

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2026 – 12/31/2026

Coverage for: Individual/Couple/Family | Plan Type: PPO



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, 1.888.758.1616 or at 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 1-888-758-1616 or at 787-281-2800 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	Please see the common events table below to see the service costs covered by this plan .
Are there services covered before you meet your deductible ?	Yes. Preventive care and primary care services are covered before you reach your deductible .	This plan covers some items and services even if you haven't yet met the full deductible . However, 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 There are no other specific deductibles.	You must pay all costs for these services up to the specified amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	Not Applicable	The plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit ?	Premiums , Health Care not covered by the plan, Value-added Programs, Major Medical Expenses, Cost-sharing paid by a third party (example: discount programs, patient assistance programs provided by manufacturers or foundations), Expenses for the following coverages: dental and vision.	Even if you pay these expenses, they don't count toward your out-of-pocket limit .

Important Questions	Answers	Why This Matters:
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 in-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). Keep in mind that your in-network provider may use an out-of-network provider for some services (such as laboratory tests). Consult with your provider before obtaining 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	\$9 / visit	You pay 100% of the costs at the time of service. MCS will reimburse you based on the contracted rate with a participating provider less any applicable copayments or coinsurance for the services received.	
	Specialist visit	\$15 / visit		
	Sub-Specialist visit	\$15 / visit		
	Preventive care/screening/immunization	No charge		
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance		PPO Laboratory Network
	Imaging (CT/PET scans, MRIs)	25% coinsurance		Preauthorization is required from the MCS Life Clinical Affairs Department.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://mcs.com.pr/en/Pages/tools-services/drug-formulary.aspx	Generic drugs	Point of Service (POS): \$5 copayment / Retail 90-day Supply: \$10 copayment / Mail Order: \$10 copayment	You pay 100% of the costs at the time of	Drug Formulary: https://mcs.com.pr/en/Pages/tools-services/drug-formulary.aspx Rule C - Bioequivalent first option. Generic copayment plus difference brand and generic.
	Generic drugs Non-preferred	Point of Service (POS): \$5 copayment / Retail 90-day Supply: \$10 copayment / Mail Order: \$10 copayment		

* 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)	
	Preferred brand drugs	Point of Service (POS): 20% Min. \$10 Max. \$40 copayment / Retail 90-day Supply: 20% Min. \$20 Max. \$80 copayment / Mail Order: 20% Min. \$20 Max. \$80 copayment	service. MCS will reimburse you based on the contracted rate with a participating provider less any applicable copayments or coinsurance for the services received.	
	Non-preferred brand drugs	Point of Service (POS): 20% Min. \$10 Max. \$40 copayment / Retail 90-day Supply: 20% Min. \$20 Max. \$80 copayment / Mail Order: 20% Min. \$20 Max. \$80 copayment		
	Specialty drugs	20% coinsurance	You pay 100% of the costs at the time of service. MCS will reimburse you based on the contracted rate with a participating provider less any applicable copayments or coinsurance for the services received.	Covered through the Specialty Drug Program.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 / visit		25% coinsurance for endoscopic procedures in an outpatient facility
	Physician/surgeon fees	No charge		
If you need immediate medical attention	Emergency room care	No charge – accident \$40 / visit – illness		
	Emergency medical transportation	Ground ambulance in PR: MCS will reimburse up to a maximum of \$75 per trip.		Ground ambulance in PR - maximum of 4 trips per policy year under reimbursement. Air ambulance in PR - maximum of one trip per policy year. Subject to evaluation of

* 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)	
		Air ambulance in PR: A 20% coinsurance applies to the rates established by MCS with the contracted service provider for these services.	You pay 100% of the costs at the time of service. MCS will reimburse you based on the contracted rate with a participating provider less any applicable copayments or coinsurance for the services received.	MCS Life.
	Urgent care	\$25 / visit		
If you have a hospital stay	Facility fee (e.g., hospital room)	\$60 / visit		
	Physician/surgeon fees	No charge		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 / visit		
	Inpatient services	\$60 / visit (hospitalization) \$60 / visit (partial hospitalization)		
If you are pregnant	Office visits	\$15 / visit		Dependent Daughter Included
	Childbirth/delivery professional services	No charge		Dependent Daughter Included
	Childbirth/delivery facility services	\$60 / visit		Dependent Daughter Included
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 service. MCS will	Maximum of 60 days per policy year. Coordinated through MCS Life Clinical Affairs Department.
	Rehabilitation services	No charge		Covered through Home Health Care. Coordinated through MCS Life Clinical Affairs Department.
	Habilitation services	No charge		Covered through Home Health Care. Coordinated through MCS Life Clinical Affairs Department.
	Skilled nursing care	No charge		Coordinated through MCS Life Clinical Affairs Department.

* 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)	
	Durable medical equipment	20% coinsurance	reimburse you based on the contracted rate with a participating provider less any applicable copayments or coinsurance for the services received.	Preauthorization required.
	Hospice services	20% coinsurance		Covered through Major Medical coverage. Coordinated through MCS Life Clinical Affairs Department.
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		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.
		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.		

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:		
- Charges the person is not legally obligated to pay - Cosmetic surgery - Drugs or medicine obtained without a doctor's prescription or not approved by the Food and Drug Administration (FDA). - Expenses or services for new medical procedures considered experimental or investigative, until MCS determines their inclusion. - Hearing aids	- Injuries arising as a result of intent to commit an illegal act. - Long term care - Non-emergency care when traveling outside the US - Payments made by person covered under this policy to a participating provider without being obliged by this contract to do so. - Private-duty nursing - Services not medically necessary	- 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. - Treatments for infertility - Weight loss programs
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 (CCIO) contact www.ccio.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 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: 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

[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 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, kwijigo 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.

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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	\$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	\$12,350
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$360
Coinsurance	\$260
<i>What isn't covered</i>	
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 Copayment	\$15
■ Hospital (facility) Copayment	\$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	\$6,130
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$470
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,260

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	\$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	\$1,570
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$350
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$370

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