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.**	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?	No.	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?	**$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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, Health care not covered by the Plan and expenses of the Dental optional coverage.	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.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.

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	$10 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.	---None---
	Specialist visit	$15 copay - visit to specialist		---None---
	Subspecialist visit	$15 copay - visit to subspecialist		---None---
	Chiropractor (first visit)	$15 copay		---None---
	Chiropractor (manipulations) Physical Therapy	$0 copay $10 copay		Maximum of 20 manipulations per policy year. Physical Therapy covered without limit.
	Respiratory Therapy	$10 copay		Respiratory Therapy covered without limit.
	Preventive care/screening/ immunization	No charge		$0/0% applies as long as these services were defined as preventive service coverage in the "(P.L. 111-148) and the (P.L. 111-152). Grandfathered groups: None
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance		---None---
	Imaging (CT/PET scans, MRIs)	30% coinsurance		Requires preauthorization through Clinical Affairs.

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 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		Preferred Drug List - PDL (B) PPO Pharmacy Network Dispensing Rule B - Dispense as written. 0% coinsurance - Oral Chemotherapy through Point of Service and Mail Order 20% coinsurance, maximum $200 copay - Medical Component Drug List. 0% coinsurance - Radiotherapy and Chemotherapy Drug List. *Maintenance drugs only.
	Preferred brand drugs	Point of Service: $15 copay/ 90-Day Supply*: $30 copay/ Mail Order*: $30 copay		
	Non-preferred brand drugs	Point of Service: 20% max. $200 copay/ 90-Day Supply*: 20% max. $400 copay/ Mail Order*: 20% max $400 copay		
	Over-the-Counter Drugs (OTC)	$1 copay		According to the Food and Drug Administration (FDA), non-prescribed drugs are as safe and effective as prescribed drugs. At the same time, they offer more treatment options for various health conditions, often at a lower price than prescribed drugs are: • Non-sedative antihistamines (NSAs) • Proton Pump Inhibitors (PPIs) • Ophthalmic Solutions • Non-steroidal anti-inflammatory drugs (NSAIDS) • Antifungals • Laxatives • Analgesics • Cough combinations • Combinations for ulcer therapies • Nasal steroids

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)	
				• Artificial Tears and lubricants
	Specialty drugs	20% coinsurance, max. $200		Covered through the Specialty Drug Program
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay - outpatient facility	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.	0% for endoscopic procedures in an outpatient facility.
	Physician/surgeon fees	No charge.		---None---
If you need immediate medical attention	Emergency room care	$0 copay - accident $50 copay - sickness		---None---
	Emergency medical transportation	Ground ambulance in PR: $50 copay - trip between non-hospital facilities $0 copay - trip between hospital facilities		**Ground Ambulance in PR** - unlimited trips.
		Air ambulance in PR: $50 copay applies through contracted facilities for such services.		**Air Ambulance in PR** - includes Vieques and Culebra. Subject to evaluation by MCS.
	Urgent care	$35 copay		---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay - hospitalization		---None---
	Physician/surgeon fees	No charge.		---None---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay - psychology visit $15 copay - psychiatrist visit		Covered directly through contracted providers or through MCS Solutions. Apply specialist copay. Psychologists - covered directly through contracted providers or through MCS Solutions. Social Worker - covered only through MCS Solutions. EAP 1-8 visits without co-payment by insured person through MCS Solutions. For additional visits, apply a specialist copay.
	Inpatient services	$100 copay - hospitalization and partial hospitalization		----None---
If you are pregnant	Office visits	$15 copay for specialist		Includes dependent daughters.

* For more information about limitations and exceptions, see the plan or policy document at http://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)	
	Childbirth/delivery professional services	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.	Includes dependent daughters.
	Childbirth/delivery facility services	$100 copay - hospitalization		Includes dependent daughters.
If you need help recovering or have other special health needs	Home health care	No charge		Maximum of 60 days per policy year. Coordinated through Clinical Affairs. Unlimited hyperalimentation services; 30% coinsurance applies.
	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	$100 copay		Maximum of 60 days per policy year. Coordinated through Clinical Affairs
	Durable medical equipment	30% coinsurance		Requires preauthorization.
	Hospice services	$100 copay		Covered through basic medical coverage. Coordinated through Clinical Affairs.
If your child needs dental or vision services	Children's eye exam	$0 copay		One per policy year.
	Children's glasses	Not covered		Not covered
	Pediatric dental checkup	Not covered		Not covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (on dental coverage)
- Lenses
- Long-term care
- Private-duty nursing
- Weight loss programs
- Non-emergency care when traveling outside the US
- Infertility treatment

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
- 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)

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

- Acupuncture
- Bariatric surgery
- Hearing aids
- Routine visual care (ophthalmologist or optometrist)
- Routine foot care (podiatrist)
- Refraction test
- Chiropractic
- Value Programs
  - MCS Alivia
  - MCS Solutions
  - MCS Medilínea
  - MCS Medilínea MD
  - MCS Madres y Bebés Saludables
  - MCS Step to Wellness
  - MCS Enlace
  - MCS Asistencia al Viajero
  - MCS Rewards
  - MCS Care Clubs

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**

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

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 copayment	$15
Hospital (facility) copayment	$100
Diagnostic tests 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	**$12,257**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$314
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$714**

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	$15
Hospital (facility) copayment	$100
Diagnostic tests 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	**$6,353**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$478
Coinsurance	$558
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,036**

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

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$100
Diagnostic tests 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	**$1,633**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$285
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$305**

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