

20  
26



# Summary of Benefits and Coverage (SBC)

## Triple-S Directo Silver



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](http://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 <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	This plan covers preventive services and immunizations, 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.	You do not have to pay <a href="#">deductibles</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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$0 <a href="#">copayment</a>	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
	<a href="#">Specialist</a> visit	\$0 SALUS / \$15 <a href="#">copayment</a> / specialist \$0 SALUS / \$25 <a href="#">copayment</a> / 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.
	<a href="#">Preventive care/screening/immunization</a>	Nothing for the preventive services by Federal Law. Nothing for other immunizations 30% <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> . 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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% SALUS / 40% <a href="#">coinsurance</a> X-rays; 0% SALUS / 35% <a href="#">coinsurance</a> laboratories	Not covered	Applies Blue Select Network of Laboratories, Radiology and Imaging.
	Imaging (CT/PET scans, MRIs)	\$0 SALUS / 45% <a href="#">coinsurance</a>	Not covered	PET Scan and PET CT subject to pre-certification. MRI, up to one (1) per anatomical region. Blue Select Network.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.ssspr.com">www.ssspr.com</a>	Generic drugs	\$10 <a href="#">copayment</a> / \$20 <a href="#">copayment</a> for 90 days	Not covered	<p>The following rules apply:</p> <ul style="list-style-type: none"> <li>• This coverage is subject to a Drug Formulary.</li> <li>• Generics as first option.</li> <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> </ul>
	Preferred brand drugs	90% <a href="#">coinsurance</a> / 68% <a href="#">coinsurance</a> for 90 days	Not covered	
	Non-preferred brand drugs	90% <a href="#">coinsurance</a> / 68% <a href="#">coinsurance</a> 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)	
	<a href="#">Specialty drugs</a>	Preferred Specialty: 90% <a href="#">coinsurance</a> Non Preferred Specialty: 90% <a href="#">coinsurance</a>	Not covered	• Specialty products are not available for 90 days.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$200 <a href="#">copayment</a>	Not covered	-----none-----
	Physician/surgeon fees	65% <a href="#">coinsurance</a> in ambulatory surgery	Not covered	-----none-----
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$50 <a href="#">copayment</a> due to accident / visit, \$100 <a href="#">copayment</a> due to illness / visit	\$50 <a href="#">copayment</a> due to accident / visit, \$100 <a href="#">copayment</a> due to illness / visit	<a href="#">Copayment</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	\$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.
	<a href="#">Urgent care</a>	\$0 SALUS \$15 <a href="#">copayment</a> for illness or accident / visit	\$15 <a href="#">copayment</a> for illness or accident / visit	<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)	\$350	Not covered	-----none-----
	Physician/surgeon fees	None, except 65% <a href="#">coinsurance</a> for lithotripsy and invasive cardiovascular tests and 50% <a href="#">coinsurance</a> 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.

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>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$15 <a href="#">copayment</a> / group therapy \$15 <a href="#">copayment</a> / visit (includes collateral); \$0 SALUS psychology / visit	Not covered	-----none-----
	Inpatient services	\$350; Partial Admission: 0%	Not covered	-----none-----
<b>If you are pregnant</b>	Office visits	\$0 SALUS / \$15 <a href="#">copayment</a>	Not covered	Depending on the type of services a <a href="#">coinsurance</a> or <a href="#">copayment</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	\$350	Not covered	-----none-----
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a>	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>	\$15 <a href="#">copayment</a> for visit / physical therapy and \$15 <a href="#">copayment</a> chiropractor manipulations	Not covered	Up to 20 manipulations and physical therapies, combined with habilitation, per insured, per policy year.
	<a href="#">Habilitation services</a>	\$15 <a href="#">copayment</a> physical therapy and \$15 <a href="#">copayment</a> chiropractor manipulations	Not covered	Up to 20 manipulations and physical therapies, combined with habilitation, per insured, per policy year.

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>If your child needs dental or eye care</b>	<a href="#">Skilled nursing care</a>	\$200 <a href="#">copayment</a>	Not covered	Up to 120 days per year, per insured. Requires pre-certification.
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a>	Not covered	Requires pre-certification of the plan.
	<a href="#">Hospice services</a>	Not covered	Not covered	Not covered
	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 <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> .)		
<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Cosmetic surgery</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Medications administered in an outpatient facility, including injectable medications, except those required by law</li> </ul>	<ul style="list-style-type: none"> <li>Weight loss program</li> <li>Non-emergency outside the United States</li> <li>Infertility treatment</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<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 356Guaynabo, 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$0/\$15
■ Hospital (facility) <a href="#">copayment</a>	\$350
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$365
<a href="#">Coinsurance</a>	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$965</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$0/\$15
■ Hospital (facility) <a href="#">copayment</a>	\$350
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$365
<a href="#">Coinsurance</a>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$865</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$0/\$15
■ Hospital (facility) <a href="#">copayment</a>	\$350
■ Other <a href="#">coinsurance</a>	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>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$365
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$565</b>

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)