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 **www.ssspr.com** or by calling **(787) 774-6060**.

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 a general 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 deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. For medical, hospital and prescription drug services provided by in-network providers - **$6,350** Individual / **$12,700** Family. Major Medical coverage - **$1,000** Individual / **$3,000** 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. For a list of **network providers**, visit **www.ssspr.com** or call (787) 774-6060.	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 permission from this plan.

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	$15 copay / visit	20% coinsurance, covered by reimbursement.	----------none----------
	Specialist visit	$20 copay / specialist visit $20 copay / subspecialist visit	20% coinsurance, covered by reimbursement.	----------none----------
	Other practitioner office visit	$15 copay / podiatrist, optometrist, and audiologist visit	20% coinsurance, covered by reimbursement.	Chiropractors are covered under the Major Medical coverage
	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.	20% coinsurance, covered by reimbursement.	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 test (x-ray, blood work)	30% coinsurance	20% coinsurance, covered by reimbursement.	----------none----------
	Imaging (CT/PET scans, MRIs)	30% coinsurance	20% coinsurance, covered by reimbursement.	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.

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 drugs	$10 copay /$20 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 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. • Mail order is not available for specialty drugs • Some medications require precertification from the plan and the use of step therapy. • Chemotherapy covered at100%.
	Brand drugs and new drugs	$25 copay /$50 copay mail order		
	Specialty drugs	20% maximum $200		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copay / visit	20% coinsurance, covered by reimbursement.	----------none----------
	Physician/surgeon fees	No Charge	20% coinsurance, covered by reimbursement.	----------none----------
If you need immediate medical attention	Emergency room services/ Urgent care	$75 copay / visit	$75 copay / visit	No charge if recommended by *Teleconsulta*. Coinsurance may apply for non-routine diagnostic tests.
	Emergency medical transportation	Up to $80 / occurrence	Up to $80 / occurrence	Covered by reimbursement
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay / admission	20% coinsurance, covered by reimbursement.	----------none----------
	Physician/surgeon fee	No charge, except for lithotripsy and invasive cardiovascular test	20% coinsurance, covered by reimbursement.	Lithotripsy requires pre-certification.
If you have mental health, behavioral health,	Mental/Behavioral health outpatient services	$5 copay / group therapy $20 copay / visit (includes collaterals)	20% coinsurance, covered by reimbursement.	----------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)	
or substance abuse needs	Mental/Behavioral health inpatient services	$100 copay / admission $50 copay / partial admission	20% coinsurance, covered by reimbursement.	----------none----------
	Substance use disorder outpatient services	$5 copay / group therapy $20 copay / visit (includes collaterals)	20% coinsurance, covered by reimbursement.	----------none----------
	Substance use disorder inpatient services	$100 copay / admission $50 copay / partial admission	20% coinsurance, covered by reimbursement.	----------none----------
If you are pregnant	Prenatal and postnatal care	No charge / preventive annual visit $20 copay / routine care visit	20% coinsurance, covered by reimbursement.	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	$100 copay / admission	20% coinsurance, covered by reimbursement.	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	20% coinsurance, covered by reimbursement.	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	No charge	20% coinsurance, covered by reimbursement.	Physical therapy covered unlimited.
	Skilled nursing care	No charge	Covered by reimbursement or assignment of benefits.	Up to 120 days 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	30% coinsurance	20% coinsurance, covered by reimbursement.	Up to one (1) refraction exam per member, per year.
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

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
- Glasses
- 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 (This is not a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery subject to pre-certification
- Chiropractic care (covered through Major Medical coverage)
- Hearing aids (covered through Major Medical coverage)
- Routine eye care
- Routine foot care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State Laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at (787) 774-6060. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact our Customer Service Department at (787) 774-6060 or visit www.ssspr.com. For more information on the appeals process, call Triple-S at (787) 774-6060 and in external appeals, 1-877-549-8152 free of charge or you may send an e-mail to **disputedclaims@opm.gov**.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en español, llame al (787) 774-6060.

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.

Having a baby
(normal delivery)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) coinsurance	$75
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	**$12,300**

In this examples, patient pays:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
Total	**$760**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) coinsurance	$75
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	**$6,200**

In this examples, patient pays:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
Total	**$1,260**

Simple Fracture
(Emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) coinsurance	$75
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	**$1,600**

In this examples, patient pays:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
Total	**$420**

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

Questions: Call (787) 774-6060 or visit us at www.ssspr.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.ssspr.com.