Triple-S Salud

http://www.ssspr.com
Customer Service 787-774-6081 or 1-800-981-3241

2016

A Health Maintenance Organization (High option) with a Point of Service

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details.

IMPORTANT
- Rates: Back Cover
- Changes for 2016: Page 14
- Summary of benefits: Page 84

Serving: All of Puerto Rico and United States Virgin Islands

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 12 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
893 Self Plus One	853 Self Plus One
892 Self and Family	852 Self and Family

Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-016

Important Notice from Triple-S Salud About

Our Prescription Drug Coverage and Medicare

The U. S. Office of Personnel Management (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. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug 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 Medicare Part D 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 will 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 15 through December 7) 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

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. Customer service may be reached at 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 1-800-982-3241 (TTY: 1-866-215-1999) from the United States Virgin Islands or through our website: www.ssspr.com. 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 verbal 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 787-774-6081 (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. If you enroll in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2016, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each Plan annually. Benefit changes are effective January 1, 2016, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

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.
- Our brochure and other FEHB Plans’ brochures have the same format and similar descriptions to help you compare Plans.

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.
- Periodically review your claims history for accuracy to ensure we have not been billed for services that you did not receive.
- 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 787-774-6081 (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

877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to

ensure accuracy, and a quicker response time.

You can also 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 and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- 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 or nutritional supplements 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.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur cost to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events, if you use Triple-S Salud's participating providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

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.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **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 that 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 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 Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. 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 Plus One or 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 Plus One or 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 Plus One or 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.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-event. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **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. A Self Plus One enrollment covers you and one eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren 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 employer-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 Plus One or 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 Plus One or 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 Plus One or Self and Family coverage, as appropriate, 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 Plus One or Self and Family, as appropriate, 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 Plus One or Self and Family, as appropriate, 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. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. 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 2016 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 2015 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 who is 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 additional information about your coverage choices. You can also visit OPM's website at http://www.opm.gov/healthcare-insurance/healthcare/plan-information/.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal 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 or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHBP coverage.

- **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 or Tribal 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.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit **www.HealthCare.gov**. This is a website provided by the U. S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

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.

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 in full for the services rendered and Triple-S Salud will reimburse you based on the established fees. 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 for services you receive 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 emergency services are rendered outside the service area, this Plan pays based on usual, customary and reasonable charges of the area where services were rendered or according to the Blue Cross Blue Shield local Plan's fees. When we precertify services that you receive outside the service area, we will pay for covered services according to: 1) the usual, customary and reasonable charges of the area where services were rendered; 2) the Blue Cross Blue Shield local Plan's fees; or 3) Triple-S Salud's established fees. The written precertification that we provide to you and the provider will indicate the allowance we will use. When you receive covered services outside the service area that are neither emergency nor precertified, we will reimburse 90% of Triple-S Salud's established fees, after any applicable copay or coinsurance. You are responsible up to the billed charges for these services.

For services received by an employee (not available for dependents) 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 notifying 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 (out-of-network). 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 reimburse members in Puerto Rico and in the United States Virgin Islands based on the "medical benefits schedule" and the member is responsible up to the billed charges for these services. When emergency services are rendered outside the service area, this Plan pays based on usual, customary and reasonable charges of the area where services were rendered or according to the Blue Cross Blue Shield local Plan's fees. When we precertify services that you receive outside the service area, we will pay for covered services according to: 1) the usual, customary and reasonable charges of the area where services were rendered; 2) the Blue Cross Blue Shield local Plan's fees; or 3) Triple-S Salud's established fees. The written precertification that we provide to you and the provider will indicate the allowance we will use. When you receive covered services outside the service area that are neither emergency nor precertified, we will reimburse 90% of Triple-S Salud's established fees, after any applicable copay or coinsurance. You are responsible up to the billed charges for these services.

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 website (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 787-774-6081 (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 website 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 emergency care outside our service area, we will base payment for covered services based on usual, customary and reasonable charges of the area where the services were rendered or according to the Blue Cross Blue Shield local Plan's fees. When we precertify services that you receive outside the service area, we will pay for covered services according to: 1) the usual, customary and reasonable charges of the area where services were rendered; 2) the Blue Cross Blue Shield local Plan's fees; or 3) Triple-S Salud's established fees. The written precertification that we provide to you and the provider will indicate the allowance we will use. When you receive covered services outside the service area that are neither emergency nor precertified, we will reimburse 90% of Triple-S Salud's established fees, after any applicable copay or coinsurance. You are responsible up to the billed charges for these services. When receiving out of area care for services without a precertification from the plan, you are responsible for paying the providers up front and Triple-S Salud will reimburse up to the established fee after any applicable copay 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 subject to the terms and conditions of this plan. 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. Changes for 2016

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

- Self Plus One enrollment type has been added effective January 1, 2016.
- We have removed the Section 6. General Exclusion for services, drugs, or supplies related to sex transformations. Please see Section 5. Benefits for information. See page 63.

Changes to this Plan

- Your cost of the non-Postal premium will stay the same for Self only or Self and Family in Puerto Rico and the U. S. Virgin Islands. See page 84.
- We now cover Adaptive Behavior Assessment and Treatment when it is rendered within the Triple-S network. See Adaptive Behavior Assessment and Treatment in Section 5(a), page 28.
- We will cover up to $500 maximum every 2 years for hearing aids. Previously, we covered a maximum of $250 every 2 years for hearing aids. See pages 29 and 31.
- We use a managed formulary to administer the prescription drug benefits. Certain drugs require prior authorization for medical necessity. These drugs are excluded from the formulary and we will not cover them unless we determine that they are medically necessary based on objective clinical evidence. You are responsible for the full cost of drugs and services that we determine are not medically necessary. Please visit www.ssspr.com for a list of drugs that require prior authorization for medical necessity. See Section 5(f). Prescription drug benefits.
- Your copayment for covered diagnostic laboratory services is $1 when you use a network provider. Previously, the copayment was $7.50. See page 24.
- As an incentive for completing a health risk assessments (HRA), we will send you an exercise kit that consists of a backpack, water bottle, pedometer, wrist band, and jump rope. You have access to the HRA at www.ssspr.com. See page 58.

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 787-774-6081 (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 website 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 website.

- **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 website.

- **Other Providers**

Non-Plan Providers: These are other health professionals and providers of services which are covered by this Plan. Usually we reimburse members based on 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 787-774-6081 (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**

Your general practitioner physician may refer you for most services. For certain services, your physician 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 787-774-6081 (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 precertification from this Plan for the following benefits or services:

- Services outside the Service Area, except emergencies; we will precertify services outside the service area, which will include payment determination, 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 for each transplant phase.

How to request precertification for an admission or 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) 774-6081 (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 precertification 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 days requested for hospital stay.

- **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 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.

- **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 judgment 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 let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required 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.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 787-774-6081 (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 call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 1-800-981-3241 (TTY: 1-866-215-1999) from the United States Virgin Islands. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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 before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. 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 24 hours after we receive the claim.

- **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 rules when using non-network providers

We will review your treatment. In the event that we determine it is not medically necessary and/or subject to exclusion, 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.
  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 to 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.

  Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite 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:

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.
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 Network specialist, you pay a copayment of $10 per office visit.
Coinsurance	Coinsurance is the percentage of our negotiated fee that you must pay for your care. Example: In our Plan, you pay 20% of our allowance for certain diagnostic tests.
Differences between our Plan allowance and the bill	When you receive services from network providers, you limit your liability 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	After your network copayments and coinsurance for covered services total $6,600 under a Self only enrollment, you no longer have to pay coinsurance or copayments for covered services that you receive within the network during that year. The out-of-pocket maximum under Self plus One or Self and Family is $13,200 combined for covered services that you and covered family members receive within the network but will not exceed $6,600 per member. The following services do not count toward your out-of-pocket maximum and you must continue to pay for these services: • Difference between our Plan allowance and the billed charges for a covered service or supply; • Cost of non-covered services or supplies; and • Coinsurance you pay when you use non-Plan providers.
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 14 for how our benefits changed this year and pages 82 and 83 for a benefits summary.

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-participating doctor or provider within the service area, you pay for services rendered and the Plan will reimburse 90% of the Plan's established fee, after any applicable copay or coinsurance. When emergency services are rendered outside the service area, this Plan pays 90% of the usual, customary and reasonable charges of the area where services were rendered or according to the Blue Cross Blue Shield local Plan's fees. When we precertify services that you receive outside the service area, we will pay for covered services according to the 90% of: 1) the usual, customary and reasonable charges of the area where services were rendered; 2) the Blue Cross Blue Shield local Plan's fees; or 3) Triple-S Salud's established fees. The written precertification that we provide to you and the provider will indicate the allowance we will use. When you receive covered services outside the service area that are neither emergency nor precertified, we will reimburse 90% of Triple-S Salud's established fees, after any applicable copay or coinsurance. You are responsible up to the billed charges for these services.

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
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 • Prostate specific antigen (PSA test)	Network: $1.00 per laboratory Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
• Polysomnography • Genetic amniocentesis • Non-invasive vascular and cardiovascular tests, including electrocardiogram and EEG	Network: 20% 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**
We cover a comprehensive range of A & B rated preventive care services for adults as recommended by the United States Preventive Services Task Force (USPSTF). Members over age 21 may obtain covered preventive services through our network Preventive Centers. Routine physical every year which includes routine screenings as follows: • Total Blood Cholesterol	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**
• Colorectal Cancer Screening, including: - Fecal occult blood test - Sigmoidoscopy screening-every 5 years starting at age 50 - Colonoscopy - every ten years starting at age 50 • Osteoporosis Screening	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Well woman care-including but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	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) Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/.	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**
Well child-care charges for periodic routine 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
• Childhood immunizations recommended by the American Academy of Pediatrics, such as: - Diphtheria-tetanus-pertussis - Diphtheria-tetanus toxoids - Measles, mumps and rubella - Varicella	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**
- Hemophilus influenza B - Tetanus toxoid - Hepatitis B - Prevnar, up to 24 months of age - Meningococcal conjugate vaccine - Diphteria tetanus acellular pertusis - 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 and males between 11 and 27 years of age Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/.Influenza	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	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
• Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk • Breastfeeding support and counseling for each birth Note: See Section 5(a) Durable Medical Equipment for information on obtaining the breast pump.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
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.	

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**High Option**
- 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 Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. - We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5(c)) and Surgery benefits (Section 5(b)).	
Family planning	**High Option**
A range of voluntary family planning services, limited to: • Contraceptive counseling on an annual basis • 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: Nothing 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*

Benefit Description	You pay
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*
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 38 through 42. • Respiratory and inhalation therapy up to a maximum of 20 sessions per year. We may extend coverage for services that exceed the visit limit if we determine the services are medically necessary through the precertification process. • 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. We will only cover GHT when we precertify the treatment. You or your Plan doctor should call 787-774-6081 (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.
Adaptive behavior assessment and treatment for Autism Spectrum Disorder • Behavior identification assessment • Observational and Exposure behavioral follow-up assessment • Adaptive behavior treatment • Group and Family adaptive behavior treatment Note: Covered members must receive care within the network. Services are subject to Triple-S' protocols.	Network: $10 per office visit Out-of-Network: All Charges

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	**High Option**
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: 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. We may extend coverage for services that exceed the visit limit if we determine the services are medically necessary through the precertification process.	$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*
Speech therapy	**High Option**
Speech therapy rendered by certified speech therapist up to 60 therapies per condition. We may extend coverage for therapy that exceeds the limit if we determine the services are medically necessary through the precertification process.	$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 $500 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

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

Benefit Description	You pay
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**
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
• One pair of eyeglasses or contact lenses annually for members up to age 21 from Network providers.	Network: Nothing up to contracted fee. Member pays any balance exceeding contracted fee. Out-of-Network: All charges
Not covered: • *Corrective lenses and fitting of contact lenses* • *Eye exercises and orthoptics* • *Multifocal Intraocular Lens* • *Radial keratotomy and other refractive surgery* • *Supplies*	*All charges*
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*

Benefit Description	You pay
Orthopedic and prosthetic devices	**High Option**
• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Surgically implanted breast implant following mastectomy	Network: Nothing Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
• Internal prosthetic devices (implants), such as artificial joints, pacemakers, and cochlear implants. Prosthetics for lower and upper limbs, and orthotics, up to a maximum of $5,000 in combination, per year • Repair of externally worn prosthetic devices • 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 $500 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: 20% 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: • *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* • *Replacement of certain implants* • *Testing and examinations for hearing aids*	*All charges*
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 type beds • Wheelchairs • Walkers • Blood glucose monitors • Iron lungs • Other respiratory equipment	Network: 20% Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**High Option**
• Ostomy supplies • Tracheostomy supplies • Basic Continuous positive airway pressure device (CPAP) equipment (full face and nasal masks) and supplies • Insulin pumps and/or their supplies for patients with uncontrolled diabetes who require multiple daily injections of insulin and demonstrate wide fluctuations in glucose levels (see note below) • Manual breast pump for mothers who have just given birth, limited to one per birth Note: You must obtain a precertification from us. Refer to Section 3. Call us at 787-774-6081 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. Breast pumps do not require precertification from us but must be obtained from our DME provider. Note: In order to be eligible for the coverage of an insulin pump, you must enroll and participate in our Disease Management Program.	Network: 20% 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: • *Crutches* • *Other durable medical equipment not shown above* • *Supplies for blood glucose monitors, such as: lancets and strips*	*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-network: 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.	Network: Nothing Out-of-Network: Nothing up to our established fee and all charges there after
Alternative treatments	**High Option**
No Benefit	*All charges*
Educational classes and programs	**High Option**
Disease Management 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. **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.	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
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 prescription drugs to control it, signals and symptoms of complications and the importance of medical monitoring of the condition. Our health professionals help patients to know their condition 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. **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

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
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
Obesity Management Program This program includes orientations and education about adopting good dietary habits, choosing healthy foods, reading nutritional labels, and food choices when eating out, among other topics. This program has been developed for enrollees with a body mass index (BMI) of 30.0 kg/m2 and above, who also meet established criteria for participation. When the enrollee takes part in the program, he/she will receive nutritional interventions by a duly certified and trained dietitian-nutritionist. The educational program includes six educational sessions in a group setting, one telephone-based educational intervention, and a monthly coaching. The program's general objective is to offer enrollees access to nutrition education services through a dietitian-nutritionist who will guide them in the self-management of obesity, through dietary-habit modification and the promotion of physical activity. **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 services listed below are for the charges billed by a physician or other health care professional for your surgical care. See 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-participating doctor or provider within the service area, you pay for services rendered and the Plan will reimburse 90% of the Plan's established fee, after any applicable copay or coinsurance. When emergency services are rendered outside the service area, this Plan pays 90% of the usual, customary and reasonable charges of the area where services were rendered or according to the Blue Cross Blue Shield local Plan's fees. When we precertify services that you receive outside the service area, we will pay for covered services according to the 90% of: 1) the usual, customary and reasonable charges of the area where services were rendered; 2) the Blue Cross Blue Shield local Plan's fees; or 3) Triple-S Salud's established fees. The written precertification that we provide to you and the provider will indicate the allowance we will use. When you receive covered services outside the service area that are neither emergency nor precertified, we will reimburse 90% of Triple-S Salud's established fees, after any applicable copay or coinsurance. You are responsible up to the billed charges for these services.
- If you use a non-Plan doctor or provider for precertified 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.

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	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**
• Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. 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.* • *Surgery 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 precertification procedures. • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated 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 precertification 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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (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., Hurler'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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (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 precertification procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (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
Not covered: • *Anesthesia performed for non-covered surgery or procedures*	*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 within the service area, you pay for services rendered and the Plan will reimburse 90% of the Plan's established fee, after any applicable copay or coinsurance. When emergency services are rendered outside the service area, this Plan pays 90% of the usual, customary and reasonable charges of the area where services were rendered or according to the Blue Cross Blue Shield local Plan's fees. When we precertify services that you receive outside the service area, we will pay for covered services according to the 90% of: 1) the usual, customary and reasonable charges of the area where services were rendered; 2) the Blue Cross Blue Shield local Plan's fees; or 3) Triple-S Salud's established fees. The written precertification that we provide to you and the provider will indicate the allowance we will use. When you receive covered services outside the service area that are neither emergency nor precertified, we will reimburse 90% of Triple-S Salud's established fees, after any applicable copay or coinsurance. You are responsible up to the billed charges for these services.
- If you use a non-participating hospital for precertified 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.

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* • *Hospitalization for non-covered surgery or procedures*	*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: Nothing for x-rays, $1.00 per laboratory; 20% for polysomnography, genetic amniocentesis, non-invasive vascular and cardiovascular tests, including electrocardiogram and EEG 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: • *Outpatient hospital or facility charges you incur for a non-covered surgery or procedure*	*All Charges*

Benefit Description	You pay
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 16 through 18.	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*
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 recommendation or a registration number, 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 66 through 68.

Benefit Description	You pay
Emergency within our service area	**High Option**
• Emergency care at a doctor's office	$7.50 per office visit to your general practitioner physician or $10 per office visit to a specialist physician
• Emergency care at a hospital 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.	10% of our allowance Note: When using Non-plan providers, 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 or according to the Blue Cross Blue Shield local Plan's Non-plan providers' fees, after any applicable copay or coinsurance. When using Plan providers, plan will pay to the providers 90% of usual, customary and reasonable charges for the area in which emergency services are rendered or according to the Blue Cross Blue Shield local Plan's fees, after any applicable copay or coinsurance.
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 mental health provider should call 1-800-660-4896 to coordinate services for your treatment plan.** This toll-free telephone number is available 24-hours a day and 7 days a week, to provide you with assistance in obtaining mental and/or substance abuse care.
- If you use a non-participating doctor, hospital, or provider within the service area, you pay for services rendered and the Plan will reimburse 90% of the Plan's established fee, after any applicable copay or coinsurance. When emergency services are rendered outside the service area, this Plan pays 90% of the usual, customary and reasonable charges of the area where services were rendered or according to the Blue Cross Blue Shield local Plan's fees. When we precertify services that you receive outside the service area, we will pay for covered services according to the 90% of: 1) the usual, customary and reasonable charges of the area where services were rendered; 2) the Blue Cross Blue Shield local Plan's fees; or 3) Triple-S Salud's established fees. The written precertification that we provide to you and the provider will indicate the allowance we will use. When you receive covered services outside the service area that are neither emergency nor precertified, we will reimburse 90% of Triple-S Salud's established fees, after any applicable copay or coinsurance. You are responsible up to the billed charges for these services.

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) • 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.

Professional services - continued on next page

Benefit Description	You pay
Professional services (cont.)	**High Option**
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 X-rays and $1.00 per laboratory; 20% 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 not described in this section* *Note: OPM will base its review of disputes about a treatment plan on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*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 53.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We use a managed formulary (List of Drugs) to administer the prescription drug coverage. We exclude certain drugs from the formulary and will not cover them unless we determine they are medically necessary to treat your condition. You are responsible for the full cost of drugs that we determine are not medically necessary.
- A generic drug will be dispensed if it is available.
- In some cases, we require you to try one drug to treat your medical condition before we will cover another drug for that condition. This practice is called step-therapy. Please refer to the specific information below regarding step-therapy.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- 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.

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. We reserve the right to choose those prescription drugs to be included in its Prescription Drug Coverage. Any expense for new prescription drugs will not be covered until said prescription drug is evaluated and recommended for inclusion by our Pharmacy and Therapeutics Committee. In addition, any new prescription drug of an excluded therapeutic classification will also be considered an exclusion.

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 a 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 787-774-6081 (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 non-controlled prescription drugs dispensed within twelve months (with 5 refills) 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 precertification. The List of Drugs identifies the drugs that require precertification 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 (CVS Caremark Specialty Pharmacy or Axium Healthcare Specialty Pharmacy), in order to verify that these drugs are appropriately prescribed and dispensed. To get a list of these drugs call 787-774-6081 (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 difference in cost between the name brand drug and the generic when the brand is not medically necessary. 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 since you pay nothing. 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. Using the most cost-effective medication saves money.

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, Angiotensin receptor blockers (ARBs) for hypertension, Hypnotics, Pain Management drugs, ADHD, Asthma, Diabetes, and Antidepressants.

Specialty Pharmacy Program

Specialty products are medications for the treatment of chronic and high-risk conditions such as Cancer, Rheumatoid Arthritis, Multiple Sclerosis, Hemophilia, Hepatitis C, among others. They require special administration and/or management, given their complex composition. You must fill all specialty medication through two specialty pharmacies, CVS Caremark Specialty Pharmacy or Axium Healthcare Specialty Pharmacy. Once you select your preferred pharmacy, you will receive an evaluation from personnel specialized in the management of chronic conditions in order to identify your specific needs or answer questions you may have regarding your medication. In addition, you will be able to coordinate the delivery of your medications to the location of your choice, you will also have access to pharmacy personnel and the option to order refills or check on their status through a dedicated website for program participants. This personnel will collaborate with your physician in the management of your condition and your drug therapy. For more information call 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 1-800-981-3241 (TTY: 1-866-215-1999) from the United States Virgin Islands.

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 call 1-866-881-6221 (toll free) or 1-605-978-3902.
- **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 787-774-6081 (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 • 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 - $0.00 for unit or refill. • Tier 2: Preferred brand prescription drugs - $20 for unit or refill. • Tier 3: Non-preferred brand name drugs - 20% or $20, whichever is higher, up to $125 maximum out of pocket for unit or refill • Tier 4: Preferred Specialty/biotech drugs - 25% or $200 whichever is the lowest for unit or refill • Tier 5: Non-Preferred Specialty/biotech drugs - 30% or $300 whichever is the lowest for unit or refill Note: If you or your doctor chooses a brand name prescription drug, for which a generic prescription drug exists, you will pay 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.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• Women's contraceptive drugs and devices with a written prescription Note: Over-the-counter contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider.	Network: Nothing
• FDA approved tobacco cessation drugs (over-the-counter and prescription), including nicotine patches	Nothing
• Vitamin D for adults 65 and older Note: Written prescription by an approved provider is required	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Nutrients and food supplements, even if a physician prescribes or administers them, are not covered except as shown as covered* • *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).* • *Hormone therapy for non-approved Federal Food and Drug Administration (FDA) conditions*	*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 - $0.00 for unit or refill • Tier 2: Preferred brand prescription drug - $40 for unit or refill • Tier 3: Non-preferred brand name drugs - 20% or $60, whichever is higher, up to a $375 maximum out of pocket for unit or refill Note: You will not pay shipping charges. Note: Tier 4 and Tier 5 are 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 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: 25% 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 (D0120) • Limited oral evaluation (D0140) • Comprehensive oral evaluation (D0150) • Periapical and bitewing X-rays, limited to six periapical X-rays and no more than two bitewing X-rays per calendar year (D0220, D0230, D0270, D0272) • Preventive Prophylaxis, adult and child limited to one every six months (D1110, D1120)	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 children under 19 (D1208)	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount.
• Fluoride treatment, one every six months for enrollees over 19 years of age (D1208) • Panoramic X-rays, up to 1 set every 3 years (D0330)	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 (D2140 - D2161) • Plastic, porcelain or composite, anterior and posterior tooth (D2330 - D2335, D2391, D2392 - D2394) • Other restorative services, pin retention per tooth in addition to restorations (D2951) • Sedative filling (D2940)	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 (D9910) • Treatment of complications, post-surgical, unusual circumstances, by report (D9930)	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 (D3110) • Pulp capping-indirect, excluding final restoration (D3120) • Pulpal debridement in primary and permanent teeth for emergency purposes (D3221)	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 (D7140) • Surgical removal of erupted teeth (D7210) • Surgical removal of residual tooth roots (D7250) • Incision and drainage of abscess - intra-oral soft tissue (D7510) • Surgical removal of impacted teeth (D7220 - D7240)	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, 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 use 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 members who receive covered emergency or precertified services outside the service area of Triple-S Salud through program plan providers. When services are received outside the area 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 arrangements as an estimate amount equivalent between the local Blue Cross or Blue Shield Plan of the area with its 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 BlueCard Program is available to all members insured with a Blue Cross and Blue Shield Association Plan. When you need emergency or precertified 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 787-774-6081 (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. Remember that you are responsible for paying the applicable copays or coinsurances related to out of area care according to the terms of your coverage.
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.

Feature	Description
Centers of Excellence for transplants/heart surgery/etc.	We offer you the benefit of the Blue Distinction Centers for Transplants (BDCT) which is a cooperative effort among the Blue Cross and/or Blue Shield Plans, Blue Cross and Blue Shield Association and Participating Institutions to facilitate the provision of quality care in a cost-effective manner from leading institutions for six transplant types: heart, single or bilateral lung, combination heart-bilateral lung, liver, simultaneous pancreas-kidney, and bone marrow/stem cell (autologous/allogeneic). Call 1-800-981-4860 or 787-749-4949 extensions 4361 or 4312 for additional information.
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 787-774-6081 (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.
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. Beginning on January 1, 2016, you will receive an Exercise Kit that includes a backpack with a water bottle, pedometer, wrist band, and jump rope once you complete your HRA. **Register today** at our website www.ssspr.com. **Stay active, Stay healthy!**

Feature	Description
Preventive Care Centers	Get your medical checkups in a single visit. You have more obligations every day but less time to accomplish them and healthcare is no exception. The time it takes you to visit the doctor, get routine checkups and manage your existing conditions-in addition to the amount you spend on copays- are obstacles on your path to health. Triple-S Salud brings you the Preventive Care Program. Members 21 years and older may receive all of their preventive services in one place! All around our Island you will find eight Preventive Care Centers located at: Arecibo, Bayamón, Caguas, Canovanas, Carolina, Guaynabo, Mayaguez, Ponce, and San Sebastian. In these facilities you will be able to receive services that include Evaluations, such as: medical history, physical exams, depression screening, high-risk behaviors, and health education; Tests, such as: CBC, cholesterol, Pap (cervical cancer), chlamydia, gonorrhea, syphilis, HIV, glycated hemoglobin, vision; Medical Referrals, such as: Mammograms, vaccines, bone density test, colonoscopy, sigmoidoscopy, and much more. Recommended tests and medical orders are based on clinical guidelines or medical criteria. For additional information please visit us at www.sssspr.com/preventivos/.

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 precertified.

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 precertified. When services are rendered outside the service area and are emergency cases, the Plan's payment is based on usual, customary and reasonable charges of the area where the services were rendered or according to the Blue Cross Blue Shield local Plan's fees. When we precertify services that you receive outside the service area, we will pay for covered services according to: 1) the usual, customary and reasonable charges of the area where services were rendered; 2) the Blue Cross Blue Shield local Plan's fees; or 3) Triple-S Salud's established fees. The written precertification that we provide to you and the provider will indicate the allowance we will use.

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.

When you use a non-participating doctor, hospital, or other provider within the service area, you pay for services rendered and we will reimburse 90% of the Plan's established fee, after any applicable copay or coinsurance. For emergency services rendered outside the service area, we provide 90% of the usual, customary and reasonable charge of the area where the services were rendered or pay according to the Blue Cross Blue Shield local Plan's fees, after any applicable copay or coinsurance. When we precertify services that you receive outside the service area, we will pay for covered services according to: 1) the usual, customary and reasonable charges of the area where services were rendered; 2) the Blue Cross Blue Shield local Plan's fees; or 3) Triple-S Salud's established fees. The written precertification that we provide to you and the provider will indicate the allowance we will use. When you receive covered services outside the service area that are neither emergency nor precertified, we will reimburse 90% of Triple-S Salud's established fees, after any applicable copay or coinsurance. You are responsible up to the billed charges for these services.

For services rendered outside the service area for an emergency or that we have precertified, we provide 90% of the usual, customary and reasonable charge of the area, after any applicable copay or coinsurance. For out of area non-emergency and unauthorized services, you must pay for services rendered and Triple-S Salud will reimburse based on the established fees in Puerto Rico after any applicable copay or coinsurance. You are responsible up to the billed charge for services from providers that are not part of our network.

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 787-774-6081 (TTY: 787-792-1370) or visit the website at www.ssspr.com.

Triple-S Salud Medicare Advantage Plans: Triple-S Medicare Advantage 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 several options. These Plans cover all Medicare Parts A and B benefits and offer other benefits not covered by the Traditional Medicare Plan.

Triple-S Medicare Advantage plans offer you various options that include Plans from $0 to low premium, low copayments 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 choose your doctors and providers. With several of 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, asthma, and chronic heart failure
- Alternative Medicine Coverage
- 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 – services, drugs and supplies we do not 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 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 supplies 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 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 1-800-981-3241 (TTY: 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:
  - Prescription drug name;
  - Daily dosage;
  - Prescription number;
  - Dispensed supply; and
  - National Drug Code (NDC)

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

Triple-S Salud

PO Box 363628

San Juan, PR 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.

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 permitted 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.

Notice Requirements

If you live in a country where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may 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. To make your request, please contact our Customer Service Department by writing Triple-S Salud, Inc. (Triple-S Salud) 1441 Roosevelt Avenue San Juan, Puerto Rico 00920 or calling 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 1-800-982-3241 (TTY: 1-866-215-1999) from the United States Virgin Islands.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

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, Grievances and Appeals Department, 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 decision 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.

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

3

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 file a lawsuit, 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 file a lawsuit 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 787-774-6081 (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 expedite 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.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Worker's Compensation programs if you are receiving Worker's Compensation benefits.

Section 9. Coordinating benefits with Medicare and 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' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at http://www.NAIC.org.

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.

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 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

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

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 or by phone at 1-877-888-3337, (TTY: 1-877-889-5680), 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

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

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.

When you have Medicare

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 69.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. 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. For people with limited income and resources, extra help in paying for a Medicare prescription drug Plan is available. 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).

- **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 787-774-6081 (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 website 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 website 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). However, 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.

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

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

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 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. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 20.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 20.

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.
Network	In-network or network providers are the Doctors, group of doctors, other health professionals, hospitals and other health care facilities that have an agreement with us to accept our payment and any copayment or coinsurance as a full payment. We have made some arrangements with these providers so they can offer services covered by our plan to our enrollees.
Out-of-Network	Doctors, group of doctors, other health professionals, hospitals and other health care facilities who do not have an active contract with Triple-S Salud, Inc. to accept our payment and any copay or coinsurance as a full payment.
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.
Precertification	Advanced authorization from Triple-S Salud for the payment of any of the benefits and coverage under this policy and its riders, in cases Triple-S Salud deems necessary. Some of the objectives of the precertification are: evaluate if the service is medically necessary, evaluate the adequacy of the service location, verify the eligibility of the insured for the requested service, and its availability in Puerto Rico. Precertifications will be evaluated based on the precertifications policies that Triple-S Salud has set forth through time. Triple-S Salud will not be liable for payment of services that have been rendered or received without this authorization from Triple-S Salud.
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.

Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
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 787-774-6081 (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. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

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. Participating employees save an average of about 30% on products and services they 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 $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **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).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plans, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **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 out-of-pocket 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).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent 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 eligible 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. **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 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**
Vision Insurance	All vision Plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or 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/vision and www.opm.gov/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) , visit www.ltcfeds.com.

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

Notes

Notes

Notes

Summary of benefits for the Triple-S Salud Plan - 2016

- **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 the office	Network: $7.50 office visit copay for PCP or $10 specialist; Nothing for X-rays and $1.00 per laboratory Out-of-Network: 10% of our allowance plus any difference between allowance and billed amount	23--24
Services provided by a hospital:		
• Inpatient	Network: Nothing Out-of-Network: 10% of our allowance plus any difference between allowance and billed amount	43
• Outpatient	Network: $25 facility copay for outpatient surgery Out-of-Network: 10% of our allowance plus any difference between allowance and billed charge	44
Emergency benefits:		
• In-area	Emergency room $25; if we recommend the visit $10. Nothing for hospital.	47
• Out-of-area	10% plus all charges that exceed our allowance	47
Mental health and substance abuse treatment	Regular cost-sharing	48--49
Prescription drugs:		
• Retail pharmacy - up to a 30-day supply	• Tier 1: generic prescription drugs, $0.00 for unit or refill. • Tier 2: preferred brand prescription drug, $20 for unit or refill. • Tier 3: non-preferred brand name drugs, 20% or $20, whichever is higher, $125 maximum out of pocket for unit or refill. • Tier 4: Preferred Specialty/biotech drugs, 25% or $200, whichever is the lowest for unit or refill • Tier 5: Non-Preferred Specialty/biotech drugs, 30% or $300, whichever is the lowest for unit or refill	52
• Mail Order and Flex90® Programs - up to a 90-day supply of certain maintenance drugs	• Tier 1: generic prescription drugs, $0.00 for unit or refill • Tier 2: preferred brand prescription drug, $40 for unit or refill • Tier 3: non-preferred brand name drugs, 20% or $60, whichever is higher, $375 maximum out of pocket for unit or refill.	54

Benefits	You Pay	Page
Dental care	Nothing for diagnostic services; 30% all other services.	55--56
Vision care	$10 per office visit	30
Special Features	Flexible benefits option · Teleconsulta· Blue Card Program · Centers of Excellence for transplants · Telexpreso · Medication Therapy Management Program · Total Wellness Program · Health Risk Assessment (HRA) tool	57--59

2016 Rate Information for Triple-S Salud

For 2016 health premium information, please see: http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.