Triple-S Salud

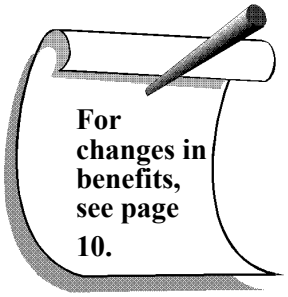
http://www.ssspr.com

2012

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 8 for requirements.



Enrollment Codes for this Plan:

For Residents in Puerto Rico	For Residents in U.S. Virgin Islands
891 Self Only	851 Self Only
892 Self and Family	852 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from Triple-S Salud About

Our Prescription Drug Coverage and Medicare

OPM has determined that the Triple-S Salud 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 (October 15th through December 7th) 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 1-877-486-2048).

Table of Contents

Introduction 3
Plain Language 3
Stop Health Care Fraud! 3
Preventing Medical Mistakes 4
Section 1. Facts about this HMO Plan 7
- Who provides my health care 7
- We have Open Access benefits 7
- We have Point-of-Service (POS) benefits 7
- How we pay providers 7
- Your Rights 8
- Your medical and claims records are confidential 8
- Service Area 8

Section 2. How we change for 2012 10
- Program-wide changes 10
- Changes to this Plan 10

Section 3. How you get care 11
- Identification cards 11
- Where you get covered care 11
  - Plan providers 11
  - Plan facilities 11
  - Other Providers 11
- What you must do to get covered care 11
  - Primary care 11
  - Specialty care 11
  - Hospital care 12
  - If you are hospitalized when your enrollment begins 12
- You need prior Plan approval for certain services 12
- Inpatient hospital admission 12
- Other Services requiring our prior approval or authorization 12
- How to request precertification for an admission or get prior authorization for Other services 13
  - Non-urgent care claims 14
  - Urgent care claims 14
  - Emergency inpatient admission 14
  - Maternity care 14
  - If your treatment needs to be extended 14
- What happens when you do not follow the precertification or prior authorization rules when using non-network providers 14
- If you disagree with our pre-service claim decision 14
- To reconsider an urgent care claim 15
- To reconsider a non-urgent care claim 15
- To file an appeal with OPM 15
- Circumstances beyond our control 15

Section 4. Your costs for covered services 16
- Copayment 16
- Cost-sharing 16
- Coinsurance 16

Your catastrophic protection out-of-pocket maximum for coinsurance and copayments....16
Carryover....16
When Government facilities bill us....16
Section 5. Benefits....17
Non-FEHB benefits available to Plan members....55
Section 6. General exclusions – things we don't cover....56
Section 7. Filing a claim for covered services....57
Section 8. The disputed claims process....59
Section 9. Coordinating benefits with other coverage....61
When you have other health coverage....61
What is Medicare?....61
- Should I enroll in Medicare?....61
- The Original Medicare Plan (Part A or Part B)....62
- Tell us about your Medicare coverage....62
- Medicare Advantage (Part C)....63
- Medicare prescription drug coverage (Part D)....63

TRICARE and CHAMPVA....65
Workers' Compensation....65
Medicaid....65
When other Government agencies are responsible for your care....65
When others are responsible for injuries....65
When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage....65
Clinical Trials....65
Section 10. Definitions of terms we use in this brochure....67
Section 11. FEHB Facts....69
Coverage information....69
- No pre-existing condition limitation....69
- Where you can get information about enrolling in the FEHB Program....69
- Types of coverage available for you and your family....69
- Children's Equity Act....70
- When benefits and premiums start....71
- When you retire....71

When you lose benefits....70
- When FEHB coverage ends....71
- Upon divorce....71
- Temporary Continuation of Coverage (TCC)....71
- Converting to individual coverage....72
- Getting a Certificate of Group Health Plan Coverage....72

Section 12. Other Federal Programs....73
The Federal Flexible Spending Account Program - FSAFEDS....72
The Federal Employees Dental and Vision Insurance Program - FEDVIP....73
The Federal Long Term Care Insurance Program - FLTCIP....73
Index....76
Summary of benefits for the Triple-S Salud Plan 2012....77
2012 Rate Information for Triple-S Salud....79

Introduction

This brochure describes the benefits of Triple-S Salud 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 Salud, Inc. (Triple-S Salud)
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, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each Plan annually. Benefit changes are effective January 1, 2012, and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means Triple-S Salud.
- 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 fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support , 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.

- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- 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, DC 20415-1100

- Do not maintain as a family member on your policy:

  Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

  Your child age 26 or over (unless he/she is disabled and incapable of self-support prior to age 26).
- 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.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

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.

Patient Safety Links

- www.ahrq.gov/consumer/. 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.

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 Salud 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.

This plan is a "grandfathered health plan" under the Affordable Care Act. A grandfathered plan must preserve basic health coverage that was already in effect when the law passed. Specifically, this plan cannot eliminate all or substantially all benefits to diagnose or treat a particular condition; it cannot increase your coinsurance (the percentage of a bill you pay); and any increases in deductibles, out-of-pocket limits, and other copayments (the fixed-dollar amount you pay) must be minimal.

Questions regarding what protections apply may be directed to us at Triple-S Salud, PO Box 363628, San Juan, PR 00936-3628. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

Who provides my health care

Triple-S Salud 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 Salud 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 Salud. 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 Salud 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 Salud or Blue Cross Blue Shield to render hospital services to persons insured by Triple-S Salud. 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 Salud.

Benefits in Puerto Rico or United States Virgin Islands are paid according to the "medical benefits schedule" of Triple-S Salud 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 Salud established fees, after any applicable copayment or coinsurance.

For services received by an employee due to Temporary Duty Assignment (TDY), Triple-S Salud will pay based usual, customary, and reasonable charges of the area where the services were rendered. The Agency must provide an official letter notifiying Triple-S Salud of the assignment. Services will be covered for a period of up to a maximum of three months.

For services received by a dependent that is a full time student in a recognized educational institution in the United States, Triple-S Salud 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; every semester, quarter, or trimester, as applicable. The same benefit will apply to students entering TCC due to his/her age while they are full time students.

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 have higher out-of-pocket-costs than our in-network benefits. When you receive out-of-network services, we pay 90% of the established fee for allowable charges. You are responsible for paying the non-participating provider up front for covered services and filing a claim for reimbursement. We will reimburse you directly for covered services unless the provider accepts assignment of benefits. You are responsible for all charges that exceed our payment.

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 Salud established fees, after any applicable copayment or coinsurance.

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.

- Triple-S was organized by a group of physicians and dentists in 1959 and has been a health insurance option for Federal employees and annuitants since 1962.
- Triple-S is an independent licensee of the Blue Cross Blue Shield Association (BCBS). Triple-S Management Corporation is a publicly traded company on the New York Stock Exchange under the symbol GTS.

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. 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. When services rendered out of the service area are neither emergencies nor preauthorized, this Plan will pay up to Triple-S Salud 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 2012

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.

Program-wide changes

- Sections 3, 7 and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148.

Changes to this Plan

- Your share of the non-Postal premium will increase for *Self Only* and for *Self and Family*, for enrollees in Puerto Rico.
- You share of the non-Postal premium for Self only or Self and Family has not changed for enrollees in the U. S. Virgin Islands.
- We have added a copay waiver incentive for generic drugs. We will waive the generic copayment for a period of 6 months when you switch from a brand name drug to a generic drug in the following therapeutic classes: Anti-hypertensive, Anti-diabetic, Anti-depressive, Hyperlipidemia, and CHF medications. See Section 5(f).
- We have changed the prescription drug benefit structure from a 5 tier structure to a 4 tier structure. Please refer to Section 5(f).
- We have included the Zoster Vaccine among covered immunizations with $0 copay under Preventive Care, adult among the Adult routine immunizations edorsed by the Centers for Disease Control and Prevention (CDC). See Section 5(a).
- We have eliminated the age limit for Hepatitis A and Meningococcal conjugate vaccines among covered immunizations in the Preventive Care, children section. See Section 5(a).
- We have increased the age limit for the Gardasil or Cervarix vaccines among covered immunizations in the Preventive Care, children section. See Section 5(a).
- We will provde coverage for insulin pumps and supplies, subject to precertification and enrollment in our disease management programs. See Section 5(a).

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 Salud, Inc. (Triple-S Salud), Customer Service Department, 1441 Roosevelt Avenue, San Juan, Puerto Rico 00920. You may also request replacement cards through our Web site at www.ssspr.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurances. 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 CMS 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;
  - 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;
- 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.

You need prior Plan approval for certain services

Since your network physician arranges inpatient hospitalization and most referrals to specialists, the pre-service claim approval process only applies to care shown under Other services or out-of-network care when you self-refer.

- **Inpatient hospital admission**

Precertification is the process by which we evaluate the medical necessity and the number of days for the proposed hospital stay to treat your condition.

- **Other Services requiring our prior approval or authorization**

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 prior 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 (see Note below)
- Lithotripsy;
- Osteotomy;
- Mammoplasty;
- Growth hormone therapy;
- Drugs identified with a **PA** in the List of Drugs;
- Positron Emission Tomography (PET AND PET-CT);
- Septoplasty;
- Rhinoplasty;
- Blepharoplasty;
- Office surgeries to be performed at Hospitals;
- Surgical treatment of morbid obesity (bariatric surgery);
- Prosthetic tracheostomy speaking valve; and
- Tracheo-esophageal voice prosthesis
- Insulin pumps and/or their supplies

Note: There is a special prior approval process for transplant cases. To be considered for an organ/tissue transplant, members must:

- have a diagnosis indicative for transplant;
- have a medical history with recent documents including results of laboratories, tests and consultations; and
- meet the clinical criteria for the transplant.

The referral can be sent thru fax (787) 706-4018 / (787) 774-4824 or by e-mail at lsilvest@ssspr.com to the Case Management Department. All organ/tissue services require our prior approval.

How to request precertification for an admission or get prior authorization for Other services

When you remain within our network, network providers will take care of precertification for you. When you seek out-of-network care, your physician, your hospital, you or your representative, must 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 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of planned days of confinement.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or facility the care that we approve for services that must have prior approval. We will make our decision within15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received neccesary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgement of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

You do not need to precertify your normal delivery. If you are out of the area, please refer to Section 5(d) emergency benefits for information.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification or prior authorization rules when using non-network providers

We will review your treatment to determine if it is medically necessary. In the event that we determine it is not medically necessary, you are responsible for all charges.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug or supply, or

2. Ask you or your provider for more information

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.

3. Write you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Circumstances beyond our control

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

Section 4. Your costs for covered services

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

Copayment	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 25% of our allowance for diagnostic tests.
Differences between our Plan allowance and the bill	When you receive services from network providers, you limit your liablity for covered services. When you receive covered services from out-of-network providers, you are responsible for the difference between the Plan allowance and the billed charge.
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. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits

(See page 9 for how our benefits changed this year and pages 76 and 77 for a benefits summary.)

Section 5. Benefits 17
Section 5(a). Medical services and supplies provided by physicians and other health care professionals 19
- Diagnostic and treatment services 19
- Lab, X-ray and other diagnostic tests 20
- Preventive care, adult 20
- Preventive care, children 21
- Maternity care 22
- Family planning 23
- Infertility services 23
- Allergy care 23
- Treatment therapies 24
- Physical and occupational therapies 24
- Speech therapy 25
- Hearing services (testing, treatment, and supplies) 25
- Vision services (testing, treatment, and supplies) 25
- Foot care 26
- Orthopedic and prosthetic devices 26
- Durable medical equipment (DME) 27
- Home health services 27
- Chiropractic 28
- Nutrition 28
- Alternative treatments 28
- Educational classes and programs 28

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals 31
- Surgical procedures 31
- Reconstructive surgery 32
- Oral and maxillofacial surgery 33
- Organ/tissue transplants 33
- Anesthesia 37

Section 5(c). Services provided by a hospital or other facility, and ambulance services 38
- Inpatient hospital 38
- Outpatient hospital or ambulatory surgical center 39
- Extended care benefits/Skilled nursing care facility benefits 39
- Hospice care 40
- Ambulance 40

Section 5(d). Emergency services/accidents 41
- Emergency within our service area 42
- Emergency outside our service area 42
- Ambulance 42

Section 5(e). Mental health and substance abuse benefits 43
Section 5(f). Prescription drug benefits 45
- Covered medications and supplies 47
- Mail Order and Flex90® Programs 48

Section 5(g). Dental benefits 49
- Accidental injury benefit 49

Dental Benefits....49
Section 5(h). Special features....51
Flexible benefits option....51
24 hours, 7 days a week call center....51
Blue Card Program....51
Centers of Excellence for transplants/heart surgery/etc....52
Blue Card Worldwide....52
Mental Health Management Program for Federal Employees....52
Telexpreso....52
Medication Therapy Management Program....52
Health Risk Assessment (HRA) tool....53
Section 5(i). Point of Service benefits....54
Non-FEHB benefits available to Plan members....55
Summary of benefits for the Triple-S Salud Plan 2012....77

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 Salud 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	**High Option**
Professional services of physicians • In Integrated Care Centers (CCI); these benefits will be offered through centers located in Puerto Rico.	Nothing per office visit to general practitioners, family medicine physicians and internists at participating Integrated Care Centers (CCI) located in Puerto Rico. Pediatricians and gynecologists' services also available in some CCI.
Professional services of physicians • In physician's office	Network: $ 7.50 per office visit to your general practitioner physician or $10 per office visit to a specialist physician Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Professional services of physicians • In an urgent care center or emergency room • During a hospital stay • In a skilled nursing facility – precertification required (refer to Section 3)	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
• Office medical consultations by specialists	Network: $10 per office visit Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount

Diagnostic and treatment services - continued on next page

Benefit Description	You pay
Diagnostic and treatment services (cont.)	**High Option**
• Second surgical opinion	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
At home	Network: $15 per physician visit or nothing for nurse or home health aide visit Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Not covered: • *Private nursing care, except for treatment of mental illness*	*All charges*
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as*:* • Blood tests • Urinalysis	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
• Polysomnography • Genetic amniocentesis • Non-invasive vascular and cardiovascular tests, including electrocardiogram and EEG	Network: 25% Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
• 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	Network: Nothing Out-of-Network: 10% of the allowable charges, plus any difference between our allowance and the billed amount
Preventive care, adult	**High Option**
Preventive annual exam, up to one (1) per policy year, at participating Integrated Care Centers (CCI), which includes: • Initial office visit for medical evaluation • Follow-up examination • Clinical laboratory tests (CBC, comprehensive metabolic panel, urinalysis, lipid panel) • Follow-up visit with Preventive Medical Counseling	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
Routine physical every year which includes routine screenings as follows: • Total Blood Cholesterol • Colorectal Cancer Screening, including: - Fecal occult blood test - Sigmoidoscopy, screening • Osteoporosis Screening	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
• Prostate Specific Antigen (PSA test)	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Routine Pap test	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Routine mammogram-covered for women age 35 and older, as follows: • 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	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Preventive care, children	**High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics, such as - 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 - Diphteria tetanus acellular pertusis	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**High Option**
- Hepatitis A - Pediarix (DTaP-IPV-HEP B) - Respiratory syncitial virus vaccine (palivizumab), subject to a precertification - Rotavirus (Rotateq, up to 6 years of age; Rotarix, up to 2 years of age) - Pentacel (Hib, DTaP, IPV), up to 4 years of age - Kinrix, up to 6 years of age - Flumist, up to 8 years of age - Varivax, up to 18 years of age - Gardasil or Cervarix, for females between 11 and 27 years of age	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
• Examinations, such as: - 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	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: - You do not need to precertify your normal delivery. - You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. - We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. 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 (b)).	Network: $10 per office visit. Nothing for delivery Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount

Benefit Description	You pay
Family planning	**High Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Intrauterine devices (IUDs) Note: We cover oral and injectable contraceptives and devices such as diaphragms, under the prescription drug benefit (Section 5(f)).	Network: $10 per office visit Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of infertility, such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI)	Network: $10 per office visit Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm or cost of donor egg* • *Fertility drugs*	*All charges*
Allergy care	**High Option**
• Testing and treatment • Allergy vaccine	Network: $10 per office visit Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
• Allergy serum	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*

Benefit Description	You pay
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on pages 29 through 33. • 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) Note: Growth hormone is covered under the prescription drug benefit. 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 *Services requiring our prior approval* in Section 3.	Network: $10 per office visit and/or respiratory therapy session Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Not covered: Services not shown as covered	*All charges*
Physical and occupational therapies	**High Option**
Physical and occupational therapies Up to 60 therapies per condition, if significant improvement can be expected, for the services ordered by a physician of each of the following: • Physical therapy - rendered by qualified physical therapists supervised by a physician specialized in physical therapy; • Occupational therapy - rendered by certified occupational therapists 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.	$10 per office visit plus any difference between our allowance and the billed amount Note: For physical and occupational therapy, you should pay the provider's claim and seek reimbursement from us. Physical and occupational therapists are not plan providers and do not have to accept the established fees as payment in full.
Not covered: • *long-term rehabilitative therapy* • *exercise programs* • *cardiac rehabilitation*	*All charges*

Benefit Description	You pay
Speech therapy	**High Option**
Speech therapy rendered by certified speech therapist up to 60 therapies per condition	$10 per office visit and/or speech therapy plus all charges that exceed our established fees Note: For speech therapy you should pay the provider's claim and seek reimbursement from us. Speech therapists are not Plan providers and do not have to accept the established fees as payment in full.
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by a Plan physician or audiologist • Tympanometry Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
• External hearing aids, up to a maximum of $250 every two years (see Section 5(a) Orthopedic and prosthetic devices)	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Not covered: • *Supplies*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• 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)	Network: $10 per office visit Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
• Optometrist services	Network: $7.50 per office visit Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses, corrective lenses, frames, fitting of contact lenses* • *Eye exercises and orthoptics* • *Multifocal Intraocular Lens* • *Radial keratotomy and other refractive surgery* • *Supplies*	*All charges*

Benefit Description	You pay
Foot care	**High Option**
• 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	Network: $7.50 per office visit to a general practitioner or podiatrist or $10 per office visit to a specialist Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Not covered: • *Treatment of weak, strained or flat feet*	*All charges*
Orthopedic and prosthetic devices	**High Option**
• 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. Prosthetics for lower and upper limbs, and orthotics, up to a maximum of $5,000 in combination, per year • Prosthetic tracheostomy speaking valve, requires prior approval • Lumbosacral supports, requires prior approval • Tracheo-esophageal voice prosthesis, requires prior approval • External Hearing aids, up to a maximum of $250 every two years Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5 (c) Services provided by a hospital or other facility, and ambulance services.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Diabetic Shoes* • *Heel pads and heel cups* • *Certain Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Artificial eyes; stump hose* • *Testing and examinations for hearing aids*	*All charges*

Benefit Description	You pay
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment prescribed by your physician, at our option, including repair and adjustment. Covered items include: • Oxygen • Hospital beds • Wheelchairs • Walkers • Blood glucose monitors • Iron lungs • Other respiratory equipment • Ostomy supplies • Tracheostomy supplies • Continuous positive airway pressure devices (CPAP) • Insulin pumps and/or their supplies, subject to enrollment in our Disease Management Program Note: You must obtain a precertification from us. Refer to Section 3. Call us at 787-774-6060 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.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Not covered: • *Crutches* • *Other durable medical equipment not shown above*	*All charges*
Home health services	**High Option**
• 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	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.* • *Homemaker services.*	*All charges*

Benefit Description	You pay
Chiropractic	**High Option**
• Manipulation of the spine and extremities, up to 15 visits per year. Note: We also cover one initial visit, one follow-up visit, and X-rays for neck, thorax and lumbosacral spine column area.	Network: Nothing Out-of-nework: 10% of the allowable charges plus any difference between our allowance and the billed amount Note: 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 Salud will reimburse you up to the established fees.
Nutrition	**High Option**
Nutritionists' services, up to four (4) visits per year, at some participating Integrated Care Centers (CCI) located in Puerto Rico.	Nothing
Alternative treatments	**High Option**
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Osteopathic services* • *Acupuncture*	*All charges*
Educational classes and programs	**High Option**
Total Wellness Program This program focuses in the attention of the five most common chronic conditions among Puerto Ricans: diabetes, asthma, hypertension, chronic obstructive pulmonary disease (COPD) and heart failure. It includes services such as: clinical treatment (provided by your physician), follow-up and guidance by nursing professionals and health educators, who will speak to you in educational workshops or by phone, and will share educational material through the mail about how to care for each condition. **Diabetes Program -** Consists of educational orientations for Plan members over the age of 18 years with diabetes. The following are among the topics that are discussed in the workshops and telephone calls: What is diabetes?, emotional aspects of the diabetic person, exercise, nutrition, use of medications, and complications, among others. We offer these orientations about the care and control of the condition through different health professionals —nurses, health educators and nutritionists — who will be contacting you to offer the help you need to control the condition.	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
Hypertension Program - Consists of educational activities focused on Plan members with hypertension (high or uncontrolled arterial blood pressure) who are over the age of 18 years. You will learn: What is hypertension?, What are the signs and symptoms?, How to modify your lifestyle, and How to keep blood pressure under control. It is important to keep your blood pressure under control to reduce the risk of complications such as: heart attack and stroke, among others. Triple-S Salud has a team of professionals available to help you modify the lifestyles that keep you from controlling your condition. **Chronic Obstructive Pulmonary Disease Program -** Plan members who are over 40 years of age and have chronic obstructive pulmonary disease (COPD) receive counseling on their condition, the use of prescritpion drugs to control it, signals and symptons of complications and the importance of medical monitoring of the condition. Our health professionals help patients to know their conditition well and to adopt healthy lifestyles in order to avoid complications and enjoy a better quality of life. **Heart Failure Program -** For Plan members over the age of 18 years that suffer from cardiac (heart) failure. Heart failure is a condition in which the pumping of blood to the body does not occur normally. When the condition is severe, nursing professionals from the Heart Failure Program will offer you guidance on how to take care of yourself, which will make you feel better. When you participate in the program, you will receive educational materials in your home. Plan members whose condition is not severe, will be invited by health educators to educational activities. All of this will help you control your condition, prevent complications and improve your quality of life. **For more information:** Call the Department of Education and Disease Management at Triple-S Salud. The toll-free telephone number is 1-866-788-6770 or (787) 793-8383, extensions 3106 or 3154.	Nothing
Prenatal Program - Offers education focused on the importance of early prenatal care and on the risk factors of which the mom-to-be should be aware. Pregnant Plan members will receive educational brochures about pregnancy care and baby care. In addition, the Plan member will be able to receive guidance over the telephone from a specialist in clinical management in the prenatal field and orientations through educational workshops offered by the health educators. **Health Education Program -** Health education is an essential component in the prevention of diseases and for enjoying good quality of life. Disease prevention and a good quality of life can be achieved partly through orientations and educational experiences in which you participate. These experiences will be of help to you and will provide you with the information that you need to voluntarily adopt healthy lifestyles. Through educational activities, the health educators and other professionals at Triple-S Salud will help you identify those lifestyles that will be of benefit to your health.	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
For more information: Call the Department of Education and Disease Management at Triple-S Salud. The toll-free telephone number is 1-866-788-6770 or (787) 793-8383, extensions 3106 or 3154.	Nothing
Tobacco Cessation Program Triple-S Salud offers you an educational and health promotion program, to help you quit tobacco. This program focuses on tobacco users and their family members who want to participate voluntarily. It offers individual/group and telephone counseling. See *Section 5(h): Special Features*. Note: Triple-S Salud FEHBP covers tobacco cessation drugs, over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. See *Section 5(f): Prescription Drug Benefit*. **For more information:** Call the Department of Education and Disease Management at Triple-S Salud. The toll-free telephone number is 1-866-788-6770 or (787) 793-8383, extensions 3106 or 3154.	Nothing
Weight Control Program This health promotion program provides education to enrollees about weight control. It also focus on childhood obesity. **For more information:** Call the Department of Education and Disease Management at Triple-S Salud. The toll-free telephone number is 1-866-788-6770 or (787) 793-8383, extensions 3106 or 3154.	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 Salud 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	**High Option**
A comprehensive range of services, such as: • 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 • 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.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount Note: See Section 5 (c) for outpatient surgical facility copay Note: For insertion of internal prosthetic devices, member pays nothing if provided by a Plan doctor or provider. For all out-of-network services, *you should pay the provider's claim and seek reimbursement from us. We will reimburse you 90% of our established fees.*

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
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.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount Note: See Section 5 (c) for outpatient surgical facility copay Note: For insertion of internal prosthetic devices, member pays nothing if provided by a Plan doctor or provider. For all out-of-network services, *you should pay the provider's claim and seek reimbursement from us. We will reimburse you 90% of our established fees.*
• 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. Bariatric surgery requires prior approval (refer to Section 3) and eligible members must be age 18 or over. This Plan uses the following criteria: - Patients with a body mass index (BMI) of greater than 40 kg/m2 or greater than 35 kg/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	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount Note: See Section 5 (c) for outpatient surgical facility copay.
Not covered: • *Reversal of voluntary sterilization*	*All Charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - 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: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices)	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount Note: See Section 5 (c) for outpatient surgical facility copay.

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**High Option**
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.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount Note: See Section 5 (c) for outpatient surgical facility copay.
Not covered: • *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.* • *Surgeries related to sex transformation*	*All Charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, *performed only when medically necessary,* limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount Note: See Section 5 (c) for outpatient surgery facility copay.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Services requiring our prior approval* in Section 3 for prior authorization procedures. • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney	Network: Nothing Out-of-Network: All charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• Liver • Lung: single/bilateral • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	Network: Nothing Out-of-Network: All charges
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Services requiring our prior approval* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Network: Nothing Out-of-Network: All charges
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. The medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency	Network: Nothing Out-of-Network: All charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Ependymoblastoma - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer	Network: Nothing Out-of-Network: All charges
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Services requiring our prior approval* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reocurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reocurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency	Network: Nothing Out-of-Network: All charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reocurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reocurrence (relapsed) - Amyloidosis - Neuroblastoma	Network: Nothing Out-of-Network: All charges
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma, up to 65 years of age • Mini-transplants (non-myeloblative allogeneic, reduced intensity conditioning (RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia, up to 60 years of age - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma, up to 65 years of age - Sickle cell anemia • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Breast Cancer - Childhood rhabdomyosarcoma - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer	Network: Nothing Out-of-Network: All charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Mantle Cell (Non-Hodgkin lymphoma)	Network: Nothing Out-of-Network: All charges
Note: For all covered organ/tissue transplants, we cover the related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	Network: Nothing Out-of-Network: All charges
National Transplant Program (NTP)	Network: Nothing Out-of-Network: All charges
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Living donors for intestine transplant in adults and children* • *Transplants not listed as covered* • *Transportation, meals, and lodging expenses*	*All Charges*
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Network: Nothing Out-of-Network: All charges

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 Salud 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	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • 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.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowable charges and the billed amount
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowable charges and the billed amount

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
• Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowable charges and the billed amount
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care.* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All Charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• 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 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.	Network: $25 facility copay when outpatient surgery is performed Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount.
• Pre-surgical testing	Network: The coinsurance established in Section 5 (a) for laboratories, X-rays and other diagnostic tests Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount.
Extended care benefits/Skilled nursing care facility benefits	**High Option**
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 pages 11 and 12.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount.
Not covered: custodial care, rest cures, domiciliary or convalescent care	*All Charges*

Benefit Description	You pay
Hospice care	**High Option**
Not covered: Independent nursing, homemaker services, hospice care	*All Charges*
Ambulance	**High Option**
• 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.
• Air ambulance services within the Service Area when rendered by a Plan provider	Nothing
Not covered: • *Air ambulance outside of the Service Area* • *Air ambulance services not rendered by a Plan provider*	*All Charges*

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 CMS 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 59 and 60.

Benefit Description	You pay
Emergency within our service area	**High Option**
• Emergency care at a doctor's office	$10 per office visit
• Emergency care at emergency room and an urgent care center	$25; if we recommend the visit $10
• Emergency care as an inpatient at a hospital, including doctors' services.	Nothing
Not covered: Elective care or non-emergency care	*All Charges*
Emergency outside our service area	**High Option**
• 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. Note: See Section 5(h) Special Features for information on the Blue Card Program.	*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.*
Ambulance	**High Option**
• Local professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	You should submit the provider's claim and seek reimbursement from us. We pay all charges. You pay nothing.
• Air ambulance services within the Service Area when rendered by a Plan provider.	Nothing
Not covered: • *Air ambulance outside of the Service Area.* • *Air ambulance services not rendered by a Plan provider.*	*All Charges*

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 PRE-REGISTER FOR MENTAL HOSPITALIZATION SERVICES**. To be eligible to receive the hospital benefits you must complete the following precertification process: 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.
- **IT IS IMPORTANT THAT YOU OR YOUR PLAN DOCTOR CALL AT 1-800-660-4896 TO 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 Salud 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
Professional services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. 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.	Network: Your cost-sharing responsibilities are no greater than for other illnesses or conditions. Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits)	Network: $7.50 per office visit and/or therapy Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount.

Professional services - continued on next page

Benefit Description	You pay
Professional services (cont.)	**High Option**
• Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Network: $7.50 per office visit and/or therapy Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount.
Inpatient hospital visit by a physician	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount.
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	Network: Nothing for laboratories and X-rays; 25% for some diagnostics tests. See Lab, X-ray and other diagnostic tests (Section 5a). Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount.
• Psychological tests if performed by a qualified psychologist	Plan reimburses you up to $35 for a full battery of tests. You pay the remaining charges.
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services Remember: These services require a precertification, please see *Important things you should keep in mind about these services* at the beginning of this section.	Network: Nothing Out-of-Network: 10% of the allowable charges, plus any difference between our allowance and the billed amount.
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount.
Not covered	**High Option**
• Services that are not part of a preauthorized approved treatment plan *Note: OPM will base its review of disputes about a treatment plan on the treatment plan's clinical appropiateness. OPM will generally not order us to pay or provide one clinically appropiate treatment plan in favor of another.*	All Charges

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 page 44.
- 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 Drug List. A Drug List 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. Please, refer to the Drug List to find out more information regarding benefit level descriptions, pharmacy terms, utilization edits, and special instructions.

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, dentist or podiatrist's original prescription not to exceed the normal monthly 30-day 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 787-792-1370) 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 Salud 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.

*Triple-S Salud Pharmacy Program is a Triple-S Salud product administered by MC-21 Corp., a pharmacy services independent contractor.

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. As an incentive to use generic drugs, we will waive your generic copay for a period of six months when you switch from a brand-name drug to a generic drug.

Step Therapy Program

In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B. This program will require the utilization of Over-The-Counter (OTC) drugs or Generic drugs before using other drugs to treat your medical condition. The "OTC First" portion includes Proton Pump Inhibitors (PPI), Non-sedating antihistamines, and Ocular allergies agents. The "Generic First" portion includes Cholesterol drugs-Statins, Osteoporosis-Oral Bisphosphonates, Allergies-Nasal Corticosteroids, and Angiotensin receptor blockers (ARBs) for hypertension.

Mail Service Prescription Drug Program

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

Complete the initial mail order form and please complete one for each person participating in the program. You must return the enrollment form 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. Mail your order with the required information to: MedVantx, Inc., PO Box 5736, Sioux Falls, SD 57117. You should allow approximately 10 days for delivery.

After your initial fill for mail order medication, you can order your refills as follows:

- **Through the mail** - You must use the form that we sent to you in order to refill the medication. Remember to request refills on time to avoid a delay in receiving the refill.
- **By phone** - You can may at 1-866-881-6221, toll free.
- **By fax** - You may send your documents at 1-877-999-3679

90-Day Supply Retail Service (Flex90®)

Flex90® is a voluntary program that allows the member to obtain a 90-day supply of some 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.

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
Covered medications and supplies	**High Option**
We will cover prescription drugs based on a List of Drugs. We cover the following medications and supplies prescribed by a Plan physician or dentist and obtained from a Plan pharmacy: • 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" 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).	You will pay the following copayments for drugs in the List of Drugs obtained from a Plan pharmacy: • Tier 1: generic prescription drugs, $5.00 for unit or refill. • Tier 2: preferred brand prescription drug, $12 for unit or refill. • Tier 3: non-preferred brand name drugs, 20% or $15, whichever is higher, $100 maximum out of pocket for unit or refill • Tier 4: Specialty/biotech drugs, 25% or $175 whichever is the lowest for unit or refill; annual maximum out-of-pocket $3,000. 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. Note: If a generic does not exist, you will still have to pay the brand name copay.
• FDA approved tobacco cessation drugs (over-the-counter and presription), including nicotine patches	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Nutrients and food supplements even if a physician prescribes or administers them* • *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).* • *Medical supplies such as dressings, antiseptics, lancets and strips* • *Drugs supplied by pharmacies located outside of Puerto Rico, United States Virgin Islands, the United States and its territories, except for emergencies.* • *Drugs for treatment of infertility* • *Drugs to enhance athletic performance* • *Drugs that are experimental or investigational unless approved by the Federal Food and Drug Administration (FDA)* • *Obesity control and related medications used in its treatment (except medications for morbid obesity that are covered).*	*All Charges*

Benefit Description	You pay
Mail Order and Flex90® Programs	**High Option**
The program has the following characteristics: • 90-day supply, including one (1) refill Note: These programs are only for some maintenance medications. The exclusions and limitations mentioned above apply to these programs. The following drug classifications will not be dispensed through these 90-day supply programs: Anticoagulants, Migraine, Sexual Dysfunction, Psychotherapeutics, Injectables, Drops, Solutions, Inhalators, Sprays, Antibiotics, Antimycobacterial agents, Antineoplastics, Corticosteroids, Patches, Topic creams, Vitamins, Antihistamines, Proton Pump Inhibitors (PPI), H-2 Antagonists, Urinary Antispasmodics, Analgesics - Anti-inflammatory, and Gout. Please refer to Section 7 for instructions on how to use Mail Service Prescription Drug Program.	You will pay the following copayments for drugs in the List of Drugs: • Tier 1: generic prescription drugs, $10 for unit or refill • Tier 2: preferred brand prescription drug, $24 for unit or refill • Tier 3: non-preferred brand name drugs, 15% or $30, whichever is higher, $200 maximum out of pocket for unit or refill Note: You will not pay shipping charges. Note: Tier 4 is not available under Mail Order or Flex90® Programs because specialty/biotech drugs are dispensed only by specialty pharmacies. 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.

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 payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- 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.
- 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 Salud 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 Salud or Blue Cross Blue Shield of the United States Virgin Islands to render dental services.
- 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	**High Option**
We cover restorative services and supplies necessary to repair (but not replace) sound natural teeth, within a six-month period. The need for these services must result from an accidental injury. An injury caused by chewing is not considered an accidental injury.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount.

Benefit Description	You Pay
Dental Benefits	**High Option**
Dental coverage is limited to: Diagnostic • 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, limited to one every six months) • Fluoride treatment, one every six months for enrollees under 19 years of age.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount.

Dental Benefits - continued on next page

Benefit Description	You Pay
Dental Benefits (cont.)	**High Option**
• Fluoride treatment, one every six months for enrollees over 19 years of age. • Panoramic X-rays, up to 1 set every 3 years	Network: 30% Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount.
Restorative • Amalgam restorations • Plastic, porcelain or composite (anterior and posterior tooth) • Other restorative services (pin retention per tooth, in addition to restorations) • Sedative filling	Network: 30% Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount.
Adjunctive General Services • 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)	Network: 30% Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount.
Endodontics • Pulp capping-direct (excluding final restoration) • Pulp capping-indirect (excluding final restoration) • Pulpal debridement in primary and permanent teeth for emergency purposes	Network: 30% Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount.
Oral Surgery • 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	Network: 30% Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount.
Not covered: Other dental services not shown as covered.	*All charges*

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, it at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24 hours, 7 days a week call center	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.
Blue Card Program	Triple-S Salud is an independent concessionaire of the Blue Cross and Blue Shield Association. As in other Blue Cross and Blue Shield Plans, Triple-S Salud 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 Salud. 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: • the amount invoiced for covered services, or • the amount or fee negotiated that Triple-S Salud receives from the Blue Cross or Blue Shield Plan of the area in which the insured person receives the service. 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. 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.

	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. 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) from 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.
Centers of Excellence for transplants/heart surgery/etc.	We offer you the benefit of the Blue Distintion 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.
Mental Health Management Program for Federal Employees	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: • **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
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.
Medication Therapy Management Program	We offer a Medication Therapy Management Program at no additional cost to members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. This program was developed for us by a team of pharmacists and doctors. We use this Medication Therapy Management Program to help us provide better coverage for our members. For example, this program helps us make sure that our members are using appropriate drugs to treat their medical conditions and helps us identify possible medication errors. We may contact members who qualify for this program. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you don't need to pay anything extra to participate. If you are selected to join a Medication Therapy Management Program, we will send you information about the program, including information about how to access it.

Feature	Description
Health Risk Assessment (HRA) tool	We developed an HRA tool that evaluates lifestyles, risk factors, and existing conditions, among others. It will help us have a clear profile of our insured population and help us determine where to direct our health education and prevention strategies. The HRA will also help enrollees do a health-assessment to find out where they are in term of compliance with preventive tests, the changes they need to make, and to gain greater awareness to prevent future health problems. Register at our Web site www.ssspr.com and start living a healthier life!

Section 5(i). Point of Service benefits

Facts about this Plan's Point of Service (POS) Benefits

You can receive care from any licensed non-Plan doctor of medicine (M. D.) without a referral. Non-Plan doctors do not have to accept Triple-S Salud established fees as payment in full. If you use a non-Plan doctor you must pay the difference between the billed charges and the amount that we pay you.

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 Salud 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 Salud 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 Salud 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 Salud established fees.

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

Non-Plan providers are under no obligation to accept our established fees as payment in full. In addition to copayments and coinsurance, you are responsible up to the billed charges when you use non-Plan providers.

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

- Prescription drugs
- Organ/tissue transplants
- All exclusions that appear in Sections 5 and 6

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 Salud Medicare Advantage Plans: Triple-S Medicare Óptimo Plans focus 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 and Triple-S Medicare Óptimo Plus. 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.

With any of our products you will enjoy:

- $0 and/or low copayments and coinsurances when you obtain most of the services through our Plan providers
- You can visit any Lead Physician 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 Total Wellness Program for members with diabetes, hypertension, and chronic heart failure
- Medicare Prescription drug (Part D) Plans with no initial annual deductible. Services can be accessed through over 1,000 pharmacies in Puerto Rico and over 55,000 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 Salud 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 throughout 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 5:00 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 it is medically necessary to treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior plan approval.*

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);
- Extra care and research costs of clinical trials;
- 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

This Section primarily deals with post-service claims (claims for services, drugs or suppies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. 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 CMS-1500, Health Insurance Claim Form. Facilities will file on the UB-04 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 or visit us at our Website at www.ssspr.com.

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

- Covered member's name, date of birth, address, phone number 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 payor -- such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services
- For prescription drugs also include: Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.
  - Prescription drug name;
  - Daily dosage;
  - Prescription number;
  - Dispensed supply; and
  - National Drug Code (NDC)

Submit your claims to:

Triple-S Salud

PO 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.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Urgent care claims procedures

If you have an urgent care claim, please contact our Customer Service Department 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. Urgent care claims must meet the definition found in Section 10 of this brochure, and most urgent care claims will be claims access to care rather than claims for care already received. We will notify you of our decision not later than 72 hours after we receive the claim as long as you provide us with sufficient information to decide the claim. If you or your authorized representative fails to provide sufficient information, we will inform you or your authorized representative of the specific information necessary to complete the claim not later than 24 hours after we receive the claim. You or your authorized representative must provide the requested information within 48 hours. We will answer your request within 48 hours after we receive this information. If no additional information is received, we will make a determination with the information already submitted.

We may provide our decision orally within these time frames, but we will follow up with a written or electronic notification within three days of oral notification.

Concurrent care claims procedures

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment as an appealable decision. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 72 hours after we receive the claim.

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. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permited to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7, and 8 of this brochure, please visit www.ssspr.com .

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service (a claim where services, drugs or supplies have already been provided). In Section 3. *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

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 Salud, 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

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

e) Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration deciision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim or

b) Write to you and maintain our denial or

c) Ask you or your provider for more information

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.

3 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, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance (HI) 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.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

4 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 you did not indicate that your claim was a claim for urgent care, 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. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance (HI) 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 payor and the other Plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

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

When we are the secondary payor, 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
- 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 (1-800-633-4227), (TTY 1-877-486-2048) 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 page 63.
- 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 (TTY 1-800-325-0778) 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 didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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

Claims process when you have the Original Medicare Plan - You 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 payor, we process the claim first.

When Original Medicare is the primary payor, 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 payor--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.

You can find more information about how our plan coordinates benefits with Medicare in our Web site at www.ssspr.com.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **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), (TTY 1-877-486-2048) 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 Salud 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 or coinsurance. 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 payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, 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 payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) 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 #3 above	✓	
5) 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	✓	
6) 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 #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
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 payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
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 (or a covered family member) 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.

Clinical Trials

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial that is covered or is receiving standard therapy. These costs are covered by this plan.

- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, this plan does not cover these costs.

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.

Clinical Trials Cost Categories

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 13.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 13.

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

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:

- 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

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.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity

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

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

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

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: the Plan allowance in our service area, Puerto Rico 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.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department 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. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and we refer to Triple-S Salud.

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
- What happens when your enrollment ends
- 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. For information on your premium deductions, you must also contact 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 dependent children including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 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 of changes in family member status, including your marriage, divorce, annulment, or when your child under reaches age 26.

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.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children,and stepchildren	Natural and adopted children are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but NOT their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own emplyer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure.

- **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 2012 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 2011 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.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance 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 for 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 26, 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. Other Federal Programs

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, 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 eligible dependents.

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

The Federal Flexible Spending Account Program - *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **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)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) 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 tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependant on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attend school full-time to be eligilble for DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

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 separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental Plans provide a comprehensive range of services, including:

- 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 for dependent children.

Vision Insurance

All 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/vision and www.opm.gov/insure/dental. These sites also provide 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 1-877-889-5680).

The Federal Long Term Care Insurance Program - *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help 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 such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY 1-800-843-3557) or visit www.ltcfeds.com .

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy PCIP coverage if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition.

- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.):
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbie, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Birginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY): 1-866-561-1604.

Index

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

Accidental injury.....33, 49
Allergy tests.....23
Allogeneic (donor) bone marrow transplant 36, 52
Alternative treatments.....28
Ambulance.....38, 40, 43
Anesthesia.....5, 31, 37, 39
Autologous bone marrow transplant...24, 36, 52
Biopsy.....31
Blood and blood plasma.....38-39
Casts.....31, 38-39
Catastrophic protection (out-of-pocket maximum).....16, 56
Changes for 2012.....10
Chemotherapy.....24
Chiropractic.....11, 28
Cholesterol tests.....21
Claims.....14, 41, 51, 58-61,69
Coinsurance.....16
Colorectal cancer screening.....21
Congenital anomalies.....31-32
Contraceptive drugs and devices.....23, 47
Crutches.....27
Definitions.....68
Dental care.....39, 49-50, 73-75, 79
Diagnostic services...16, 19-20, 25, 38-39, 43-44
Donor expenses.....37
Dressings.....39-40, 48
Durable medical equipment.....13, 27
Effective date of enrollment.....12
Emergency.....14, 41-42, 51-52, 54, 78
Experimental or investigational...33, 47, 57
Eyeglasses.....25
Family planning.....23
Fecal occult blood test.....21
Fraud.....3-4, 72
General exclusions.....57
Hearing services.....25
Home health services.....27, 47, 75
Hospital...4, 5, 7, 11-12, 14, 18, 22,33,37, 39-40, 43, 44-45, 53, 55, 66, 72
Immunizations.....7, 10, 21-22
Infertility.....23, 47
Inpatient hospital benefits.....38-39, 44,60
Insulin.....47, 74
Magnetic Resonance Imagings (MRIs) 20
Mammogram.....20-21
Maternity benefits.....22, 38
Medicaid.....66
Medically necessary...8, 12-14, 22, 24, 33, 36, 38, 57, 69
Medicare.....63-64
  Advantage.....56, 63-64
  Original.....63-64
Members
  Associate.....80
  Family...3-4, 11-12, 16, 52, 62, 65, 69-70, 74-75, 80
  Plan.....28, 29, 46, 56
Mental Health/Substance Abuse Benefits 43-44, 52, 78-79
Newborn care.....22
Non-FEHB benefits.....56, 72
Nurse
  Licensed Practical Nurse (LPN)...39, 51
  Nurse Anesthetist (NA).....39, 51
  Registered Nurse.....39, 51
Occupational therapy.....24
Office visits.....7
Oral and maxillofacial surgery.....33
Out-of-pocket expenses...10, 16, 47, 56, 63, 66, 68, 74, 78
Oxygen.....27, 38-39
Pap test.....20
Physician.....19-20, 31
Point of Service (POS).....8, 11, 54, 79
Precertification.....12-14, 54, 69
Prescription drugs.....10, 45-48, 56, 78
Preventive care, adult.....20-21
Preventive care, children.....21-22
Preventive services.....22
Prior approval.....12-13
Prosthetic devices.....26, 31
Psychologist.....43-44
Radiation therapy.....24
Room and board.....38, 44
Second surgical opinion.....20
Skilled nursing facility care...13, 19, 37, 39
Social worker.....43
Speech therapy.....25
Splints.....36
Subrogation.....66
Substance abuse.....43-44
Surgery
  Oral.....50, 75
  Outpatient.....33, 39, 78
  Reconstructive.....32-33
Syringes.....47
Temporary Continuation of Coverage (TCC).....4, 65, 72-73
Transplants.....13, 24, 31, 33-37, 52, 57, 79
Treatment therapies.....24
Vision care.....22, 25, 66, 74, 79
Wheelchairs.....27
Workers Compensation.....65-66
X-rays...20, 28, 36, 38-39, 44, 49-50, 66, 68, 75, 78

Summary of benefits for the Triple-S Salud Plan 2012

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

Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in Integrated Care Centers (CCI)	Nothing	19
Diagnostic and treatment services provided in the office	Office visit copay: $7.50 general practitioner or $10 specialist; 25% for certain diagnostic tests; Nothing for laboratory tests and X-rays.	19
Services provided by a hospital:		
• Inpatient	Nothing	38-39
• Outpatient	$25 facility copay for outpatient hospital or ambulatory surgical center when outpatient surgery is performed	39
Emergency benefits:		
• In-area	Emergency room $25; if we recommend the visit $10. Nothing for hospital.	42
• Out-of-area	10%	42
Mental health and substance abuse treatment	Regular cost-sharing	43
Prescription drugs:		
• Retail pharmacy	• Tier 1: generic prescription drugs, $5.00 for unit or refill. • Tier 2: preferred brand prescription drug, $12 for unit or refill. • Tier 3: non-preferred brand name drugs, 20% or $15, whichever is higher, $100 maximum out of pocket for unit or refill. • Tier 4: Specialty/biotech drugs, 25% or $175, whichever is the lowest for unit or refill; annual maximum out-of-pocket $3,000. • $0 for smoking cessation drugs, including nicotine patches	47

Benefits	You Pay	Page
• Mail Order and Flex90® Programs	• Tier 1: generic prescription drugs, $10 for unit or refill • Tier 2: preferred brand prescription drug, $24 for unit or refill • Tier 3: non-preferred brand name drugs, 15% or $30, whichever is higher, $200 maximum out of pocket for unit or refill.	48
Dental care	Nothing for diagnostic services; 30% all other services.	49-50
Vision care	$10 per office visit	25
Special Features	Flexible benefits option · 24 hours, 7 days a week call center · Blue Card Program · Centers of Excellence for transplants/heart surgeries/etc. · Blue Card Worldwide · Mental Health Management Program for Federal Employees · Mail Service Prescription Drug Program · 90-day Supply Retail Service (Flex 90) · Telexpreso · Medication Therapy Management Program · Total Wellness Program · Health Risk Assessment (HRA) tool	50-53
Point of Service benefits	You are responsible for all charges that exceed our payment for covered services. When you receive out-of-network services, we pay 90% of the established fee for allowable charges. You are responsible for paying the non-participating provider up front for covered services and filing a claim for reimbursement. We will reimburse you directly for covered services unless the provider accepts assignment of benefits.	54-55

2012 Rate Information for Triple-S Salud

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 career employees covered by the National Postal Mail Handlers Union (NPMHU), National Association of Letter Carriers (NALC) and Postal Police bargaining units.

Postal Category 2 rates apply to other non-APWU, non-PCES, non-law enforcement Postal Service career employees, including management employees, and employees covered by the National Rural Letter Carriers' Association bargaining unit.

Special Guides to Benefits are published for American Postal Workers Union (APWU) employees (see RI 70-2A) including Material Distribution Center, Operating Services and Information Technology/Accounting Services employees and Nurses; Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees (see RI 70-2IN), Postal Career Executive Service (PCES) employees (see RI 70-2EX), and noncareer employees (see RI 70-8PS).

Career APWU employees hired before May 23, 2011, will have the same rates as the Category 2 rates shown below. In the Guide to Benefits for APWU Employees (RI 70-2A) this will be referred to as the "Current" rate; otherwise, "New" rates apply.

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
Puerto Rico							
High Option Self Only	891	$116.16	$ 38.72	$251.68	$ 83.89	$ 25.56	$ 24.01
High Option Self and Family	892	$261.35	$ 87.12	$566.27	$188.75	$ 57.50	$ 54.01
Virgin Islands							
High Option Self Only	851	$142.68	$ 47.56	$309.14	$103.05	$ 31.39	$ 29.49
High Option Self and Family	852	$324.03	$108.01	$702.07	$234.02	$ 71.29	$ 66.97