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. 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. 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 get the FEHB Plan brochure at http://www.ssspr.com/en, and view the Glossary at https://www.healthcare.gov/sbc-glossary or call 787-774-6081 from Puerto Rico and 1-800-716-6081 from the U.S. Virgin Islands to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable	You don't have to meet deductibles for specific services, but a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$ 6,600 / Self Only $ 13,200 / Self Plus One $ 13,200 / Self and Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, payments for non-essential benefits, out-of-network coinsurance / copayments, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.ssspr.com or call 787-774-6081 from Puerto Rico or 1-888-716-6081 from USVI for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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 copay for services rendered in SALUS Clinics / $7.50 copay / visit	10% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	————none————
	Specialist visit	$0 copay for services rendered in SALUS Clinics / $7.50 copay / specialist visit	10% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	————none————
	Preventive care/screening/ immunization	No charge	10% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$0 copay for services rendered in SALUS Clinics / $1.00 copay / per blood work No charge / x-ray	10% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	————none————
	Imaging (CT/PET scans, MRIs)	No charge	10% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	Pet scan and PET CT, subject to pre-certification.
	Generic drugs	$2 copay / $4 copay for mail order	Prescription drug coverage - covered in United States or	The following rules apply:

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://salud.grupotriples.com/en/health-insurance-plans/triple-s-salud-for-federal-employee/	Preferred brand drugs	$20 copay / $40 copay mail order	its territories by reimbursement to the members. The member will be responsible for the 25% of the Triple-S Salud established fees, less the applicable drug copayment and/or coinsurance.	• 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.
	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		
	Specialty drugs	Preferred 25% coinsurance or $200 copay, whichever is lowest / Non Preferred 30% coinsurance or $300 copay, whichever is lowest		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$25 copay / visit	10% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	————none————
	Physician/surgeon fees	No charge	10% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	————none————
If you need immediate medical attention	Emergency room care	$25 copay / visit	$25 copay / visit	————none————
	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
	Urgent care	$0 copay for services rendered in Urgent SALUS Clinics / $10 copay / visit	$10 copay / visit	See emergency room services
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	10% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	————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)	
	Physician/surgeon fees	No charge	10% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	Lithotripsy requires precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$7.50 copay / group therapy $7.50 copay / visit (includes collaterals)	10% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	————none————
	Inpatient services	No charge	10% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	————none————
If you are pregnant	Office visits	$7.50 copay / visit	10% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No charge	10% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	————none————
	Childbirth/delivery facility services	No charge	10% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	————none————
If you need help recovering or have other special health needs	Home health care	No charge	10% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	————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)	
	Rehabilitation services	$10.00 copay for therapy, plus any difference between our allowance and the billed amount	10% **coinsurance**. In-network cost-sharing applies, 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% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	Requires precertification.
	Durable medical equipment	25% coinsurance	10% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	Requires precertification.
	Hospice services	Covered through Case Management, subject to a precertification.	Not covered	————none————
If your child needs dental or eye care	Children's eye exam	$7.50 copay /visit	10% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	————none————
	Children's glasses	Nothing up to contracted fee. Member pays any balance exceeding contracted fee.	Covered by reimbursement up to contracted fee. Member pays any balance exceeding contracted fee.	One pair of eyeglasses or contact lenses annually for members up to age 21.
	Children's dental check-up	No charge	10% **coinsurance**. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	Covered through dental coverage. Up to 1 dental check-up every 6 months.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan's FEHB brochure for more information and a list of any other excluded services.)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)

- Bariatric surgery subject to precertification
- Chiropractic care up to 20 manipulation visits per year
- Dental care (Adult)
- Hearing aids up to $1,000 maximum every 2 years for one or both ears combined
- Infertility treatment
- Routine eye care (Adult)
- Routine foot care

For more information about limitations and exceptions, see the FEHB Plan brochure RI 73-016 at www.ssspr.com/en.

Your Rights to Continue Coverage: There are agencies that can help you if you want to keep your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 787-774-6081 from Puerto Rico and 1-888-716-6081 from U.S. Virgin Islands or visit www.opm.gov/healthcare-insurance/healthcare/. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit 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 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: 787-774-6081 from Puerto Rico and 1-888-716-6081 from U.S. Virgin Islands or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act

Does this plan provide Minimum Essential Coverage? **Yes**
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 787-774-6081, Libre de costo 1-800-981-3241. (TTY/TDD) al 787-792-1370 o al 1-866-215-1999.

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	$7.50
Hospital (facility) copayment	$0
Other copayment	$1

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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$30**

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	$7.50
Hospital (facility) copayment	$0
Other coinsurance	20%

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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$600**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$7.50
Hospital (facility) copayment	$25
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$150**

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.