b>	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.

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

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019) (DOL - OMB control number: 1210-0147/Expiration date:5/31/2022) (HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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 <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$10 <a href="#">copay</a> / visit	Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage	Telemedicine services (Teleconsulta MD) through virtual medical consultations, unlimited. \$10.00 <a href="#">copay</a> will apply per consult.
	<a href="#">Specialist/</a> subspecialist visit	\$20 <a href="#">copay</a> / <a href="#">specialist</a> visit \$20 <a href="#">copay</a> / subspecialist visit	Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage	-----none-----
	<a href="#">Preventive care/screening</a> /immunization	No charge for preventive services according to the Federal Law No charge for other immunizations 20% <a href="#">coinsurance</a> for the immunization for respiratory syncytial virus.	Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage	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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	25% <a href="#">coinsurance</a>	Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage	-----none-----

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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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)	
	Imaging (CT/PET scans, MRIs)	25% <a href="#">coinsurance</a>	Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage	Pet scan and PET CT, up to one (1) per year, per member, subject to <a href="#">precertification</a> . MRI and CT, up to two (2) per anatomical region, per year, per member. Excess MRI and CT subject to <a href="#">precertification</a> .
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.ssspr.com">www.ssspr.com</a> .	Preferred Generic drugs	\$10 <a href="#">copay</a> / \$20 <a href="#">copay</a> 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 <a href="#">copayment</a> or <a href="#">coinsurance</a> .	The following rules apply: <ul style="list-style-type: none"> <li>• <b>Apply Preferred Drug List (PDL)</b></li> <li>• This coverage is subject to a Drug List</li> <li>• Generic drugs as first option.</li> <li>• Up to 30 (retail) and 90 (mail order) day supply for 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> and the use of step therapy.</li> </ul>
	Non-Preferred Generic drugs	\$10 <a href="#">copay</a> / \$20 <a href="#">copay</a> mail order		
	Preferred Brand drugs	25% <a href="#">coinsurance</a> minimum \$15 <a href="#">copay</a> / 20% <a href="#">coinsurance</a> minimum \$40 <a href="#">copay</a> mail order		
	Non-Preferred Brand Drugs	25% <a href="#">coinsurance</a> minimum \$16 <a href="#">copay</a> / 20% <a href="#">coinsurance</a> minimum \$40 <a href="#">copay</a> mail order		
	Preferred <a href="#">Specialty drugs</a>	30% <a href="#">coinsurance</a>		
	Non-Preferred Specialty drugs	30% <a href="#">coinsurance</a>		
	Drugs for chemotherapy	10% <a href="#">coinsurance</a>		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$125 <a href="#">copay</a> / visit	Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage	-----none-----
	Physician / surgeon fees	No Charge	Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage	-----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)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$65 <a href="#">copay</a> / illness visit No charge / accident visit	\$65 <a href="#">copay</a> / illness visit No charge / accident visit	\$25 <a href="#">copay</a> if recommended by <i>Teleconsulta</i> . <a href="#">Coinsurance</a> may apply for non-routine <a href="#">diagnostic tests</a> .
	<a href="#">Emergency medical transportation</a>	Up to \$80 / occurrence	Up to \$80 / occurrence	You pay for the services and the <a href="#">plan</a> will reimbursement the submitted charges.
	<a href="#">Urgent care</a>	\$35 <a href="#">copay</a> / illness visit No charge / accident visit	\$35 <a href="#">copay</a> / illness visit No charge / accident visit	<a href="#">Coinsurance</a> may apply for non-routine <a href="#">diagnostic tests</a> other than x-rays.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$125 <a href="#">copay</a> / admission	Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage	-----none-----
	Physician/surgeon fees	No charge, except for lithotripsy and invasive cardiovascular test	Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage	Lithotripsy requires <a href="#">precertification</a> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$5 <a href="#">copay</a> / group therapy \$20 <a href="#">copay</a> / visit (includes collaterals)	Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage	-----none-----
	Inpatient services	\$125 <a href="#">copay</a> / admission \$50 <a href="#">copay</a> / partial admission	Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage	-----none-----
If you are pregnant	Office visits	\$20 <a href="#">copay</a>	Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage	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 at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage	

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)	
	Childbirth/delivery facility services	\$125 <a href="#">copay</a>	Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage	
If you need help recovering or have other special health needs	<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>	\$7 <a href="#">copay</a> / physical therapies and chiropractor's manipulations \$7 <a href="#">copay</a> / chiropractor visit	Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage	Up to 15 physical therapies per policy year, per member. Up to 15 manipulations per policy year, per member.
	<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. 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-----
If your child needs dental or eye care	Children's eye exam	25% <a href="#">coinsurance</a>	Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage	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 up to \$100 per year for glasses and contact lenses. This benefit does not apply to the <a href="#">out-of-pocket limit</a> .
	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
- 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](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, 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 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](#) \$20
- Hospital (facility) [copayment](#) \$125
- 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>	\$100
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$500</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](#) \$20
- Hospital (facility) [copayment](#) \$125
- 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>	\$0
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,300</b>

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

- The plan's overall [deductible](#) \$0
- [Specialist copayment](#) \$20
- Hospital (facility) [copayment](#) \$125
- 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>	\$0
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$490</b>