Summary of Benefits and Coverage (SBC)

BRONZE

2025

TRIPLE-S SALUD

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 you can access www.ssspr.com or call (787)774-6060. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-981-3241.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$75 Individual / $150 Family for medica services	Generally, you must pay all provider costs up to the deductible amount before this plan begins to pay. If you have other family members on this plan, they must meet their own deductibles until the family's overall out-of-pocket limit is met. This deductible will apply to services provided by out-of-network providers.
Are there services covered before you meet your deductible?	Yes.	This plan covers preventive services and vaccines even if you have not yet met the deductible amount. However, a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For medical-hospital services and medications provided by in-network providers - **$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, you have to meet your own direct out-of-pocket limits until the family's out-of-pocket limit has been reached.
What is not included in the out-of-pocket limit?	Premiums, payments for non-essential benefits, payments for non-covered services, services provided by out-of-network providers.	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.ssspr.com or call 1-800-981-3241 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.https://www.healthcare.gov/sbc-glossary/

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	$0 SALUS / $10 copayment / visit	Not covered	----------none----------
	Specialist visit	$0 SALUS / $25 copayment / specialist $0 SALUS / $30 copayment / subspecialist	Not covered	----------none----------
	Preventive care/screening/ immunization	Nothing for the preventive services by Federal Law. Nothing for other immunizations. 40% coinsurance for the vaccine for the respiratory syncytial virus.	Not covered	Vaccine for respiratory syncytial virus requires pre-certification of the plan.
If you have a test	Diagnostic test (x-ray, blood work)	0% SALUS / 60% coinsurance X-rays; 0% SALUS/ 60% coinsurance laboratories	Not covered	Applies the Blue Select Network of Laboratories, Radiology and Imaging.
	Imaging (CT/PET scans, MRIs)	0% SALUS/ 75% coinsurance	Not covered	PET Scan and PET CT subject to pre-certification. MRI, up to one (1) per anatomical region. Blue Select Network.
If you need drugs to treat your illness or	Generic drugs	$10 copayment / $20 copayment for 90 days.	Not covered	The following rules apply:

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)	
condition More information about **prescription drug coverage** is available at www.ssspr.com	Preferred brand drugs	95% coinsurance / 72% coinsurance for 90 days	Not covered	• This coverage is subject to a Drug Formulary. • Generics as first option. • Up to 30 and 90 days of supply for maintenance medications. • Some medications require precertification of the plan and the use of step therapy. • • Specialty products are not available for 90 days.
	Non-preferred brand drugs	95% coinsurance / 72% coinsurance for 90 days	Not covered	
	Specialty drugs	95% coinsurance Preferred Specialty/ 95% coinsurance Non Preferred Specialty	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	60% de coinsurance	Not covered	----------none----------
	Physician/surgeon fees	75% coinsurance in ambulatory surgery	Not covered	----------none----------
If you need immediate medical attention	Emergency room care	$50 copayment due to accident/visit, $100 copayment due to illness/visit	$50 copayment due to accident/visit, $100 copayment due to illness/visit	Coinsurance can be applied for non-routine diagnostic tests.
	Emergency medical transportation	$0 in cases of emergencies. In non-emergency cases, the insured person pays the full cost and Triple-S Salud reimburses you, up to a maximum of $80 per case for reimbursement.	$0 in cases of emergencies. In non-emergency cases, the insured person pays the full cost and Triple-S Salud reimburses you, up to a maximum of $80 per case for reimbursement.	Covered through refund.
	Urgent care	$15 copay for illness or accident / visit	$15 copay for illness or accident / visit	Coinsurance can be applied for non-routine diagnostic tests.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500	Not covered	----------none----------

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)	
	Physician/surgeon fees	Nothing, except 75% coinsurance for Lithotripsy and invasive cardiovascular tests and 60% coinsurance for bariatric surgeries.	Not covered	Lithotripsy and Bariatric requires precertification. Bariatric surgery has a limit of one per lifetime, and a twelve-month waiting period.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment / group therapy $25 copayment / visit. (includes collateral); $0 SALUS facility for psychologists / visits	Not covered	----------none----------
	Inpatient services	$500; 20% admisión parcial	Not covered	----------none----------
If you are pregnant	Office visits	$0 SALUS / $25 copayment	Not covered	Depending on the type of services, a coinsurance or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	Nothing	Not covered	----------none----------
	Childbirth/delivery facility services	$500	Not covered	
If you need help recovering or have other special health needs	Home health care	60% coinsurance	Not covered	Nursing and Auxiliary Services up to a maximum of two (2) daily visits. Up to 40 visits per year for Physical, Occupational and Speech Therapies. They require recertification

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)	
	Rehabilitation services	60% coinsurance / physical therapy and 60% coinsurance chiropractor manipulations	Not covered	Up to 20 manipulations and physical therapies, combined with habilitation, per insured, per policy year.
	Habilitation services	60% coinsurance / physical therapy and 60% coinsurance chiropractor manipulations	Not covered	Up to 20 manipulations and physical therapies, combined with habilitation, per insured, per policy year.
	Skilled nursing care	60% coinsurance	Not covered	Up to 120 days per year, per insured. Requires pre-certification.
	Durable medical equipment	75% coinsurance	Not covered	Requires pre-certification of the plan
	Services through a palliative care program	Not covered	Not covered	Not covered
If your child needs dental or eye care	Children's eye exam	Nothing	Not covered	Up to one (1) refraction exam per year, per insured.
	Children's glasses	Nothing	Not covered	1 pair per year policy, per insured person up to 21 years of age.
	Children's dental check-up	Nothing	Not covered	Covered under the dental cover up to one (1) revision every six (6) months.

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.)

- Hearing aids
- Infertility treatment
- Cosmetic surgery
- Long-term care
- Private-duty nursing
- Medications administered in an outpatient facility, including injectable medications, except those required by law
- Weight loss program
- Non-emergency outside the United States

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

- Acupuncture (Triple-S Natural
- Bariatric surgery, subject to precertification
- Dental Care
- Routine foot care
- Routine eye care (Adult)
- Visual care
- Chiropractic visits

Your Rights to Continue Coverage: There are agencies that can help you if you want to keep your coverage after it ends. For more information about your rights to continue your coverage, contact the plan at (787) 774-6060. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Office of the Insurance Commissioner of Puerto Rico, B5 Tabonuco Street Suite 216 PMB 356 Guaynabo PR 00968-3029, telephone: 787-304-8686; Health Advocate PO BOX 11247 San Juan PR 00910-2347 Telephone: 787-977-0909. Other coverage options may be available to you too, including buying individual insurance coverage. For more information about individual insurance coverage, visit www.ssspr.com or call 787-774-6060 or toll free at 1-800-981-3241. There may be other coverage options available to you, such as purchasing 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: Complaints and Appeals Department at PO Box 11320 San Juan, PR 00922-9905, Fax Appeals: 787-706-4057, Email: qacomercial@ssspr.com. For more information about the appeals process, call Triple-S at (787) 774-6060 and in case of external appeals to the Office of the Insurance Commissioner, Investigation Division B5 Tabonuco Street Suite 216 PMB 356Guaynabo, PR 00968-3029, email: investigaciones@ocs.pr.gov, by fax: 787-273-6082 or by phone 787-304-8686.

Does this plan provide Minimum Essential Coverage? **Not applicable**

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 (787-774-6060)
English (Inglés): For assistance in English, call (787-774-6060)
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (787-774-6060)
Chinese (中文): 如果需要中文的帮助，请拨打这个号码(787-774-6060)
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (787-774-6060)

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** **$75**
- **Specialist** ***copayment*** **$0/$25**
- Hospital (facility) ***copayment*** **$500**
- Other ***coinsurance*** **50%**

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$75
Copayments	$525
Coinsurance	$700
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,300**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The **plan's** overall **deductible** **$75**
- **Specialist** ***copayment*** **$0/$25**
- Hospital (facility) ***copayment*** **$500**
- Other ***coinsurance*** **50%**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$75
Copayments	$525
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,200**

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

- The **plan's** overall **deductible** **$75**
- **Specialist** ***copayment*** **$0/$25**
- Hospital (facility) ***copayment*** **$500**
- Other ***coinsurance*** **60%**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$75
Copayments	$525
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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

Note: These numbers assume the patient is not participating in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact us.

787.774.6060
787.792.1370
TTY/TDD

Lunes a viernes *Monday through Friday*	7:30 a.m. - 8:00 p.m.
Sábados *Saturday*	9:00 a.m. - 6:00 p.m.
Domingos *Sunday*	11:00 a.m. - 5:00 p.m.

www.ssspr.com