ARBOR E&T DBA EQUUS (4169)

Summary of Coverage: What this Plan Covers and what it Costs

Contract Period: 01/01/2026 - 12/31/2026

Coverage: Individual/Couple/Family | **Plan Type**: PPO

The Summary of Benefits and Coverage (SBC) is a document that will help you choose a health plan. The SBC shows you how you and the plan would share the cost of covered medical services. NOTE: Information about the cost of this plan (called a premium) will be provided separately. This is just a summary. For more information about your Coverage, or to obtain a copy of the full coverage terms, you can access by calling 1-888-318-0274. For a definition of commonly used terms, such as allowable amount, balance billing, coinsurance, copayment, deductible, provider, or other terms outlined, please refer to the Glossary. You can view a copy of the Glossary by calling 1-888-318-0274.

Important Questions	Answers	Why is it important?
What is the overall deductible?	No general deductible.	See the table that begins on page 3 for the costs of the services covered by this plan.
Are there services covered before the deductible is met?	No.	You will not have to pay deductibles for specific services, but a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes, Major Medical Expenses Individual $100.00 Family $300.00	You must pay for all services until the specific amount of the deductible is met before the plan begins to pay for those services.
Is there an out–of–pocket limit on my expenses?	Yes. The cost for Individual is $6,350 and Family is $12,700.	The out-of-pocket limit is the most you would pay for your share of the costs of covered services (usually one year). This limit helps you plan for your health care expenses.
What expenses are not included in the out–of–pocket limit?	Premiums, health care not covered under this plan, and services provided by out-of-network providers.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Is there an overall annual limit to what the plan pays?	No.	The table beginning on page 3 describes the limits of what the plan will pay for specific covered services, such as visits to a doctor's office.

Important Questions	Answers	Why is it important?
Does this plan use a network of providers?	Yes. For a list of in-network providers, go to www.firstmedicalpr.com or call (787) 878-6909 to speak with the Department of Providers.	If you use an in-network doctor or other health care provider, this plan will pay for some or all of the costs for covered services. Be aware if your in-network provider or hospital uses an out-of-network provider for some services. Plans use the terms in-network, preferred, or participating to refer to the providers in their network. Refer to the chart that begins on page 3 for how this plan pays the different kinds of providers.
If I use an In-Network Provider, would I pay less?	Yes. For a list of in-network providers, go to www.firstmedicalpr.com or call (787) 878-6909 to speak with the Department of Providers.	If you use an in-network doctor or other health care provider, this plan will pay for some or all of the costs for covered services. Be aware if your in-network provider or hospital uses an out-of-network provider for some services. Plans use the terms in-network, preferred, or participating to refer to the providers in their network. Refer to the chart that begins on page 3 for how this plan pays the different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without the need for a referral.
Are there service(s) that the plan does not cover?	Yes.	Consult your contract or plan document for additional information about excluded services.

- **Copayment** is the fixed dollar amount (for example, $15) that you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs for a covered service, calculated as a percentage of the allowed amount for the service. You pay this in addition to any deductible you have in this plan. For example, if the health plan's allowed amount for an overnight hospital stay is $1,000, and you have reached your deductible, your coinsurance payment of 20% would be $200. This may change if you have not 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 will pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the plan's allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan encourages the use of in-network providers by charging you lower deductibles, copayments, and coinsurance amounts.

Common medical events	Services you may need	Your cost if you use an in-network provider	Your cost if you use an out-of-network provider	Limitations and exceptions
If you visit a health care provider's office or clinic	Primary care physician visit to treat an injury or illness	$10.00 copay	Covered through reimbursement at the FMHP contracted rate with another provider of the same specialty, minus the applicable copayment.	None.
	Specialist / subspecialist visit	Specialist $15.00 copay. Subspecialist $18.00 copay.	Covered through reimbursement at the FMHP contracted rate with another provider of the same specialty, minus the applicable copayment.	None.
	Visit to another health professional's office	Podiatrist, Audiologist, and Chiropractor $15.00 copay. Optometrist $15.00 copay.	Covered through reimbursement at the FMHP contracted rate with another provider of the same specialty, minus the applicable copayment.	None.
If you visit a health care provider's office or clinic	Preventive care / screening / immunization	$0 copay for preventive services by Federal Law $0 copay for other immunizations	Covered through reimbursement at the FMHP contracted rate with another provider of the same specialty, minus the applicable copayment.	None.

Common medical events	Services you may need	Your cost if you use an in-network provider	Your cost if you use an out-of-network provider	Limitations and exceptions
If you have to be tested	Diagnostic Tests (X-rays, Blood work)	35%/$0* coinsurance 0% coinsurance in Metro Pavía Hospitals and Clínicas (Affiliated Preferred Network).	Covered through reimbursement at the FMHP contracted rate with another provider of the same specialty, minus the applicable copayment.	None.
	Images (CT/PET Scans, MRIs)	35% coinsurance	Covered only if the specialty is not available in the FMHP provider network.	PET Scan and PET CT, up to one per subscriber per contract year, requires prior plan authorization. MRI and CT, up to one per anatomical region, per subscriber year contract. Requires prior authorization from the plan.
If you need medication **For more information about prescription drug coverage, visit** www.firstmedicalpr.com	Maximum Benefit Without Limit	Not covered	Only covered at pharmacies in the United States that are international, such as: Walgreens, Wal-Mart, or CVS and in the community pharmacies.	The following rules apply: • Generic drugs as first choice • Benefits may be subject to dispatch limits and require prior authorization from the plan. • Up to a 30-day supply for maintenance drugs • Up to a 15-day supply for acute medications.
	Preferred Bioequivalents	10% minimum $10.00		
	Non-preferred Bioequivalents	10% minimum $10.00		
	Preferred Brand	20% minimum $15.00		
	Non-preferred Brand	30% minimum $20.00		
	Preferred Specialty Drugs	40% coinsurance		
	Non-preferred Specialty Drugs	40% coinsurance		
	Cost equal to or less than $10.00	Not covered		

Common medical events	Services you may need	Your cost if you use an in-network provider	Your cost if you use an out-of-network provider	Limitations and exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance Ambulatory Procedures.	Covered through reimbursement at the FMHP contracted rate with another provider of the same specialty, minus the applicable copayment.	None.
	Doctor/Surgeon Fee	No Charge	None.	None.
If you need immediate medical attention	Emergency room / urgent care services	$50.00 copay / $25* copay at our Metro Pavia Hospitals facilities and Clinics.	You must pay for the service, and FMHP will reimburse you according to similar contracted rates for a network provider.	Co-insurance could apply for non-routine diagnostic tests that are not x-rays.
	Emergency medical transportation	Ground ambulance Up to $90 per ride. Air ambulance 1 trip for services in Puerto Rico, including Vieques and Culebra, applies 20% coinsurance.	Covered through reimbursement at the FMHP contracted rate with another provider of the same specialty, minus the applicable copayment.	None.
Si lo admiten al hospital	Facility fee (e.g. hospital room)	$100.00 copay / $0.00 copay at our Metro Pavia Hospitals facilities and Clinics.	Covered through reimbursement at the FMHP contracted rate with another provider of the same specialty, minus the applicable copayment.	None.
	Physician / surgeon fee	No Charge.	No Charge.	None.

Common medical events	Services you may need	Your cost if you use an in-network provider	Your cost if you use an out-of-network provider	Limitations and exceptions
If you have mental health, behavioral health, or substance abuse problems	Mental health outpatient services	Psychiatrist $15.00 copay Psychologist $15.00 copay Neuropsychological evaluation $15.00 copay	Covered through reimbursement at the FMHP contracted rate with another provider of the same specialty, minus the applicable copayment.	None.
	Mental health inpatient services	Hospitalization $100.00 copay and Partial Hospitalization $50.00 copay.		None.
	Substance abuse outpatient services	Psychiatrist $15.00 copay Psychologist $15.00 copay		None.
	Substance abuse inpatient services	Hospitalization $100.00 copay and Partial Hospitalization $50.00 copay.		None.

Common medical events	Services you may need	Your cost if you use an in-network provider	Your cost if you use an out-of-network provider	Limitations and exceptions
If you are pregnant	Prenatal and postnatal care	Copay for visit to specialist $15.00	Covered through reimbursement at the FMHP contracted rate with another provider of the same specialty, minus the applicable copayment.	Covered, only for the primary subscriber or their spouse and/or cohabitant.
	Office Visits	Copay for visit to specialist $15.00		None.
	Maternity services, all hospitalization services and postnatal care services	$100.00 copay / $0.00 copay at our Metro Pavia Hospitals facilities and Clinics.		According to Law 248 of 1999, hospitalization is a minimum of 48 hours in the event of a natural childbirth and 96 hours in the event of a cesarean delivery.
If you need help recovering or have other special needs	Home Health Care	Through Major Medical $100 individual / $300.00 family		Up to twenty (20) visits through the Major Medical Cover, after the services under the basic coverage.
	Rehabilitation/Habilitation Services	$7 copayment physical therapy $7 Copayment for manipulations	Covered through reimbursement at the FMHP contracted rate with another provider of the same specialty, minus the applicable copayment.	Up to 15 physical therapies per subscriber per contract year combined with chiropractor manipulations.
	Skilled nursing care	Through Major Medical $100 individual $300 family	Covered through reimbursement at the FMHP contracted rate with another provider of the same specialty, minus the applicable copayment.	Up to $2,000 (two thousand dollars).

Common medical events	Services you may need	Your cost if you use an in-network provider	Your cost if you use an out-of-network provider	Limitations and exceptions
If you need help recovering or have other special needs	Durable medical equipment	Through Major Medical $100 individual / $300.00 family	Covered through reimbursement at the FMHP contracted rate with another provider of the same specialty, minus the applicable copayment.	Requires pre-authorization from the plan. Subject to: (1) The equipment is primarily used for medical purposes. (2) The equipment can be effectively used in a non-medical facility (e.g. at home). (3) The equipment can make a significant contribution in the course of treatment of the disease or injury. (4) The cost of the equipment is proportional to the therapeutic benefits derived from its use. (5) or The decision to rent or purchase the durable medical equipment will be made by First Medical Health Plan, Inc. based on a cost-effectiveness analysis.
If you need help recovering or have other special needs	Skilled Nursing Facility	Through Major Medical $100.00 individual $300.00 family	Covered through reimbursement at the FMHP contracted rate with another provider of the same specialty, minus the applicable copayment.	Up to $2,000.00 (two thousand dollars)

Common medical events	Services you may need	Your cost if you use an in-network provider	Your cost if you use an out-of-network provider	Limitations and exceptions
If your child needs eye care services	Eye exam	$0.00 copay.	Covered through reimbursement at the FMHP contracted rate with another provider of the same specialty, minus the applicable copayment.	(1) refraction (eye exam) per year
	Glasses	Eyeglasses Frames cost of $18.00	Cost according to the lens and frame selected.	Ivision International: One (1) frame per year contract Preferred collection or you can choose contact lenses $36.00.
If your child needs dental care services	Oral exams Pediatric and Preventive Diagnosis	0%	Covered through reimbursement at the FMHP contracted rate with another provider of the same specialty.	One (1) every six (6) months. Covered only if the insured has Dental Coverage.

Note: In the event of any discrepancy in relation to this coverage summary, the provisions of the contract shall prevail.

Excluded Services and Other Covered Services:

Services that your Plan generally does NOT cover (see the plan's policy or document for more information and a list of other excluded services).

- Hearing Aids
- Long-term care
- Cosmetic surgery
- Non-emergency services outside the United States
- Private Nurse Practitioners
- Treatment for Infertility

Other Covered Services (limitations may apply to these services. This is not a complete list. Check your plan document.)

- Chiropractor visits
- Dental care
- Visual care
- Bariatric surgery, subject to precertification
- Podiatrist visits and routine foot care
- Nutritionist

Rights to Continue Your Coverage: For more information about your rights to continue your coverage, contact the Plan at 1-888-318-0274. There are agencies that can help you if you want to continue your coverage when it ends. The contact information for these agencies is: the Office of the Commissioner of Insurance of Puerto Rico, B5 Calle Tabonuco Suite 216 PMB 356 Guaynabo PR 00968-3029, telephone: 787-304-8686; Health Attorney: PO BOX 11247 San Juan PR 00910-2347 Phone: 787-977-0909. Other Options: Coverage may be available to you as well, including purchasing individual insurance coverage. For more information about individual insurance coverage, visit www.firstmedicalpr.com.com or call 1-888-318-0274.

Notice of Nondiscrimination

First Medical Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. First Medical does not exclude people or treat them differently because of their ethnicity, color, national origin, age, disability, or sex. If you believe that First Medical Health Plan, Inc. failed to provide these services to you or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you may file a complaint in writing with First Medical's Compliance Department, PO Box 191580, San Juan PR 00919-1580, or by calling 787-625-9557 ext. 2108, TTY: 1-844-347-7805, or fax 787-300-3913, e-mail address: cumplimiento@firstmedicalpr.com. You can also visit any of our Customer Service Offices. If you need help doing so, our Service Representatives are available to provide it.

You may 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 to the following address: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at 1-800-368-1019, 800-537-7697 (TDD).

Right to File a Grievance or Appeal

There are agencies that can help you if you have a complaint against your plan for denying a claim. This complaint is called a grievance or appeal. For more information about your rights, see the explanation of benefits you will receive for this medical claim. Your plan documents will also include complete information on how to file a grievance, appeal, or grievance with your plan for any reason. For more information about your rights, this notice, or for assistance, contact the Grievance Department at 787-474-3999, by fax at 787-625-8765, in person by visiting one of our Service Offices, or by mail:

First Medical Health Plan, Inc.
PO BOX 191580
San Juan, PR 00918-1580

A FMHP Service Representative will address your concern, either by phone or in person at one of our sixteen (16) service offices. If your concern is not resolved immediately, your situation will become a complaint, which will be referred to the FMHP Grievance Department.

The FMHP Grievance Department has established, pursuant to Chapter 22 of the Puerto Rico Health Code, a process to evaluate and resolve any complaint efficiently and in a timely manner.

Every covered person or personal representative has the right to receive, upon request, free of charge, reasonable access and copies of all documents, records, and other information pertinent to the claimant's claim for benefits. Whether it is a document, record, or other information that is relevant to a claim for benefits.

All FMHP subscribers have the right to contact the Office of the Commissioner of Insurance (OCS) or the Office of the Health Advocate (PAHO) in the following ways:

Oficina del Comisionado de Seguros de Puerto Rico (OCS)
#361 Calle Calaf
P.O. Box 195415
San Juan, PR 00919
Teléfono 787- 304-8686

Oficina del Procurador de la Salud (OPS)
PO Box 11247
San Juan, PR 00910-2347
Teléfono 787-977-0909

Language Services:
Español: Para obtener asistencia en Español, llame al 1-888-318-0274
English (Inglés): For assistance in English, call 1-888-318-0274
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-318-0274
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-888-318-0274
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-318-0274

For examples of how this plan might cover the costs of a hypothetical medical situation, see the next section.

Does this plan provide minimum essential coverage?: Yes. The Affordable Care Act requires most people to have health coverage that qualifies as minimum essential benefit coverage. This coverage provides minimum coverage for essential benefits.

Does this plan meet the minimum value standards?: Yes The Affordable Care Act establishes a minimum standard value for health coverage benefits. The minimum standard value is 60% (actuarial value). This coverage meets the minimum standard value for the benefits it provides.

About coverage examples:

This is not a cost estimator. The treatments illustrated are examples of how this plan might cover medical care. Current costs may be different, depending on the care you end up receiving, the prices charged by your providers, and many other factors. Use this information to compare the portion of costs you would have to pay with other health plans. Keep in mind that these coverage examples are based on individual coverage only.

Peg is pregnant (nine months of in-network prenatal care and hospital delivery)		Joe's Type 2 Diabetes Management (one year of care in the routine network of a well-managed disease)		Mia's simple fracture (in-network emergency room visit and follow-up visits)	
The general deductible of the plan	$0.00	The general deductible of the plan	$0.00	The general deductible of the plan	$0.00
Specialist Copay	$10.00	Specialist Copay	$10.00	Specialist Copay	$10.00
Hospital (facilities)	$100.00	Hospital (facilities)	$100.00	Hospital (facilities)	$20.00
Other copay	$0.00	Other copay	$0.00	Other copay	$0.00
This EXAMPLE includes services such as:		**This EXAMPLE includes services such as:**		**This EXAMPLE includes services such as:**	
Specialist visits (prenatal care)		Visits to the primary physician's office (includes information sessions about the disease)		Emergency room (includes medical supplies)	
Professional Childbirth Services		Diagnostic tests (blood tests).		Diagnostic tests (X-rays).	
Professional Birthing Facility Services		Prescription drugs		Durable medical equipment (crutches)	
Diagnostic tests (sonograms and blood tests).		Durable medical equipment (glucose meter)		Rehabilitation services (physical therapy)	
Specialist visit (anesthesia)					
Total cost of the example	**$5,600**	**Total cost of the example**	**$5,214**	**Total cost of the example**	**$450**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Shared costs		*Shared costs*		*Shared costs*	
Deductibles	$0.00	Deductibles	$0.00	Deductibles	$0.00
Copay	$240.00	Copay	$120.00	Copay	$190.00
Coinsurance	$283.80	Coinsurance	$1,160.68	Coinsurance	$6.00
What is not covered		*What is not covered*		*What is not covered*	
Limits or exclusions	N/A	Limits or exclusions	N/A	Limits or exclusions	N/A
The total that Peg would pay is	**$523.80**	**The total that Joe would pay is**	**$1,280.68**	**The total that Mia would pay is**	**$196.00**

Note: These numbers assume that the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to lower your costs. For more information about the wellness program, please contact us Health.