HEALTH PLAN SUMMARY OF BENEFITS 2025

Rent a Center

TRIPLE-S SALUD

Rent A Center (Effective Date: 1/1/2025)	
Service	**Deductibles, Copays and Coinsurance**
Basic Coverage	
Maximum Out of Pocket for medical, pharmacy and hospital services given by participating providers * * Non-essential benefits, services not covered or given by providers outside our network aren't elegible for the accumulation of maximum out of pocket.	$6,350 Individual $12,700 Family
Preventive	
Preventive Services (including those for females)	$0
Preventive Immunization (Vaccines)	$0
Immunizations (Vaccines) for Respiratory Syncytial Virus	0%
Medical Visits	
General Practitioner	$12, Salus $0
Specialist (including psychologist and psychiatrist)	$15, Salus $0
Subspecialist	$20, Salus $0
Tests	
Labs	In 35% / Out 50%
X-Rays	In 35% / Out 50%
Specialized Tests	In 35% / Out 50%
Allergy tests	$0, up to fifty (50) tests per policy year
Lithotripsy	25%
Ambulatory	
Ambulatory Surgery	$100
Therapy	
Physical Therapy	$7
Respiratory Therapy	$7
Mental Health	
Group Therapy	$5
Collateral Visits	$15
Emergency Room	
Accident	$50
Illness	$75
Recommended by Teleconsulta	$25
Urgent Care Facility	
Accident	$25
Illness	$35
Hospitalization	
Regular	Preferred $100,Non-Preferred $200
Partial (due to mental illness)	Preferred $50,Non-Preferred $100
Other	
Durable Medical Equipment	25%
Services in United States	Services provided in the United States are covered through the Blue Cross & Blue Shield (BCBS) network and require prior authorization.

Table continues on the next page.

Rent A Center (Effective Date: 1/1/2025)	
Pharmacy	
Rule of Generic Mandatory Medication	If the plan member prefers, or the doctor prescribes, a brand name drug instead of a generic drug, even if the doctor writes the original or does not substitute it on the prescription, the plan member will pay the copayment for the brand name drug plus the difference between the cost of brand name and generic drugs
Generic Medication	$10
Preferred Brand Medication	15% minimo $15.00
Non-Preferred Brand Medication	25% minimo $25.00
Preferred Specialized Medication	30%
Non-Preferred Specialized Medication	30%
OTC Medications (Triple-S specified list)	$0
Oral Chemotherapy Drug	0%
90-Day Supply for Maintenance Medication through Pharmacy	
Generic Medication	$20
Preferred Brand Medication	11% minimo $30.00
Non-Preferred Brand Medication	25% minimo $75.00
Vision	
Glasses or Contact Lenses	$150.00 every two (2) years
Refraction Exam	$0
Dental	
Diagnostic and Preventive Services	$0
Restorative Services	$0
Endodontics	20%, services up to $1,000.00 per policy year
Oral Surgery	20%
Periodontics	20%
Prostheses and Crowns	50%, up to $1,000.00 per policy year
Orthodontics	covered up to $1,000 for life
Major Medical	
Initial Deductible	$100 per insured, $300 per family
Coinsurance	20%
Maximum Payout	$2,000 per insured, $6,000 per family
Organ and Tissue Transplant	
Maximum $2,000,000 per life, Covers only transplantation of human organs and tissues, subject to pre-certification from Triple-S Salud. These services will be covered only through the facilities contracted by Triple-S Salud in and outside of Puerto Rico. They will be covered at 100% of the rates negotiated with facilities contracted by Triple-S Salud, without being subject to coinsurance or deductibles.	
Other Benefits	
Employee Assistance Program (EAP) for Mental Health Services	Evaluation and treatment services include up to ten (10) sessions per employee and each eligible dependent, per policy year. Includes up to four (4) seminars per employer.
Triple-S Natural (alternative medicine)	Maximum of 6 visits with $15 copay
Sanitas Urgent Clinics (Florida)	$50

This is a brief informational summary and does not replace or modify the policy. We urge you to review the Certificate of Benefits (Policy) so that you know in detail the benefits, limitations and exclusions of the cover.