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# Summary of Benefits and Coverage (SBC)


Silver

Pocket



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](http://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 <a href="#">deductible</a> ?	\$0	See the Common Medical Circumstances table below for costs of services covered by this <a href="#">plan</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	This plan covers preventive services and vaccines even if you have not yet met the <a href="#">deductible</a> amount. However, a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	No.	No <a href="#">deductible</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For medical-hospital services and medications provided by in-network providers - <b>\$6,350</b> Individual / <b>\$12,700</b> Family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , you have to meet your own direct <a href="#">out-of-pocket limits</a> until the family's <a href="#">out-of-pocket limit</a> has been reached
What is not included in the <a href="#">out-of-pocket limit</a> ?	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 <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.ssspr.com">www.ssspr.com</a> or call 1-800-981-3241 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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	Not covered	-----none-----
	<a href="#">Specialist</a> visit	\$0 SALUS \$0 Pocket Network with Consulting \$10 Specialist \$25 subspecialist	Not covered	-----none-----
	<a href="#">Preventive care/screening/immunization</a>	Nothing for the preventive services by Federal Law. Nothing for other immunizations 30% Pocket Network with Consulting / 50% <a href="#">coinsurance</a> for the vaccine for the respiratory syncytial virus.	Not covered	Vaccine for respiratory syncytial virus requires pre-certification of the <a href="#">plan</a> .
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$0 SALUS 40% <a href="#">coinsurance</a> for X-Rays 30% <a href="#">coinsurance</a> for laboratories	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	\$0 SALUS/ 50% <a href="#">coinsurance</a>	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 <a href="#">copayment</a> ; \$0 en TS en casa / \$20 <a href="#">copayment</a> for 90 days	Not covered	The following rules apply: <ul style="list-style-type: none"> <li>• First level of coverage up to \$1,000 individual, then 90% <a href="#">coinsurance</a></li> <li>• This coverage is subject to a Drug List.</li> <li>• Generics as first option.</li> </ul>
	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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.ssspr.com">www.ssspr.com</a>	Non-preferred brand drugs	60% min. \$25 / 45% min. \$50 for 90 days	Not covered	<ul style="list-style-type: none"> <li>Up to 30 and 90 days of supply for maintenance medications.</li> <li>Some medications require precertification of the <a href="#">plan</a> and the use of step therapy.</li> <li>Specialty products are not available for 90 days.</li> </ul>
	<a href="#">Specialty drugs</a>	Preferred Specialized and Non-Preferred Specialized 80% <a href="#">coinsurance</a>	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	50%	Not covered	-----none-----
	Physician/surgeon fees	60%	Not covered	-----none-----
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$40 <a href="#">copayment</a> for accident or \$100 <a href="#">copayment</a> for illness	\$40 <a href="#">copayment</a> for accident or \$100 <a href="#">copayment</a> for illness	<a href="#">Coinsurance</a> can be applied for non-routine diagnostic tests
	<a href="#">Emergency medical transportation</a>	\$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.
	<a href="#">Urgent care</a>	\$0 SALUS / \$15 <a href="#">copayment</a>	\$15 <a href="#">copayment</a>	<a href="#">Coinsurance</a> can be applied for non-routine diagnostic tests
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$300	Not covered	-----none-----
	Physician/surgeon fees	None, except for lithotripsy and invasive cardiovascular tests: 25% Pocket Network with Consulting / 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.
<b>If you need mental health, behavioral health, or</b>	Outpatient services	\$0 Pocket Network with Consulting / \$10 for group therapy y visits (includes collateral)	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)	
<b>substance abuse services</b>	Inpatient services	\$300 20% for partial hospitalization	Not covered	-----none-----
<b>If you are pregnant</b>	Office visits	\$0 SALUS \$0 Pocket Network with Consulting \$10 Specialist	Not covered	<a href="#">Coinsurance</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> 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-----
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% Red Pocket Network with Consulting / 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 .
	<a href="#">Rehabilitation services</a>	\$10 Red Pocket Network with Consulting / \$18 for physical therapy and chiropractic manipulations	Not covered	Up to 20 manipulations and physical therapies, combined with habilitation, per insured, per policy year.
	<a href="#">Habilitation services</a>	\$10 Red Pocket Network with Consulting / \$18 for physical therapy and chiropractic manipulations	Not covered	Up to 20 manipulations and physical therapies, combined with habilitation, per insured, per policy year.
	<a href="#">Skilled nursing care</a>	\$100 Red Pocket Network with Consulting / 50%	Not covered	Up to 120 days per year, per insured. Requires pre-certification.
	<a href="#">Durable medical equipment</a>	50%	Not covered	Requires pre-certification of the <a href="#">plan</a>
	<a href="#">Hospice services</a>	Not covered	Not covered	Not covered

<b>If your child needs dental or eye care</b>	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:**

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Private-duty nursing</li> <li>• Medications administered in an outpatient facility, including injectable medications, except as required by law.</li> </ul>	<ul style="list-style-type: none"> <li>• Weight loss program</li> <li>• Non-emergency outside the United States</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture (Triple-S Natural</li> <li>• Bariatric surgery, subject to precertification</li> </ul>	<ul style="list-style-type: none"> <li>• Dental Care</li> <li>• Routine foot care</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Visual care</li> <li>• Chiropractic visits</li> </ul>

**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](http://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](http://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](mailto: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 356 Guaynabo, PR 00968-3029, email: [investigaciones@ocs.pr.gov](mailto: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, kwijigo 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

*Cost Sharing*

<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$310
<a href="#">Coinsurance</a>	\$500

*What isn't covered*

Limits or exclusions	\$0
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<b>The total Peg would pay is</b>	<b>\$810</b>
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### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

*Cost Sharing*

<a href="#">Deductibles</a> (more medications)	\$0
<a href="#">Copayments</a>	\$310
<a href="#">Coinsurance</a>	\$500

*What isn't covered*

Limits or exclusions	\$0
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<b>The total Joe would pay is</b>	<b>\$810</b>
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### 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

*Cost Sharing*

<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$310
<a href="#">Coinsurance</a>	\$200

*What isn't covered*

Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$510</b>
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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)

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Monday to Friday 7:30 a.m. - 8:00 p.m.

Saturday Sunday 9:00 a.m. - 6:00 p.m.

11:00 a.m. - 5:00 p.m.

[www.ssspr.com](http://www.ssspr.com)