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 obtain a copy of the full coverage terms, call the following telephone numbers according to coverage; for medical-hospital services call 1.855.830.9887 or 787.945.1348, for pharmacy benefits call 1.855.252.2292 / 1.800.850.6682 TTY/TDD and for dental services call 1.855.359.6409. 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 1-855-830-9887 or 787-945-1348 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$ 0</td>
<td>See the Common Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>No</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You have to meet deductibles for specific services before this plan begins to pay for these services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Yes</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, Health care not covered by the Plan and expenses of the following coverages: Vision</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a medical network provider?</td>
<td>Yes. For the medical-hospital service network visit <a href="http://www.mcs.com.pr">www.mcs.com.pr</a> or call 1.787.945.1348 for a list of network providers.</td>
<td>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.</td>
</tr>
</tbody>
</table>

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 1-855-830-9887 or 787-945-1348 to request a copy.
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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$10 copay - visit to generalist</td>
<td>---None---</td>
<td>---None---</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$10 copay - visit to specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>25% coinsurance</td>
<td></td>
<td>$0/0% applies as long as these services were defined as preventive service coverage in the “Patient Protection and Affordable Care Act (P.L.111-148) and the “Health Care and Education Affordability Act of 2010” (P.L. 11-152)</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>25% coinsurance</td>
<td></td>
<td>---None---</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Point of Service: $0 copay / by Mail $0 copay</td>
<td>Covers pharmacies only in the United States. MC-21 LLC will reimburse you for 75% of the rate established for a network pharmacy after discounting the</td>
<td>The following rules apply:</td>
</tr>
<tr>
<td></td>
<td>Brand Drugs</td>
<td>Point of Service: 25% coinsurance / by Mail $20 copay</td>
<td></td>
<td>--- Generics as a first option /</td>
</tr>
<tr>
<td></td>
<td>New drugs</td>
<td>Point of Service: 25% coinsurance / by Mail $20 copay</td>
<td></td>
<td>--- Up to 30 and 90 days of supply for maintenance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>--- Specialty drug are not available for mailing.</td>
</tr>
</tbody>
</table>

More information about prescription drug coverage is available at www.mc-21.com
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Specialty drugs</td>
<td>Point of Service: $250 copay 30% co-insurance whichever is less</td>
<td>applicable copayment and / or co-insurance.</td>
<td>--- Some medications require pre-certification of the plan</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$25 copay - Outpatient facility</td>
<td>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.</td>
<td>0% for endoscopic procedures in outpatient facility. Requires pre-authorization through Clinical Affairs. --- None ---</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Emergency room care</td>
<td>$10 copay - accident $10 copay - sickness</td>
<td></td>
<td>--- None ---</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Ground ambulance in PR: MCS will reimburse up to a maximum of $75 per trip.</td>
<td></td>
<td>--- Ground Ambulance in PR- maximum of 4 trips per policy year per reimbursement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Air ambulance in PR: 20% coinsurance out of the fares established by MCS with the contracted facilities for such services.</td>
<td></td>
<td>-- Air Ambulance in PR- maximum of one trip per policy year. Subject to evaluation by MCS.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$10 copay - accident $10 copay - sickness</td>
<td></td>
<td>--- None ---</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$50 copay - hospitalization</td>
<td></td>
<td>--- None ---</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge.</td>
<td></td>
<td>--- None ---</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>--------------------------</td>
<td>------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$10 copay - psychology visit</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$10 copay - psychiatrist visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$50 copay - hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$50 copay - partial hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$8 copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$50 copay for hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Maximum of 60 days per policy year. Coordinated through Clinical Affairs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge</td>
<td>Covered under Home Health Care. Coordinated through Clinical Affairs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No charge</td>
<td>Covered under Home Health Care. Coordinated through Clinical Affairs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Coordinated through Clinical Affairs. Requires preauthorization.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------------------</td>
<td>-----------------------------------------</td>
<td>-------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children’s eye exam</td>
<td>$0 co-payment</td>
<td>One per policy year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>$130 maximum benefit per policy year</td>
<td>By Contracted Facility or Reimbursement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If your child needs</td>
<td></td>
<td></td>
<td>Covered as an optional benefit if you choose to subscribe to dental coverage. Up to one (1) review every six (6) months.</td>
<td></td>
</tr>
<tr>
<td>dental or eye care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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
- Long-term care
- Private-duty nursing
- Hospice
- Weight loss programs
- Non-emergency care when traveling outside the US
- Infertility treatment.

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

- Acupuncture (through MCS Alivia)
- Lenses
- Hearing aids (Covered with $250 copayment per ear every 24 months)
- Bariatric surgery
- Routine visual care (ophthalmologist or optometrist)
- Routine foot care (podiatrist)
- Chiropractic
Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. 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). 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: for medical hospital service at http://www.mcs.com.pr, for pharmacy benefits, www.mc-21.com and dental services https://deltadentalpr.com or calling to the number specified in the back of your health plan card. For the 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 para servicios médicos-hospitalarios llamar al 1.855.830.9887 o al 787.945.1348, beneficio de farmacia llamar al 1.855.252.2292/ 1.800.850.6682 TTY/TDD y para servicios dentales llamar al 1.855.359.6409
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog turnawag sa serbisyo ng medikal-ospital tawag 1.855.830.9887 o 787.945.1348, ang paghatid ng bawal na gamot (pharmacy) tawag 1.855.252.2292/ 1.800.850.6682 TTY/TDD / at serbisyo dental tawag 1.855.359.6409
Chinese (中文): 如果需要中文的帮助，请拨打这个号码医疗服务电话 1.855.830.9887 或 787.945.1348，药品供应（药房）电话 1.855.252.2292/ 1.800.850.6682 TTY/TDD，牙科服务电话 1.855.359.6409

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. 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**: $10
- **Hospital (facility) copayment**: $50
- **Diagnostic tests coinsurance**: 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**: $12,891

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$240</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$262</td>
</tr>
</tbody>
</table>

**What isn’t covered**

| Limits or exclusions | $96 |

**The total Peg would pay is**: $598

---

#### 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**: $10
- **Hospital (facility) copayment**: $50
- **Diagnostic tests coinsurance**: 20%

**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**: $7,389

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$100</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$379</td>
</tr>
</tbody>
</table>

**What isn’t covered**

| Limits or exclusions | $4,313 |

**The total Joe would pay is**: $4,792

---

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

- **The plan’s overall deductible**: $0
- **Specialist copayment**: $10
- **Hospital (facility) copayment**: $50
- **Diagnostic tests coinsurance**: 20%

**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**: $1,925

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$308</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$15</td>
</tr>
</tbody>
</table>

**What isn’t covered**

| Limits or exclusions | $0 |

**The total Mia would pay is**: $323

---

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

The Associates’ Health and Welfare Plan (AHWP) respects the dignity of each individual who participates in the Plan.

The AHWP does not discriminate on the basis of race, color, national origin, sex, age, or disability and strictly prohibits retaliation against any person making a complaint of discrimination. Additionally, we gladly provide our participants with language assistance, auxiliary aids and services at no cost. We value you as our participant and your satisfaction is important to us.

If you need such assistance or have concerns with your Plan services, please call the number on the back of your plan ID card. If you have any questions or concerns, please use one of the methods below so that we can better serve you.

For assistance, call the number on the back of your plan ID card.

To learn about or use our grievance process, contact People Services at:

- 1-800-421-1362

To file a complaint of discrimination, contact the U.S. Department of Health and Human Services, Office of Civil Rights:

- Phone: 1-800-368-1019 or 1-800-537-7697 (TDD)
- Website: https://ocrportal.hhs.gov/ocr/cp/wizard_cp.jsf
- Email: OCRCompliant@hhs.gov

Interpreter Services are available at no cost. 1-800-421-1362

Arabic
 خدمات الترجمة الفورية متاحة دون تكلفة. 214-421-1260.

Chinese
汉语普通话
翻译服务免费提供。1-800-421-1362.

Burmese

Farsi
 خدمات مترجم بدون هزینه ای در دسترس می‌باشد. 214-421-1362 1-800-421-1362
French
Des services d'interprètes sont disponibles sans frais. 1-800-421-1362.

Haitian Creole
Gen Sèvis entèprèt ki disponib gratis. 1-800-421-1362.

Japanese
通訳サービスは無料でご利用いただけます。1-800-421-1362.

Korean
통역 서비스를 무료로 이용하실 수 있습니다. 1-800-421-1362.

Polish
Usługi tłumacza dostępne są bez zadnych kosztów. 1-800-421-1362.

Portuguese
Serviços de interprète estão disponíveis grátis. 1-800-421-1362.

Punjabi
ਟੇਂਗ਼ਿਅੰਧ ਮੈਂਡਰੋ ਭੁਕਰ ਇਖਹਰਾਜ ਵਲੋ। 1-800-421-1362.

Romanian
Serviciile de interpretări sunt disponibile gratuit. 1-800-421-1362.

Russian
Переводческие Услуги оказываются бесплатно. 1-800-421-1362.

Somali
Adeegyada Turjumaanka waxaa lagu heli karaa kharash la’aan. 1-800-421-1362.

Spanish
Los servicios de interpretación están disponibles de manera gratuita. 1-800-421-1362.

Swahili
Huduma za tafsiri zipo bila malipo. 1-800-421-1362.

Vietnamese
Dịch Vụ Thồng Dịch có sẵn miễn phí. 1-800-421-1362.