

Triple-S

<http://www.ssspr.com>

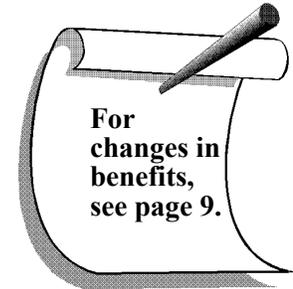


An Independent Licensee
of the BlueCross and
BlueShield Association

2008

A health maintenance organization with a point of service product

Serving: All of Puerto Rico and United States Virgin Islands



Enrollment in this Plan is limited. You must live in our geographic service area to enroll. See page 7 for requirements.

Enrollment Codes for this Plan:

For Residents in Puerto Rico

891 Self Only

892 Self and Family

For Residents in U.S. Virgin Islands

851 Self Only

852 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

**Important Notice from Triple-S About
Our Prescription Drug Coverage and Medicare**

OPM has determined that the Triple-S prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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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 787-774-6060 (TTY 787-792-1370) from Puerto Rico or 1-800-981-3241 (TTY 1-866-215-1999) from the United States Virgin Islands.

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, 2008, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2008, and changes are summarized on page 8. 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 U.S. Office of Personnel Management, Insurance Services Programs, 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 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 that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- 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) statements 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 787/774-6060 (TTY 787-792-1370) from Puerto Rico or 1-800-981-3241 (TTY 1-866-215-1999) from the United States Virgin Islands 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, DC20415-1100

- 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.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.

- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

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.

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.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 health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. 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 health care 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 health care 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 practice 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 pay only 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 have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

We have Point-of-Service (POS) benefits

Our HMO offers POS benefits. This means you can receive covered services from a non-participating provider. However, out-of-network benefits may 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 and in the United States Virgin Islands based on the "medical benefits schedule". We pay non-Plan providers outside of Puerto Rico and United States Virgin Islands 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 neither emergencies nor preauthorized, this plan will pay up to Triple-S established fees, after any applicable copayment or coinsurance.

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 or in the United States Virgin Islands, 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, 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 or the United States Virgin Islands that has signed a contract with Triple-S or Blue Cross Blue Shield 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 or United States Virgin Islands are paid according to the “medical benefits schedule” of Triple-S in Puerto Rico and in the United States Virgin Islands. 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 the service area, this Plan pays based on usual, customary and reasonable charges. When services rendered out of the service area are neither emergencies nor preauthorized, this plan will pay up to Triple-S established fees, after any applicable copayment or coinsurance.

For services received by a dependent that is a full time student in a recognized educational institution in the United States, Triple-S will pay based on usual, customary and reasonable charges of the area where the services were rendered. The child must present a certification from the recognized educational institution that he/she is enrolled in a full course of studies pursuant to an associate or bachelor’s degree or is pursuing graduate studies (e.g., for a master’s degree), under criteria of the institution where the child studies. The same benefit will apply to students entering TCC due to his/her age while they are full time students.

Your rights

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

- Years in existence
- Profit status

If you want more information about us, call 787/774-6060 (TTY 787-792-1370) from Puerto Rico or 1-800-981-3241 (TTY 1-866-215-1999) from the United States Virgin Islands, 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.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

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

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 neither emergencies nor preauthorized, this plan will pay up to Triple-S established fees after any applicable copayment or coinsurance.

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 2008

Do not rely only on these change descriptions; this Section 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.

Changes to this Plan

- Your share of the non-Postal premium will decrease by 14.9% for Self Only and 8.9% for Self and Family for enrollees in Puerto Rico.
- Your share of the non-Postal premium will increase by 5% for Self Only and 5% for Self and Family for enrollees in the United States Virgin Islands.
- We have added services to the list of services requiring our prior approval as established in Section 3.
- We will cover tympanometry as part of our hearing services as established in Section 5 (a).
- We will reduce the laboratory tests coinsurance as established in Section 5 (a).
- We will modify the pre and post natal care visit copayment as established in Section 5 (a).
- We will modify the outpatient surgery center copayment as established in Section 5 (c).
- We will modify the emergency room and urgent care copayment as established in Section 5 (d).
- We will cover OTC Medications: Prilosec 20mg Tab, Claritin and Zador as established in Section 5 (f).
- We will provide a 5 Tier retail pharmacy benefit and a 4 Tier mail order pharmacy benefit as established in Section 5 (f).
- We will modify the generic substitution policy as established in Section 5 (f).
- We will modify the brand name and non-preferred copayment as established in Section 5 (f).
- We are going to move specialty/biotech drugs to a fifth tier as established in Section 5 (f).
- We will cover a 90-day supply retail service (Flex 90) as established in Section 5 (f).
- We will offer a Medicare Advantage option as established in Non-FEHB benefits Section at the end of Section 5.

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. Your ID card does not have an expiration date to ensure the continuity of services and to avoid waiting for a new one. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as 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 787-774-6060 (TTY 787-792-1370) from Puerto Rico or 1-800-981-3241 (TTY 1-866-215-1999) from the United States Virgin Islands, 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, deductibles, and/or coinsurance, if you use our point-of-service program, you can also get care from non-Plan providers but it will cost you more. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

- **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 primary care physician. This decision is important since your primary care physician provides or arranges 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.

- **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 hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 787-774-6060 (TTY 787-792-1370) from Puerto Rico or 1-800-981-3241 (TTY 1-866-215-1999) from the United States Virgin Islands. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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 cases, 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.

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 787-774-6060 (TTY 787-792-1370) from Puerto Rico or 1-800-981-3241 ((TTY 1-866-215-1999) from the United States Virgin Islands.

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; we will only precertify services outside the service area for those services that are not available in Puerto Rico;
- 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);
- Growth hormone therapy;
- Drugs identified with a **PA** in the List of Drugs;
- Positron Emission Tomography (PET AND PET-CT)
- Septoplasty;
- Rhinoplasty;
- Blepharoplasty; and
- Office surgeries to be performed at Hospitals

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care

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

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

Cost-sharing Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

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

Example: In our Plan, you pay 10% of our allowance for laboratory 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 a 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 prescription drug, if you or your physician chooses the use of a brand name drug indicating in the prescription Original or Dispense as written, for which a generic prescription drug exists.

Carryover If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

When Government facilities bill Us Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

Section 5. Benefits

(See page 8 for how our benefits changed this year and pages 68 and 69 for a benefits summary.)

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

Important things you should 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 FOR 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 pay 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 pay 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.

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

Benefit Description	You pay
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis 	10% for laboratory tests in lab facilities
<ul style="list-style-type: none"> • Polysomnography • Genetic amniocentesis • Non-invasive vascular and cardiovascular tests, including electrocardiogram and EEG 	25%
<ul style="list-style-type: none"> • Pathology • Non-routine Pap tests • X-rays • Non-routine Mammograms • Nuclear medicine tests • Hepatobiliary ductal system imaging (HIDA) • Cat Scans/Magnetic resonance (MRI, MRA) • Ultrasound, including Biophysical Profile • Invasive cardiovascular tests 	Nothing
Preventive care, adult	
Routine physical every year, which includes: 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 • Osteoporosis Screening 	\$7.50 per office visit to your general practitioner physician, \$10 per office visit to a specialist physician; 10% for laboratory tests in lab facilities and 25% for diagnostic tests, except those specified to pay nothing under Lab, X-rays and other diagnostic tests.
<ul style="list-style-type: none"> • Prostate Specific Antigen (PSA test) 	\$7.50 per office visit to your general practitioner physician, \$10 per office visit to a specialist physician; and 10% for laboratory tests in lab facilities.
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 calendar year • At age 65 and older, one every two consecutive calendar years 	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	\$7.50 for general physician or \$10 per specialist physician office visit. Nothing per immunization.

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
<i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges</i>
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 - Hemophilus influenza B - Influenza - Tetanus toxoid - Hepatitis B - Prevnar, up to 24 months of age - Meningococcal conjugate vaccine, up to 18 years of age - Diphteria tetanus acellular pertusis - Hepatitis A, up to 23 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	
<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. 	\$10 per office visit, nothing for delivery

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	
<ul style="list-style-type: none"> 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. Surgical benefits, not maternity benefits, apply to circumcision. 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)). 	\$10 per office visit, nothing for delivery
<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
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary surgical sterilization</i> <i>Genetic counseling</i> 	<i>All charges</i>
Infertility services	
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) 	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <i>in vitro fertilization</i> <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> <i>Services and supplies related to ART procedures</i> <i>Cost of donor sperm</i> <i>Cost of donor egg.</i> 	<i>All charges</i>

Benefit Description	You pay
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy vaccine 	\$10 per office visit
<ul style="list-style-type: none"> • 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 <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on pages 27 through 30.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy up to a maximum of 20 sessions per year • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We will only cover GHT when we precertify the treatment. You or your Plan doctor should call 787-774-6060 (TTY 787-792-1370) from Puerto Rico or 1-800-981-3241 (TTY 1-866-215-1999) from the United States Virgin Islands, 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 	<p>\$10 per office visit and/or physical or occupational therapy</p> <p>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).</p>

Physical and occupational therapies - continued on next page

Benefit Description	You pay
Physical and occupational therapies (cont.)	
<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>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>\$10 per office visit and/or physical or occupational therapy</p> <p>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).</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> 	<p><i>All charges</i></p>
Speech therapy	
<p>Speech therapy rendered by certified speech therapist up to two consecutive months per condition</p>	<p>\$10 per office visit and/or speech therapy</p> <p>For speech therapy you should pay the provider's claim and seek reimbursement from us. You are responsible for all charges over the established fees. Speech therapists are not Plan providers and do not have to accept the established fees as payment in full.</p>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Hearing testing performed by a Plan physician for adults and children (see <i>Preventive care, children</i>) • Timpanometry 	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Hearing aids, testing and examinations for them</i> • <i>Supplies</i> 	<p><i>All charges</i></p>
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. • Intraocular lenses during cataract removal • Eye exam to determine the need for vision correction for children (see preventive care) 	<p>\$10 per office visit</p>
<ul style="list-style-type: none"> • Optometrist services 	<p>\$7.50 per office visit</p>

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay
Vision services (testing, treatment, and supplies) (cont.)	
<p><i>Not covered:</i></p> <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>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 	<p>\$7.50 per office visit if a general practitioner or podiatrist rendered the services</p> <p>\$10 per office visit if a specialist rendered the services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Treatment of weak, strained or flat feet</i> 	<i>All charges</i>
Orthopedic and prosthetic devices	
<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: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device 	<p>Nothing if provided by a Plan doctor or provider</p> <p>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</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoe</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> 	<i>All charges</i>

Benefit Description	You pay
Durable medical equipment (DME)	
<p>We cover rental or purchase of durable medical equipment prescribed by your physician, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen; • Hospital beds; • Wheelchairs; • Walkers; • Blood glucose monitors; • Iron lungs; and • Other respiratory equipment <p>Note: You must obtain a precertification from us. Refer to Section 3. Call us at 787-749-4777 from Puerto Rico or 1-800-981-3241 from the United States Virgin Islands 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>	Nothing
<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> 	<i>All charges</i>
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 	Nothing
<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> 	<i>All charges</i>

Benefit Description	You pay
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>If the chiropractor accepts assignment of benefits you will not have to pay up front; if not, you should pay the provider's claim and Triple-S will reimburse you up to the established fees. You are responsible for all charges over the established fees. Chiropractors are not Plan providers and do not have to accept the established fees as payment in full.</p>
Alternative treatments	
<ul style="list-style-type: none"> • Podiatric services 	\$7.50 per office visit
<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> 	<i>All charges</i>
Educational classes and programs	
<p>Our disease management programs are addressed to deal with pregnancy, asthma and diabetes. 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. • Controlling diabetes - Offers information on diabetes and answers your questions about this condition. Also, offers information on adequate nutrition and physical activity. We will collaborate with your physician and promote an action plan to monitor diabetes and prevent or avoid complications. A wide array of educational materials is available through the mail. <p>These 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

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

Important things you should 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 FOR 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 pay 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 pay 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.

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 • Correction of congenital anomalies (see Reconstructive surgery) • Surgical assistants 	<p>Nothing, see Section 5 (c) for outpatient surgical facility copay.</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>

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
<ul style="list-style-type: none"> • Surgical treatment of morbid obesity (bariatric surgery) – 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. This plan uses the following criteria: <ul style="list-style-type: none"> - Patients with a body mass index (BMI) of greater than 40/Kg/m2 or greater than 35Kg/m2 in conjunction with severe comorbidities such as cardiopulmonary complications, severe diabetes or obstructive sleep apnea - BMI is calculated using the following formula: Weight (Kg) ÷ height (m2) = BMI • 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, see Section 5 (c) for outpatient surgical facility copay.</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; 	<p>Nothing, see Section 5 (c) for outpatient surgical facility copay.</p>

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	
<ul style="list-style-type: none"> - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) <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, see Section 5 (c) for outpatient surgical facility copay.
<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 <p>Other surgical procedures that do not involve the teeth or their supporting structures.</p>	Nothing, see Section 5 (c) for outpatient surgery facility copay.
<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>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Lung single, double or lobar lung • Kidney • Liver • Pancreas 	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	Nothing
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity requirement is considered satisfied if the patient meets the staging description)</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) <p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced forms of myelodysplastic syndromes - Advanced neuroblastoma - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Mucopolysaccharidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) 	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants) 	Nothing
<ul style="list-style-type: none"> • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Amyloidosis - Ependyblastoma - Ewing’s sarcoma - Medulloblastoma, not covered as initial treatment, covered as salvage treatment to consolidate remission <p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols for:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma, up to 65 years of age • Nonmyeloablative allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia, up to 60 years of age - Advanced forms of myelodysplastic syndromes - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma, up to 65 years of age • Autologous transplants for <ul style="list-style-type: none"> - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • National Transplant Program (NTP) <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing

Benefit Description	You pay
Organ/tissue transplants (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Living donors for intestine transplant in adults and children.</i> • <i>Transplants not listed as covered</i> 	<i>All Charges</i>
Anesthesia	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • 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

Important things you should 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.
- 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 in Sections 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. You pay all remaining charges.
- 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 after any applicable copayment or coinsurance. If the hospitalization is neither an emergency nor preauthorized, it will be paid up to Triple-S established fees. You pay all remaining charges.
- If you use a non-participating 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 within the service area.

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. Plan reimburses you the established fees for an inpatient admission to a non-Plan hospital in the service area. You pay all remaining charges.
Other hospital services and supplies, such as: <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 	Nothing

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
<ul style="list-style-type: none"> • Medical supplies and equipment, including oxygen 	Nothing
<ul style="list-style-type: none"> • 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 • Pathology services • Administration of blood and blood plasma, and other biologicals • Blood or blood plasma, if not donated or replaced • 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>	\$25 facility copay when outpatient surgery is performed
<ul style="list-style-type: none"> • Pre-surgical testing 	The coinsurance established in Section 5 (a) for laboratories, X-rays and other diagnostic tests
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 a Skilled Nursing Facility confinement, as discussed on page 11.</p>	Nothing
<p><i>Not covered: custodial care, rest cures, domiciliary or convalescent care</i></p>	<i>All Charges</i>

Benefit Description	You pay
Hospice care	
<i>Not covered: Independent nursing, homemaker services, hospice care</i>	<i>All Charges</i>
Ambulance	
<ul style="list-style-type: none"> Local professional ambulance service when medically appropriate. 	You should submit the provider's claim and seek reimbursement from us. We pay all charges. You pay nothing
<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(d). Emergency services/accidents

Important things you should 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.

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 go to the nearest hospital emergency room. When you call the 24 hour toll free number and receive a precertification from there, the \$25 copay is waived and you pay only \$10 copay. 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. You pay all remaining charges.

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. You pay all remaining charges.

- 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 53 and 54.

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> Emergency care at a doctor's office 	\$10 per office visit
<ul style="list-style-type: none"> Emergency care at emergency room and an urgent care center 	\$25; if we recommend the visit \$10
<ul style="list-style-type: none"> Emergency care as an inpatient at a hospital, including doctors' services. 	Nothing
<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. 	<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>
Ambulance	
<ul style="list-style-type: none"> Local professional ambulance service when medically appropriate. <p>Note: See 5(c) for non-emergency service.</p>	You should submit the provider's claim and seek reimbursement from us. We pay all charges. You pay nothing.
<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

Important things you should 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 FOR MENTAL HOSPITALIZATION SERVICES.** See the instructions after the benefits description below.
- **IT IS IMPORTANT THAT YOU OR YOUR PLAN DOCTOR NOTIFY US OF YOUR AMBULATORY SERVICES, AT THE BEGINING OF YOUR TREATMENT,** to coordinate your case and to help you receive the appropriate treatment and services.
- If you use a non-Plan doctor or provider: you pay for services rendered and the Plan will pay 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 pay 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 can access information about the Mental Health Parity Act by visiting our Web site at <http://www.ssspr.com>.

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 registered treatment plan. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: To coordinate your services and ensure you are receiving the appropriate care, you or your plan doctor must notify us at the beginning of your ambulatory care. You or your plan doctor should call 1-800-660-4896 to register and for assistance.</p>	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<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 	\$10 per office visit and/or therapy
<ul style="list-style-type: none"> • Diagnostic tests 	10% laboratory and 25% diagnostic tests. Nothing for X-rays. See Lab, X-ray and other diagnostic tests (Section 5a).
<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 	Nothing

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay
Mental health and substance abuse benefits (cont.)	
<p>Note: These services require a precertification, please see precertification section on this page for more information.</p>	Nothing
<ul style="list-style-type: none"> • Not covered: Services we have not approved. <p>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.</p>	<i>All Charges</i>

Precertification	<p>To be eligible to receive the hospital benefits you must complete all of the following precertification process:</p> <ul style="list-style-type: none"> • 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.
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POS mental health and substance abuse benefits	
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<p>This Plan pays its established fees for necessary professional services.</p> <ul style="list-style-type: none"> • If you use a non-Plan doctor or provider, you pay for services rendered and the Plan will pay 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 pay 90% of the Plan's established fees, when services are rendered within the service area and are precertified; or • If you use a non-Plan doctor or provider, you pay for services rendered and the Plan will pay 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 and are precertified. • If you use a non-Plan hospital, you pay for services rendered and the Plan will pay 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 and are precertified. <p>You must obtain our approval before hospitalization services are rendered.</p> <p>It is important that you or your plan doctor notify us of your ambulatory services, at the beginning of your treatment, to coordinate your case and to help you receive the appropriate treatment and services.</p>

Benefit Description	You pay
POS Mental Health and substance abuse benefits	
<ul style="list-style-type: none"> • Special nursing care for each 8-hour period not to exceed 72 consecutive hours, when ordered by the attending psychiatrist. • Psychological tests if performed by a qualified psychologist 	<p>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.</p> <p>Plan reimburses you up to \$35 for a full battery of tests. You pay the remaining charges.</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>	<i>All charges</i>

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.
- If you use a non-Plan pharmacy, this Plan will pay 75% of this Plan's established fees for prescription drugs and you pay all remaining charges.

There are important features you should be aware of. These include:

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 List of Drugs. A List of Drugs 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 guarantees the therapy quality, minimizing inadequate utilization that could affect the patient's health.

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.

We have an open List of Drugs. 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 the List of Drugs. 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 List of Drugs, call 787-774-6060 (TTY 787-792-1370) from Puerto Rico or 1-800-981-3241 (TTY 1-866-215-1999) from the United States Virgin Islands.

These are the dispensing limitations. Federal Drug Administration (FDA) guidelines are used by this Plan to manage the pharmacy coverage. These include dosing, generic medications and new drug classifications, among others.

We cover prescription drugs dispensed within six months of a doctor or dentist's original prescription not to exceed the normal monthly 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.

Some drugs require a preauthorization. The List of drugs identifies the drugs that require preauthorization with a **PA**. 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 787-774-6060 (TTY 787-7921370) from Puerto Rico or 1-800-981-3241 (TTY 1-866-215-1999) from the United States Virgin Islands.

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.

A generic will be dispensed if it is available. If you or your physician chooses the use of a brand name drug indicating in the prescription Original or Dispense as written when a Federally approved generic drug exists, you have to pay the generic copay plus the difference in cost between the name brand drug and the generic. Triple-S will pay up to the generic drug cost. If a generic is not manufactured, the brand name drug will be dispensed and you will pay the brand copay.

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 787-774-6060 (TTY 787-792-1370) from Puerto Rico or 1-800-981-3241 (TTY 1-866-215-1999) from the United States Virgin Islands.

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, but it will cost you more. Using the most cost-effective medication saves money.

When you do 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
<p>Covered medications and supplies</p> <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 List of Drugs. You will pay the generic copay and the difference between the cost of the brand name prescription drug and the cost of the generic prescription drug, if you choose a brand name prescription drug, for which a generic prescription drug is available. 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 Not covered. • Insulin • Disposable needles and syringes for the administration of covered medications • Contraceptive drugs and devices • Drugs for sexual dysfunction - 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 copayments for drugs in the List of Drugs obtained from a plan pharmacy:</p> <ul style="list-style-type: none"> • Tier 1: generic prescription drugs, \$5 for unit or refill • Tier 2: preferred brand prescription drug, \$10 for unit or refill • Tier 3: brand name drugs, \$15 for unit or refill. • Tier 4: non-preferred drugs, <ul style="list-style-type: none"> - \$5 for generic prescription drug unit or refill. - 20% or \$15, whichever is higher, for brand name prescription drug unit or refill. • Tier 5: Specialty/biotech drugs, 20% up to \$100.00 for unit or refill <p>Note: If you or your doctor chooses a brand name prescription drug, for which a generic prescription drug exists, you will pay the generic copay plus the difference between the cost of the brand name prescription drug and the cost of the generic prescription drug, even if your physician has specified Dispense as Written.</p> <p>Note: If a generic does not exist, you will still have to pay the brand name copay.</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> 	<p><i>All Charges</i></p>

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
<ul style="list-style-type: none"> • <i>Drugs available without a prescription or for which there is a nonprescription equivalent available (Except: Prilosec OTC 20 mg, Claritin and its generics; and Zaditor and its generics that are covered with no copayment, when a physician prescribes them).</i> • <i>Medical supplies such as dressings, antiseptics, lancets and strips</i> • <i>Drugs supplied by pharmacies located outside of Puerto Rico, United States Virgin Islands, 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> • <i>Obesity control and related medications used in its treatment (except medications for morbid obesity that are covered).</i> 	<p><i>All Charges</i></p>
Mail Order Program and Flex 90	
<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 Mail Service Prescription Drug Program</p>	<p>You will pay the following copayments for drugs in the List of Drugs:</p> <ul style="list-style-type: none"> • Tier 1: generic prescription drugs, \$10 for unit or refill • Tier 2: preferred brand prescription drug, \$20 for unit or refill • Tier 3: brand name drugs, \$30 for unit or refill. • Tier 4: non-preferred drugs, <ul style="list-style-type: none"> - \$10 for generic prescription drug unit or refill. - 20% or \$30, whichever is higher, for brand name prescription drug unit or refill. <p>Note: Tier 5 is not available under Mail Order Program because specialty/biotech drugs are dispensed only by specialty pharmacies.</p> <p>Note: You will not pay shipping charges.</p> <p>Note: If you or your doctor chooses a brand name prescription drug, for which a generic prescription drug exists, you will pay the generic copay plus the difference between the cost of the brand name prescription drug and the cost of the generic prescription drug, even if your physician has specified Dispense as Written.</p>

Section 5(g). Dental benefits

Important things you should 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
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- 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, *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.

Benefit Description	You Pay
Accidental injury benefit	
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

If you use a non-Plan dentist, you pay for services rendered and the Plan will pay 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. You pay all remaining charges. In United States Virgin Islands, the dentist will submit the claim directly to us and we will pay up to Plan’s established fees for the United States Virgin Islands.

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, or has a license rendered by the United States Virgin Islands Health Department, who has signed a contract with Blue Cross Blue Shield 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 or Blue Cross Blue Shield of the United States Virgin Islands to render dental services.

Benefit Description	You Pay
Dental Benefits	
Dental coverage is limited to: Diagnostic <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) • Fluoride treatment, one every six months for enrollees under 19 years of age. 	Nothing

Dental Benefits - continued on next page

Benefit Description	You Pay
Dental Benefits (cont.)	
<ul style="list-style-type: none"> • Fluoride treatment, one every six months for enrollees over 19 years of age. • Panoramic X-rays, up to 1 set every 3 years 	30%
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(h). Special features

Feature	Description
Flexible benefits option	<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. <p>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>Through Teleconsulta, members can have immediate access to the advice of professional nurses to help them decide whether to go to the emergency room immediately, visit or call their physician or follow self care instructions to feel better. Nurses uses scientifically based algorithms developed by physicians of all specialties to reach a recommendation for the member. Call us at 1-800-255-4375, toll free. We will be glad to assist you.</p>
Blue Card Program	<p>Triple-S is an independent concessionaire of the Blue Cross and Blue Shield Association. As in other Blue Cross and Blue Shield plans, Triple-S participates in a program called the BlueCard Program. This program is of benefit for insured persons who receive services covered outside the service area of Triple-S.</p> <p>This benefit translates into savings for the insured. When services are received outside of the geographic area of Puerto Rico and claims for such services are processed through the BlueCard Program, the amount (coinsurance, co-payment or deductible) paid for these services will be determined based on the lesser of:</p> <ul style="list-style-type: none"> • the amount invoiced for covered services, or • the amount or fee negotiated that Triple-S receives from the Blue Cross or Blue Shield Plan of the area in which the insured person receives the service. <p>In many cases, the fee negotiated is a fixed discount. It may be an estimated amount equivalent to an adjustment of the total estimated payments made as per agreements or other arrangements between the Blue Cross or Blue Shield Plan of the area with all or one or more of their participating providers. The negotiated fee may be a discount of invoiced charges equivalent to an average of the savings that the area Blue Cross or Blue Shield Plan expects to receive from all or a specific group of its participating providers.</p> <p>The Blue Cross or Blue Shield Plan may adjust prospectively the estimated amount or average discount to correct the previous fees in the claims of the BlueCard Program, if payment has been underestimated or overestimated. However, the amount that you pay is considered as a final fee.</p> <p>In addition, the laws of some states require that the Host Blue where the service is rendered use a predetermined formula to determine the coinsurance, co-payment or deductible for covered services, irrespective of the savings received or estimated by a particular claim, or add a surcharge. In these cases, the amount of coinsurance, copayment or deductible will be determined based on the method the law has established in the aforementioned state.</p>

	The BlueCard 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 787-774-6060 (TTY 787-792-1370) from Puerto Rico or 1-800-981-3241 (TTY 1-866-215-1999) for additional information.
Centers of Excellence for transplants/heart surgery/ etc	We offer you the benefit of the Blue Distinction Centers for Transplants (BDCT) 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.
Prenatal orientation program	The pregnancy orientation 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 from Puerto Rico or 1-800-981-3241 extension 4286 from the United States Virgin Islands, for additional information.
Blue Card Worldwide	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.
Mental Health Management Program for Federal Employees	<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: www.achievesolutions.net/sss
Mail Service Prescription Drug Program	<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 on weekdays from 9:00 a.m. to 6:00 p.m. • You will be able to obtain medications not covered by your health insurance at a 20% discount off the regular price

	To receive information and to clarify any doubts and to answer any questions about the program, please call us 1-866-881-6221, toll free.
Asthma and your health	Healthcare professionals will offer guidance about asthma management and answer your questions about this condition. The importance of medical treatment and the prevention of asthma exacerbations are emphasized, in accordance with the guidelines of the National Institutes of Health. Information is also provided about the use of equipment to help control the condition. You will receive educational materials through the mail. To enroll in the program, call (787) 749-4102 from Puerto Rico or 1-800-981-3241 extension 4102 from the United States Virgin Islands.
Controlling diabetes	Healthcare professionals offer information on diabetes and answer your questions about this condition. A licensed dietitian will assist you with information on adequate nutrition and physical activity. We will collaborate with your physician and promote an action plan to monitor diabetes and prevent or avoid complications. A wide array of educational materials is available through the mail. If you are 18 years of age or older and have diabetes, call to enroll in the program at 787-749-4949 ext 2204 from Puerto Rico or 1-800-981-3241 ext. 2204 from the United States Virgin Islands.
90-Day Supply Retail Service (Flex 90)	Flex 90 is a voluntary program that allows the member to obtain a 90-day supply of maintenance drugs at retail pharmacies participating in the program. For more information call us at 787-774-6060 (TTY 787-792-1370) from Puerto Rico or 1-800-981-3241 (TTY 1-866-215-1999) if you call from United States Virgin Islands.
Telexpreso	Automatic interactive voice response unit that allows the member to access information and make transactions without a direct intervention of a Customer Service Representative. Through this system the member verifies benefits, asks for a duplicate ID card and verifies the status of a claim, among other services. Call us at 787-774-6060 (TTY 787-792-1370) from Puerto Rico or 1-800-981-3241 (TTY 1-866-215-1999) from the United States Virgin Islands.

Section 5(i). Point of Service benefits

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 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 and United States Virgin Islands, 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.

For services received by a dependent that is a full time student in a recognized educational institution in the United States, Triple-S will pay based on usual, customary and reasonable charges of the area where the services were rendered. The child must present a certification from the recognized educational institution that he/she is enrolled in a full course of studies pursuant to an associate or bachelor's degree or is pursuing graduate studies (e.g., for a master's degree), under criteria of the institution where the child studies. The same benefit will apply to students entering TCC due to his/her age while they are full time students.

If you use a non-Plan doctor or provider, you pay for services rendered and we will pay 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 pay 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 pay 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 pay 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.

Facts about this Plan's POS option

Please see above.

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 5. Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, you cannot file an FEHB disputed claim about them, and they are not available for residents in the United States Virgin Islands. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 787-774-6060 (TTY 787-792-1370) or visit the website at www.ssspr.com.

Triple-S Medicare Advantage plans: Triple-S Óptimo focuses on the health and well-being of Medicare beneficiaries, including seniors 65 and older and people with disabilities age 21 and older. You can choose among Triple-S Medicare Óptimo Plus and Triple-S Medicare Óptimo Superior. These plans cover all Medicare Parts A and B benefits and offer other benefits not covered by the Traditional Medicare Plan.

Triple-S Medicare Óptimo plans offer you various options. Our options include plans from \$0 to low premium, \$0 copayment for the majority of the services obtained within the plan network, and plans with Part D extended prescription drug coverage. In some plans, you can get an additional coverage for medically necessary services in the United States with a 20% coinsurance.

With any of our products you will enjoy:

- \$0 copayment or coinsurance when you obtain most of the services through our plan providers
- You can visit any plan or non plan doctor with \$0.00 copayment.
- You choose your doctors and providers. With our plans you don't need referrals to visit any physician or to receive any covered services.
- Teleconsulta, our 24 hours, 7 days health orientation line.
- Our Cuidado Especial Program for members with diabetes, hypertension, asthma and chronic heart failure.
- Medicare Prescription drug (Part D) plans with no initial annual deductible. Services can be accessed through over 940 pharmacies in Puerto Rico and 45,400 in the United States.

If you have Medicare Parts A and B, reside permanently in Puerto Rico and do not have end stage renal disease, you are eligible! Triple-S helps offer peace of mind for Medicare beneficiaries residing in Puerto Rico by offering more services than traditional Medicare for little additional cost or no cost at all. For more information visit any of our Service Centers across the Island or visit our webpage at www.ssspr.com. Prospective members can also call toll free at 1-877-207-8777 and TTY/TDD should call 1-800-383-4457, Monday through Saturday from 8:00 a.m. to 6:00 p.m.

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. 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 pages 10 and 11.

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; (see specifics regarding transplants)
- 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 787-774-6060 (TTY 787-792-1370) from Puerto Rico or 1-800-981-3241 (1-866-215-1999) from the United States Virgin Islands.

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

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 benefits for 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: FMRx, P O Box 5736, Sioux Falls, SD, 57117.
 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 1-866-881-6221, toll free.
- By fax – you can send your documents at 1-877-999-3679

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/prior approval required by Section 3

- 1** Ask us in writing to reconsider our initial decision. You must:
- a) Write to us within 6 months from the date of our decision; and
 - b) Send your request to us at: Triple-S, P.O. Box 363628, San Juan, Puerto Rico 00936-3628; and
 - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

- 2** We have 30 days from the date we receive your request to:
- a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
 - b) Write to you and maintain our denial -- go to step 4; or

Ask 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** 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.

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.

We will write to you with our decision.

- 4** If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.

Send OPM the following information:

- 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; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

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.

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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 787-774-6060 (TTY 787-792-1370) from Puerto Rico or 1-800-981-3241 (TTY 1-866-215-1999) from the United States Virgin Islands, 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 has coverage under any other health plan or has 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 or older.
- Some people with disabilities under 65 years of age; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) 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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• 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 more 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.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **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.

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.

If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

Claims process when you have the Original Medicare Plan - You will probably not need 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. To find out if you need to do something to file your claim, call us at 787-774-6060 (TTY 787-792-1370) from Puerto Rico or 1-800-981-3241 (TTY 1-866-215-1999) from the United States Virgin Islands, or see our Web site at www.ssspr.com.

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.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when our Medicare Advantage plan is primary, even when you visit non plan providers of our Medicare Advantage plan (but they are network providers of Triple-S regular plan servicing FEHB). If you enroll in our Medicare Advantage plan, please tell us. We will need to know if you are enrolled in our Medicare Advantage plan as soon as you subscribe to it, so we can correctly coordinate benefits with the FEHB Plan from the beginning of your Medicare Advantage coverage.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage 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 Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
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) and you are not covered under FEHB through your spouse under #1 above	✓	
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) and you are not covered under FEHB through your spouse under #1 above	✓	
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	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

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

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 TRICARE or CHAMPVA.

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.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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 12.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
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>
Medically necessary	<p>Services, drugs, supplies, or equipment provided by a hospital or covered provider of health care services that the Plan determines:</p> <ul style="list-style-type: none">• 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 and United States Virgin Islands, 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 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/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits*, 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 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.

- **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 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 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 2008 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 2007 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).

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.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

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

- **Upon divorce** 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 provide health coverage to you. However, you may be eligible for your own FEHB coverage under either 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 Benefits 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 Federal 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 Benefits 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.

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 at 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 information about Federal and State agencies you can contact for more information.

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents.

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or any other insurance.

Dependent Care FSA (DCFSA) – Pays for eligible dependent care expenses for your child(ren) under age 13 or for dependants unable to care for themselves that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program has no pre-existing condition limitations. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dental/vision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877-889-5680).

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

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Summary of benefits for the Triple-S Plan - 2008

- **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	You Pay
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$7.50 general practitioner; \$10 specialist, 10% for laboratory and 25% for diagnostic tests; nothing for X-rays.	15
Services provided by a hospital:		
• Inpatient	Nothing	31
• Outpatient	\$25 facility copay for outpatient hospital or ambulatory surgical center when outpatient surgery is performed	32
Emergency benefits:		
• In-area	Emergency room \$25; if we recommend the visit \$10. Nothing for hospital.	35
• Out-of-area	10%	35
Mental health and substance abuse treatment:		
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Prescription drugs:		
• Retail pharmacy	<ul style="list-style-type: none"> • Tier 1: generic prescription drugs, \$5 for unit or refill • Tier 2: preferred brand prescription drug, \$10 for unit or refill • Tier 3: brand name drugs, \$15 for unit or refill. • Tier 4: non-preferred drugs, <ul style="list-style-type: none"> - \$5 for generic prescription drug unit or refill. - 20% or \$15, whichever is higher, for brand name prescription drug unit or refill. • Tier 5: Specialty/biotech drugs, 20% up to \$100.00 for unit or refill 	39
• Mail order	<ul style="list-style-type: none"> • Tier 1: generic prescription drugs, \$10 for unit or refill • Tier 2: preferred brand prescription drug, \$20 for unit or refill • Tier 3: brand name drugs, \$30 for unit or refill. 	41

	<ul style="list-style-type: none"> • Tier 4: non-preferred drugs, <ul style="list-style-type: none"> - \$10 for generic prescription drug unit or refill. - 20% or \$30, whichever is higher, for brand name prescription drug unit or refill. 	
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2008 Rate Information for Triple-S, Inc.

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

Postal Category 1 rates apply to certain career non-law enforcement Postal Service employees. **Postal Category 2 rates** apply to other career non-law enforcement Postal Service employees. *PostalEASE*, the employee self-service system used for FEHB enrollment, automatically provides the applicable premium to individual employees. Career non-law enforcement employees may also refer to the *Guide to Federal Benefits for United States Postal Service Employees, RI 70-2*, to determine their rates.

Different rates apply and a special Guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center

1-877-477-3273, Option 5

TTY: 1-866-260-7507

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 *Guide to Federal Benefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share

Rates for Puerto Rico Residents

High Option Self Only	891	90.65	30.21	196.40	65.46	15.11	13.60
High Option Self and Family	892	208.48	69.49	451.70	150.57	34.75	31.27

Rates for United States Virgin Islands Residents

High Option Self Only	851	142.68	47.56	309.14	103.05	23.78	21.40
High Option Self and Family	852	324.03	108.01	702.07	234.02	54.00	48.60