Summary of Benefits and Coverage (SBC)

2027



Pocket Policy
Silver

Pocket

TRIPLE-S SALUD
ESTAMOS CONTIGO

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?	$0	See the Common Medical Circumstances table below for costs of services covered by this plan.
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.	No deductible 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.

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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 Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0	Not covered	----------none----------
	Specialist visit	$0 SALUS $0 Pocket Network $10 Specialist $25 subspecialist	Not covered	----------none----------
	Preventive care/screening/ immunization	Nothing for the preventive services by Federal Law. Nothing for other immunizations 30% Pocket Network / 50% 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 40% coinsurance for X-Rays 30% coinsurance for laboratories	Not covered	----------none----------
	Imaging (CT/PET scans, MRIs)	$0 SALUS/ 50% coinsurance	Not covered	PET Scan and PET CT subject to pre-certification. MRI, up to one (1) per anatomical region. Apply Blue Select Network.
If you need drugs to treat your illness or condition	Generic drugs	$10 copayment; $0 en TS en casa / $20 copayment for 90 days	Not covered	The following rules apply: • First level of coverage up to $1,000 individual, then 90% coinsurance • This coverage is subject to a Drug List. • Generics as first option.
	Preferred brand drugs	60% mín. $20 / 45% mín. $40 for 90 days	Not covered	

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
More information about **prescription drug coverage** is available at www.ssspr.com	Non-preferred brand drugs	60% mín. $25 / 45% mín. $50 for 90 days	Not covered	• 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.
	Specialty drugs	Preferred Specialized and Non-Preferred Specialized 80% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50%	Not covered	----------none----------
	Physician/surgeon fees	60%	Not covered	----------none----------
If you need immediate medical attention	Emergency room care	$50 copayment for accident or $200 copayment for illness	$50 copayment for accident or $200 copayment for illness	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 copayment	$15 copayment	Coinsurance can be applied for non-routine diagnostic tests
If you have a hospital stay	Facility fee (e.g., hospital room)	$300	Not covered	----------none----------
	Physician/surgeon fees	None, except for lithotripsy and invasive cardiovascular tests: 25% Pocket Network / 50% Bariatric surgeries: 50%	Not covered	Lithotripsy and Bariatric require pre-authorization. Bariatric surgery has a one per lifetime limit, and a twelve-month waiting period.
If you need mental health, behavioral health, or	Outpatient services	$0 Pocket Network / $10 for group therapy y visits (includes collateral)	Not covered	----------none----------

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
substance abuse services	Inpatient services	$300 0% for partial hospitalization	Not covered	----------none----------
If you are pregnant	Office visits	$0 SALUS $0 Pocket Network $10 Specialist	Not covered	Coinsurance does not apply for preventive services. Depending on the type of services, a coinsurance 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	$300	Not covered	----------none----------
If you need help recovering or have other special health needs	Home health care	20% Pocket Network / 50%	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.
	Rehabilitation services	$10 Pocket Network / $18 for physical therapy and chiropractic manipulations	Not covered	Up to 20 manipulations and physical therapies, combined with habilitation, per insured, per policy year.
	Habilitation services	$10 Pocket Network / $18 for physical therapy and chiropractic manipulations	Not covered	Up to 20 manipulations and physical therapies, combined with habilitation, per insured, per policy year.
	Skilled nursing care	$100 Pocket Network / 50%	Not covered	Up to 120 days per year, per insured. Requires pre-certification.
	Durable medical equipment	50%	Not covered	Requires pre-certification of the plan
	Hospice services	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 as 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 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.

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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*** **$0/$10**
- **Hospital (facility) *copayment*** **$300**
- **Other *coinsurance*** **35%40%**

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	$310
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$810**

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/$10**
- **Hospital (facility) *copayment*** **$300**
- **Other *coinsurance*** **35%40%**

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 (more medications)	$0
Copayments	$310
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$810**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist *copayment*** **$0/$10**
- **Hospital (facility) *copayment*** **$300**
- **Other *coinsurance*** **35%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	$310
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$510**

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 (hearing impaired)

Monday to Friday	7:30 a.m. - 8:00 p.m.
Saturday	9:00 a.m. - 6:00 p.m.
Sunday	11:00 a.m. - 5:00 p.m.

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