Summary of Benefits and Coverage (SBC)

SILVER

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. Para obtener más información sobre su cobertura u obtener una copia de los términos completos de la cobertura, **www.ssspr.com** o llamar al **(787) 774-6060.** Para ver las definiciones de términos frecuentes, como cantidad permitida, facturación de saldo, coaseguro, copago, deducible, proveedor u otros términos subrayados, consulte el glosario. Puede consultar el glosario en https://www.healthcare.gov/sbc-glossary o llamar al **1-800-981-3241**.

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 preventive services and immunizations, 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 do not have to pay 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 copayment	Not covered	None. You may have to pay for services that are not preventive. Ask your doctor if the needed services are preventive. Then, check to see what the plan will pay
	Specialist visit	$0 SALUS / $15 copayment / specialist $0 SALUS / $25 copayment / subspecialist	Not covered	None. You may have to pay for services that are not preventive. Ask your doctor if the needed services are preventive. Then, check to see what the plan will pay.
	Preventive care/screening/ immunization	Nothing for the preventive services by Federal Law. Nothing for other immunizations 30% coinsurance for the vaccine for the respiratory syncytial virus.	Not covered	Vaccine for respiratory syncytial virus requires pre-certification of the **plan**. You may have to pay for services that are not preventive. Ask your doctor if the needed services are preventive. Then, check to see what the plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	0% SALUS / 40% coinsurance X-rays; 0% SALUS / 35% coinsurance laboratories	Not covered	Applies Blue Select Network of Laboratories, Radiology and Imaging.
	Imaging (CT/PET scans, MRIs)	0% SALUS / 45% 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	90% coinsurance / 68% 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	90% coinsurance / 68% coinsurance for 90 days	Not covered	
	Specialty drugs	Preferred Specialty: 90% coinsurance Non Preferred Specialty: 90% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copayment	Not covered	----------none----------
	Physician/surgeon fees	65% 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	Copayment 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	$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	Covered through refund.
	Urgent care	$15 copayment for illness or accident / visit	$15 copayment 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)	$350	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	None, except 65% coinsurance for lithotripsy and invasive cardiovascular tests and 50% coinsurance for bariatric surgery.	Not covered	Lithotripsy and Bariatric requires precertification. Bariatric surgery has a limit of one per lifetime, and a twelve (12) month waiting period.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copayment / group therapy $15 copayment / visit (includes collateral); $0 SALUS psychology / visit	Not covered	----------none----------
	Inpatient services	$350; Partial Admission: $50	Not covered	----------none----------
If you are pregnant	Office visits	$0 SALUS / $15 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	Nada	Not covered	----------none----------
	Childbirth/delivery facility services	$350	Not covered	----------none----------
If you need help recovering or have other special health needs	Home health care	40% 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	$15 copayment for visit / physical therapy and $15 copayment chiropractor manipulations	Not covered	Up to 20 manipulations and physical therapies, combined with habilitation, per insured, per policy year.
	Habilitation services	$15 copayment physical therapy and $15 copayment chiropractor manipulations	Not covered	Up to 20 manipulations and physical therapies, combined with habilitation, per insured, per policy year.
	Skilled nursing care	$200 copayment	Not covered	Up to 120 days per year, per insured. Requires pre-certification.
	Durable medical equipment	50% coinsurance	Not covered	Requires pre-certification of the plan.
	Hospice services	Not covered	Not covered	Not covered
If your child needs dental or eye car	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
- 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
- Infertility treatment

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 if you want to continue 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 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)

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.

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	$0/$15
Hospital (facility) copayment	$350
Other coinsurance	35%

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	$0
Copayments	$365
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$965**

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	$0/$15
Hospital (facility) copayment	$350
Other coinsurance	35%

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	$0
Copayments	$365
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$865**

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

The plan's overall deductible	$0
Specialist copayment	$0/$15
Hospital (facility) copayment	$350
Other coinsurance	40%

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	$0
Copayments	$365
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$565**

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.

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