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, please call to 1.888.758.1616 (toll free) or 787.281.2800. 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 www.mcs.com.pr or www.healthcare.gov/sbc-glossary, or call to 1-888-758-1616 or 787-281-2800 to request a copy.

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?	**Yes, emergency services.**	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**Yes.** Major Medical Coverage: **$100** - Individual deductible / **$300** - Family deductible.	You have to meet deductibles for specific services before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**Not Applicable**	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	**Not Applicable**	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.mcs.com.pr or call 1-888-758-1616 (toll free) or 787-281-2800 (metro area) 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.

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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	$9 copay - visit to generalist	You pay 100% of the costs at the time of receiving the services. MCS will reimburse the contracted rate base with a participating provider less any copayment or co-insurance applicable for the service received.	
	Specialist visit	$15 copay - visit to specialist		
	Sub-especialist visit	$15 copay - visit to sub-specialist		
	Preventive care/screening/ immunization	No charge		
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance		
	Imaging (CT/PET scans, MRIs)	25% coinsurance		Requires preauthorization through Clinical Affairs.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.mcs.com.pr/	Generic drugs	Point of Service: $5 copay / 90-Day Supply: $10 copay / Mail Order: $10 copay	You pay 100% of the costs at the time of receiving the services. MCS will reimburse the contracted rate base with a participating provider less any copayment or co-insurance applicable for the service received.	
	Preferred brand drugs	Point of Service: 20% min. $10, max. $40 copay / 90-Day Supply: 20% min. $20, max. $80 copay / Mail Order: 20% min. $20, max. $80 copay		
	Non-preferred brand drugs	Point of Service: 20% min. $10, max. $40 copay / 90-Day Supply: 20% min. $20, max. $80 copay / Mail Order: 20% min. $20, max. $80 copay		

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)	
	Over-the-Counter Drugs (OTC)	$1 copay		
	Specialty drugs	20% coinsurance		Covered through the Specialty Drug Program.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay - outpatient facility		25% for endoscopic procedures in outpatient facility.
	Physician/surgeon fees	No charge.		
If you need immediate medical attention	Emergency room care	$0 copay - accident $40 copay - sickness	You pay 100% of the costs at the time of receiving the services. MCS will reimburse the contracted rate base with a participating provider less any copayment or co-insurance applicable for the service received.	
	Emergency medical transportation	Ground ambulance in PR: MCS will reimburse up to a maximum of $75 per trip. Air Ambulance in PR: 20% coinsurance applies to the rates established by MCS with the facility contracted for these services.		**Ground ambulance in PR** - maximum of 4 trips per year policy for reimbursement. **Air ambulance in PR** - maximum of one trip per policy year. Subject to evaluation by MCS.
	Urgent care	$25 copay		
If you have a hospital stay	Facility fee (e.g., hospital room)	$60 copay - hospitalization		
	Physician/surgeon fees	No charge.		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay - psychology visit $15 copay - psychiatrist visit	You pay 100% of the costs at the time of receiving the services. MCS will reimburse the contracted rate base with a participating provider less any copayment or co-insurance applicable for the service received.	
	Inpatient services	$60 copay - hospitalization and partial hospitalization		

* For more information about limitations and exceptions, see the plan or policy document at www.mcs.com.pr.

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 copay for specialist		Includes dependent daughters.
	Childbirth/delivery professional services	No charge.		Includes dependent daughters.
	Childbirth/delivery facility services	$60 copay - hospitalization		Includes dependent daughters.
If you need help recovering or have other special health needs	Home health care	No charge	You pay 100% of the costs at the time of receiving the services. MCS will reimburse the contracted rate base with a participating provider less any copayment or co-insurance applicable for the service received.	Maximum of 60 days per policy year. Coordinated through Clinical Affairs.
	Rehabilitation services	No charge		Covered under Home Health Care. Coordinated through Clinical Affairs.
	Habilitation services	No charge		Covered under Home Health Care. Coordinated through Clinical Affairs.
	Skilled nursing care	No charge		Coordinated through Clinical Affairs.
	Durable medical equipment	20% coinsurance		Requires prior authorization.
	Hospice services	20% coinsurance		Covered through Major Medical. Coordinated through Clinical Affairs.
If your child needs dental or eye care	Children's eye exam	$0 copay		One per policy year.
	Children's glasses	$125 Maximum Benefit each policy year		Covered through contracted facilities or reimbursement.
	Children's dental check-up	0% coinsurance - Diagnostic & Preventive 30% coinsurance - Space Maintainers 30% coinsurance - Restorative, Oral Surgery, Endodontic and Periodontic 50% coinsurance - Crowns and Prosthesis Orthodontics - covered by 50% reimbursement up to the established maximum.		Covered only if the insured has dental coverage. Maximum of $1,000 per policy year per insured. This maximum does not apply to minors under 19 years of age. Orthodontics - maximum of $1,000 per lifetime per insured person.

* For more information about limitations and exceptions, see the plan or policy document at www.mcs.com.pr.

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.)

Some General Exclusions:

- Services not medically necessary
- Charges the person is not legally obligated to pay
- Injuries arising as a result of intent to commit an Illegal act.
- Hearing aids
- Services provided and/or covered under state or federal law, for which the insured is not legally obligated to pay, such as services rendered by the Automobile Accident Compensation Administrator (Spanish acronym ACAA) and the State Insurance Fund.
- Expenses or services for new medical procedures considered experimental or investigative, until MCS determines their inclusion.
- Payments made by person covered under this policy to a participating provider without being obliged by this contract to do so.
- Drugs or medicine obtained without a doctor's prescription or not approved by the Food and Drug Administration (FDA).

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (through MCS Alivia)
- Bariatric surgery
- Chiropractic care
- Dental care (adults)
- Routine eye care (adults)
- 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: for the Puerto Rico's Office of Commissioner of Insurances, contact www.ocs.gobierno.pr or call to 787.304.8686; for the Department of Health & Human Services' Center for Consumer Information & Insurance Oversight (CCIIO) contact www.cciio.cms.gov or call to 1.877.267.2323 x. 61565; for the Department of Labor's Employee Benefits Security Administration (EBSA) contact www.dol.gov/ebsa/contactEBSA/consumerassistance.html or call to 1.866.444.EBSA (3272). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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: MCS Life Insurance Company at http://www.mcs.com.pr or calling to the number specified in the back of your health plan card, or 1.888.758.1616 toll free (TTY/TDD users 1.866.627.8182); Puerto Rico's Office of Commissioner of Insurances, contact www.ocs.gobierno.pr or call to 787.304.8686; or to Department of Labor's Employee Benefits Security Administration (EBSA) contacting www.dol.gov/ebsa/healthreform or call to 1.866.444.EBSA (3272).

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1.888.758.1616 (TTY: 1.866.627.8182).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1.888.758.1616 (TTY: 1.866.627.8182).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1.888.758.1616 (TTY: 1.866.627.8182).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1.888.758.1616 (TTY: 1.866.627.8182).

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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 *[cost sharing]*	**$15**
Hospital (facility) *[cost sharing]*	**$60**
Other *[cost sharing]*	**25%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,352**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$358
Coinsurance	$262
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$620**

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 *[cost sharing]*	**$15**
Hospital (facility) *[cost sharing]*	**$60**
Other *[cost sharing]*	**25%**

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	**$6,519**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$405
Coinsurance	$465
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$870**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist *[cost sharing]*	**$15**
Hospital (facility) *[cost sharing]*	**$60**
Other *[cost sharing]*	**25%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,573**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$348
Coinsurance	$17
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$365**

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