



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?	Yes. Major Medical coverage - <b>\$100</b> Individual / <b>\$300</b> Family. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these 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</b> Individual / <b>\$12,700</b> Family. Major Medical coverage - <b>\$2,000</b> Individual / <b>\$6,000</b> Family.	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 <b>1-800-981-3241</b> 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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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control number: 0938-1146/Expiration date: 10/31/2023)



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 <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$5 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	-----none-----
	<a href="#">Specialist/</a> subspecialist visit	\$15 <a href="#">copay</a> / <a href="#">specialist</a> visit \$15 <a href="#">copay</a> / subspecialist visit	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	-----none-----
	<a href="#">Preventive care/screening</a> /immunization	No charge for preventive services according to the Federal Law No charge for other immunizations No charge for the immunization for respiratory syncytial virus.	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	25% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	25% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	Pet Scan and Pet CT are covered under the Major Medical coverage, subject to a <a href="#">precertification</a> .
<b>If you need drugs to treat your illness or condition</b>	Preferred Generic drugs	\$5 <a href="#">copay</a> / \$10 <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>• 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>.</li> <li>• Some medications require <a href="#">precertification</a> from the <a href="#">plan</a>.</li> </ul>
More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.ssspr.com</a> .	Non-Preferred Generic drugs	\$5 <a href="#">copay</a> / \$10 <a href="#">copay</a> mail order		
	Preferred Brand drugs	\$8 <a href="#">copay</a> / \$16 <a href="#">copay</a> 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)	
	Non-Preferred Brand Drugs	\$10 <a href="#">copay</a> / \$20 <a href="#">copay</a> mail order		
	Preferred <a href="#">Specialty drugs</a>	20% or \$10, whichever is higher		
	Non-Preferred Specialty drugs	20% or \$10, whichever is higher		
	Drugs for chemotherapy	No Charge		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	-----none-----
	Physician / surgeon fees	No Charge	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$20 <a href="#">copay</a> / visit	\$20 <a href="#">copay</a> / visit	No charge 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	Covered by reimbursement
	<a href="#">Urgent care</a>	See emergency room services	See emergency room services	<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)	\$50 <a href="#">copay</a> / admission	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	-----none-----
	Physician/surgeon fees	No charge, except for lithotripsy and invasive cardiovascular test	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	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 \$15 <a href="#">copay</a> / visit (includes collaterals)	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	-----none-----
	Inpatient services	\$50 <a href="#">copay</a> / admission \$50 <a href="#">copay</a> / partial admission	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	-----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 are pregnant	Office visits	\$15 <a href="#">copay</a>	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	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	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	
	Childbirth/delivery facility services	\$50 <a href="#">copay</a>	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	
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>	\$5 <a href="#">copay</a> / physical therapies and chiropractor's manipulations \$15 <a href="#">copay</a> / chiropractor visit	20% <a href="#">coinsurance</a> , covered by reimbursement after <a href="#">annual deductible</a>	Up to 50 physical therapies per policy year, per member. Up to 30 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	No charge	Balances over network allowance	Children are covered for exams and lenses once per year up through the ages of 18. Children are covered for frames once per 24 months through the age of 18. Benefits are separately administered by Davis Vision.
	Children's glasses	No charge	Balances over \$100 network allowance	
	Children's dental check-up	No charge for up to two per calendar year.	Balances over network allowance	

## 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
- 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
- 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, 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.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 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.

<b>Peg is Having a Baby</b> (9 months of in-network pre-natal care and a hospital delivery)	<b>Managing Joe's type 2 Diabetes</b> (a year of routine in-network care of a well-controlled condition)	<b>Mia's Simple Fracture</b> (in-network emergency room visit and follow up care)																																										
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<p><b>This EXAMPLE event includes services like:</b>  <a href="#">Specialist</a> office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services  <a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)  <a href="#">Specialist</a> visit (<i>anesthesia</i>)</p>	<p><b>This EXAMPLE event includes services like:</b>  <a href="#">Primary care physician</a> office visits (<i>including disease education</i>)  <a href="#">Diagnostic tests</a> (<i>blood work</i>)  <a href="#">Prescription drugs</a>  <a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</p>	<p><b>This EXAMPLE event includes services like:</b>  <a href="#">Emergency room care</a> (<i>including medical supplies</i>)  <a href="#">Diagnostic test</a> (<i>x-ray</i>)  <a href="#">Durable medical equipment</a> (<i>crutches</i>)  <a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</p>																																										
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services