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**A Health Maintenance Organization with a Point of Service product**

**Serving: All of Puerto Rico**

You must live in the service area to enroll in this Plan

**Enrollment code:**

**891 Self only**

**892 Self and family**

**Service area:** Services from Plan providers are available only in the following area:

The Commonwealth of **Puerto Rico**

Triple-S, Inc. (Triple-S), 1441 Roosevelt Avenue, San Juan, Puerto Rico 00920, has entered into a contract (CS 1090) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called Triple-S or the Plan.

This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. A person enrolled in the Plan is entitled to the benefits stated in this brochure. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1998, and are shown on the inside back cover of this brochure.

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# Inspector General Advisory: Stop Health Care Fraud!

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Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 787/749-4777 and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE  
202/418-3300

The Office of Personnel Management  
Office of the Inspector General Fraud Hotline  
1900 E Street, N.W., Room 6400  
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

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## General Information

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### Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

### If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. **As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor, except in the case of emergency as described on page 13.** If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See "If you are hospitalized" on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

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## General Information *continued*

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### If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

### Your responsibility

**It is your responsibility to be informed about your health benefits.** Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

### Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).

- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.

- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.

- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency benefits.

- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.

- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.

- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.

- Report additions and deletions (including divorces) of covered family members to the Plan promptly.

If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

You may also remain enrolled in this Plan when you join a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

### Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

#### Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

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# General Information *continued*

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

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

**NOTE:** If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

## **Notification and election requirements**

**Separating employees** — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

**Children** — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

**Former spouses** — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

**Important:** The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

## **Conversion to individual coverage**

When none of the above choices are available — or chosen — when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

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## Facts about this Plan

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This Plan is a health maintenance organization (HMO) that offers a point of service, or POS, product. Whenever you need services, you may choose to obtain them from your personal doctor within the Plan's provider network or go outside the network for treatment. Within the Plan's network you are encouraged to select a personal doctor who will provide or arrange for your care and you will pay minimal amounts for comprehensive benefits. There are no claims forms when plan doctors are used. When you choose a non-Plan doctor or other non-Plan provider, you will pay a substantial portion of the charges and the benefits available may be less comprehensive.

Your decision to join an HMO should be based on your preference for the plan's benefit and delivery system, not because a particular provider is in the plan's network. You cannot change plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

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### **Who provides care to Plan members?**

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

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

Benefits are paid according to the "medical benefits schedule". This is the schedule of established fees on which the Plan's payment of covered medical expense is based, when the services are rendered within the service area. The medical benefits schedule applies to Puerto Rico. When services are rendered outside the area the Plan pays usual, customary and reasonable charges.

### **Role of a primary care doctor**

You are encourage to select a primary care doctor (e.g. family practitioner, internist, pediatrician, OB-GYN) for you and for each family member. Your primary care doctor can help coordinate your care.

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## Facts about this Plan *continued*

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### Choosing your doctor

The Plan's provider directory lists Plan doctors and providers with their locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Client Services Department at 787/749-4777. You can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan. Important note: **When you enroll in this plan, services are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed.** Members may change Plan doctors at any time.

### Referrals for specialty care

Except in a medical emergency you are encourage to contact your primary care physician when you need a referral to another Plan doctor or for hospital or other services and to follow any arrangements made for coordinating your care.

### Authorizations

The Plan will provide benefits for covered services only when services are medically necessary to prevent, diagnose or treat your illness or condition. Your Plan doctor will determine medical necessity but you must obtain authorization from the Plan before: services outside the Service Area, except emergencies; Magnetic Resonance Imaging (MRI), rental or purchase of durable medical equipment, rehabilitation therapy, Skilled Nursing Facility, lithotripsy, organ and tissue transplants, and hospitalizations for certain inpatient dental procedures (See pages 12 thru 14 for coverage provided).

### For new members

If you are under the care of a specialist, you should inform the Plan primary care doctor you select so that your care can be coordinated to the extent necessary.

### Hospital care

If you require hospitalization, your Plan doctor or authorized specialist will make the necessary arrangements and continue to supervise your care.

### Out-of-pocket maximum

Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated coinsurances which are required for a few benefits when Plan providers are used. You are also responsible for any difference between a non-Plan provider's actual charge and the Plan's benefit payment.

### Deductible carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January **before** the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

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## Facts about this Plan *continued*

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### Submit claims promptly

Where noted throughout this brochure, the Plan covers services from non-Plan providers. When covered services are received from non-Plan providers, you should pay the provider and seek reimbursement from the Plan after you have paid the claim. When you have a claim for such services notify Triple-S promptly and the proper forms will be sent to you within 15 days of receipt of your notice.

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. If you need help in filing your claim, get in touch with the Triple-S offices.

### Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

### The Plan's service and enrollment areas

The service area for this Plan, where providers and facilities are located, is described on the front cover of this brochure. You must live in the service area to enroll in this Plan. Benefits for care outside the service area are limited to emergency services, as described on page 13.

If you or a covered family member move outside the enrollment area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

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## General Limitations

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### Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan.** This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.

### Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

### Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

#### Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, benefits will be coordinated with Medicare according to Medicare's determination of which coverage is primary. Generally, you do not need to take any action after informing the Plan of your or your family member's eligibility for Medicare. Your Plan will provide you with further instructions if a Medicare claim needs to be filed.

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## **General Limitations** *continued*

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### **Group health insurance and automobile insurance**

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

### **CHAMPUS**

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

### **Medicaid**

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

### **Workers' compensation**

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.). This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP for services it provided that were later found to be payable by OWCP.

### **DVA facilities, DoD facilities, and Indian Health Service**

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

### **Other Government agencies**

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

### **Liability insurance and third party actions**

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the plan will provide you with its subrogation procedures.

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## General Exclusions

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All benefits are subject to the limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition** and the Plan agrees, as discussed under Authorizations on Page 7. The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see Emergency Benefits) or eligible self-referred services;
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs or devices that are experimental or investigational;
- Procedures, services, drugs and supplies related to sex transformations; and
- Procedures, services, drugs and 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.

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## Medical and Surgical Benefits

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### What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** a \$5 copay for each office visit to a Plan doctor and 25% of the fee schedule allowance for laboratory and diagnostic tests out of hospital, but no additional copayment for X-ray examinations. You must use a Triple-S participating laboratory and X-ray facility. Within the service area, house calls will be provided if, in the judgement of the Plan doctor, such care is necessary and appropriate; **you pay** a \$15 copay for a doctor's house call and nothing for home visits by nurses and health aides. The physician may charge a differential to a member who requests a private room in the hospital if semiprivate rooms are available. The physician will bill the Plan on the basis of the established fees for such purposes and will charge the member any difference directly.

If you use a non-Plan doctor, **you pay** for services rendered and the Plan will reimburse you 1) 90% of the Plan's established fee when services are rendered within the service area, or 2) 90% of the usual, customary and reasonable charge of the area in which the services are rendered when services are rendered outside the service area. **You also pay** a \$5 copay for each office visit to a non-Plan doctor, a \$15 copay per doctor's house call, and nothing for visits of nurses and health aides.

The following services are included:

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays. You must obtain authorization from your Plan before Magnetic Resonance Imaging (MRI) or lithotripsy, as discussed on Page 7.
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. Copays are waived for maternity care. The mother at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services
- Tuboplasty
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints. The Plan pays 100% of the submitted charge when the implant device is provided and billed by a Plan doctor or provider. If the implant device is provided and billed by a non-Plan doctor, provider, or medical equipment supplier, the Plan will reimburse you 90% of the established fee.
- Cornea, heart, heart/lung, lung, kidney, kidney/pancreas and liver transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retro peritoneal and ovarian germ cell tumors. Transplants are covered when approved by the Plan. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan. You must obtain authorization from your Plan before an organ or tissue transplant, as discussed on Page 7.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Lenses following cataract removal

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS**

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## Medical and Surgical Benefits *continued*

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- Surgical treatment of morbid obesity
- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers.

### Limited benefits

**Oral and maxillofacial surgery** is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. Mandibular and maxillary osteotomy are also covered. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including shortening of the mandible or maxillae for cosmetic purposes, and any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

**Reconstructive surgery** will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery.

**Short-term rehabilitative therapy** (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two consecutive months per condition if significant improvement can be expected within two months. You must obtain authorization from your Plan before rehabilitative therapy, as discussed on Page 7. Physical therapy must be provided by or under the supervision of a doctor specializing in physical therapy and speech and occupational therapy must be referred by a Plan doctor to a provider certified to provide such therapy; **you pay** a \$5 copay per outpatient session, and nothing per inpatient session. There are no participating Plan providers for speech therapy and occupational therapy. 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. As discussed on page 8 of this brochure, you should pay the provider's claim and seek reimbursement from the Plan.

**Diagnosis and treatment of infertility** is covered, (excluding drug treatment); **you pay** a \$5 office visit copay. Artificial insemination is covered; **you pay** a \$5 office visit copay; the cost of donor sperm is not covered. Fertility drugs are covered. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization and embryo transfer, are not covered.

**Respiratory therapy** is covered for up to two sessions per day to a maximum of 20 sessions per year; **you pay** a \$5 copayment per session.

**Second surgical opinions** - A second surgical opinion is required for certain elective surgeries. Your participating doctor will inform you when a second opinion is required and provide you with a report on your condition and the need for surgery. You must contact the Plan to arrange for a second opinion to be provided by a consulting physician or Plan medical personnel. If the second opinion does not confirm the medical necessity of the surgery, the Plan will refer you to another physician. If that physician also determines the surgery is not medically necessary, the Plan will not provide coverage for the surgery. The cost of the second and any additional opinion is covered in full by the Plan.

**Durable medical equipment** is limited to coverage for oxygen equipment, wheel chairs, hospital type beds, and iron lungs and other respiratory equipment. The item will be rented or purchased at the Plan's discretion and must be prescribed by a Plan doctor and obtained from Plan sources. You must obtain authorization from your Plan before purchase or rental of durable medical equipment, as discussed on Page 7.

### What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Plastic surgery primarily for cosmetic purposes
- Transplants not listed as covered
- Long-term rehabilitative therapy
- Hearing aids
- Orthopedic devices, such as braces; foot orthotics
- Prosthetic devices, such as artificial limbs
- Private nursing care (except for treatment of mental illness)
- Assistance at surgery services
- Podiatric services
- Chiropractic services
- Homemaker services
- Cardiac rehabilitation

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS**

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# Hospital/Extended Care Benefits

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## What is covered

### Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit for a member who is hospitalized in a participating hospital. **You pay** nothing per inpatient admission to a participating hospital in the service area. If you use a nonparticipating hospital, the Plan will reimburse \$60 per day, except for hospitalization due to accidental injury or a medical emergency as shown on page 13. **You pay** all remaining charges. **All necessary services are covered** including:

- Semiprivate room accommodations, including general nursing care, meals and special diets. (If for any reason a private room is used, you must pay the difference between the hospital's charge for these accommodations and the special rates contracted for by Triple-S. Also, if a private room is selected, you must pay any difference between your physician's normal fee and the Plan's established fees. You can learn the special contract rates for any particular hospital by calling Triple-S).
- Specialized care units, such as intensive care or cardiac care units

Outside the service area hospital benefits for special cases that require equipment, mode of treatment or specialist care are not available in Puerto Rico are covered by the Plan. However, Triple-S must approve the hospitalization of special cases in advance. (See page 13 for coverage provided for hospitalization due to accidental injury or medical emergency). Plan pays usual, customary and reasonable charges of the area in which hospital services are rendered. **You pay** any charges for services which are not a covered benefit of this Plan.

### Extended care

The Plan provides a comprehensive range of benefits in Plan facilities with no dollar or day limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility medically appropriate as determined by a Plan doctor and approved by the Plan. **You pay** nothing. **All necessary services are covered** 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 must obtain authorization from your Plan before a Skilled Nursing Facility confinement, as discussed on Page 7.

### Ambulance service

Benefits are provided for terrestrial or maritime ambulance transportation ordered or authorized by a Plan doctor. This is an indemnity benefit and is payable directly to you after you have paid the claim.

## Limited benefits

### Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease. Authorization must be obtained from the Triple-S Plan prior to admission. **You pay** nothing for covered hospital services.

### Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 14 for nonmedical substance abuse benefits.

## What is not covered

- Personal comfort items, such as telephone and television
- Custodial care, rest cures, domiciliary or convalescent care
- Air ambulance service
- Hospice Care

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS**

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# Emergency Benefits

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## What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that 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 the Plan may determine are medical emergencies — what they all have in common is the need for quick action.

## Emergencies within the service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system or 343-2550) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours unless it was not reasonably possible to notify the Plan within that time. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency **only** if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

### Plan pays...

90% of Plan's established fees for doctor's services and full coverage for other services to the extent the services would have been covered if received from Plan providers.

### You pay...

\$5 per hospital emergency room visit or urgent care center visit for services that are covered benefits of this Plan and any remaining charges. If the emergency results in admission to a hospital, you pay nothing for the inpatient admission and the emergency room copay is waived.

## Emergencies outside the service area

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

### Plan pays...

90% of usual, customary and reasonable charges for the area in which the emergency services are rendered.

### You pay...

The copayments shown above for within-area benefits

## What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Terrestrial or maritime ambulance service approved by the Plan

## What is not covered

- Elective care or nonemergency care
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the Service Area
- Air ambulance

## Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. 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 the 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 the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 17.

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# Mental Conditions/Substance Abuse Benefits

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## Mental conditions

### What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders. Non-Plan providers are under no obligation to accept the Triple-S established fees as payment in full. **You pay** all charges remaining for outpatient care above the Plan's established fee when non-Plan providers are used, in addition to the copays noted below. **You pay** only the copays noted below when Plan providers are used. For all other care under this benefit **you pay** all remaining charges after the Plan has paid benefits. The Plan provides a 24 hour toll free number to help you obtain the most appropriate care for your mental or substance abuse related needs. Call **1-800/660-4896** for further assistance. Your Plan doctor will use this number also to coordinate any of the mental or substance abuse benefits covered by this Plan.

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

### Outpatient care

For up to 40 full treatment visits per calendar year; you pay \$5 per visit for visits 1-20, 50% of charges for visits 21-40-all charges thereafter.

For up to 40 group therapy visits per calendar year; you pay \$5 per visit-all charges thereafter.

For collateral visits with immediate members of the patient's family (5 visits over age 18, 20 visits under age 18). **You pay** \$5 per visit.

### Inpatient care

Hospital benefits, as shown on page 12 for up to 90 days each calendar year, in hospitals approved to render these services. Two days of partial hospitalization are equivalent to one full day of hospitalization.

For necessary professional services, the Plan pays its established fees up to the actual charge. Covered services include but are not limited to: medical care, consultations, laboratory and x-ray, radiotherapy, physiotherapy, and psychotherapy.

For special nursing care, the Plan pays the following when ordered by the attending psychiatrist, for each 8-hour period not to exceed 72 consecutive hours: \$18 for a registered nurse; \$12 for a licensed practical nurse; \$12 for a psychiatric aide.

### In or out of the hospital

Psychological tests - if performed by a qualified psychologist, up to \$35 for a full battery of tests.

Electroshock therapy - up to 10 treatments in a calendar year

Anesthetic for electroshock therapy - up to 10 treatments in a calendar year

Electroencephalography

### What is not covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition
- Charges from a residential treatment facility
- Benefits not shown as covered above

## Substance abuse

### What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition. Services for the psychiatric aspects are provided in conjunction with mental conditions benefits shown above. Outpatient visits to Plan mental health providers for follow-up care and counseling are covered, as well as inpatient services necessary for diagnosis and treatment. The mental conditions benefits visit/day limitations and copayments apply to any covered substance abuse care. The Plan provides a 24 hour toll free number to help you obtain the most appropriate care for your mental or substance abuse related needs. Call **1-800/660-4896** for further assistance. Your Plan doctor will use this number also to coordinate any of the mental or substance abuse benefits covered by this Plan.

### What is not covered

- Benefits not shown as covered above.
- Treatment that is not authorized by a Plan doctor.

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS**

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# Prescription Drug Benefits

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**What is covered** Prescription drugs dispensed within six months of a doctor's original prescription not to exceed the normal supply. Nonformulary drugs will be covered when prescribed by a Plan doctor. **You pay** 20% coinsurance with a minimum copay of \$5 and maximum of \$10 per brand name prescription unit or refill, or nothing per generic bioequivalent prescription unit or refill. If you use a non-Plan pharmacy, the Plan will reimburse you 75% of the Plan's established fees for prescription drugs and **you pay** all remaining charges. Coinsurance/copayment amounts also apply to disposable needles and syringes.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Insulin
- Vitamins only if they include the legend: "Federal law prohibits dispensing without a prescription"
- Smoking cessation drugs and medication, including nicotine patches
- Disposable needles and syringes needed to inject covered prescribed medication
- Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits (also covered under Medical and Surgical Benefits when provided as part of a home health service program).

## What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Medical supplies such as dressings and antiseptics
- Contraceptive drugs and devices; contraceptive diaphragms
- Drugs supplied by pharmacies located outside of Puerto Rico, the United States and its territories
- Medication for the treatment of infertility or impotence
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Implanted time-release medications, such as Norplant

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# Other Benefits

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## Dental care

**What is Covered** This Plan provides the following dental coverage shown below; **you pay** 30% of the Plan's established fees for routine extractions and fillings and nothing for oral examination, prophylaxis, fluoride treatment and x-ray services, if a Plan dentist is used. If a non-Plan dentist is used, **you pay** a 30% coinsurance and any remaining difference between the Plan's payment of 90% of its established fee and the actual charge for services rendered in Puerto Rico. For care outside of Puerto Rico, the member will **pay** the 30% coinsurance and any remaining difference between 100% of the Plan's payment established fee and the actual charge.

The following list shows the dental services covered by the Plan. Coverage is limited to these items:

- Oral examination, prophylaxis and fluoride treatment (once every six months for each service). Fluoride treatment is limited to members under nineteen years of age.
- Periapical and bitewing x-rays (limited to six periapical x-ray per calendar year and no more than two bitewing x-rays every two calendar years).
- Routine extractions (impacted teeth are not covered)
- Fillings only, consisting of silver, plastic or composite.

**Accidental injury benefit** Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered. The need for these services must result from an accidental injury. An injury caused by chewing is not considered an accidental injury.

**Definitions** 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 member "bona-fide" of the "Colegio de Cirujanos Dentistas de Puerto Rico", who has signed a contract with Triple-S to render dental services.

Non-Plan dentist: Means a duly authorized dentist with a regular license, who has not signed a contract with Triple-S to render dental services.

**What is not covered** • Other dental services not shown as covered.

## Vision care

**What is covered** 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. **You pay** a \$5 copay per office visit.

**What is not covered** • Eye exercises  
• Corrective lenses, eyeglasses, frames, contact lenses, fitting of contact lenses

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS**

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# How to Obtain Benefits

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## Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Client Services Department at 787/749-4777 or you may write to the Plan at P.O. Box 363628, San Juan, P.R. 00936-3628.

## Disputed claims review

### Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

### OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms; and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

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## How to Obtain Benefits *continued*

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### **OPM review (continued)**

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 234, P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement — If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

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## How Triple-S Changes January 1998

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Do not rely on this page; it is not an official statement of benefits.

### **Program-wide Changes**

This year, the Office of Personnel Management (OPM) instituted minimum benefits levels in all plans for normal deliveries (48 hours of inpatient care), caesarian sections (96 hours of inpatient care) and mastectomies (48 hours of inpatient care). See page 10 for this Plan's benefits.

OPM also requires each prepaid plan to list the specific artificial insemination procedures that it covers. See page 11 for this Plan's benefits.

# Summary of Benefits for Triple-S - 1998

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

Benefits	Plan pays/provides	Page
<b>Inpatient Hospital care</b>	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. <b>You pay</b> nothing.....	12
<b>Extended Care</b>	All necessary services, no dollar or day limit. <b>You pay</b> nothing.....	12
<b>Mental Conditions</b>	Up to 90 days of inpatient care per calendar year. Two days of partial hospitalization are equivalent to one full day of hospitalization. <b>You pay</b> nothing per admission to a participating hospital.....	14
<b>Substance Abuse</b>	Covered under Mental Conditions Benefits.....	14
<b>Outpatient care</b>	Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. <b>You pay</b> a \$5 copay per office visit to a Plan doctor (copay is waived for maternity care); and \$15 per doctor's home visit.....	10, 11
<b>Home Health Care</b>	All necessary visits by nurses and health aides. <b>You pay</b> nothing.....	10, 11
<b>Mental Conditions</b>	Up to 40 outpatient visits per year. <b>You pay</b> a \$5 copay per visit for visits 1-20, and 50% of charges for visits 21-40.....	14
<b>Substance Abuse</b>	Covered under Mental Conditions Benefits.....	14
<b>Emergency care</b>	Reasonable charges for services and supplies required because of a medical emergency. <b>You pay</b> a \$5 copay to the hospital for each emergency room visit and any charges for services that are not covered benefits of this Plan.....	13
<b>Prescription drugs</b>	Prescribed drugs provided by a Plan pharmacy. <b>You pay</b> 20% coinsurance with a minimum copay of \$5 and maximum of \$10 per brand name prescription unit or refill, or nothing per generic bioequivalent prescription unit or refill.....	15
<b>Dental care</b>	Accidental injury benefits; oral examinations, fluoride treatments, prophylaxis, x-rays, extractions, and fillings. <b>You pay</b> a percentage of charges as shown.....	16
<b>Vision care</b>	Refractions. <b>You pay</b> \$5 per visit.....	16
<b>Out-of-pocket maximum</b>	Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments which are required for benefits when Plan providers are used.....	7