

Summary of Benefits and Coverage

Coverage Period: 01/01/2017–12/31/2017

Coverage for: Self Only, Self Plus One or Self and Family | Plan Type: HMO



This is only a summary. Please read the FEHB Plan brochure (RI 73-016) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. You can get the FEHB Plan brochure at www.ssspr.com or by calling 787-774-6081.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$6,600 Self / \$13,200 Self Plus One / \$13,200 Self and Family	The <u>out-of-pocket limit</u> , or catastrophic maximum, is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for health care expenses. The "per covered individual" amount is the most that any one member would have to pay, regardless of whether the individual is enrolled in Self Plus One, or Self and Family.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, payments for non-essential benefits, payments for services not covered, services provided by non-network providers.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of <u>providers</u> ?	Yes. For a list of network providers , visit www.ssspr.com or call (787) 774-6081.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. We use the terms preferred or participating for providers in our network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See this plan's FEHB brochure for additional information about excluded services .

Questions: Call (787) 774-6081 or visit us at www.ssspr.com.

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$7.50 copay / visit	10% of the allowable charges after applicable copay, plus any difference between our allowance and the billed amount	—————none—————
	Specialist visit Subspecialist visit	\$10 copay / specialist visit \$10 copay / subspecialist visit	10% of the allowable charges after applicable copay, plus any difference between our allowance and the billed amount	—————none—————
	Other practitioner office visit	\$7.50 copay / podiatrist and optometrist No charge / chiropractor visit	10% of the allowable charges after applicable copay, plus any difference between our allowance and the billed amount	Up to 15 chiropractor manipulations per policy year
	Preventive care / screening / immunization	No charge	10% of the allowable charges plus any difference between our allowance and the billed amount	—————none—————
If you have a test	Diagnostic test (x-ray, blood work)	\$1.00 copay / per blood work No charge / x-ray	10% of the allowable charges after applicable copay, plus any difference between our allowance and the billed amount	—————none—————
	Imaging (CT/PET scans, MRIs)	No charge	10% of the allowable charges plus any difference between our allowance and the billed amount	Pet scan and PET CT, subject to pre-certification.

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ssspr.com .	Generic drugs	No charge / No charge for mail order	Prescription drug coverage - covered in United States or its territories by reimbursement to the members up to 75% of Triple-S Salud established fees, less the applicable drug co-payment or co-insurance.	The following rules apply: <ul style="list-style-type: none"> • Subject to a prescription drug list • Generic drugs as first option. • Up to 30 (retail) and 90 (mail order) day supply for maintenance drugs. • Some medications require precertification from the plan and the use of step therapy. • Mail order is not available for specialty drugs and are only dispensed by our contracted specialized pharmacy network.
	Preferred brand drugs	\$20 copay / \$40 copay mail order		
	Non-preferred brand drugs	20% coinsurance or \$20 copay, whichever is higher, up to a maximum of \$125 / 20% coinsurance or \$60 copay, whichever is higher, up to a maximum of \$375 mail order		
	Preferred Specialty drugs	25% coinsurance or \$200 copay, whichever is lowest		
	Non Preferred Specialty drugs	30% coinsurance or \$300 copay, whichever is lowest		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$25 copay / visit	10% of the allowable charges after applicable copay, plus any difference between our allowance and the billed amount	—————none—————
	Physician/surgeon fees	No charge	10% of the allowable charges, plus any difference between our allowance and the billed amount	—————none—————
If you need immediate medical attention	Emergency room services	\$25 copay / visit	\$25 copay / visit	\$10 copay if recommended by <i>Teleconsulta</i> . Coinsurance may apply for non-routine diagnostic tests.
	Emergency medical transportation	No charge. Covered through reimbursement	No charge. Covered through reimbursement	You pay for the services and the plan will reimburse the submitted charges

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider (plus you may be balance billed)	Limitations & Exceptions
	Urgent care	See emergency room services	See emergency room services	See emergency room services
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	10% of the allowable charges plus any difference between our allowance and the billed amount	—————none—————
	Physician/surgeon fee	No charge	10% of the allowable charges plus any difference between our allowance and the billed amount	Lithotripsy requires precertification.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$7.50 copay / group therapy \$7.50 copay / visit (includes collaterals)	10% of the allowable charges after applicable copay, plus any difference between our allowance and the billed amount	—————none—————
	Mental/Behavioral health inpatient services	No charge	10% of the allowable charges plus any difference between our allowance and the billed amount	—————none—————
	Substance use disorder outpatient services	\$7.50 copay / group therapy \$7.50 copay / visit (includes collaterals)	10% of the allowable charges after applicable copay, plus any difference between our allowance and the billed amount	—————none—————
	Substance use disorder inpatient services	No charge	10% of the allowable charges after applicable copay, plus any difference between our allowance and the billed amount	—————none—————
If you are pregnant	Prenatal and postnatal care	\$10 copay / visit	10% of the allowable charges after applicable copay, plus any difference between our allowance and the billed amount	—————none—————
	Delivery and all inpatient services	No charge	10% of the allowable charges plus any difference between our allowance and the billed amount	—————none—————

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	10% of the allowable charges plus any difference between our allowance and the billed amount	—————none—————
	Rehabilitation services	\$10 copay / visit, plus any difference between our allowance and the billed amount	10% of the allowable charges after applicable copay, plus any difference between our allowance and the billed amount	Up to 60 physical and occupational therapies per condition, policy year. You pay for services and request reimbursement.
	Habilitation services	See Rehabilitation services	See Rehabilitation services	See Rehabilitation services
	Skilled nursing care	No charge	10% of the allowable charges plus any difference between our allowance and the billed amount	Requires precertification.
	Durable medical equipment	20% coinsurance	10% of the allowable charges after applicable coinsurance, plus any difference between our allowance and the billed amount	Requires precertification.
	Hospice service	Covered through Case Management, subject to a precertification.	Not covered	—————none—————
If your child needs dental or eye care	Eye exam	\$10 copay / visit	10% of the allowable charges after applicable copay, plus any difference between our allowance and the billed amount	—————none—————
	Glasses	No charge. Insured is responsible for balance exceeding contracted fees.	Not covered	One pair of eyeglasses or contact lenses annually for members up to age 21 from Network providers.
	Dental check-up	No charge	10% of the allowable charges plus any difference between our allowance and the billed amount	Covered through Dental coverage. Up to 1 dental check-up every 6 months.

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check this plan's FEHB brochure for other excluded services.)

- Acupuncture
- Long-term care
- Private-duty nursing
- Cosmetic surgery
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Other Covered Services (This isn't a complete list. Check this plan's FEHB brochure for other covered services and your costs for these services.)

- Bariatric surgery, subject to precertification
- Hearing aids
- Routine eye care
- Chiropractic care
- Infertility treatment
- Routine foot care
- Dental care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. An individual policy may also provide different benefits than you had while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, see the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at (787) 774-6081 or visit www.opm.gov/insure/health.

Your Appeals Rights:

If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can contact: call Triple-S Salud at (787) 774-6081 and in external appeals, 1-877-549-8152 free of charge or you may send an e-mail to disputedclaims@opm.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **Coverage under this plan qualifies as minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.**

Language Access Services:

Para obtener asistencia en español, llame al (787) 774-6081.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,370
- Patient pays \$170

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$20
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$170

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,980
- Patient pays \$420

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Copays	\$90
Coinsurance	\$250
Limits or exclusions	\$80
Total	\$420

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Notice: Informing individuals about nondiscrimination and accessibility requirements and nondiscrimination statement: Discrimination Is Against The Law

Triple S Salud, Inc. complies with applicable federal civil rights laws and does not discriminate, exclude people or treat individuals differently because of race, color, national origin, age, disability, or sex.

Triple S Salud, Inc.

- Provides free aids and services to people with disabilities 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 services to people whose primary language is not English, such as:
 - Qualified interpreters,
 - Information written in other languages.

If you need these services, contact a customer a Service Representative.

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

Compliance and Privacy Office

P. O. Box 363628, San Juan, PR 00936-3628

Telephone: (787) 277-6686

Fax: (787) 706-4004

E-mail: privacidad@ssspr.com

You can file a grievance in person or by mail, fax, or email. 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 of Civil Rights Portal available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at:

200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

Telephone: 1-800-368-1019, TDD: 1-800-537-7697

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Gọi số dịch vụ khách hàng trên thẻ ID của quý vị để được hỗ trợ bằng Tiếng Việt.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

العربية باللغة المساعدة على الحصول هويتك بطاقة على الموجود العملاء خدمة برقم اتصل

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Pour une assistance en français du Canada, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

Ligue para o número de telefone de atendimento ao cliente exibido no seu cartão de identificação para obter ajuda em português.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatory.

日本語でのサポートは、IDカードに記載のカスタマーサービス番号までお電話でお問い合わせください。

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Rufen Sie den Kundendienst unter der Nummer auf Ihrer ID-Karte an, um Hilfestellung in deutscher Sprache zu erhalten.

دیوریگ تماس است شده درج شما پی شناسا کارت یرو بر که یشتر خدمات شماره با ، یراس زبان به یرا هئما افتی در یرا