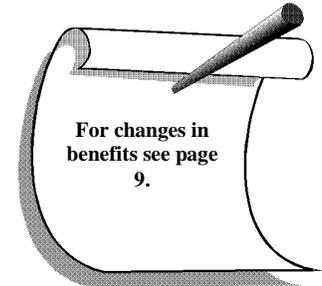




Triple-S
<http://www.ssspr.com>

2004

**A Health Maintenance Organization
with a point of service product**



Serving: All of Puerto Rico

Enrollment in this Plan is limited. You must live in our geographic service area to enroll. See page 8 for requirements.

Enrollment codes for this Plan:

**891 Self Only
892 Self and Family**

Authorized for distribution by the:



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>



RI 73-016



OFFICE OF THE DIRECTOR

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this 2004 Federal Employees Health Benefits (FEHB) Program plan brochure. The brochure describes the benefits this plan offers you for 2004. Because benefits vary from year to year, you should review your plan's brochure every Open Season – especially Section 2, which explains how the plan changed.

It takes a lot of information to help a consumer make wise healthcare decisions. The information in this brochure, our FEHB Guide, and our web-based resources, make it easier than ever to get information about plans, to compare benefits and to read customer service satisfaction ratings for the national and local plans that may be of interest. Just click on www.opm.gov/insure!

The FEHB Program continues to be an enviable national model that offers exceptional choice, and uses private-sector competition to keep costs reasonable, ensure high-quality care, and spur innovation. The Program, which began in 1960, is sound and has stood the test of time. It enjoys one of the highest levels of customer satisfaction of any healthcare program in the country.

I continue to take aggressive steps to keep the FEHB Program on the cutting edge of employer-sponsored health benefits. We demand cost-effective quality care from our FEHB carriers and we have encouraged Federal agencies and departments to pay the full FEHB health benefit premium for their employees called to active duty in the Reserve and National Guard so they can continue FEHB coverage for themselves and their families. Our carriers have also responded to my request to help our members to be prepared by making additional supplies of medications available for emergencies as well as call-up situations and you can help by getting an Emergency Preparedness Guide at www.opm.gov. OPM's *HealthierFeds* campaign is another way the carriers are working with us to ensure Federal employees and retirees are informed on healthy living and best-treatment strategies. You can help to contain healthcare costs and keep premiums down by living a healthy life style.

Open Season is your opportunity to review your choices and to become an educated consumer to meet your healthcare needs. Use this brochure, the FEHB Guide, and the web resources to make your choice an informed one. Finally, if you know someone interested in Federal employment, refer them to www.usajobs.opm.gov.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay Coles James".

Kay Coles James
Director



Notice of the Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.

- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
United States Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

Table of Contents

Introduction.....4

Plain Language4

Stop Health Care Fraud!4

Preventing medical mistakes5

Section 1. Facts about this HMO plan7

 We also have point-of service (POS) benefits7

 How we pay providers7

 Who provides my health care?7

 Your Rights.....8

 Service Area.....8

Section 2. How we change for 2004.....9

 Program-wide changes.....9

 Changes to this Plan.....9

Section 3. How you get care10

 Identification cards10

 Where you get covered care.....10

 • Plan providers.....10

 • Plan facilities10

 • Other providers.....10

 What you must do to get covered care.....10

 • Primary care10

 • Specialty care11

 • Hospital care.....11

 Circumstances beyond our control.....11

 Services requiring our prior approval12

Section 4. Your costs for covered services13

 • Copayments13

 • Coinsurance13

 Your catastrophic protection out-of-pocket maximum for coinsurance and copayments.....13

Section 5. Benefits14

 Overview.....14

 (a) Medical services and supplies provided by physicians and other health care professionals15

 (b) Surgical and anesthesia services provided by physicians and other health care professionals.....25

 (c) Services provided by a hospital or other facility, and ambulance services29

 (d) Emergency services/accidents.....32

 (e) Mental health and substance abuse benefits.....34

 (f) Prescription drug benefits36

 (g) Special features40

 • Flexible Benefits Option

 • 24 hours 7 days a week call center

 • Blue Card Program

 • Centers of excellence for transplants/heart surgery/etc.

 • High risk pregnancies program

 • Blue Card Worldwide

 • Mental Health Management

 • Pharmicare Express Mail Service Prescription Drug Program

Table of Contents (Continued)

(h) Dental benefits	42
(i) Point of service benefits	44
Section 6. General exclusions -- things we don't cover	46
Section 7. Filing a claim for covered services	47
Section 8. The disputed claims process	49
Section 9. Coordinating benefits with other coverage	51
When you have other health coverage	51
• What is Medicare?	51
• Should I enroll in Medicare?	51
• Medicare + Choice.....	54
• TRICARE and CAMPVA	55
• Worker's Compensation	55
• Medicaid	55
• Other Government agencies	55
• When others are responsible for injuries	55
Section 10. Definitions of terms we use in this brochure	56
Section 11. FEHB facts.....	58
Coverage information	58
• No pre-existing condition limitation.....	58
• Where you can get information about enrolling in the FEHB Program.....	58
• Types of coverage available for you and your family.....	58
• Children's Equity Act	59
• When benefits and premiums start	59
• When you retire	59
When you lose benefits.....	60
• When FEHB coverage ends.....	60
• Spouse equity coverage	60
• Temporary Continuation of Coverage (TCC).....	60
• Converting to individual coverage.....	60
• Getting a Certificate of Group Health Plan Coverage	61
Two new Federal Programs complement FEHB benefits.....	62
The Federal Flexible Spending Account Program – <i>FSAFEDS</i>	62
The Federal Long Term Care Insurance Program.....	65
Index	66
Summary of benefits.....	67
Rates.....	Back cover

Introduction

This brochure describes the benefits of Triple-S under our contract (CS-1090) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for Triple-S administrative offices is:

Triple-S, Inc. (Triple-S)
1441 Roosevelt Avenue
San Juan, Puerto Rico 00920

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits. Brochures are available in Spanish. You can get a copy by calling 787-749-4777.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2004, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2004, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; “we” means Triple-S.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Insurance Services Program, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud - Here are some things you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

Stop Health Care Fraud! (Continued)

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 787/749-4777 and explain the situation.
 - If we do not resolve the issue:

**CALL -- THE HEALTH CARE FRAUD HOTLINE
202-418-3300**

OR WRITE TO:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child over age 22 (unless he/she is disabled and incapable of self-support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. **Ask questions if you have doubts or concerns.**
 - Ask questions and make sure you understand the answers.
 - Choose a doctor with whom you feel comfortable talking.
 - Take a relative or friend with you to help you ask questions and understand answers.
2. **Keep and bring a list of all the medicines you take.**
 - Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
 - Tell them about any drug allergies you have.
 - Ask about side effects and what to avoid while taking the medicine.
 - Read the label when you get your medicine, including all warnings.

- Make sure your medicine is what the doctor ordered and know how to use it.
 - Ask the pharmacist about your medicine if it looks different than you expected.
3. **Get the results of any test or procedure.**
 - Ask when and how you will get the results of tests or procedures.
 - Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
 - Call your doctor and ask for your results.
 - Ask what the results mean for your care.
 4. **Talk to your doctor about which hospital is best for your health needs.**
 - Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
 - Be sure you understand the instructions you get about follow-up care when you leave the hospital.
 5. **Make sure you understand what will happen if you need surgery.**
 - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
 - Ask your doctor, "Who will manage my care when I am in the hospital?"
 - Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after surgery?
 - How can I expect to feel during recovery?
 - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's healthcare delivery system.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see those physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practices when prescribing any course of treatment.

Benefits offered under this plan may be modified by Triple-S to authorize payment for treatment methods or therapies not expressly provided for but not prohibited by law or rule if otherwise that method or therapy is as cost effective as providing benefits to which the enrollee otherwise is entitled.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

We also have Point-of-Service (POS) benefits:

Our HMO offers Point-of-Service (POS) benefits. This means you can receive covered services from a non-Plan provider within our service area and outside our service area. These out-of-network benefits have higher out-of-pocket costs than our in-network benefits.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. When you get services out-of-network, we pay non-Plan providers in Puerto Rico based on the "medical benefits schedule" and we pay non-Plan providers outside of Puerto Rico based on usual, customary, and reasonable charges when the services are preauthorized or due to any emergency. When services rendered out of the service area are not emergencies neither preauthorized, this plan will reimburse up to Triple-S established fees.

Who provides my health care?

Triple-S is an individual practice prepayment plan. You can receive care from any Plan doctor. A Plan doctor is a doctor of medicine (M.D.) licensed to practice in the Commonwealth of Puerto Rico who has agreed to accept the Triple-S established fees as payment in full for surgery and certain other services. If you use a non-Plan doctor (except for speech or occupational therapy) you must pay the difference between the non-Plan doctor's charge and the amount paid to you by Triple-S. A non-Plan doctor is any licensed doctor of medicine (M.D.) who is not a Plan doctor. Non-Plan doctors do not have to accept Triple-S established fees as payment in full. Most doctors practicing in Puerto Rico are Plan doctors.

You can also receive services from a Plan hospital. This is a licensed general hospital in Puerto Rico that has signed a contract with Triple-S to render hospital services to persons insured by Triple-S. A non-Plan hospital is any licensed institution that is not a Plan hospital and that is engaged primarily in providing bed patient with diagnosis and treatment under the supervision of physicians with 24-hour-a-day registered graduate nursing services. You must pay any difference between the non-Plan hospital's charges and the amount paid to you by Triple-S.

Benefits in Puerto Rico are paid according to the "medical benefits schedule". This is the schedule of established fees on which this Plan's payment of covered medical expense is based, when the services are rendered within the service area. When preauthorized or emergency services are rendered outside Puerto Rico, this Plan pays based on usual, customary and reasonable charges. When services rendered out of the service area are not emergencies neither preauthorized, this plan will reimburse up to Triple-S established fees.

Section 1. Facts about this HMO plan (*Continued*)

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you.

If you want more information about us, call 787/749-4777, or write to P. O. Box 363628, San Juan, Puerto Rico, 00936-3628. You may also contact us by fax at 787/749-4108 or visit our Web site at www.ssspr.com.

Service Area

To enroll in this Plan, you must live in our Service Area. This is where our providers practice. Our service area is: Only Puerto Rico.

Ordinarily, you get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits and preauthorized care based on usual, customary and reasonable charges of the area where the services were rendered. When services rendered out of the service area are not emergencies and have not been preauthorized, this plan will reimburse up to Triple-S established fees.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. This Plan offers reciprocity with the Blue Cross Blue Shield network through the Blue Card Program. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2004

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- We added information regarding two new Federal Programs that complement FEHB benefits, the Federal Flexible Spending Account Program - *FSAFEDS* and the Federal Long Term Care Insurance Program. See pages 62-65.
- We added information regarding Preventing medical mistakes. See pages 5-6.
- We added information regarding enrolling in Medicare. See pages 51-52
- We revised the Medicare Primary Payer Chart. See pages 53-54.

Changes to this Plan

- Your share of the non-Postal premium will increase by 18% for Self Only and 18% for Self and Family.
- We will modify our podiatric service coverage as established in Section 5 (a).
- We will modify our out of area non-emergency, non-authorized services coverage (Section 1 and Section 5).
- We will cover surgical assistants. (Section 5(b))
- We will change the medication copayments in the Prescription Drug Benefit Coverage. (Section 5 (f))
- We will limit the Viagra dispensing as established in Section 5 (f).
- We clarify x-rays and other diagnostic tests coinsurances. (Section 5(a))
- We clarify chiropractic service copayment. (Section 5(a))
- We clarify that certain medications will be dispensed by specialty pharmacies only (Section 5 (f)).

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 787-749-4777 or write to us at Triple-S, Inc. (Triple-S), Customer Service Department, 1441 Roosevelt Avenue, San Juan, Puerto Rico 00920. You may also request replacement cards through our Web site at www.ssspr.com.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments and/or coinsurance, and you will not have to file claims. You can also get care from non-Plan providers, but it will cost you more.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site.

- **Other Providers**

Non-Plan Providers: These are other health professionals and providers of services which are covered by this Plan. Usually we reimburse them paying our established fees. Throughout the introductions in Section 5 we explain how we reimburse these services.

For chiropractic and podiatric services we also offer the alternative to pay the services rendered by these professionals using the Assignment of Benefits. Just by filing the HCFA 1500 form we can pay the chiropractor or podiatrist directly for these services, once the enrollee authorizes us to do so.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a general practitioner physician. This decision is important since your general practitioner physician provides for most of your health care.

- **Primary care**

Your general practitioner physician can be, for example, a family practitioner. Your physician will provide most of your health care, or refer you to a specialist.

If you want to change your general practitioner physician or if your general practitioner physician leaves the Plan, call us. We will help you select a new one.

Section 3. How you get care (*Continued*)

• Specialty care

Your general practitioner physician will refer you to a specialist for needed care. However, you may see any specialist without a referral.

Here are other things you should know about specialty care:

- If you are seeing a specialist and your specialist leaves the Plan, call us. We will provide you a list of specialists within your area. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

- terminate our contract with your specialist for other than cause; or
- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
- reduce our service area and you enroll in another FEHB Plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

• Hospital care

Your Plan general practitioner physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 787-749-4777. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Section 3. How you get care (*Continued*)

Services requiring our prior approval

Your general practitioner physician may refer you for most services. For certain services, however, you or your Plan doctor must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. We call this review and approval precertification. Call us at 787-749-4777.

We will provide benefits for covered services only when services are medically necessary to prevent, diagnose or treat your illness or condition. You or your Plan doctor must obtain authorization from this Plan for the following benefits or services:

- Services outside the Service Area, except emergencies;
- Rental and purchase of durable medical equipment;
- Skilled Nursing Facility;
- Organ and tissue transplants;
- Lithotripsy;
- Osteotomy;
- Mammoplasty;
- Mental health and substance abuse services (including hospitalizations) rendered by Plan providers, and non Plan providers (point of service benefits); and
- Growth hormone therapy.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments**

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

Example: When you see your specialist you pay a copayment of \$10 per office visit.

- **Coinsurance**

Coinsurance is the percentage of our negotiated fee that you must pay for your care.

Example: In our Plan, you pay 25% of our allowance for laboratory and diagnostic tests.

Your catastrophic protection out-of-pocket maximum for coinsurance and copayments

We do not have a catastrophic protection out-of-pocket maximum. Your out-of-pocket expenses for benefits covered under this Plan are:

- The stated copayments and coinsurances that are required for covered benefits;
- Remaining charges after we reimburse you our established fees for point of service benefits when non-Plan providers are used.
- The 10% you pay of our established fees when you use non-Plan providers in our service area.
- The 10% you pay of the usual, customary and reasonable charge when you use non-Plan doctor or provider outside of our service area, if the service is an emergency or is preauthorized.
- The 25% you pay of our established fees when you use a non network pharmacy within or outside of our service area.
- The difference between the cost of the brand name prescription drug and the cost of the generic bioequivalent prescription drug, if you choose a brand name prescription drug, for which a generic-bioequivalent prescription drug exists and your physician has not specified Dispense as Written.

Section 5. Benefits -- OVERVIEW

(See page 9 for how our benefits changed this year and page 67 for a benefits summary.)

Note: This benefits section is broken into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 787-749-4777 or at our Web site at www.ssspr.com.

(a) Medical services and supplies provided by physicians and other health care professionals	15-24
•Diagnostic and treatment services	•Speech therapy
•Lab, X-ray, and other diagnostic tests	•Hearing services (testing, treatment and supplies)
•Preventive care, adult	•Vision services (testing, treatment and supplies)
•Preventive care, children	•Foot care
•Maternity care	•Orthopedic and prosthetic devices
•Family planning	•Durable medical equipment (DME)
•Infertility services	•Home health services
•Allergy care	•Chiropractic
•Treatment therapies	•Alternative treatments
•Physical and occupational therapies	•Educational classes and programs
(b) Surgical and anesthesia services provided by physicians and other health care professionals	25-28
•Surgical procedures	•Oral and maxillofacial surgery
•Reconstructive surgery	•Organ/tissue transplants
	•Anesthesia
(c) Services provided by a hospital or other facility, and ambulance services	29-31
•Inpatient hospital	•Extended care benefits/skilled nursing care
•Outpatient hospital or ambulatory surgical center	facility benefits
	•Hospice care
	•Ambulance
(d) Emergency services/accidents	32-33
•Medical emergency	•Ambulance
(e) Mental health and substance abuse benefits	34-35
(f) Prescription drug benefits	36-39
(g) Special features	40-41
• Flexible Benefits Option • 24 hours, 7 days a week call center • Blue Card Program • Centers of excellence for transplants/heart surgeries/etc • High risk pregnancies program • Blue Card Worldwide • Mental Health Management Program for Federal Employees • Pharmacare Express Mail Service Prescription Drug Program	
(h) Dental benefits	42-43
(i) Point of service benefits	44-45
Summary of benefits	67

Section 5 (a) Medical services and supplies provided by physicians and other health care professionals

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Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU OR YOUR PLAN DOCTOR MUST GET PRECERTIFICATION OF SOME MEDICAL SERVICES AND SUPPLIES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.
- If you use a non-Plan doctor or provider: you pay for services rendered and the Plan will reimburse you 90% of the Plan’s established fee, after any applicable copay or coinsurance, when services are rendered within the service area; or 90% of the usual, customary and reasonable charge of the area, after any applicable copay or coinsurance, when services are rendered outside the service area and are an emergency or are preauthorized. The plan will reimburse for non-emergency, non-authorized but otherwise covered services rendered outside the service area up to Triple-S established fees, after any applicable copay or coinsurance. You pay all remaining charges.

Note: In general, we will only authorize care, equipment, or professional services that are not available from a Plan provider within the service area.

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Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office 	\$ 7.50 per office visit to your general practitioner physician \$10 per office visit to a specialist physician
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center or emergency room • During a hospital stay • In a skilled nursing facility – <i>precertification required (refer to Section 3)</i> 	Nothing
<ul style="list-style-type: none"> • Office medical consultations by specialists 	\$10 per office visit

Diagnostic and treatment services – Continued on next page

Diagnostic and treatment services (<i>Continued</i>)	You pay
<ul style="list-style-type: none"> • Second surgical opinion 	Nothing
At home	\$15 per physician visit. Nothing for nurse or home health aide visit
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Private nursing care, except for treatment of mental illness</i> 	<i>All charges</i>
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Hepatobiliary ductal system imaging (HIDA) • Polysomnography – <i>precertification required (refer to Section 3)</i> • Genetic amniocentesis • Non-invasive vascular and cardiovascular tests, including electrocardiogram and EEG 	25%.
<ul style="list-style-type: none"> • Pathology • X-rays • Non-routine Mammograms • Nuclear medicine tests • Cat Scans/Magnetic resonance (MRI, MRA) • Ultrasound, including Biophysical Profile • Invasive cardiovascular tests 	Nothing
Preventive care, adult	
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening • Prostate Specific Antigen (PSA test) • Osteoporosis Screening 	\$7.50 per office visit to your general practitioner physician, \$10 per office visit to a specialist physician; and 25% for laboratory tests in lab facilities and diagnostic tests.

Preventive Care, adult – Continued on next page

Preventive care, adult <i>(Continued)</i>	You pay
Routine pap test	Nothing if you receive these services during your office visit; otherwise, \$10 per office visit.
Routine mammogram –covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every one or two calendar years • At age 65 and older, one every two consecutive calendar years 	Nothing
Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria • Influenza • Pneumococcal vaccine, annually, age 65 and over • Tetanus toxoid • Hepatitis B 	\$10 per office visit. Nothing per immunization.
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics, such as <ul style="list-style-type: none"> • Diphtheria-tetanus-pertussis • Diphtheria-tetanus toxoids • Measles, mumps and rubella • Varicella and varivax • Hemophilus influenza B • Influenza • Tetanus toxoid • Hepatitis B • Prevnar, up to 24 months of age 	\$10 per office visit. Nothing per immunization.
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care • Examinations, such as: <ul style="list-style-type: none"> — Eye exams to determine the need for vision correction. — Ear exams to determine the need for hearing correction — Examinations done on the day of immunizations 	\$10 per office visit. Nothing per immunization

Maternity care	You Pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Circumcision is included as a surgical benefit. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5(c)) and Surgery benefits (Section 5(b)). 	Nothing
<i>Not covered: Routine sonograms to determine fetal age, size or sex</i>	<i>All charges</i>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Intrauterine devices (IUDs) <p>Note: We cover oral and injectable contraceptives and devices such as diaphragms, under the prescription drug benefit (Section 5(f)).</p>	\$10 per office visit
<i>Not covered: reversal of voluntary surgical sterilization, genetic counseling</i>	<i>All charges</i>

Infertility services	You Pay
Diagnosis and treatment of infertility, such as: <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> – <i>intravaginal insemination (IVI)</i> – <i>intracervical insemination (ICI)</i> – <i>intrauterine insemination (IUI)</i> 	\$10 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Infertility services after voluntary sterilization.</i> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>in vitro fertilization</i> – <i>embryo transfer, gamete GIFT and zygote ZIFT</i> – <i>Zygote transfer</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>Fertility drugs</i> 	<i>All charges</i>
Allergy care	
Testing and treatment Allergy vaccine	\$10 per office visit
Allergy serum	Nothing
<i>Not covered: provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on pages 27 and 28. <ul style="list-style-type: none"> • Respiratory and inhalation therapy up to a maximum of 20 sessions per year • Dialysis – hemodialysis and peritoneal dialysis 	\$10 per office visit and/or respiratory therapy session

Treatment therapies – Continued on next page

Treatment therapies (Continued)	You pay
<ul style="list-style-type: none"> • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: – We will only cover GHT when we precertify the treatment. You or your Plan doctor should call 787-749-4777 for precertification. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	\$10 per office visit and/or respiratory therapy session
<i>Not covered: Services not shown as covered</i>	<i>All charges</i>
Physical and occupational therapies	
<p>Physical and occupational therapies</p> <p>Up to two consecutive months per condition, if significant improvement can be expected, for the services ordered by a physician of each of the following:</p> <ul style="list-style-type: none"> • Physical therapy <ul style="list-style-type: none"> — rendered by qualified physical therapists supervised by a physician specialized in physical therapy; • Occupational therapy <ul style="list-style-type: none"> — rendered by certified occupational therapists. 	<p>\$10 per office visit and/or physical or occupational therapy</p> <p><i>For occupational therapy you should pay the provider's claim and seek reimbursement from us as we explain in the introduction of Section 5(a).</i></p>
<p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>long-term rehabilitative therapy</i> • <i>exercise programs</i> • <i>cardiac rehabilitation</i> 	<i>All charges</i>

Speech Therapy	You Pay
<ul style="list-style-type: none"> • Speech therapy rendered by certified speech therapist up to two consecutive months per condition. 	\$10 per office visit and/or speech therapy <i>For speech therapy you should pay the provider's claim and seek reimbursement from us as we explain in the introduction of Section 5(a).</i>
Hearing services (testing, treatment and supplies)	
<ul style="list-style-type: none"> • Hearing testing performed by a Plan physician for adult and children (see <i>Preventive care, children</i>) 	\$10 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Hearing aids, testing and examinations for them</i> • <i>Supplies</i> • <i>Timpanometry</i> 	<i>All charges</i>
Vision services (testing, treatment and supplies)	
<ul style="list-style-type: none"> • In addition to medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (that include the written lens prescription) may be obtained from Plan providers. 	\$10 per office visit
<ul style="list-style-type: none"> • Intraocular lenses during cataract removal 	\$10 per office visit
<ul style="list-style-type: none"> • Eye exam to determine the need for vision correction for children (see preventive care) 	\$10 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses, corrective lenses, frames, fitting of contact lenses</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> • <i>Optometrist services</i> • <i>Supplies</i> 	<i>All charges</i>
Foot care	
<ul style="list-style-type: none"> • Routine foot care performed by a Plan doctor when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. • Podiatric services 	\$7.50 per office visit if a general practitioner or podiatrist rendered the services \$10 per office visit if a specialist rendered the services \$7.50 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Treatment of weak, strained or flat feet</i> 	<i>All charges</i>

Orthopedic and prosthetic devices	You Pay
<ul style="list-style-type: none"> • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5 (b) for coverage of the surgery to insert the device. 	<p>Nothing if provided by a Plan doctor or provider</p> <p><i>If provided by a non-Plan doctor, provider or medical equipment supplier, you should pay the provider's claim and seek reimbursement from this Plan. Plan reimburses you 90% of established fees.</i></p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>orthopedic and corrective shoes</i> • <i>arch supports</i> • <i>foot orthotics</i> • <i>heel pads and heel cups</i> • <i>lumbosacral supports</i> • <i>corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>artificial limbs and eyes; stump hose</i> 	<p><i>All charges</i></p>
Durable medical equipment (DME)	
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and other respiratory equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • hospital type beds; • wheelchairs • iron lungs; • walkers, • blood glucose monitors, • oxygen equipment; and • other respiratory equipment <p>Note: You must obtain a precertification from us. Refer to Section 3. Call us at 787-749-4777 as soon as your Plan physician prescribes this equipment to obtain a precertification. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>Nothing</p>

Durable medical equipment (DME) – Continued on next page

Durable medical equipment (DME) (Continued)	You Pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Crutches</i> • <i>Insulin pumps</i> • <i>Other durable medical equipment not shown above.</i> 	<p><i>All charges</i></p>
Home health services	
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician (who will periodically review the program for continuing appropriateness and need) and provided by nurses or home health aides. • Services include oxygen therapy, intravenous therapy and medications. 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative;</i> • <i>services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication;</i> • <i>homemaker services.</i> 	<p><i>All charges</i></p>
Chiropractic	
<ul style="list-style-type: none"> • Manipulation of the spine and extremities, up to 15 visits per year. <p>Note: We also cover one initial visit, one follow-up visit, and X-rays for neck, thorax and lumbosacral spine column area.</p>	<p>No copayment</p> <p><i>If chiropractor accepts assignment of benefits you will not pay; if not, you should pay the provider's claim and Triple-S will reimburse you up to the established fees.</i></p>
Alternative treatments	
<ul style="list-style-type: none"> • Podiatric services 	<p>\$7.50 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>naturopathic services</i> • <i>hypnotherapy</i> • <i>biofeedback</i> • <i>osteopathic services</i> • <i>acupuncture</i> 	<p><i>All charges</i></p>

Educational classes and programs	You Pay
<p>Our disease management programs are addressed to deal with pregnancy and asthma conditions. They provide individual education by using recognized protocols of professional entities. Counseling from professional specialists is also available.</p> <ul style="list-style-type: none"> • Asthma program – Addressed to enhance the quality of life of the asthmatic by teaching them self health care and illness management. • Pregnancy educational program – Provides education about pregnancy during prenatal, delivery and postnatal stages. Emphasizes risk factors that every woman should know to have a healthy delivery and to avoid complications. • Both programs coordinate services with the case management program when the insured needs service alternatives to handle his/her health care. Individual education also includes the distribution of written literature. 	<p>Nothing</p>

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

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Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5 (c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU OR YOUR PLAN DOCTOR MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.
- If you use a non-Plan doctor or provider: you pay for services rendered and the Plan will reimburse you 90% of the Plan's established fee, after any applicable copay or coinsurance, when services are rendered within the service area; or 90% of the usual, customary and reasonable charge of the area, after any applicable copay or coinsurance, when services are rendered outside the service area and are an emergency or are preauthorized. The plan will reimburse for non-emergency, non-authorized but otherwise covered services rendered outside the service area up to Triple-S established fees, after any applicable copay or coinsurance. You pay all remaining charges.
- If you use a non-Plan doctor or provider for preauthorized organ and tissue transplants outside our service area, we will pay the usual, customary and reasonable charges of the area where the services were rendered.

Note: In general, we will only authorize care, equipment, or professional services that are not available from a Plan provider within the service area.

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Benefit Description	You pay
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts 	Nothing

Surgical procedures - Continued on next page

Surgical procedures (Continued)	You pay
<ul style="list-style-type: none"> • Correction of congenital anomalies (see reconstructive surgery) • Surgical assistants • Surgical treatment of morbid obesity – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. • Lithotripsy procedure • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>Nothing</p> <p>For insertion of internal prosthetic devices member pays nothing if provided by a Plan doctor or provider. <i>If provided by a non-Plan doctor, provider or medical equipment supplier, you should pay the provider's claim and seek reimbursement from us. We will reimburse you 90% of our established fees.</i></p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> 	<p><i>All charges</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> — the condition produced a major effect on the member's appearance and — the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> — surgery to produce a symmetrical appearance of breasts; — treatment of any physical complications, such as lymphedemas; — breast prostheses and surgical bras and replacements (see Prosthetic devices) 	<p>Nothing</p>

Reconstructive surgery - Continued on next page

Reconstructive surgery (Continued)	You Pay
<p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<i>All charges</i>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, <i>performed only when medically necessary</i>, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<i>All charges</i>
Organ/tissue transplants	
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas 	Nothing

Organ and tissue transplants - Continued on next page

Organ/tissue transplants <i>(Continued)</i>	You Pay
<ul style="list-style-type: none"> • Liver • Lung: Single –Double • Intestinal transplant (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • You or your Plan doctor must obtain a precertification from us before an organ and tissue transplant. Refer to Section 3. <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Living donors for intestine transplant in adults and children. • Transplants not listed as covered 	<i>All charges</i>
Anesthesia	
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing
Professional services provided in – <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing

Section 5 (c). Services provided by a hospital or other facility, and ambulance services

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Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- For maximum benefits Plan physicians should provide or arrange your care and you should be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).
- If you use a non-participating hospital in the service area, we will reimburse you 90% of the Plan's established fees, after any applicable copayment or coinsurance.
- If you use a non-participating hospital outside the service area we will pay if the service is preauthorized up to the usual and customary charges of the area where service was rendered. If the service is a result of an emergency we will pay up to 90% of the usual, customary and reasonable charges of the area where the service was rendered. If hospitalization is not an emergency nor preauthorized it will be paid up to Triple-S established fees.
- If you use a non-hospital for preauthorized organ and tissue transplants outside our service area, we will pay the usual, customary and reasonable charges of the area where the services were rendered.

Note: In general, we will authorize out of area hospitalizations only for special cases that require equipment, mode of treatment or specialist care not available in Puerto Rico.

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Benefit Description	You pay
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing per inpatient admission to a Plan hospital. <i>Plan reimburses you the established fees for an inpatient admission to a non-Plan hospital in the service area. You pay all remaining charges.</i>

Inpatient hospital – Continued on next page

Inpatient hospital (Continued)	You pay
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care, rest cures, domiciliary or convalescent care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood and blood plasma, and other biologicals • Blood or blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	Nothing

Extended care benefits/skilled nursing care facility benefits	
<p>Skilled nursing facility (SNF): Unlimited medically appropriate care, including bed, board and general nursing care; drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor. You or your Plan doctor must obtain authorization from your Plan before Skilled Nursing Facility confinement, as discussed on page 12.</p>	Nothing
<p><i>Not covered: custodial care, rest cures, domicile or convalescent care.</i></p>	All charges
Hospice care	
<p><i>Not covered: Independent nursing, homemaker services, hospice care</i></p>	All charges
Ambulance	
<ul style="list-style-type: none"> • Local professional ambulance service authorized by a Plan doctor when medically appropriate • Air ambulance services within the Service Area when rendered by a Plan provider. 	<p><i>You should submit the provider's claim and seek reimbursement from us. We pay all charges. You pay nothing.</i></p> <p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Air ambulance outside of the Service Area.</i> • <i>Air ambulance services not rendered by a Plan provider.</i> 	All charges

Section 5 (d). Emergency services/accidents

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Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency?

Emergencies within our service area:

We have available a 24 hour toll free number. Call **1-800-255-4375** for professional medical advice regarding your condition. Also, you can contact your general practitioner physician. In extreme emergencies, if you are unable to contact your general practitioner physician or the 24-hour toll free number, contact the local emergency system (e.g., the 911 telephone system or 787-343-2550) or go to the nearest hospital emergency room. When you call the 24 hour toll free number and receive a precertification from there, the \$5 copay is waived. Also, if the emergency results in admission to a hospital, you pay nothing for the inpatient admission.

- When non-Plan providers or hospitals are used, this Plan pays 90% of Plan's established fees after any applicable copayment or coinsurance.

Emergencies outside our service area:

You can contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness through Blue Cross and Blue Shield plan providers. When non-Plan providers are used this Plan pays 90% of usual, customary and reasonable charges for the area in which the emergency services are rendered, after any applicable copay or coinsurance.

- With your authorization, this Plan will pay benefits directly to non-Plan providers of your emergency care upon receipt of their claims. Non-Plan physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to this Plan along with an explanation of the services and the identification information from your ID card.
 - Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with this Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on pages 49 and 50.
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Section 5 (d). Emergency services/accidents (Continued)

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at emergency room and an urgent care center • Emergency care as an inpatient at a hospital, including doctors' services. 	<p>\$10 per office visit</p> <p>\$5; if we recommend the visit, the copayment is waived</p> <p>Nothing</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
Emergency outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	<p><i>You should submit the provider's claim and seek reimbursement from this Plan. Plan reimburses you 90% of usual, customary and reasonable charges for the area in which emergency services are rendered, after any applicable copay or coinsurance. With your authorization, this Plan will pay benefits directly to non-Plan providers of your emergency care upon receipt of their claims.</i></p>
Ambulance	
<ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate. See 5(c) for non-emergency service. 	<p>Nothing.</p> <p><i>You should submit the provider's claim and seek reimbursement from us. We pay all charges.</i></p>
<ul style="list-style-type: none"> • Air ambulance services within the Service Area when rendered by a Plan provider 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Air ambulance outside of the Service Area.</i> • <i>Air ambulance services not rendered by a Plan provider.</i> 	<i>All charges</i>

Section 5 (e). Mental health and substance abuse benefits

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Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU OR YOUR PLAN DOCTOR MUST GET PRECERTIFICATION OF THESE SERVICES.** See the instructions after the benefits description below.
- If you use a non-Plan doctor or provider: you pay for services rendered and the Plan will reimburse you 90% of the Plan's established fee, after any applicable copay or coinsurance, when services are rendered within the service area; or 90% of the usual, customary and reasonable charge of the area, after any applicable copay or coinsurance, when services are rendered outside the service area and are an emergency or are preauthorized. The plan will reimburse for non-emergency, non-authorized but otherwise covered services rendered outside the service area up to Triple-S established fees, after any applicable copay or coinsurance. You pay all remaining charges. Note: In general, we will only authorize care, equipment, or professional services that are not available from a Plan provider within the service area.
- You must obtain our approval before services are rendered.

You can access information about the Mental Health Parity Act by visiting our Web site at <http://www.ssspr.com>.

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Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$10 per office visit and/or therapy</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>25% laboratory and diagnostic tests. Nothing for X-rays. See Lab, X-ray and other diagnostic tests (Section 5a).</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way houses, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>Nothing</p>

Mental health and substance abuse benefits -- Continued on next page

Mental health and substance abuse benefits <i>(Continued)</i>	You pay
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about a treatment plan on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All charges</i></p>

Precertification

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes:

- You or your Plan doctor or provider should call **1-800-660-4896** for assistance. This is a 24-hour toll free number to help you obtain the precertification and the most appropriate care for your mental or substance abuse condition.

POS mental health and substance abuse benefits	
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This Plan pays its established fees for necessary professional services.

- If you use a non-Plan doctor or provider, you pay for services rendered and the Plan will reimburse you 90% of the Plan's established fees, after any applicable copay or coinsurance, when services are rendered within the service area;
- If you use a non-Plan hospital, you pay for services rendered and we will reimburse you 90% of the Plan's established fees, when services are rendered within the service area; or
- If you use a non-Plan doctor or provider, you pay for services rendered and the Plan will reimburse you 90% of the usual, customary and reasonable charge of the area in which the services are rendered, after any applicable copay or coinsurance, when services are rendered outside the service area.
- If you use a non-Plan hospital, you pay for services rendered and the Plan will reimburse you 100% of the usual, customary and reasonable charge of the area in which the services are rendered, after any applicable copay or coinsurance, when services are rendered outside the service area.

You must obtain our approval before services are rendered.

<p>Special nursing care for each 8-hour period not to exceed 72 consecutive hours, when ordered by the attending psychiatrist.</p> <p>Psychological tests if performed by a qualified psychologist.</p>	<p><i>Plan reimburses you \$18 per period for a registered nurse; \$12 per period for a licensed practical nurse; \$12 per period for a psychiatric aide. You pay the remaining charges.</i></p> <p><i>Plan reimburses you up to \$35 for a full battery of tests. You pay the remaining charges.</i></p>
<p><i>Not covered: POS services we have not approved, halfway home, residential treatment and services related to a drug detection and rehabilitation program.</i></p>	<p><i>All charges</i></p>

Section 5 (f). Prescription drug benefits

I M P O R T A N T	<p>Here are some important things to keep in mind about these benefits:</p> <ul style="list-style-type: none"> • We cover prescribed drugs and medications, as described in the chart beginning on the next page. • All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary. • Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. • If you use a non-Plan pharmacy, this Plan will reimburse you 75% of this Plan's established fees for prescription drugs and you pay all remaining charges. 	I M P O R T A N T
	<p>There are important features you should be aware of. These include:</p> <ul style="list-style-type: none"> • Who can write your prescription. A licensed physician or dentist must write the prescription. • Where you can obtain them. You may fill the prescription at a network pharmacy or a non-network pharmacy. We pay a higher level of benefits when you use a network pharmacy. • We use a formulary. A formulary is a list of medicines that represents a previous evaluation of the Plan's Pharmacy and Therapeutics Committee regarding their efficiency, safety and cost effectiveness; that guarantee the therapy quality, minimizing inadequate utilization that could affect the patient's health. <p>Benefits are provided to the member and member's covered dependents, for medications prescribed by a doctor or a dentist after applicable copays are paid.</p> <p>We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug formulary list, call 787-749-4777.</p> <ul style="list-style-type: none"> • These are the dispensing limitations. Federal Drug Administration (FDA) guidelines are used by this Plan to manage the pharmacy coverage. These include dosing, generic bioequivalent medications and new drug classification, among others. <p>We cover prescription drugs dispensed within six months of a doctor or dentist's original prescription not to exceed the normal 34 days supply. The pharmacy network will not dispense any order too soon after the last one was filled. If this is your case, the pharmacy will contact the Plan to obtain an authorization. Also, the pharmacy will contact the Plan to obtain an authorization for dose changes and for charges over \$500 per dispensed prescription. Some drugs will be dispensed by Specialty Pharmacies only, in order to verify that these drugs are appropriately prescribed and dispensed. To get a list of these drugs call 787-749-4777.</p> <p>When you are planning a trip and need a prescription drug refill in advance, you must show the pharmacy the prescription, along with the airline tickets, to allow the pharmacy to contact the Plan to obtain an authorization.</p> <p>A generic bioequivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally approved generic drug exists, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the brand name copay and the difference in cost between the name brand drug and the generic. If a generic bioequivalent is not available, you still have to pay the brand copay.</p>	

Prescription drug benefits - Continued on next page.

Section 5 (f). Prescription drug benefits (*Continued*)

Certain medications will be dispensed by specialty pharmacies only as a way to verify that these drugs are appropriately prescribed and dispensed. To get a list of these drugs call 787-749-4777.

- **Why use generic drugs?**

Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

You can save money by using generic drugs. However, you and your plan physician have the option to request a name brand if a generic option is available. Using the most cost-effective medication saves money.

- **When you have to file a claim.**

You must file a claim whenever you use a non-network pharmacy. The Plan reimburses 75% of its established fees for prescription drugs and you pay the remaining charges. Submit your itemized bill and/or receipts to us. Also read Section 7 *Filing a claim for covered services* for required information.

Benefit Description	You pay
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician or dentist and obtained from a Plan pharmacy:</p> <p>We will cover prescription drugs based on a formulary. You will pay the brand name copay and the difference between the cost of the brand name prescription drug and the cost of the generic bioequivalent prescription drug, if you choose a brand name prescription drug, for which a generic bioequivalent prescription drug is available, unless your physician has specified Dispense as Written. Covered prescription drugs and accessories include:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Disposable needles and syringes for the administration of covered medications • Contraceptive drugs and devices • Drugs for sexual dysfunction. Viagra is limited to six (6) pills per month for men age 18 years and over. • Vitamins only if they include the legend: “Federal law prohibits dispensing without a prescription” • Smoking cessation drugs, including nicotine patches <p>Note: Intravenous fluids and drugs for home use, implantable drugs, and some injectable drugs are covered under the Medical and Surgical Benefits (also covered under the Medical and Surgical Benefits provided as part of a home health service program).</p>	<p>You will pay the following in-formulary copayments:</p> <ul style="list-style-type: none"> • \$5 for bioequivalent prescription drug unit or refill • \$8 for preferred brand prescription drug unit or refill • \$12 for brand name unit or refill. <p>Note: If you choose a brand name prescription drug, for which a generic bioequivalent prescription drug exists, you will pay the brand name copay and the difference between the cost of the brand name prescription drug and the cost of the generic bioequivalent prescription drug, unless your physician has specified Dispense as Written.</p> <p>You will pay the following out of the formulary copayment:</p> <ul style="list-style-type: none"> • \$5 for bioequivalent prescription drug unit or refill. • 20% or \$12, whichever is higher, for out of formulary brand name prescription drug unit or refill.

Covered medications and supplies - Continued on next page

Covered medications and supplies <i>(Continued)</i>	You Pay
	<p>Note: If a generic bioequivalent does not exist, you will still have to pay the brand name copay.</p> <p>Note: If you choose a brand name prescription drug out of the formulary, for which a generic bioequivalent prescription drug exists, you will pay the brand name copay and the difference between the cost of the brand name prescription drug and the cost of the generic bioequivalent prescription drug, unless your physician has specified Dispense as Written.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Drugs available without a prescription or for which there is a nonprescription equivalent available</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs supplied by pharmacies located outside of Puerto Rico, the United States and its territories, except for emergencies</i> • <i>Drugs for treatment of infertility</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs that are experimental or investigational unless approved by the Federal Drug Administration (FDA)</i> 	<p><i>All Charges</i></p>
Mail Order Program	
<p>The program has the following characteristics:</p> <ul style="list-style-type: none"> • 90-day supply, including one (1) refill <p>Note: This program is only for maintenance medications. The exclusions and limitations mentioned above apply to this program. Please refer to Section 7 for instructions on how to use Pharmacare Express Mail Service Prescription Drug Program.</p>	<p>You will pay the following in-formulary copayments for the 90-day supply:</p> <ul style="list-style-type: none"> • \$10 for bioequivalent prescription drug • \$16 for preferred brand prescription drug • \$24 for brand name <p>Note: You will not pay shipping charges.</p>

Mail Order Program - Continued on next page

Mail Order Program <i>(Continued)</i>	You Pay
	<p>Note: If you choose a brand name prescription drug, for which a generic bioequivalent prescription drug exists, you will pay the brand name copay and the difference between the cost of the brand name prescription drug and the cost of the generic bioequivalent prescription drug, unless your physician has specified Dispense as Written.</p> <p>You will pay the following out of the formulary copayment for the 90-day supply:</p> <ul style="list-style-type: none"> • \$10 for bioequivalent prescription drug • 20% or \$24, whichever is higher, for out of formulary brand name prescription drug <p>Note: You will not pay shipping charges.</p> <p>Note: If you choose a brand name prescription drug out of the formulary, for which a generic bioequivalent prescription drug exists, you will pay the brand name copay and the difference between the cost of the brand name prescription drug and the cost of the generic bioequivalent prescription drug, unless your physician has specified Dispense as Written.</p>

Section 5 (g). Special Features

Feature	Description
<p>Flexible benefits option</p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
<p>24 hours, 7 days a week call center</p>	<p>We offer these services so the members can have immediate access to clinical advice to help them decide when to go to the emergency room immediately, and how to avoid a visit to the emergency room for routine care. Scientifically based protocols are entered into a computer and are followed consistently. Members are oriented on how to reduce risk and manage their disease. Call us at 1-800-255-4375.</p>
<p>Blue Card Program</p>	<p>Blue Card Program is available to all members insured with a Blue Cross and Blue Shield Association Plan. When you need hospital and medical services in any state out of the service area, you can receive them through the Plan providers of this Program. Call 1-800-810-2583 or 787-749-4777 for additional information.</p>
<p>Centers of excellence for transplants/heart surgery/etc</p>	<p>We offer you the benefit of the Blue Quality Centers for Transplants which is a cooperative effort among the Blue Cross and/or Blue Shield Plans, Blue Cross and Blue Shield Association and Participating Institutions to facilitate the provision of quality care in a cost-effective manner from leading institutions for six transplant types: heart, single or bilateral lung, combination heart-bilateral lung, liver, simultaneous pancreas-kidney, and bone marrow/stem cell (autologous/allogeneic). Call 1-800-981-4860 or 787-749-4949 extensions 4361 or 4312 for additional information.</p>
<p>High risk pregnancies program</p>	<p>Our pregnancy educational program provides information about the prenatal, delivery and postnatal stages. Emphasizes risk factors that every woman should know to have a healthy delivery and to avoid complications. Call 787-749-4949 extension 4286 for additional information.</p>
<p>Blue Card Worldwide</p>	<p>Blue Card Worldwide is available to all members insured with a Blue Cross and Blue Shield Association Plan. When you need emergency hospital and medical services out of the service area and the United States of America, you can receive them through the Plan providers of this Program in other countries. Call 1-800-810-2583 for additional information.</p>

Special Features - Continued on next page

Section 5 (g). Special Features (Continued)

Feature	Description
<p>Mental Health Management Program for Federal Employees</p>	<p>This program is available to all Federal employees and their family members 24 hours a day, 7 days a week. The program includes some technological features to ensure quality service:</p> <ul style="list-style-type: none"> • Interactive Voice Response (IVR): Through the IVR your provider can register your care, verify eligibility, and register your visits through the phone keypad. • The Diary of My Recovery: This is a guide or daily register designed to help you obtain better results from your treatment and to measure the progress you are making during the recovery process. Contact your Case Manager at 1-800-660-4896. • Questions?: This service is open for receiving information regarding your services, orientation, comments or any other question you might have. Our electronic address is available for you at: federaleless@valueoptions.com.
<p>Pharmacare Express Mail Service Prescription Drug Program</p>	<p>You can enjoy the many advantages that this program offers:</p> <ul style="list-style-type: none"> • It is convenient: Once you enroll in the program, you will receive maintenance medications at home through our mail delivery. You can order refills through the mail or over the telephone. Shipping is free. • It is safe: The mail order prescription drug program places at your disposal a team of pharmacists who guarantee that every prescription dispensed is carefully verified before being shipped. This way, you will receive the correct amount and the required dose of the medications up to a 90-day supply. • It is easy: You can pay the copayments or coinsurances for your medications with a check, money order, credit card or automatic debit from your bank account. • It is accessible: You can obtain information about your prescription history, order status and drug information over the telephone. The pharmaceutical personnel will be available to answer your questions for extended hours until 9:00 p.m. on weekdays and until 5:00 p.m. on Saturdays. • You will be able to obtain medications not covered by your health insurance at a 20% discount off the regular price <p>To receive information and to clarify any doubts and to answer any questions about the program, please call us at 787-772-9885 in the Metro Area or at 1-866-374-2800 outside the Metro Area, toll free.</p>

Section 5 (h). Dental benefits

I M P O R T A N T	<p>Here are some important things to keep in mind about these benefits:</p> <ul style="list-style-type: none"> • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5 (c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below. • Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. 	I M P O R T A N T
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Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. An injury caused by chewing is not considered an accidental injury.	Nothing
Dental benefits	You pay

If you use a non-Plan dentist, you pay for services rendered and the Plan will reimburse you 90% of the Plan's established fees after any applicable copay or coinsurance when services are received within the service area; or the Plan's established fees when services are rendered outside the service area after any applicable copayment or coinsurance.

Plan dentist means a duly authorized dentist with a regular license issued by the designated entity of the government of Puerto Rico, and who is a bona fide member of the "Colegio de Cirujanos Dentistas de Puerto Rico", who has signed a contract with Triple-S to render dental services. Non-Plan dentist means a duly authorized dentist with a regular license, who has not signed a contract with Triple-S to render dental services.

Dental coverage is limited to:	
Diagnostic	Nothing
<ul style="list-style-type: none"> • Periodic oral evaluation • Limited oral evaluation • Comprehensive oral evaluation • Periapical and bitewing X-rays (limited to six periapical X-rays and no more than two bitewing X-rays per calendar year) • Preventive Prophylaxis (adult and child) 	
<ul style="list-style-type: none"> • Panoramic X-rays, up to 1 set every 3 years • Fluoride treatment, one every six month. 	30%

Dental benefits - Continued on next page

Dental benefits <i>(Continued)</i>	You pay
Restorative <ul style="list-style-type: none"> • Amalgam restorations • Plastic, porcelain or composite (anterior and posterior tooth) • Other restorative services (pin retention per tooth, in addition to restorations) • Sedative filling 	30%
Adjunctive General Services <ul style="list-style-type: none"> • Application of desensitizing medicament • Gingival curettage, surgical (emergency treatment), for one or two teeth in the same quadrant • Treatment of complications (post-surgical-unusual circumstances, by report) 	30%
Endodontics <ul style="list-style-type: none"> • Pulp capping-direct (excluding final restoration) • Pulp capping-indirect (excluding final restoration) • Pulpal debridement in primary and permanent teeth for emergency purposes 	30%
Oral Surgery <ul style="list-style-type: none"> • Extractions • Surgical removal of erupted teeth • Surgical removal of residual tooth roots • Incision and drainage of abscess - intra-oral soft tissue • Surgical removal of impacted teeth 	30%
<i>Not covered: Other dental services not shown as covered.</i>	<i>All charges</i>

Section 5 (i). Point of service benefits

Facts about this Plan's POS option

At your option, within our service area (Puerto Rico) you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care, except for the benefits listed below under "What is not covered." Outside of our service area, emergency care or care that has been preauthorized will be covered under the POS option based on the usual and customary charges of the area where the service was rendered; care that is neither an emergency nor preauthorized will be covered based on Triple-S established fees. In general, we will only authorize coverage outside of our service area for care, equipment, or professional services that are not available from a Plan provider.

Point of Service (POS) Benefits

You can receive care from any non-Plan doctor without a referral. A non-Plan doctor is any licensed doctor of medicine (M.D.) who is not a Plan doctor. Non-Plan doctors do not have to accept Triple-S established fees as payment in full. If you use a non-Plan doctor (except for speech or occupational therapy) you must pay the difference between the non-Plan doctor's charge and the amount paid to you by us.

You can also receive services from a non-Plan hospital. A non-Plan hospital is any licensed institution that is not a Plan hospital and that is engaged primarily in providing bed patient with diagnosis and treatment under the supervision of physicians with 24-hour-a-day registered graduate nursing services. A non-Plan hospital does not have to accept Triple-S established fees as payment in full. You must pay any difference between the non-Plan hospital's charges and the amount paid to you by us. We reimburse you according to our established fee for non-Plan hospital inpatient admissions within our service area, or for services outside the service area that are neither an emergency nor preauthorized.

Benefits are paid according to the "medical benefits schedule". This is the schedule of established fees on which this Plan's payment of covered medical expense is based, when the services are rendered within the service area, Puerto Rico, or out of the service area that are neither an emergency nor preauthorized. When services are rendered outside the service area and are emergencies or preauthorized cases, the Plan's payment is based on usual, customary and reasonable charges.

If you use a non-Plan doctor or provider, you pay for services rendered and we will reimburse you 90% of the Plan's established fees, after any applicable copay or coinsurance, when services are rendered within the service area. For services rendered outside the service area that are an emergency or preauthorized we will reimburse you 90% of the usual, customary and reasonable charge of the area in which the services are rendered, after any applicable copay or coinsurance. For services rendered outside the service area that are neither an emergency nor preauthorized we will reimburse you up to Triple-S established fees after any applicable copayment or coinsurance.

If you use a non-participating hospital in the service area, we will reimburse you 90% of the Plan's established fees. If you use a non-participating hospital outside the service area we will pay if the service is preauthorized up to the usual and customary charges of the area where service was rendered. If the service is a result of an emergency we will pay up to 90% of the usual, customary and reasonable charges of the area where the service was rendered. If the hospitalization is neither an emergency nor preauthorized, it will be paid up to Triple-S established fees.

If you use a non-Plan dentist, you pay for services rendered and the Plan will reimburse you 90% of the Plan's established fees after any applicable copay or coinsurance when services are received within the service area; or the Plan's established fees when services are rendered outside the service area after any applicable copayment or coinsurance.

Non-Plan providers are under no obligation to accept our established fees as payment in full. You pay all charges remaining for outpatient care above our established fees when non-Plan providers are used, in addition to the copayments and coinsurances. For all other care under this benefit you pay all remaining charges after we have paid benefits.

Point of service benefits - Continued on next page

Section 5 (i). Point of service benefits (continued)

What is covered

Point of service benefits are described in Section 5 of this brochure.

Precertification

Read Section 3 for services requiring our prior approval.

What is not covered

Point of service benefits exclusions are described in Sections 5 and 6 of this brochure.

Section 6. General exclusions - things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness or condition and we agree, as discussed under *What Services Require Our Prior Approval* on page 12.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel;
- Drug detection tests for employment purposes; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical, hospital and drug benefits In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 787-749-4777.

When you must file a claim -- such as for services you receive outside of the Plan's service area -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer --such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.
- For prescription drugs also include:
 - Prescription drug name;
 - Daily dosage;
 - Prescription number;
 - Dispensed supply; and
 - National Drug Code (NDC)

Submit your claims to:

Triple-S

P.O. Box 363628

San Juan, Puerto Rico 00936-3628

Section 7. Filing a claim for covered services *(Continued)*

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Mail Service Prescription Drug Program

We will send you information on our Mail Service Prescription Drug Program, including an initial mail order form.

1. When you visit your physician show him the card: **Important Notice for Physicians.** For initial enrollment in the program he or she must write you two prescriptions:
 - One prescription for a 30-day supply to be dispensed immediately by any participating pharmacy.
 - One prescription for a 90-day supply, including one (1) refill. This prescription is the one to be dispensed by the Mail Order Pharmacy.
2. Complete the initial mail order form; please complete one for each person participating in the program. You must return the enrollment form, a photocopy of your Triple-S ID card and of a valid ID card with photo (driver's license, voter's registration card, etc.) and the original prescription. Use the pre-addressed envelope included in the information package.
 - If a plan member is under the age of 18, the father, mother or legal guardian must sign the form.
3. Mail your order with the required information to: Pharmicare Express, Call Box 28001, San Juan, PR, 00928.
4. Allow approximately 5 to 10 days for delivery.

After that, you can order your refills through the mail or by phone:

- Through the mail - with your first mail, you will receive a form to reorder the medication. Remember to request it on time.
- By phone - You can call at 787-772-9885 in the Metro Area or at 1-866-374-2800 outside the Metro Area, toll free.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for precertification:

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: Triple-S, P.O. Box 363628, San Juan, Puerto Rico 00936-3628; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial -- go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, D.C. 20415-3620.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none">A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;Copies of all letters you sent to us about the claim;Copies of all letters we sent to you about the claim; andYour daytime phone number and the best time to call. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>

Section 8. The disputed claims process (*Continued*)

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

- 5** OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- (a) We haven't responded yet to your initial request for care or precertification/prior approval, then call us at 787-749-4777 and we will expedite our review; or
- (b) We denied your initial request for care or precertification/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 2 at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage You must tell us if you or a covered family member have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

•What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or both Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

Section 9. Coordinating benefits with other coverage *(Continued)*

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

• **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in Original Medicare along with this plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan -- You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 787-749-4777.

We waive some costs if the Original Medicare Plan is your primary payer--We will waive some out-of-pocket costs, as follows:

- Medical Services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part A and Part B we will waive copays and coinsurance.

(Primary payer chart begins on next page.)

Section 9. Coordinating benefits with other coverage (Continued)

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Are an active employee with the Federal government and... • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
2) Are an annuitant and... • You have FEHB coverage on your own or through your spouse who is also an annuitant	✓	
• You have FEHB coverage through your spouse who is an active employee		✓
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case)	✓*	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and... • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge)	✓*	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty)	✓**	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and... • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and... • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	

Section 9. Coordinating benefits with other coverage (Continued)

Primary Payer Chart		
C. When either you or your spouse are eligible for Medicare solely due to disability and you	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Are an active employee with the Federal government and... • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
2) Are an annuitant and... • You have FEHB coverage on your own or through your spouse who is also an annuitant	✓	
• You have FEHB coverage through your spouse who is an active employee		✓
D. Are covered under the FEHB Spouse Equity provision as a former spouse	✓	

* Unless you have FEHB coverage through your spouse who is an active employee

** Workers' Compensation is primary for claims related to your condition under Workers' Compensation

• Medicare + Choice

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare + Choice plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare + Choice plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare + Choice plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare + Choice plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare + Choice plan, the following options are available to you:

This Plan and another plan's Medicare + Choice plan: You may enroll in another plan's Medicare + Choice plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare + Choice plan is primary, even out of the Medicare + Choice plan's network and/or service area (if you use our Plan providers) and we will waive our copayments and coinsurance.

If you enroll in a Medicare + Choice plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare + Choice plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare + Choice plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare + Choice plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare + Choice plan premium). For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare + Choice plan's service area.

Section 9. Coordinating benefits with other coverage (*Continued*)

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Assignment of Benefits	A provision in a health benefits claim form by which the insured directs the insurance company to pay any benefits directly to the provider of care on whose charge the claim is based.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 13.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	<p>Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. Custodial care that lasts 90 days or more is sometimes known as Long term care. These activities include but are not limited to:</p> <ul style="list-style-type: none">• personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;• homemaking, such as preparing meals or special diets;• moving the patient;• acting as a companion or sitter;• supervising medication that can usually be self-administered; or• treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.
Experimental or investigational services	<p>This Plan considers factors which it determines to be most relevant under the circumstances, such as: published reports and articles in the authoritative medical, scientific, and peer review literature; or written protocols used by the treating facility or being used by another facility studying substantially the same drug, device, or medical treatment. This Plan also considers Federal and other governmental agency approval as essential to the treatment of an injury or illness by, but not limited to, the following: American Medical Association, U.S. Surgeon General, U.S. Department of Public Health, the Food and Drug Administration, or the National Institutes of Health.</p>

Section 10. Definitions of terms we use in this brochure *(Continued)*

Medically necessary

Services, drugs, supplies, or equipment provided by a hospital or covered provider of health care services that the Plan determines:

- are appropriate to diagnose or treat the patient's condition, illness or injury;
- are consistent with standards of good medical practice in the United States;
- are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
- are not a part of or associated with the scholastic education or vocational training of the patient; and
- in the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug, or equipment does not, in itself, make it medically necessary.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: the plan allowance in our service area, Puerto Rico, is the medical benefits schedule, the fees Plan doctors have agreed to accept as payment in full. The Plan allowance outside of the service area is the usual, customary and reasonable charge.

Us/We

Us and we refer to Triple-S.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

Coverage Information

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

Section 11. FEHB facts (*Continued*)

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB) Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option,
- if you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- if you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2004 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2003 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as temporary continuation of coverage (TCC).

Section 11. FEHB facts (*Continued*)

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary continuation of coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Section 11. FEHB facts (*Continued*)

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans. For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB Web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Two new Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you know about two new Federal programs that complement the FEHB Program. First, the **Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside tax-free money to pay for health and dependent care expenses. The result can be a discount of 20 to more than 40 percent on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** covers long term care costs not covered under the FEHB.

The Federal Flexible Spending Account Program - *FSAFEDS*

- **What is an FSA?**

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%!*

There are two types of FSAs offered by the FSAFEDS Program:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal income tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition than that of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum amount that can be allotted for the HCFSA is \$3,000 annually. The minimum amount is \$250 annually.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you can work, or if you are married, so you and your spouse can work, or your spouse can look for work or attend school full-time.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified IRS dependent and/or with whom you jointly file your Federal income tax return.
- The maximum that can be allotted for the DCFSA is \$5,000 annually. The minimum amount is \$250 annually. *Note:* The IRS limits contributions to a Dependent Care FSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive

- **Enroll during Open Season**

You **must make an election** to enroll in an FSA during the FEHB Open Season. Even if you enrolled during the initial Open Season for 2003, you must make a new election to continue participating in 2004. Enrollment is easy!

- Enroll online anytime during Open Season (November 10 through December 8, 2003) at www.fsafeds.com.
- Call the toll-free number 1-877-FSAFEDS (372-3337) Monday through Friday, from 9 a.m. until 9 p.m. eastern time and a FSAFEDS Benefit Counselor will help you enroll.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and will be responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB– you can choose to participate in either, or both, of the flexible spending accounts. If you are not eligible for FEHB, you are not eligible to enroll for a Health Care FSA. However, almost all Federal employees are eligible to enroll for the Dependent Care FSA. The only exception is intermittent (also called when actually employed [WAE]) employees expected to work less than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers signed on. Under IRS law, FSAs are not available to annuitants. In addition, the U.S. Postal Service and the Judicial Branch, among others, are Federal agencies that have their own plans with slightly different rules, but the advantages of having an FSA are the same no matter what agency you work for.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA.

Because of the tax benefits of an FSA, the IRS places strict guidelines on them. You need to estimate how much you want to allocate to an FSA because current IRS regulations require you forfeit any funds remaining in your account(s) at the end of the FSA plan year. This is referred to as the “use-it-or-lose-it” rule. You will have until April 29, 2004 to submit claims for your eligible expenses incurred during 2003 if you enrolled in FSAFEDS when it was initially offered. You will have until April 30, 2005 to submit claims for your eligible expenses incurred from January 1 through December 31, 2004 if you elect FSAFEDS during this Open Season.

The **FSAFEDS Calculator** at www.fsafeds.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- **What can my HCFSA pay for?**

Every FEHB health plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 13 and detailed throughout this brochure. Your HCFSA will reimburse you for such costs when they are for tax deductible medical care for you and your dependents that is NOT covered by this FEHB Plan or any other coverage that you have.

Under this Plan, typical out-of-pocket expenses include: copayments for visits to physician’s office, laboratories and copayments for medications.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. If you do not see your service or expense listed in Publication 502, please call a FSAFEDS Benefit Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will also be lower. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into a FSA:	\$ 2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$ 2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax saving based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon in which retirement system you are enrolled (CSRS or FERS), as well as your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424, a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal income tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

Health care expenses

The HCFSA is tax-free from the first dollar. In addition, you may be reimbursed from the HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal income tax return. Using the example listed in the above chart, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal income tax return. In addition, money set aside through a HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal income tax return.

Dependent care expenses

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.fsafeds.com and download the Dependent Care Tax Credit Worksheet from the Quick Links box to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

Probably not. While there is an administrative fee of \$4.00 per month for an HCFSA and 1.5% of the annual election for a DCFSA, most agencies have elected to pay these fees out of their share of employment tax savings. To be sure, check the FSAFEDS.com Web site or call 1-877-FSAFEDS (372-3337). Also, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the plan year and wind up forfeiting your end of year account balance, per the IRS "use-it-or-lose-it" rule.

- **Contact us**

To find out more or to enroll, please visit the **FSAFEDS Web site** at www.fsafeds.com, or contact SHPS by email or by phone. SHPS Benefit Counselors are available from 9:00 a.m. until 9:00 p.m. eastern time, Monday through Friday.

- E-mail: fsafeds@shps.net
- Telephone: 1-877-FSAFEDS (372-3337)
- TTY: 1-800-952-0450 (for hearing impaired individuals that would like to utilize a text messaging service)

The Federal Long Term Care Insurance Program

It's important protection

Here's why you should consider enrolling in the Federal Long Term Care Insurance Program:

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive when you need assistance performing activities of daily living – such as bathing or dressing yourself. This need can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you control over the type of care you receive and where you receive it. It can also help you remain independent, so you won't have to worry about being a burden to your loved ones.
- **It's to your advantage to apply sooner rather than later.** Long term care insurance is something you must apply for, and pass a medical screening (called underwriting) in order to be enrolled. Certain medical conditions will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a change in health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. If you marry, your new spouse will also have a limited opportunity to apply using abbreviated underwriting. Qualified relatives are also eligible to apply with full underwriting.

To find out more and to request an application

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

- Accidental injury 27, 42
Allergy tests 19
Alternative treatment 23
Allogeneic (donor) bone marrow transplant 28,40
Ambulance 29, 31, 33
Anesthesia 6, 28, 30
Autologous bone marrow transplant 19, 28, 40
Biopsies 25
Blood and blood plasma 30
Breast cancer screening 16, 17
Casts 25, 30
Catastrophic protection out-of-pocket maximum 13
Changes for 2004 9
Chemotherapy 19
Childbirth 18
Chiropractic 23
Cholesterol tests 16
Claims 47-48
Coinsurance 13, 56
Colorectal cancer screening 16
Congenital anomalies 26
Contraceptive drugs and devices 37
Coordination of benefits 51-55
Covered charges 52
Crutches 23
Definitions 56-57
Dental care 42-43
Diagnostic services 15-16, 30, 34, 42
Disputed claims review 49-50
Donor expenses (transplants) 28
Dressings 30
Durable medical equipment (DME) 22-23
Educational classes and programs 24
Effective date of enrollment 56, 59
Emergency 32-33
Experimental or investigational 38, 46, 56
Eyeglasses 21
Family planning 18
Fecal occult blood test 16
Fraud 4-5
General Exclusions 46
Hearing services 21
Home health services 23
Hospice care 31
Home nursing care 23
Hospital 29-31
Immunizations 17
Infertility 19, 38
Inhospital physician care 25
Inpatient Hospital Benefits 29-31
Insulin 23, 37
Laboratory and pathological services 16, 30, 34
Magnetic Resonance Imaging (MRIs) 16
Mail Order Prescription Drugs Program 38-39, 41, 48
Mammograms 16, 17
Maternity Benefits 18
Medicaid 55
Medically necessary 12, 15, 20, 25, 29, 42, 57
Medicare 51-55
Mental Conditions/Substance Abuse Benefits 34-35, 41
Neurological testing 16
Newborn care 17-18
Nurse 16, 23, 35
 Licensed Practical Nurse 35
 Nurse Anesthetist 30
 Nurse Practitioner 35
 Psychiatric Nurse 35
 Registered Nurse 35
Nursery charges 18
Obstetrical care 18
Occupational therapy 20
Ocular injury 21
Office visits 15
Oral and maxillofacial surgery 27
Orthopedic devices 22
Out-of-pocket expenses 13
Outpatient facility care 30
Oxygen 22, 30
Pap test 16, 17
Physical therapy 20
Physician 7, 10, 15, 25
Point of service (POS) 7, 35, 44-45
Precertification 7, 12, 35, 45
Preventive care, adult 16-17
Preventive care, children 17
Prescription drugs 36-39
Preventive services 16-17, 42
Prior approval 12, 45
Prostate cancer screening 16
Prosthetic devices 22, 26
Psychologist 34, 35
Radiation therapy 19
Renal dialysis 19
Room and board 29
Second surgical opinion 16
Skilled nursing facility care 12, 28, 31
Smoking cessation 37
Speech therapy 21
Splints 30
Sterilization procedures 18, 26
Subrogation 55
Substance abuse 34-35
Surgery 25-28
 • Anesthesia 28, 30
 • Oral 43
 • Outpatient 30
 • Reconstructive 26
Syringes 37
Temporary continuation of coverage 60
Transplants 12, 27-28, 40
Treatment therapies 19-20
Vision services 17, 21
Well child care 17
Wheelchairs 22
Workers' compensation 55
X-rays 16, 30, 34, 42

Summary of benefits for the Triple-S Plan – 2004

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Benefits	You Pay	Page
Medical services provided by physicians: <ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office..... 	Office visit copay:\$7.50 general practitioner; \$10 specialist, 25% for laboratory and diagnostic tests; nothing for X-rays.	15
Services provided by a hospital: <ul style="list-style-type: none"> • Inpatient..... • Outpatient..... 	Nothing	29
Emergency benefits: <ul style="list-style-type: none"> • In-area • Out-of-area 	Emergency room \$5; waived if precertified. Nothing for hospital. 10%	32-33
Mental health and substance abuse treatment.....	Regular benefits	34
Prescription drugs	In-formulary: \$5 for bioequivalent prescription drug unit or refill; \$8 for preferred brand prescription drug unit or refill; and \$12 for brand name unit or refill. Out of the formulary: \$5 for bioequivalent prescription drug unit or refill; 20% or \$12, whichever is higher, for out of formulary brand prescription drug unit or refill.	36
Dental Care	Nothing for diagnostic services; 30% all other services.	42
Vision Care	\$10 per office visit	21
Special features: • Flexible benefits option • 24 hours, 7 days a week call center • Blue Card Program • Centers of excellence for transplants/heart surgeries/etc • High risk pregnancies program • Blue Card Worldwide • Mental Health Management Program for Federal Employees • Pharmacare Express Mail Service Prescription Drug Program		40
Point of Service benefits -- Yes		35, 44

2004 Rate Information for Triple-S, Inc.

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	891	\$84.69	\$28.23	\$183.50	\$61.16	\$100.22	\$12.70
Self and Family	892	\$181.91	\$60.64	\$394.15	\$131.38	\$215.26	\$27.29