2021

Summary of Coverage
Care Plus Medigap

TRIPLE-S SALUD

BlueCross BlueShield of Puerto Rico

TRIPLE-S SALUD, INC.
1441 Ave Roosevelt, San Juan, Puerto Rico

Independent licensee of Blue Cross and Blue Shield Association

Summary of Coverage

CARE *PLUS* MEDIGAP
(Models A, B, C, and D)

Care Plus RC 01-2020
Rev.2021

WELCOME TO TRIPLE-S SALUD, INC.

Our priority is to serve you at every stage in your life

For over 55 years, we have offered top-quality health care services for thousands of Puerto Ricans. Our priority is to serve you at every stage in your life, and we constantly work to develop initiatives that help us live up to our promise.

Triple-S Salud, Inc. (hereinafter referred to as Triple-S Salud) provides a wide range of comprehensive health care services to look after your TOTAL WELLBEING and help improve your quality of life. We also provide after-hours services at our Service Centers, including our locations in Plaza Las Américas and Plaza Carolina, available every day of the week. Besides, we provide services 24/7 through Telexpreso and our website, www.ssspr.com.

This summary of coverage for the Care *Plus* Medigap Policy Model (A, B, C, and D) will help you get to know the benefits provided by Triple-S Salud under the A, B, C, and D Models of Medicare supplemental coverage.

We encourage you to read this summary carefully and keep it at hand for future reference.

We hope you will continue being part of our family, where we care for what is most important for you and your loved ones: your health.

Madeline Hernández Urquiza, CPA
President

Triple-S Salud, Inc.
San Juan, Puerto Rico
Independent licensee of *BlueCross and BlueShield Association*

Benefits Chart for Medicare Supplement Plans – This chart shows the benefits included in each one of the standardized Medicare supplement plans. Some plans may not be available in your state. Only those applicants who have become eligible for Medicare for the first time before 2020 may purchase the C, F, and high-deductible F plans.

NOTE: The √ mark means the benefit is 100% covered.

Plans available to anyone eligible for Medicare									**Only for those eligible for Medicare before 2020**	
Benefits	**A**	**B**	**D**	G[1]	K	L	M	N	**C**	F[1]
Hospital coverage and coinsurance of Medicare Part A (covered for 365 additional days after the Medicare benefits end)	√	√	√	√	√	√	√	√	√	√
Medicare Part B coinsurances and copayments	√	√	√	√	50%	75%	√	√ **Copayment applies[3]**	√	√
Blood (first 3 pints)	√	√	√	√	50%	75%	√	√	√	√
Part A: Coinsurances and copayments for Hospice Care	√	√	√	√	50%	75%	√	√	√	√
Coinsurance for Skilled Nursing Facility			√	√	50%	75%	√	√	√	√
Medicare Part A Deductible		√	√	√	50%	75%	√	√	√	√
Medicare Part B Deductible									√	√
Medicare Part B excess charge				√						√
Foreign travel emergency (up to plan			√	√			√	√	√	√

Plans available to anyone eligible for Medicare									Only for those eligible for Medicare before 2020	
Benefits	**A**	**B**	**D**	G[1]	K	L	M	N	**C**	F[1]
limits)										
Maximum Out-of-Pocket for 2021[2]					$6,220[2]	$3,110[2]				

NOTE: Triple-S Salud will only offer Models A, B, C, and D

[1] The F and G Plans also have a high deductible option, which requires that a deductible of $2,370 be paid before the plan starts paying. Once the deductible is reached, the plan will cover services at 100% for the remaining calendar year. The High Deductible Plan G does not cover the deductible of Medicare Part B. However, the F and G plans tally your Medicare Part B deductible payments and will roll them over when the plan deductible is reached.

[2] The K and L plans pay 100% of covered services for the remaining calendar year after you reach the annual maximum out-of-pocket limit.

[3] Plan N pays 100% of the Part B coinsurance, except for copayments of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in inpatient admission.

INFORMATION ABOUT THE PREMIUMS

Triple-S Salud may only increase your premium if we increase the premium for all similar policies in Puerto Rico.

Rates	Plan A	Plan B	Plan C	Plan D
Regular Rate	$122.30	$149.05	$171.35	$152.85
Discounted Rate (1st year)	$79.50	$96.90	$111.40	$99.35
Discounted Rate (2nd year)	$100.90	$123.00	$141.40	$126.10
Discounted Rate (3rd year)	$111.60	$136.05	$156.40	$139.45

READ YOUR POLICY CAREFULLY

This is only a summary describing the most important features in your policy. The policy is your insurance contract. You must personally read your policy to ensure you understand all the rights and responsibilities shared by you and your insurance company.

RIGHT TO RETURN THE POLICY

If you are not satisfied with your policy, you may return it to PO Box 363628, San Juan, P.R. 00936- 3628. If you return the policy within 30 days after receiving it, we will treat it as if it had never been issued and refund all your payments.

REPLACING A POLICY

If you are replacing another health insurance policy, DO NOT cancel it until you receive your new policy and are sure you wish to keep it.

NOTICE

This policy may not cover all your medical expenses. Neither Triple-S Salud nor its agents, authorized representatives, producers, or other representatives are related to Medicare. This Summary of Coverage does not offer all the details of the Medicare coverage. Please contact the Social Security offices or read the Medicare Manual for more information.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, make sure you provide true and complete answers about your health and medical history. The company may cancel your policy and refuse to pay any claims if you omit or falsify important medical information. Carefully review your application before signing it. Make sure all the information has been listed correctly.

Plan – A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD			
SERVICES	**MEDICARE PAYS**	**MODEL-A PAYS**	**YOU PAY**
HOSPITALIZATION*			
Semi-private room, food, general nursing services and supplies, and miscellaneous items			
First 60 days	All minus $1484	$0	$1484 (Part A deductible)
Days 61 to 90	All minus $371 per day	$371 per day	$0
Days 91 and after:			
- While the 60 lifetime reserve days are being used	All minus $742 per day	$742 per day	$0
-After the lifetime reserve days are used:			
-365 additional days	$0	100% of eligible Medicare expenses	$0**
-Beyond the 365 days	$0	$0	All expenses
CARE AT SKILLED NURSING FACILITIES*			
You must meet Medicare's requirements, including having been admitted and hospitalized for at least 3 days at a Medicare-approved facility within 30 days after being released from the hospital.			
Days 1 to 20	All approved amounts	$0	$0
Days 21 to 100	All minus $185.50 per day	$0	Up to $185.50 per day
Days 101 and after	$0	$0	All expenses
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD			
SERVICES	**MEDICARE PAYS**	**MODEL-A PAYS**	**YOU PAY**
HOSPICE CARE Available if your physician certifies you have a terminal condition and you opt to receive these services	All copayments and coinsurances, except for very low coinsurance for outpatient drugs and inpatient respite care	Medicare copayment or coinsurance	$0

*A benefit period begins on the first day you receive services as a hospitalized patient and ends after you have been released from the hospital and have not received care at a nursing home or any other facility for 60 consecutive days.

** NOTICE: When your Medicare Part A hospital benefit is exhausted, Triple-S Salud will pay any amount that Medicare would have paid for up to 365 additional days, as provided in this basic benefit policy. During this period, the hospital may not bill you for the remaining balance based on any difference between the billed charges and the amount paid by Medicare.

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR			
SERVICES	**MEDICARE PAYS**	**MODEL-A PAYS**	**YOU PAY**
MEDICAL EXPENSES – IN OR OUTSIDE THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENTS, such as doctor services, medical and surgical supplies and services for outpatients and inpatients, physical and speech therapy, diagnostic tests, and durable medical equipment.			
First $203 of Medicare-Approved Amounts***	$0	$0	$203 (Part B deductible)
Remainder of Medicare-Approved Amounts	Usually 80%	Usually 20%	$0
Part B Excess Charges (in excess of Medicare-approved amounts)	$0	$0	All expenses

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR			
SERVICES	**MEDICARE PAYS**	**MODEL-A PAYS**	**YOU PAY**
BLOOD			
First 3 pints	$0	All expenses	$0
Next $203 of Medicare-Approved Amounts***	$0	$0	$203 (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE PART A AND PART B			
SERVICES	**MEDICARE PAYS**	**MODEL-A PAYS**	**YOU PAY**
HOME HEALTH CARE SERVICES APPROVED BY MEDICARE			
Medically necessary services for skilled care and medical supplies	100%	$0	$0
Durable medical equipment:			
First $203 of Medicare-Approved Amounts***	$0	$0	$203 (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

*** After you are billed $203 from the amounts approved by Medicare for covered services (marked with an asterisk), your Part B deductible will have been met for the calendar year.

Plan – B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD			
SERVICES	**MEDICARE PAYS**	**MODEL-B PAYS**	**YOU PAY**
HOSPITALIZATION*			
Semi-private room, food, general nursing services and supplies, and miscellaneous items			
First 60 days	All minus $1484	$1484 (Part A deductible)	$0
Days 61 to 90	All minus $371 per day	$371 per day	$0
Days 91 and after:			
- While the 60 lifetime reserve days are being used	All minus $742 per day	$742 per day	$0
-After the lifetime reserve days are used:			
-365 additional days	$0	100% of eligible Medicare expenses	$0**
-Beyond the 365 days	$0	$0	All expenses
CARE AT SKILLED NURSING FACILITIES* You must meet Medicare's requirements, including having been admitted and hospitalized for at least 3 days at a Medicare-approved facility within 30 days after being released from the hospital.			
Days 1 to 20	All approved amounts	$0	$0
Days 21 to 100	All minus $185.50 per day	$0	Up to $185.50 per day
Days 101 and after	$0	$0	All expenses
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD			
SERVICES	**MEDICARE PAYS**	**MODEL-B PAYS**	**YOU PAY**
HOSPICE CARE Available if your physician certifies you have a terminal condition and you opt to receive these services	All copayments and coinsurances, except for very low coinsurance for outpatient drugs and inpatient respite care	Medicare copayment or coinsurance	$0

*A benefit period begins on the first day you receive services as a hospitalized patient and ends after you have been released from the hospital and have not received care at a nursing home or any other facility for 60 consecutive days.

** NOTICE: When your Medicare Part A hospital benefit is exhausted, Triple-S Salud will pay any amount that Medicare would have paid for up to 365 additional days, as provided in this basic benefit policy. During this period, the hospital may not bill you for the remaining balance based on any difference between the billed charges and the amount paid by Medicare.

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR			
SERVICES	**MEDICARE PAYS**	**MODEL-B PAYS**	**YOU PAY**
MEDICAL EXPENSES – IN OR OUTSIDE THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENTS, such as doctor services, medical and surgical supplies and services for outpatients and inpatients, physical and speech therapy, diagnostic tests, and durable medical equipment.			
First $203 of Medicare-Approved Amounts***	$0	$0	$203 (Part B deductible)
Remainder of Medicare-Approved Amounts	Usually 80%	Usually 20%	$0
Part B Excess Charges (in excess of Medicare-approved amounts)	$0	$0	All expenses

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR			
SERVICES	**MEDICARE PAYS**	**MODEL-B PAYS**	**YOU PAY**
BLOOD			
First 3 pints	$0	All expenses	$0
Next $203 of Medicare-Approved Amounts***	$0	$0	$203 (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE PART A AND PART B			
SERVICES	**MEDICARE PAYS**	**MODEL-B PAYS**	**YOU PAY**
HOME HEALTH CARE SERVICES APPROVED BY MEDICARE			
Medically necessary services for skilled care and medical supplies	100%	$0	$0
Durable medical equipment:			
First $203 of Medicare-Approved Amounts***	$0	$0	$203 (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

*** After you are billed $203 from the amounts approved by Medicare for covered services (marked with an asterisk), your Part B deductible will have been met for the calendar year.

Plan – C

(Members eligible for Medicare before 2020)

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD			
SERVICES	**MEDICARE PAYS**	**MODEL-C PAYS**	**YOU PAY**
HOSPITALIZATION*			
Semi-private room, food, general nursing services and supplies, and miscellaneous items			
First 60 days	All minus $1484	$1484 (Part A deductible)	$0
Days 61 to 90	All minus $371 per day	$371 per day	$0
Days 91 and after:			
- While the 60 lifetime reserve days are being used	All minus $742 per day	$742 per day	$0
-After the lifetime reserve days are used:			
-365 additional days	$0	100% of eligible Medicare expenses	$0**
-Beyond the 365 days	$0	$0	All expenses
CARE AT SKILLED NURSING FACILITIES*			
You must meet Medicare's requirements, including having been admitted and hospitalized for at least 3 days at a Medicare-approved facility within 30 days after being released from the hospital.			
Days 1 to 20	All approved amounts	$0	$0
Days 21 to 100	All minus $185.50 per day	Up to $185.50 per day	$0
Days 101 and after	$0	$0	All expenses
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD			
SERVICES	**MEDICARE PAYS**	**MODEL-C PAYS**	**YOU PAY**
HOSPICE CARE Available if your physician certifies you have a terminal condition and you opt to receive these services	All copayments and coinsurances, except for very low coinsurance for outpatient drugs and inpatient respite care	Medicare copayment or coinsurance	$0

*A benefit period begins on the first day you receive services as a hospitalized patient and ends after you have been released from the hospital and have not received care at a nursing home or any other facility for 60 consecutive days.

** NOTICE: When your Medicare Part A hospital benefit is exhausted, Triple-S Salud will pay any amount that Medicare would have paid for up to 365 additional days, as provided in this basic benefit policy. During this period, the hospital may not bill you for the remaining balance based on any difference between the billed charges and the amount paid by Medicare.

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR			
SERVICES	**MEDICARE PAYS**	**MODEL-C PAYS**	**YOU PAY**
MEDICAL EXPENSES – IN OR OUTSIDE THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENTS, such as doctor services, medical and surgical supplies and services for outpatients and inpatients, physical and speech therapy, diagnostic tests, and durable medical equipment.			
First $203 of Medicare-Approved Amounts***	$0	$203 (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	Usually 80%	Usually 20%	$0
Part B Excess Charges (in excess of Medicare-approved amounts)	$0	$0	All expenses
BLOOD			
First 3 pints	$0	All expenses	$0
Next $203 of Medicare-Approved Amounts***	$0	$203 (Part B deductible)	$0

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR			
SERVICES	**MEDICARE PAYS**	**MODEL-C PAYS**	**YOU PAY**
BLOOD Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE PART A AND PART B			
SERVICES	**MEDICARE PAYS**	**MODEL-C PAYS**	**YOU PAY**
HOME HEALTH CARE SERVICES APPROVED BY MEDICARE Medically necessary services for skilled care and medical supplies	100%	$0	$0
Durable medical equipment: First $203 of Medicare-Approved Amounts***	$0	$203 (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

*** After you are billed $203 from the amounts approved by Medicare for covered services (marked with an asterisk), your Part B deductible will have been met for the calendar year.

OTHER BENEFITS - NOT COVERED BY MEDICARE			
SERVICES	**MEDICARE PAYS**	**MODEL-C PAYS**	**YOU PAY**
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency services beginning within the first 60 days of each trip outside the United States. First $250 of every calendar year	$0	$0	$250
Remainder of Charges	$0	80% up to a maximum lifetime benefit of $50,000	20% and amounts over the lifetime maximum of $50,000

Plan – D

(Member eligible for Medicare beginning in 2020)

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD			
SERVICES	**MEDICARE PAYS**	**MODEL-D PAYS**	**YOU PAY**
HOSPITALIZATION*			
Semi-private room, food, general nursing services and supplies, and miscellaneous items			
First 60 days	All minus $1484	$1484 (Part A deductible)	$0
Days 61 to 90	All minus $371 per day	$371 per day	$0
Days 91 and after:			
- While the 60 lifetime reserve days are being used	All minus $742 per day	$742 per day	$0
-After the lifetime reserve days are used:			
-365 additional days	$0	100% of eligible Medicare expenses	$0**
-Beyond the 365 days	$0	$0	All expenses
CARE AT SKILLED NURSING FACILITIES*			
You must meet Medicare's requirements, including having been admitted and hospitalized for at least 3 days at a Medicare-approved facility within 30 days after being released from the hospital.			
Days 1 to 20	All approved amounts	$0	$0
Days 21 to 100	All minus $185.50 per day	$0	Up to $185.50 per day
Days 101 and after	$0	$0	All expenses
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD			
SERVICES	**MEDICARE PAYS**	**MODEL-D PAYS**	**YOU PAY**
HOSPICE CARE Available if your physician certifies you have a terminal condition and you opt to receive these services	All copayments and coinsurances, except for very low coinsurance for outpatient drugs and inpatient respite care	Medicare copayment or coinsurance	$0

*A benefit period begins on the first day you receive services as a hospitalized patient and ends after you have been released from the hospital and have not received care at a nursing home or any other facility for 60 consecutive days.

** NOTICE: When your Medicare Part A hospital benefit is exhausted, Triple-S Salud will pay any amount that Medicare would have paid for up to 365 additional days, as provided in this basic benefit policy. During this period, the hospital may not bill you for the remaining balance based on any difference between the billed charges and the amount paid by Medicare.

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR			
SERVICES	**MEDICARE PAYS**	**MODEL-D PAYS**	**YOU PAY**
MEDICAL EXPENSES – IN OR OUTSIDE THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENTS, such as doctor services, medical and surgical supplies and services for outpatients and inpatients, physical and speech therapy, diagnostic tests, and durable medical equipment.			
First $203 of Medicare-Approved Amounts***	$0	$0	$203 (Part B deductible)
Remainder of Medicare-Approved Amounts	Usually 80%	Usually 20%	$0
Part B Excess Charges (in excess of Medicare-approved amounts)	$0	$0	All expenses
BLOOD			
First 3 pints	$0	All expenses	$0
Next $203 of Medicare-Approved Amounts***	$0	$0	$203 (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR			
SERVICES	**MEDICARE PAYS**	**MODEL-D PAYS**	**YOU PAY**
CLINICAL LABORATORY SERVICES – BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE PART A AND PART B			
SERVICES	**MEDICARE PAYS**	**MODEL-D PAYS**	**YOU PAY**
HOME HEALTH CARE SERVICES APPROVED BY MEDICARE			
Medically necessary services for skilled care and medical supplies	100%	$0	$0
Durable medical equipment:			
First $203 of Medicare-Approved Amounts***	$0	$0	$203 (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

*** After you are billed $203 from the amounts approved by Medicare for covered services (marked with an asterisk), your Part B deductible will have been met for the calendar year.

OTHER BENEFITS - NOT COVERED BY MEDICARE			
SERVICES	**MEDICARE PAYS**	**MODEL-D PAYS**	**YOU PAY**
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency services beginning within the first 60 days of each trip outside the United States.			
First $250 of every calendar year	$0	$0	$250
Remainder of Charges	$0	80% up to a maximum lifetime benefit of $50,000	20% and amounts over the lifetime maximum of $50,000

Triple-S Salud, Inc. cumple con las leyes federales aplicables de derechos civiles y no discrimina en base a raza, color, origen de nacionalidad, edad, discapacidad, o sexo. Triple-S Salud, Inc. complies with applicable federal civil rights laws and does not discriminate because of race, color, national origin, age, disability, or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 787-774-6060, (TTY/TDD), 787-792-1370 or 1-866-215-1919. Free of charge 1-800-981-3241. If you are a federal employee or retiree call 787-774-6081, Toll Free 1-800-716-6081; (TTY / TDD) 787-792-1370; Toll-Free 1-866-215-1999 ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística llame al 787-774-6060, Libre de costo 1-800-981-3241. (TTY/TDD) al 787-792-1370 o 1-866-215-1919.

Call the customer service number on your ID card for assistance.
請撥打您 ID 卡上的客服號碼以尋求中文協助。
Gọi số dịch vụ khách hàng trên thẻ ID của quý vị để được hỗ trợ bằng Tiếng Việt.
한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.
Para sa tulong sa Tagalog, tumawag sa número ng serbisyo sa customer na nasa inyong ID card.
Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.
العربية باللغة المساعدة على للحصول هُويتك بطاقة على الموجود العملاء خدمة برقم اتصل.
Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.
Pour une assistance en français du Canada, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.
Ligue para o número de telefone de atendimento ao cliente exibido no seu cartão de identificação para obter ajuda em português.
Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.
日本語でのサポートは、IDカードに記載のカスタマーサービス番号までお電話でお問い合わせください。
Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.
Rufen Sie den Kundendienst unter der Nummer auf Ihrer ID-Karte an, um Hilfestellung in deutscher Sprache zu erhalten.
برای دریافت راهنمایی به زبان فارسی ، با شماره خدمات مشتری که بر روی کارت شناسایی شما درج شده است تماس بگیرید.

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