



2023 Triple-S Directo
Summary of Benefits
and Coverage (SBC)

GOLD

SIEMPRE CONTIGO
DONDEQUIERA


 **TRIPLE-S SALUD** 
BlueCross BlueShield of Puerto Rico

A great network. A great life.



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.

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 ?	Not applicable.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	Yes. \$50 for prescription drug coverage	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 ?	For medical-hospital services and medications provided by in-network providers - \$6,350 Individual / \$12,700 Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , you have to meet your own direct out-of-pocket limits until the family's out-of-pocket limit has been reached.
What is not included in the out-of-pocket limit ?	Premiums, payments for non-essential benefits, payments for non-covered services, services provided by out-of-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 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	\$0 PPN / \$5 copayment / visit	Not covered	-----none-----
	Specialist visit	\$0 Salus / \$10 copayment / specialist \$0 Salus / \$15 copayment / subspecialist	Not covered	-----none-----
	Preventive care/screening/immunization	Nothing for the preventive services by Federal Law Nothing for other immunizations 30% coinsurance for the vaccine for the respiratory syncytial virus.	Not covered	Vaccine for respiratory syncytial virus requires pre-certification of the plan .
If you have a test	Diagnostic test (x-ray, blood work)	0% Salus / 30% coinsurance X-rays; 30% coinsurance laboratories	Not covered	Applies Selective Networks of Laboratories, Radiology and Imaging.
	Imaging (CT/PET scans, MRIs)	35% coinsurance	Not covered	PET Scan and PET CT subject to pre-certification. MRI, up to one (1) per anatomical region, per policy year, a precertification is required for additional CT and MRI".
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ssspr.com	Generic drugs	Generics: \$5 copayment / \$10 copayment ; 90 days	Not covered	This coverage is subject to a Drug List. The following rules apply: • First level of coverage up to \$ 700 individual, then 90% coinsurance • This coverage is subject to a Drug List. • Generics as first option. • Up to 30 and 90 days of supply for maintenance medications.
	Preferred brand drugs	25% coinsurance / 19% coinsurance ; 90 days	Not covered	
	Non-preferred brand drugs	30% coinsurance / 23% coinsurance ; 90 days	Not covered	
	Specialty drugs	40% coinsurance Preferred;	Not covered	

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

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)	
		50% Non Preferred		<ul style="list-style-type: none"> Some medications require precertification of the plan and the use of step therapy. Specialty products are not available for 90 days.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 copayment	Not covered	-----none-----
	Physician/surgeon fees	30% coinsurance in ambulatory surgery	Not covered	-----none-----
If you need immediate medical attention	Emergency room care	\$75 copayment due to illness or accident/ visit; \$50 Teleconsulta	\$75 copayment due to illness or accident/ visit; \$50 Teleconsulta	Coinsurance can be applied for non-routine diagnostic tests.
	Emergency medical transportation	\$0 in cases of emergencies. In non-emergency cases, the insured person pays the full cost and Triple-S Salud reimburses you, up to a maximum of \$80 per case for reimbursement.	\$0 in cases of emergencies. In non-emergency cases, the insured person pays the full cost and Triple-S Salud reimburses you, up to a maximum of \$80 per case for reimbursement.	Covered through refund.
	Urgent care	\$15 copay for illness or accident / visit	\$15 copay for illness or accident / visit	Coinsurance can be applied for non-routine diagnostic tests.
If you have a hospital stay	Facility fee (e.g., hospital room)	Preferred Network: \$150 Non- Preferred Network: \$500	Not covered	-----none-----
	Physician/surgeon fees	35% coinsurance Lithotripsy surgeries and invasive cardiovascular tests; \$150 copayment Bariatric surgeries	Not covered	Lithotripsy and Bariatric requires precertification.
If you need mental health, behavioral health, or substance	Outpatient services	\$10 copayment / group therapy \$10 copay / visit (includes collateral)	Not covered	-----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)	
abuse services	Inpatient services	Preferred Network: \$150 Non-Preferred Network: \$500; \$50 Preferred Network or \$100 Non-Preferred Network / partial admission (collateral)	Not covered	-----none-----
If you are pregnant	Office visits	\$0 SALUS/\$10 copayment	Not covered	Coinsurance does not apply for preventive services . Depending on the type of services, a coinsurance or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	Nothing	Not covered	-----none-----
	Childbirth/delivery facility services	Preferred Network: \$150 Non- Preferred Network: \$500	Not covered	-----none-----
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	Nursing and Auxiliary Services up to a maximum of two (2) daily visits. Up to 40 visits per year for Physical, Occupational and Speech Therapies. They require recertification.
	Rehabilitation services	\$15 copayment / physical therapy and Chiropractor manipulations	Not covered	Up to 20 manipulations and physical therapies, combined with habilitation, per insured, per policy year.
	Habilitation services	\$15 copayment / physical therapy and Chiropractor manipulations	Not covered	Up to 20 manipulations and physical therapies, combined with habilitation, per insured, per policy year.
	Skilled nursing care	\$150 copayment	Not covered	Up to 120 days per year, per insured. Requires pre-certification.

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)	
	Durable medical equipment	40% coinsurance	Not covered	Requires pre-certification of the plan
	Hospice services	Covered through Case Management, subject to a precertification.	Not covered	Requires pre-certification of the plan
If your child needs dental or eye care	Children's eye exam	Nothing	Not covered	Up to one (1) refraction exam per year, per insured.
	Children's glasses	Nothing	Not covered	1 pair per year policy, per insured person up to 21 years of age.
	Children's dental check-up	Nothing	Not covered	Covered under the dental cover up to one (1) revision every six (6) months.

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 .)		
<ul style="list-style-type: none"> Hearing aids Infertility treatment Cosmetic surgery 	<ul style="list-style-type: none"> Long-term care Private-duty nursing 	<ul style="list-style-type: none"> Weight loss program Non-emergency outside the United States

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Acupuncture (Triple-S Natural) Bariatric surgery, subject to precertification 	<ul style="list-style-type: none"> Dental Care Routine foot care Routine eye care (Adult) 	<ul style="list-style-type: none"> Visual care Chiropractic visits

Your Rights to Continue Coverage: For more information about your rights to continue your coverage, contact the [plan](#) at (787) 774-6060. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Office of the Insurance Commissioner of Puerto Rico, B5 Tabonuco Street Suite 216 PMB 356 Guaynabo PR 00968-3029, telephone: 787-304-8686; Health Advocate PO BOX 11247 San Juan PR 00910-2347 Telephone: 787-977-0909. Other coverage options may be available to you too, including buying individual insurance coverage. For more information about 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 For more information about limitations and exceptions, see the [plan](#) or policy document at www.ssspr.com.

complete information on how 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: Complaints and Appeals Department at PO Box 11320 San Juan, PR 00922-9905, Fax Appeals: 787-706-4057, Email: qacomercial@ssspr.com. For more information about the appeals process, call Triple-S at (787) 774-6060 and in case of external appeals to the Office of the Insurance Commissioner, Investigation Division B5 Tabonuco Street Suite 216 PMB 356Guaynabo, PR 00968-3029, email: investigaciones@ocs.pr.gov, by fax: 787-273-6082 or by phone 787-304-8686

Does this plan provide Minimum Essential Coverage? Not applicable

[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).

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (787-774-6060).

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(787-774-6060).

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (787-774-6060).

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.

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](#) \$0/\$10
- Hospital (facility) [copayment](#) \$150/\$500
- Other [coinsurance](#) 30%

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	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$700

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](#) \$0/\$10
- Hospital (facility) [copayment](#) \$150/\$500
- Other [coinsurance](#) 30%

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*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$600

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$0/\$10
- Hospital (facility) [copayment](#) \$150/\$500
- Other [coinsurance](#) 30%

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	\$2,800
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$500

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

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your [plan](#) or [health insurance](#) policy. Some of these terms also might not have exactly the same meaning when used in your policy or [plan](#), and in any case, the policy or [plan](#) governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or [plan](#) document.)
- [Underlined](#) text indicates a term defined in this Glossary.
- See page 6 for an example showing how [deductibles](#), [coinsurance](#) and [out-of-pocket limits](#) work together in a real life situation.

Allowed Amount

This is the maximum payment the [plan](#) will pay for a covered health care service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.”

Appeal

A request that your health insurer or [plan](#) review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

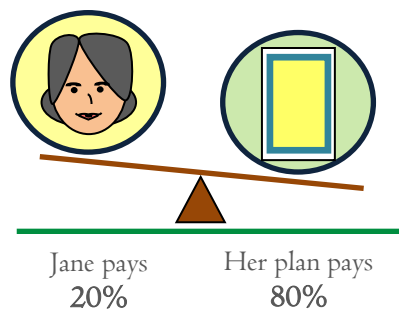
When a [provider](#) bills you for the balance remaining on the bill that your [plan](#) doesn't cover. This amount is the difference between the actual billed amount and the [allowed amount](#). For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you for the remaining \$90. This happens most often when you see an [out-of-network provider](#) ([non-preferred provider](#)). A [network provider](#) ([preferred provider](#)) may not balance bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care [provider](#) to your health insurer or [plan](#) for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the [allowed amount](#) for the service. You generally pay coinsurance *plus* any [deductibles](#) you owe. (For example, if the [health insurance](#) or [plan's](#) allowed amount for an office visit is \$100 and you've met your [deductible](#), your coinsurance payment of 20% would be \$20. The [health insurance](#) or [plan](#) pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service (sometimes called “copay”). The amount can vary by the type of covered health care service.

Cost Sharing

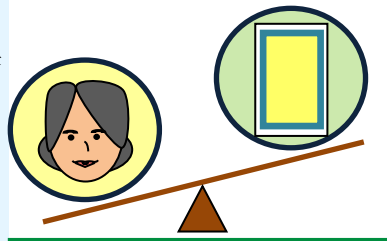
Your share of costs for services that a [plan](#) covers that you must pay out of your own pocket (sometimes called “out-of-pocket costs”). Some examples of cost sharing are [copayments](#), [deductibles](#), and [coinsurance](#). Family cost sharing is the share of cost for [deductibles](#) and [out-of-pocket](#) costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your [premiums](#), penalties you may have to pay, or the cost of care a [plan](#) doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual [plan](#) you buy through the [Marketplace](#). You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your [plan](#) begins to pay. An overall deductible applies to all or almost all covered items and services. A [plan](#) with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A [plan](#) may also have only separate deductibles. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% Her plan pays 0%
(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care [provider](#) for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an [emergency medical condition](#). Types of emergency medical transportation may include transportation by air, land, or sea. Your [plan](#) may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an [emergency medical condition](#) and treat you to keep an [emergency medical condition](#) from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for [emergency medical conditions](#).

Excluded Services

Health care services that your [plan](#) doesn't pay for or cover.

Formulary

A list of drugs your [plan](#) covers. A formulary may include how much your share of the cost is for each drug. Your [plan](#) may put drugs in different [cost-sharing](#) levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different [cost-sharing](#) amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or [plan](#).

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a [premium](#). A health insurance contract may also be called a "policy" or "[plan](#)."

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care [providers](#). Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some [plans](#) may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Coinsurance

Your share (for example, 20%) of the [allowed amount](#) for covered health care services. Your share is usually lower for in-network covered services.

In-network Copayment

A fixed amount (for example, \$15) you pay for covered health care services to [providers](#) who contract with your [health insurance](#) or [plan](#). In-network copayments usually are less than [out-of-network copayments](#).

Marketplace

A marketplace for [health insurance](#) where individuals, families and small businesses can learn about their [plan](#) options; compare plans based on costs, benefits and other important features; apply for and receive financial help with [premiums](#) and [cost sharing](#) based on income; and choose a [plan](#) and enroll in coverage. Also known as an “Exchange.” The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in [cost sharing](#) during the [plan](#) year for covered, in-network services. Applies to most types of health [plans](#) and insurance. This amount may be higher than the [out-of-pocket limits](#) stated for your [plan](#).

Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage

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](#).

Minimum Value Standard

A basic standard to measure the percent of permitted costs the [plan](#) covers. If you’re offered an employer [plan](#) that pays for at least 60% of the total allowed costs of benefits, the [plan](#) offers minimum value and you may not qualify for [premium tax credits](#) and [cost-sharing reductions](#) to buy a [plan](#) from the [Marketplace](#).

Network

The facilities, [providers](#) and suppliers your health insurer or [plan](#) has contracted with to provide health care services.

Network Provider (Preferred Provider)

A [provider](#) who has a contract with your [health insurer](#) or [plan](#) who has agreed to provide services to members of a [plan](#). You will pay less if you see a [provider](#) in the [network](#). Also called “preferred provider” or “participating provider.”

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

Out-of-network Coinsurance

Your share (for example, 40%) of the [allowed amount](#) for covered health care services to [providers](#) who don’t contract with your [health insurance](#) or [plan](#). Out-of-network coinsurance usually costs you more than [in-network coinsurance](#).

Out-of-network Copayment

A fixed amount (for example, \$30) you pay for covered health care services from [providers](#) who do *not* contract with your [health insurance](#) or [plan](#). Out-of-network copayments usually are more than [in-network copayments](#).

Out-of-network Provider (Non-Preferred Provider)

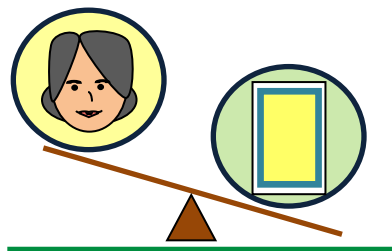
A [provider](#) who doesn’t have a contract with your [plan](#) to provide services. If your [plan](#) covers out-of-network services, you’ll usually pay more to see an out-of-network provider than a [preferred provider](#). Your policy will explain what those costs may be. May also be called “non-preferred” or “non-participating” instead of “out-of-network provider.”

Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services.

After you meet this limit the [plan](#) will usually pay 100% of the [allowed amount](#). This limit helps you plan for

health care costs. This limit never includes your [premium](#), [balance-billed](#) charges or health care your [plan](#) doesn't cover. Some [plans](#) don't count all of your [copayments](#), [deductibles](#), [coinsurance](#) payments, out-of-network payments, or other expenses toward this limit.



Jane pays
0%

Her plan pays
100%

(See page 6 for a detailed example.)

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called “health insurance plan,” “policy,” “health insurance policy,” or “[health insurance](#).”

Preauthorization

A decision by your health insurer or [plan](#) that a health care service, treatment plan, [prescription drug](#) or [durable medical equipment \(DME\)](#) is [medically necessary](#). Sometimes called “prior authorization,” “prior approval,” or “precertification.” Your [health insurance](#) or [plan](#) may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your [health insurance](#) or [plan](#) will cover the cost.

Premium

The amount that must be paid for your [health insurance](#) or [plan](#). You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private [health insurance](#). You can get this help if you get [health insurance](#) through the [Marketplace](#) and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly [premium](#) costs.

Prescription Drug Coverage

Coverage under a [plan](#) that helps pay for [prescription drugs](#). If the plan's [formulary](#) uses “tiers” (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in [cost sharing](#) will be different for each “tier” of covered [prescription drugs](#).

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including [screenings](#), check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the [plan](#), who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The [plan](#) may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral

A written order from your [primary care provider](#) for you to see a [specialist](#) or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your [primary care provider](#). If you don't get a referral first, the [plan](#) may not pay for the services.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening

A type of [preventive care](#) that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is **not** the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist

A [provider](#) focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug

A type of [prescription drug](#) that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a [formulary](#).

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what [providers](#) in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the [allowed amount](#).

Urgent Care

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require [emergency room care](#).

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500

Coinsurance: 20%

Out-of-Pocket Limit: \$5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



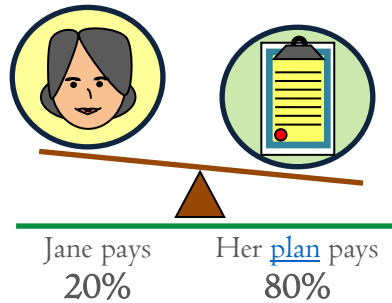
Jane hasn't reached her \$1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0



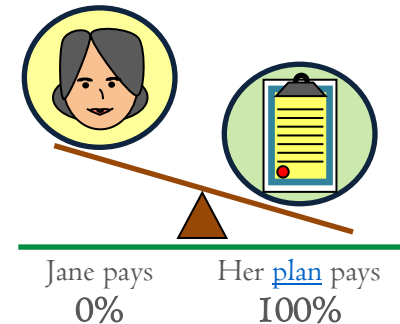
Jane reaches her \$1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid \$1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: \$125

Jane pays: 20% of \$125 = \$25

Her plan pays: 80% of \$125 = \$100



Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: \$125

Jane pays: \$0

Her plan pays: \$125

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.

787.774.6070

787.792.1370

TTY (hearing impaired)

Monday to Friday 7:30 a.m. - 8:00 p.m.

Saturday 9:00 a.m. - 6:00 p.m.

Sunday 11:00 a.m. - 5:00 p.m.

www.ssspr.com