BRILLANTE

(HMO-POS)

SUMMARY OF BENEFITS 2027

TRIPLE-S ADVANTAGE

ESTAMOS CONTIGO

SUMMARY OF BENEFITS 2027

January 1, 2027 –December 31, 2027

This Summary of Benefits contains information on the following Triple-S Advantage plan:

- Brillante (HMO-POS)

Triple-S Advantage, Inc. is a health maintenance organization (HMO) with a Medicare contract. Enrollment in Triple-S Advantage, Inc. depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service we cover or list every limitation or exclusion. To get a complete list of covered services, request the **Evidence of Coverage** by calling Member Services or visiting our website at www.sssadvantage.com.

To enroll in **Brillante (HMO-POS)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be a citizen of or lawfully present in the United States and live in our service area. Our service area includes the 78 municipalities in Puerto Rico.

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Premiums And Benefits	Brillante (HMO-POS)
Monthly Plan Premium You must continue to pay your Medicare Part B premium.	**$0** monthly premium
Part B Premium Reduction	**$40** per month.
Deductible This plan has no deductible.	You pay nothing.
Maximum Out-of-Pocket Costs (does not include prescription drugs) The maximum amount you will pay in copayments, coinsurance, and other expenses for medical services during the year.	$4,200 annually.
Inpatient Hospital Coverage This plan covers an unlimited number of days for an inpatient hospital stay. Services provided in an Inpatient Hospital Care for Intensive Rehabilitation Program require prior authorization.	Preferred Provider Network: $50 copay. Provider Network: $150 copay. Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.

SUMMARY OF BENEFITS 2027

January 1, 2027 –December 31, 2027

Premiums And Benefits	Brillante (HMO-POS)
Outpatient Hospital Coverage Some services may require prior authorization **Observation Care Coverage** Some services may require prior authorization.	Preferred Provider Network: $25 copay. Provider Network: $50 copay. You pay nothing. Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.
Ambulatory Surgery: • Ambulatory surgery center • Ambulatory facility in a hospital Some services may require prior authorization.	$25 copay $25 copay Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.
Doctor Visits: • Primary Care Physician • Specialist • Surgeries and/or procedures in a physician's office (may require prior authorization)	You pay nothing. Preferred Provider Network: You pay nothing. Provider Network: $15 copay. Preferred Provider Network: You pay nothing. Provider Network: $15 copay.

Premiums And Benefits	Brillante (HMO-POS)
	Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.
Preventive Care (e.g., flu vaccine, diabetes screening) Any additional preventive services that are approved by Medicare during the year will be covered.	You pay nothing. Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.
Emergency Care If you are admitted to the hospital within 24 hours for the same condition for which you were evaluated in the emergency room, you pay nothing for the emergency room visit. Services in the United States may also be handled through reimbursement according to Medicare rates and the location where the services were provided, minus copayment.	$50 copay.
Urgently Needed Services Services in the United States may also be handled through reimbursement according to Medicare rates and the location where the services were provided, minus copayment.	You pay nothing.
Diagnostic Services / Laboratories / Imaging: • Diagnostic tests and procedures • Laboratory service	Preferred Provider Network: You pay nothing. Provider Network: 20% coinsurance. Preferred Provider Network: You pay nothing.

Premiums And Benefits	Brillante (HMO-POS)
• Diagnostic Radiology Services (e.g. MRI) • X-Rays • Therapeutic radiology services Some services may require prior authorization.	Provider Network: 20% coinsurance. Preferred Provider Network: You pay nothing. General: You pay nothing. Complex: $75 copay. You pay nothing. You pay nothing. Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.
Hearing Services: • Hearing exam • Routine hearing exam (One (1) routine hearing exam every year) • Hearing aid fitting / evaluation (One (1) every year) • Hearing aids	You pay nothing. You pay nothing. You pay nothing. You pay nothing. Up to **$2,000** every 3 years. Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.

SUMMARY OF BENEFITS 2027

January 1, 2027 –December 31, 2027

Premiums And Benefits	Brillante (HMO-POS)
Dental Services: **Preventive:** Oral exam, cleaning, Fluoride and X-rays • One (1) cleaning every six months. • Dental X-ray • One (1) Fluoride treatment every six months. • One (1) oral exam every six months. **Comprehensive:** May require prior authorization. Covered services include but are not limited to restorations, periodontics, prosthodontics, endodontics (root canal). A maximum benefit limit applies for some services.	You pay nothing. You pay nothing. Up to **$3,000** coverage limit per year. Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.
Vision Services: • Eye exam (one (1) per year) • Routine eye exam (one (1) per year) • One (1) pair of eyeglasses or contact lenses after every cataract surgery. • Eyeglasses (frame & lenses), contact lenses.	You pay nothing. You pay nothing. You pay nothing. You pay nothing. Up to **$300** per year. Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.
Mental Health Services: • Inpatient (up to one hundred ninety (190) days lifetime in a psychiatric hospital) • Individual therapy visits	You pay nothing. You pay nothing.

Premiums And Benefits	Brillante (HMO-POS)
• Group therapy visits • Partial hospitalization (some services may require prior authorization)	You pay nothing. You pay nothing. Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.
Skilled Nursing Facility (SNF) Up to one hundred (100) days in an SNF per benefit period. Not require previous hospital stay. Requires prior authorization.	You pay nothing. Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.
Physical Therapy These services are subject to Medicare-set caps for rehabilitation services. Ask your provider to validate if the service you need is available. Some services may require prior authorization.	You pay nothing. Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.
Ambulance Non-emergent transportation requires prior authorization.	$65 copay. Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.
Transportation One-way trips for medical destinations.	You pay nothing. Up to **30** trips a year. Out-of-Network (Point of Service Option):

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	35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.
Medicare Part B Drugs • Respiratory therapy drugs • Chemotherapy drugs • Part B Insulins • Other Part B drugs Some services may require prior authorization. Step Therapy may apply for: Part B to Part B, Part B to Part D, Part D to Part B.	You pay nothing. 20% coinsurance. You pay nothing. 20% coinsurance. Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.
Rehabilitation Services: • Occupational therapy visit • Speech / language therapy visit These services are subject to Medicare-set caps for rehabilitation services. Ask your provider to validate if the service you need is available. Some services may require prior authorization.	You pay nothing. You pay nothing. Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.
Foot Care (Podiatry Services): • Foot exams and treatment • Additional routine foot care, up to four (4) visits per year, including the initial visit.	You pay nothing. You pay nothing. Out-of-Network (Point of Service Option):

Premiums And Benefits	Brillante (HMO-POS)
	35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.
Medical Equipment and Supplies: • Durable Medical Equipment (e.g., wheelchairs, oxygen)	Preferred brands and manufacturers: You pay nothing. Non-preferred brands and manufacturers: 10% coinsurance.
• Prosthetics (e.g. braces, artificial limbs): ▪ Orthopedic devices, non-surgically implanted prosthesis and cardiovascular devices	You pay nothing.
▪ Surgically implanted prosthesis, urinary system, and neuro-stimulating prosthetic device	20% coinsurance.
• Medical supplies	Preferred brands and manufacturers: You pay nothing. Non-preferred brands and manufacturers: 10% coinsurance.
• Supplies for diabetes Some durable medical equipment, prosthetics, and medical and diabetics supplies may require prior authorization.	You pay nothing. Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.
Wellness Program: • Health education materials, group interventions, and telephone education	You pay nothing.

Premiums And Benefits	Brillante (HMO-POS)
on nutrition and weight management based on your health profile. • Teleconsulta – Nursing line for health consultations, available 24 hours a day, 7 days a week. Members can call 1-800-255-4375. • Teleconsejo – Emotional support line available 24 hours a day, 7 days a week. Members can call 1-800-383-4457. • MiConsulta MD – Care stations where you can connect with a healthcare professional virtually and privately without prior appointments, and receive an instant assessment and diagnosis. Prescriptions and medical orders are provided according to the evaluation performed. For information about locations and hours, please contact our plan.	You pay nothing. You pay nothing. You pay nothing.
Chiropractic: • Visits covered by Medicare to correct subluxation. • Routine visits Up to five (5) routine visits, per year, including the initial visit. Manipulation of the spine to correct subluxation (when one or more of your spine bones move out of position).	$5 copay. $5 copay. You pay nothing at SALUS Clinics. Other providers are available in our network. Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services
Additional Telehealth Services: • Consultations with a Primary Care Physician	You pay nothing.

Premiums And Benefits	Brillante (HMO-POS)
• Consultations with Specialists	Preferred Provider Network: You pay nothing. Provider Network: $15 copay.
• Consultations for Kidney Condition Education Services	You pay nothing.
• Diabetes Self-Management Training Consultations	You pay nothing.
• Individual Consultations with a Psychiatrist or Psychologist. Contact your doctor to validate if you offer additional Telehealth services and provide you with information about the means of contact to use.	You pay nothing.
Over-the-Counter Drugs and Items (OTC) Some covered categories are: Analgesics anti-Inflammatory(NSAIDs) and non-narcotic, antihistamine hypnotics, anorectal agents, antidiarrheal, antiemetic, cough/cold/allergy products, Covid-19 tests, diabetes management supplies, dermatologicals, first aid supplies, footcare (antifungals), hair & scalp treatment (anti-dandruff shampoo), laxatives, minerals & electrolytes, oral care, naloxone product, nasal agents, nutritional supplements such as fish oil and omega 3, nutritional drinks, smoking deterrents, otic agents, ophthalmic agents (artificial tears and lubricants), supportive items for comfort, topical sunscreen, urinary analgesics, vaginal products, vitamins & minerals, calcium, cobalamins, folic acid, iron,	**$30 every three months** (non-cumulative).

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weight loss items, adult diapers/pads, and blood pressure monitor. **To access the benefit, you can use your ComboCard or your plan membership card at certain establishments.** **The blood pressure monitor is covered up to one (1) every 5 years.**	
Erectile Dysfunction Drugs Sildenafil Citrate (25, 50, and 100 mg) Tadalafil (10 and 20 mg) Up to six (6) pills monthly.	Tier 2: Generics.
Alternative Medicine / Acupuncture Up to twelve (12) combined visits each year.	You pay nothing. Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.
Nutritional / Dietary Benefit A maximum of twelve (12) individual visits per year to a nutritionist.	You pay nothing. Out-of-Network (Point of Service Option): 35% coinsurance for covered services. This plan has a maximum limit per year of $5,000 for out of network services.

Outpatient Prescription Drugs

Our plans group every drug in one of six (6) cost-sharing tiers. The amount you pay depends on the pharmacy you choose and when you change from one stage to another within the Part D benefit (Initial Coverage Stage and Catastrophic Coverage Stage).

For additional information on pharmacy cost-sharing and the benefit stages, please call us or access the **Evidence of Coverage** on our webpage.

Deductible: This plan does not have a deductible.

Stage 1: Initial Coverage Stage

What you pay until the total amount for the prescription drugs you have filled reaches $2,400.

Drug Tier (Initial Coverage Stage)	Brillante (HMO-POS)
Tier 1 – Preferred Generics	
Preferred Retail Pharmacy	
• 30-day supply	You pay nothing.
• 90-day supply	You pay nothing.
Mail Order	You pay nothing.
Standard Retail Pharmacy	
• 30-day supply	$5 copay.
• 90-day supply	$10 copay.
Tier 2 – Non-Preferred Generics	
Preferred Retail Pharmacy	
• 30-day supply	You pay nothing.
• 90-day supply	You pay nothing.
Mail Order	You pay nothing.
Standard Retail Pharmacy	
• 30-day supply	$10 copay.
• 90-day supply	$20 copay.
Tier 3 – Preferred Brand	
Preferred Retail Pharmacy	
• 30-day supply	$10 copay.
• 90-day supply	$20 copay.

Drug Tier (Initial Coverage Stage)	Brillante (HMO-POS)
Mail Order	$20 copay.
Standard Retail Pharmacy • 30-day supply	$45 copay.
• 90-day supply	$90 copay.
Tier 4 – Non-Preferred Brand	
Preferred Retail Pharmacy • 30-day supply	$40 copay.
• 90-day supply	$80 copay.
Mail Order	$80 copay.
Standard Retail Pharmacy • 30-day supply	$60 copay.
• 90-day supply	$120 copay.
Tier 5 – Specialty Drugs	
Preferred Retail and Standard Pharmacy. • 30-day supply	33% coinsurance.
• 90-day supply	33% coinsurance.
Mail Order	33% coinsurance.
Tier 6 – Select Care Drugs	
Preferred Retail Pharmacy • 30-day supply	You pay nothing.
• 90-day supply	You pay nothing.
Mail Order	You pay nothing.
Standard Retail Pharmacy • 30-day supply	$3 copay.
• 90-day supply	$6 copay.

Stage 2: Catastrophic Coverage Stage

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,400.01 limit for the calendar year. During this stage, the plan will pay all the costs for your Part D covered drugs. You pay nothing.

Additional Notices

Triple-S Advantage, Inc. is an independent licensee of the BlueCross BlueShield Association.

Brillante (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. Except in case of emergency, if you use a provider that is not in our network, the plan may not pay for these services.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users must call 1-877-486-2048.

This document is available for free in Spanish. This document is also available in alternate formats such as braille, large print, and audio. Please contact Member Services if you need plan information in another format or language.

For more information, call us toll-free at our Member Service Center at 1-888-620-1919 (TTY/TDD 1-866-620-2520). You can call us Monday through Sunday from 8:00 a.m. to 8:00 p.m., Atlantic standard time. If you are not a member of our plan, you can call toll-free at 1-877-207-8777 (TTY/TDD 1-866-620-2520). You can also visit our webpage at www.sssadvantage.com.

You can go to www.sssadvantage.com to see your plan's Provider and Pharmacy Directories. You can also view the complete plan Formulary (list of Part D prescription drugs) to see which drugs are covered and if there are any restrictions.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Under this plan, you have a Point-of-Service (POS) option. The POS option allows you to use doctors and hospitals outside of the plan's provider network. Under the Point-of-Service (POS) option for out-of-network services, you have a maximum benefit limit of **$5,000** per year for some services and may require higher cost-sharing than you would pay when using network providers. Please review your **Evidence of Coverage** for more information.

Out-of-network/non-contracted providers are under no obligation to treat Triple-S Advantage, Inc. members, except in emergency situations. Please call our Customer Service number or see your **Evidence of Coverage** for more information, including the cost-sharing that applies to out-of-network services. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for an organizational determination before you receive the service.

Out-of-network covered services under the Point-of-Service (POS) option may be subject to reimbursement. Payments will be subject to the service being covered and medically necessary, and the rate to be paid for the service will not necessarily be the rate presented by the provider that rendered the service, minus the corresponding coinsurance of your plan coverage and following the monetary limits of each benefit.

Benefits, and/or copays/coinsurance may change on January 1st of every year.

Please refer to the **Evidence of Coverage** for more information**.**

NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS AND NONDISCRIMINATION STATEMENT

Discrimination is Against the Law

Triple-S Advantage, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)**). Triple-S Advantage, Inc.** does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Triple-S Advantage, Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact a Service Representative of Triple-S Advantage.

If you believe that **Triple-S Advantage, Inc**. has failed to provide these services or discriminated in another way on the basis of race, color national origin, age, disability, or sex, you can file a grievance with:

Service Representative
Grievances & Appeals Unit
P.O Box 11320,
San Juan, PR 00922-1320
Telephone: 1-888-620-1919, TTY: 1-866-620-2520
Fax. 787-993-3261
E-mail: appeals-grievances@sssadvantage.com

You can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, a **Service Representative** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services,

200 Independence Avenue SW

Room 509F, HHH Building

Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at Triple-S Advantage website: sssadvantage.com.

Aviso de Disponibilidad de Servicios de Asistencia Lingüística, Ayudas y Servicios Auxiliares / Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-888-620-1919 (TTY/TDD 1-866-620-2520) or speak to your provider.

Español: ATENCION: Si usted habla español, servicios de asistencia lingüística gratuitos están disponibles para usted. También están disponibles ayudas y servicios auxiliares apropiados para proporcionar información en formatos accesibles, sin costo adicional. Llame al 1-888-620-1919 (TTY/TDD 1-866-620-2520) o hable con su proveedor.

中文 注意：如果您说[[中文]]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-888-620-1919 **（文本电话：**1-866-620-2520**）或咨询您的服务提供商。**

한국어 주의: [[한국어]]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-888-620-1919 (TTY: 1-866-620-2520) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Português: ATENÇÃO: Se você fala português do Brasil, tem à disposição serviços gratuitos de assistência linguística. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-888-620-1919 (TTY 1-866-620-2520) ou fale com seu provedor.

Français**:** ATTENTION: si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-888-620-1919 (TTY 1-866-620-2520) ou parlez à votre fournisseur.

Italiano: ATTENZIONE: se parli italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-888-620-1919 (TTY 1-866-620-2520) o parla con il tuo fornitore.

Deutsch: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-888-620-1919 (TTY +1-866-620-2520) an oder sprechen Sie mit Ihrem Provider

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-888-620-1919 (TTY: 1-866-620-2520) o makipag-usap sa iyong provider.

РУССКИЙ**:** ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-888-620-1919 (TTY: 1-866-620-2520) или обратитесь к своему поставщику услуг.

العربية

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-888-620-1919 (TTY 1-866-620-2520) أو تحدث إلى مقدم الخدمة".

हिंदी: ध्यान दें : यदि आप हिंदी बोलते हैं ै ं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-888-620-1919 (TTY: 1-866-620-2520) पर कॉल करें या अपने प्रदाता से बात करें।

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको लागि निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। सुलभ प्रारूपहरूमा जानकारी प्रदान गर्नको लागि उपयुक्त सहायक साधन र सेवाहरू पनि निःशुल्क उपलब्ध छन्। १-८८८-६२०-१९१९ (टिटवाई/टीडीडी १-८६६-६२०-२५२०) मा कोल गर्नुहोस् वा तपाईंको प्रदायकसँग कुरा गर्नुहोस्।

Kreyòl Ayisyen: TANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang free disponib pou ou. Zouti ak sèvis sekondè ki konvenab pou bay enfòmasyon nan fòm ki aksesib tou disponib gratis. Rele 1-888-620-1919 (TTY/TDD 1-866-620-2520) oubyen pale ak pwovidè ou.

יידיש

נאטיץ: אויב איר רעדט יידיש, שפּראך הילף סערוויסעס זענען בארעכטיגט פאר דיר פריי. צונעמען אַידס און באַדינונגס פֿאַר פּראַווייַדינג אינפֿאָרמאַציע אין צוטריטלעך פֿאָרמאַטירונגען זענען אויך בנימצא פריי. רופן (TTY: 1-866-620-2520 1-888-620-1919) אָדער רעדן מיט דיין טרעגער."

עברית

נגישים בפורמטים מידע לספק מתאימים ושירותים עזר אביזרי .לכם זמינים בחינם בשפה סיוע שירותי ,עברית דוברים אתם אם :לב שימו .בחינם הם גם זמינים .ל-1-888-620-1919 (TTY/TDD 1-866-620-2520) התקשרו או דברו עם ספקכם.

TRIPLE-S ADVANTAGE

PRE-ENROLLMENT CHECKLIST

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-888-620-1919 (TTY 1-866-620-2520).

UNDERSTANDING THE BENEFITS

___ The Evidence of Coverage (EOC) provides a complete list of all coverages and services. It is important to review the plan's coverage, costs, and benefits before enrolling. Visit www.sssadvantage.com or call 1-888-620-1919 (TTY 1-866-620-2520) to view a copy of the EOC.

___ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

___ Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

___ Review the Formulary to make sure your drugs are covered.

UNDERSTANDING IMPORTANT RULES

___ In addition to your monthly plan premium (if applicable), you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

___ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2028.

___ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the Provider Directory).

___ For **PPO and HMO-POS** plans - Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services or certain covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher cost for services received by non-contracted providers.

___ For **Chronic Conditions Special Needs** plan - This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

___ For **Platino** plans - This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a State plan under Medicaid.

___ If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

Triple-S Advantage is an independent licensee of the BlueCross BlueShield Association.