



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document 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 starting on page 2 for your costs for services this plan covers.
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.
Is there an out-of-pocket limit on my expenses?	Yes. For medical, hospital and prescription drugs services provided by in-network providers - \$ 6,350 Individual / Family \$ 12,700 . Major Medical coverage - \$2,000 Individual / \$6,000 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.
What is not included in the out-of-pocket limit ?	Premiums, payments for non-essential benefits, payments for services not covered and services provided by non-network providers.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes. For a list of network providers , visit www.ssspr.com or call (787) 774-6060.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$5 copay / visit	20% coinsurance, covered by reimbursement	—————none—————
	Specialist visit	\$15 copay / specialist visit \$15 copay / subspecialist visit	20% coinsurance, covered by reimbursement	—————none—————
	Other practitioner office visit	\$5 copay / podiatrist, optometrist, and audiologist visit \$15 copay / chiropractor	20% coinsurance, covered by reimbursement	—————none—————
	Preventive care/screening/immunization	No charge for preventive services according to the Federal Law \$5 copay for other immunizations Nothing for the immunization for respiratory syncytial virus	20% coinsurance, covered by reimbursement	Immunization for respiratory syncytial virus requires pre-certification.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	20% coinsurance, covered by reimbursement	_____none_____
	Imaging (CT/PET scans, MRIs)	25% coinsurance	20% coinsurance, covered by reimbursement	Pet Scan and Pet CT are covered under the Major Medical coverage, subject to a pre-certification.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.ssspr.com .	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 co-payment or co-insurance.	The following rules apply: <ul style="list-style-type: none"> • 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.
	Preferred brand drugs	\$8 copay / \$16 copay mail order		
	Brand drugs	\$10 copay / \$20 copay mail order		
	Non-preferred brand drugs	20% or \$10.00 whichever is higher / 20% or \$30.00 mail order		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	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	\$20 copay / visit	\$20 copay / visit	Nothing 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
	Urgent care	See emergency room services	See emergency room services	_____none_____

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	\$50 copay / admission	\$50 copay / admission	—————none—————
	Physician/surgeon fee	No charge, except for lithotripsy and invasive cardiovascular test	No charge, except for lithotripsy and invasive cardiovascular test	Lithotripsy requires pre-certification.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$5 copay / group therapy \$15 copay / visit (includes collaterals)	20% coinsurance, covered by reimbursement	—————none—————
	Mental/Behavioral health inpatient services	\$50 copay / admission \$50 copay / partial admission	\$50 copay / admission \$50 copay / partial admission	—————none—————
	Substance use disorder outpatient services	\$5 copay / group therapy \$15 copay / visit (includes collaterals)	20% coinsurance, covered by reimbursement	—————none—————
	Substance use disorder inpatient services	\$50 copay / admission \$50 copay / partial admission	\$50 copay / admission \$50 copay / partial admission	—————none—————
If you are pregnant	Prenatal and postnatal care	\$15 copay / visit	20% coinsurance, covered by reimbursement	—————none—————
	Delivery and all inpatient services	\$50 copay / admission	\$50 copay / admission	—————none—————

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If you need help recovering or have other special health needs	Home health care	25% coinsurance	25% coinsurance	Up to 40 visits per policy year for Physical, Occupational and Speech Therapies. Requires pre-certification.
	Rehabilitation services / Habilitation services	\$5 copay / physical therapies / chiropractors manipulations	20% coinsurance, covered by reimbursement	Up to 20 physical therapies per policy year, per member. Up to 30 manipulations per policy year, per member.
	Skilled nursing care	No charge	No charge	Up to 120 days per year, per member. Requires pre-certification.
	Durable medical equipment	25% coinsurance	25% coinsurance	Requires pre-certification.
	Hospice service	No charge	No charge	Covered under the Individual Case Management Program subject to the established requisites.
If your child needs dental or eye care	Eye exam	25% coinsurance	20% coinsurance, covered by reimbursement	Up to 1 refraction exam per member, per year.
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

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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 <u>excluded services</u>.)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care 	<ul style="list-style-type: none"> • Glasses • Infertility treatment • Long-term care 	<ul style="list-style-type: none"> • 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.)		
<ul style="list-style-type: none"> • Bariatric surgery subject to pre-certification • Chiropractic care 	<ul style="list-style-type: none"> • Hearing aids 	<ul style="list-style-type: none"> • 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.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,130
- Patient pays \$410

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$80
Coinsurance	\$180
Limits or exclusions	\$150
Total	\$410

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

- Amount owed to providers: \$5,400
- Plan pays \$4,620
- Patient pays \$780

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Copays	\$350
Coinsurance	\$350
Limits or exclusions	\$80
Total	\$780

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment is not covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.