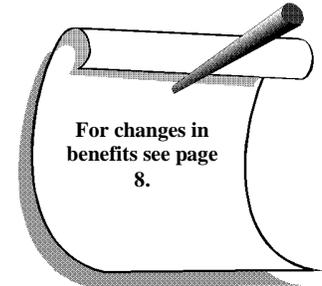




Triple-S
<http://www.ssspr.com>

2003

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



Serving: All of Puerto Rico

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

Enrollment codes for this Plan:

- 891 Self Only**
- 892 Self and Family**

Authorized for distribution by the:



**United States
Office of Personnel Management**
Retirement and Insurance Service
<http://www.opm.gov/insure>



RI 73-016



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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

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

Kay Coles James
Director



Notice of the Office of Personnel Management's Privacy Practices

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Introduction

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

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

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

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

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

Stop Health Care Fraud!

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

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

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

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

Stop Health Care Fraud! (Continued)

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

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

OR WRITE TO:

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

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

Section 1. Facts about this HMO plan

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

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

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

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

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

Our HMO offers Point-of-Service (POS) benefits. This means you can receive covered services from a non-Plan provider within our service area. These out-of-network benefits have higher out-of-pocket costs than our in-network benefits. Out of the service area, we will pay benefits only when the services are due to an emergency or have been preauthorized by us. In general, we will only authorize care, equipment, or professional services out of the service area when they are not available from a Plan provider in the service area.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. When you get services out-of-network, we pay non-Plan providers in Puerto Rico based on the "medical benefits schedule" and we pay non-Plan providers outside of Puerto Rico based on usual, customary, and reasonable charges.

Who provides my health care?

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

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

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

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

Your Rights

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

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

Service Area

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

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits and hospitalization of authorized special cases. Special case means care, equipment or professional services that are not available in our service area. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

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

Section 2. How we change for 2003

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

Program-wide changes

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal premium will increase by 5% for Self Only or 5% for Self and Family.
- We will cover chiropractic services. (Section 5 (a))
- We will cover podiatric services. (Section 5 (a))
- We offer a mail order program for maintenance medications. (Section 5(f))
- We will cover panoramic X-rays for dental services. (Section 5 (h))
- We will cover fluoride treatments for adults over nineteen (19) years. (Section 5 (h))
- We will cover pulpal debridement in primary and permanent teeth for emergency purposes. (Section 5 (h))

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 787-749-4777 or write to us at Triple-S, Inc. (Triple-S), Customer Service Department, 1441 Roosevelt Avenue San Juan, Puerto Rico 00920. You may also request replacement cards through our 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 coinsurance, and you will not have to file claims. You can also get care from non-Plan providers, but it will cost you more.

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our 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 them paying our established fees. Throughout the introductions in Section 5 we explain how we reimburse these services.

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

What you must do to get covered care

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

- **Primary care**

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

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

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

• Specialty care

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

Here are other things you should know about specialty care:

- If you are seeing a specialist and your specialist leaves the Plan, call us. We will provide you a list of specialists within your area. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause; or
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
 - reduce our service area and you enroll in another FEHB Plan,

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

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

• Hospital care

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

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

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

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

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

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

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

Services requiring our prior approval

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

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

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

Section 4. Your costs for covered services

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

- **Copayments**

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

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

- **Coinsurance**

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

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

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

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

- The stated copayments and coinsurances that are required for covered benefits;
- Remaining charges after we reimburse you our established fees for point of service benefits when non-Plan providers are used.
- The 10% you pay of our established fees when you use non-Plan providers in our service area.
- The 10% you pay of the usual, customary and reasonable charge when you use non-Plan providers outside of our service area.
- The 25% you pay of our established fees when you use a non network pharmacy within or outside of our service area.
- The difference between the cost of the brand name prescription drug and the cost of the generic bioequivalent prescription drug, if you choose a brand name prescription drug, for which a generic-bioequivalent prescription drug exists.

Section 5. Benefits -- OVERVIEW

(See page 8 for how our benefits changed this year and page 63 for a benefits summary.)

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

(a) Medical services and supplies provided by physicians and other health care professionals	14-23
•Diagnostic and treatment services	•Speech therapy
•Lab, X-ray, and other diagnostic tests	•Hearing services (testing, treatment and supplies)
•Preventive care, adult	•Vision services (testing, treatment and supplies)
•Preventive care, children	•Foot care
•Maternity care	•Orthopedic and prosthetic devices
•Family planning	•Durable medical equipment (DME)
•Infertility services	•Home health services
•Allergy care	•Chiropractic
•Treatment therapies	•Alternative treatments
•Physical and occupational therapies	•Educational classes and programs
(b) Surgical and anesthesia services provided by physicians and other health care professionals	24-27
•Surgical procedures	•Oral and maxillofacial surgery
•Reconstructive surgery	•Organ/tissue transplants
	•Anesthesia
(c) Services provided by a hospital or other facility, and ambulance services	28-30
•Inpatient hospital	•Extended care benefits/skilled nursing care facility benefits
•Outpatient hospital or ambulatory surgical center	•Hospice
	•Ambulance
(d) Emergency services/accidents	31-33
•Medical emergency	•Ambulance
(e) Mental health and substance abuse benefits	34-35
(f) Prescription drug benefits	36-39
(g) Special features	40-41
• Flexible Benefits Option •24 hours, 7 days a week call center • Blue Card Program • Centers of excellence for transplants/heart surgeries/etc • High risk pregnancies program • Blue Card Worldwide • Mental Health Management Program for Federal Employees • Pharmacare Express Mail Service Prescription Drug Program	
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Section 5 (a) Medical services and supplies provided by physicians and other health care professionals

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

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

Note: We will pay for services provided by a non-Plan provider outside the service area only if the services are for an emergency or if they have been preauthorized. In general, we will only authorize care, equipment, or professional services that are not available from a Plan provider within the service area.

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Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office 	\$ 7.50 per office visit to your general practitioner physician \$10 per office visit to a specialist physician
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center or emergency room • During a hospital stay • In a skilled nursing facility – <i>precertification required (refer to Section 3)</i> • Office medical consultations by specialists 	\$10 per office visit

Diagnostic and treatment services – Continued on next page

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

Preventive Care, adult – Continued on next page

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

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

Infertility services	You Pay
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> — <i>intravaginal insemination (IVI)</i> — <i>intracervical insemination (ICI)</i> — <i>intrauterine insemination (IUI)</i> 	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Infertility services after voluntary sterilization.</i> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> — <i>in vitro fertilization</i> — <i>embryo transfer, gamete GIFT and zygote ZIFT</i> — <i>Zygote transfer</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>Fertility drugs</i> 	<i>All charges</i>
Allergy care	
<p>Testing and treatment</p> <p>Allergy vaccine</p>	\$10 per office visit
<p>Allergy serum</p>	Nothing
<p><i>Not covered: provocative food testing and sublingual allergy desensitization</i></p>	<i>All charges</i>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on pages 26 and 27.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy up to a maximum of 20 sessions per year • Dialysis – hemodialysis and peritoneal dialysis 	\$10 per office visit and/or respiratory therapy session

Treatment therapies – Continued on next page

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

Speech Therapy	You Pay
<ul style="list-style-type: none"> • Speech therapy rendered by certified speech therapist up to two consecutive months per condition. 	<p>\$10 per office visit and/or speech therapy</p> <p><i>For speech therapy you should pay the provider's claim and seek reimbursement from us as we explain in the introduction of Section 5(a).</i></p>
Hearing services (testing, treatment and supplies)	
<ul style="list-style-type: none"> • Hearing testing performed by a Plan physician for adult and children (see <i>Preventive care, children</i>) 	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Hearing aids, testing and examinations for them</i> • <i>Supplies</i> • <i>Timpanometry</i> 	<p><i>All charges</i></p>
Vision services (testing, treatment and supplies)	
<ul style="list-style-type: none"> • In addition to medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (that include the written lens prescription) may be obtained from Plan providers. 	<p>\$10 per office visit</p>
<ul style="list-style-type: none"> • Intraocular lenses during cataract removal 	<p>\$10 per office visit</p>
<ul style="list-style-type: none"> • Eye exam to determine the need for vision correction for children (see preventive care) 	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses, corrective lenses, frames, fitting of contact lenses</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> • <i>Optometrist services</i> • <i>Supplies</i> 	<p><i>All charges</i></p>
Foot care	
<ul style="list-style-type: none"> • Routine foot care performed by a Plan doctor when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. • Podiatric services, up to 4 visits per year (including initial visit, follow-up visits and surgical procedures) 	<p>\$10 per office visit</p> <p>No copayment if podiatrist accepts assignment of benefits; if not, you should pay the provider's claim and seek reimbursement from us</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Treatment of weak, strained or flat feet</i> 	<p><i>All charges</i></p>

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

Durable medical equipment (DME) – Continued on next page

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

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

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

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

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

Note: We will pay for services provided by a non-Plan provider outside the service area only if the services are for an emergency or if they have been preauthorized. In general, we will only authorize care, equipment, or professional services that are not available from a Plan provider within the service area.

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

Surgical procedures -- Continued on next page

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

Reconstructive surgery -- Continued on next page

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

Organ and tissue transplants -- Continued on next page

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

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

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Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- For maximum benefits Plan physicians should provide or arrange your care and you should be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).
- If you use a non-participating hospital in the service area, we will reimburse according to the Plan's established fees, except for hospitalization due to accidental injury or a medical emergency as shown on pages 31 and 32.

Note: We will pay for services provided by a non-participating hospital outside the service area only if it is an emergency or if it is preauthorized. In general, we will authorize out of area hospitalizations only for special cases that require equipment, mode of treatment or specialist care not available in Puerto Rico.

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

Inpatient hospital – Continued on next page

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

Extended care benefits/skilled nursing care facility benefits	
Skilled nursing facility (SNF): Unlimited medically appropriate care, including bed, board and general nursing care; drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor. You or your Plan doctor must obtain authorization from your Plan before Skilled Nursing Facility confinement, as discussed on page 11.	Nothing
<i>Not covered: custodial care, rest cures, domicile or convalescent care.</i>	<i>All charges</i>
Hospice care	
<i>Not covered: Independent nursing, homemaker services, hospice care</i>	<i>All charges</i>
Ambulance	
<ul style="list-style-type: none"> Local professional ambulance service authorized by a Plan doctor when medically appropriate Air ambulance services within the Service Area when rendered by a Plan provider. 	<p><i>You should submit the provider's claim and seek reimbursement from us. We pay all charges. You pay nothing.</i></p> <p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Air ambulance outside of the Service Area.</i> <i>Air ambulance services not rendered by a Plan provider.</i> 	<i>All charges</i>

Section 5 (d). Emergency services/accidents

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

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

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What is a medical emergency?

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

What to do in case of emergency?

Emergencies within our service area:

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

- Benefits are available for care from non-Plan providers in a medical emergency **only** if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.
- When non-Plan providers are used this Plan pays 90% of Plan's established fees for doctor's services and full coverage for other services to the extent the services would have been covered if received from Plan providers.

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.

Section 5 (d). Emergency services/accidents (Continued)

- With your authorization, this Plan will pay benefits directly to non-Plan providers of your emergency care upon receipt of their claims. Non-Plan physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to this Plan along with an explanation of the services and the identification information from your ID card.
- Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with this Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on pages 48 and 49.

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at emergency room and an urgent care center • Emergency care as an inpatient at a hospital, including doctors' services. 	<p>\$10 per office visit</p> <p>\$5; if we recommend the visit, the copayment is waived</p> <p>Nothing</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
Emergency outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	<p><i>You should submit the provider's claim and seek reimbursement from this Plan. Plan reimburses you 90% of usual, customary and reasonable charges for the area in which emergency services are rendered, after any applicable copay or coinsurance. With your authorization, this Plan will pay benefits directly to non-Plan providers of your emergency care upon receipt of their claims.</i></p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>

Emergency outside our service area -- Continued on next page

Ambulance	You pay
<ul style="list-style-type: none"> Local professional ambulance service when medically appropriate. See 5(c) for non-emergency service. 	<p>Nothing.</p> <p><i>You should submit the provider's claim and seek reimbursement from us. We pay all charges.</i></p>
<ul style="list-style-type: none"> Air ambulance services within the Service Area when rendered by a Plan provider 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Air ambulance outside of the Service Area.</i> <i>Air ambulance services not rendered by a Plan provider.</i> 	<p><i>All charges</i></p>

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

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

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

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

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

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

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

Precertification

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

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

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

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

Note: We will pay for services provided by a non-Plan provider outside the service area only if the services are for an emergency or if they have been preauthorized. In general, we will only authorize care, equipment, or professional services that are not available from a Plan provider within the service area.

You must obtain our approval before services are rendered.

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

Section 5 (f). Prescription drug benefits

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

Prescription drug benefits - Continued on next page.

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

	<ul style="list-style-type: none"> • Why use generic drugs? Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs. You can save money by using generic drugs. However, you and your plan physician have the option to request a name brand if a generic option is available. Using the most cost-effective medication saves money. • When you have to file a claim. You must file a claim whenever you use a non-network pharmacy. The Plan reimburses 75% of its established fees for prescription drugs and you pay the remaining charges. Submit your itemized bill and/or receipts to us. Also read Section 7 <i>Filing a claim for covered services</i> for required information.
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Benefit Description	You pay
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician or dentist and obtained from a Plan pharmacy:</p> <p>We will cover prescription drugs based on a formulary. You will pay the brand name copay and the difference between the cost of the brand name prescription drug and the cost of the generic bioequivalent prescription drug, if you choose a brand name prescription drug, for which a generic bioequivalent prescription drug is available, unless your physician has specified Dispense as Written. Covered prescription drugs and accessories include:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Disposable needles and syringes for the administration of covered medications • Contraceptive drugs and devices • Drugs for sexual dysfunction • Vitamins only if they include the legend: “Federal law prohibits dispensing without a prescription” • Smoking cessation drugs, including nicotine patches <p>Note: Intravenous fluids and drugs for home use, implantable drugs, and some injectable drugs are covered under the Medical and Surgical Benefits (also covered under the Medical and Surgical Benefits provided as part of a home health service program).</p>	<p>You will pay the following in-formulary copayments:</p> <ul style="list-style-type: none"> • \$2 for bioequivalent prescription drug unit or refill • \$5 for preferred brand prescription drug unit or refill • \$10 for brand name unit or refill. <p>Note: If you choose a brand name prescription drug, for which a generic bioequivalent prescription drug exists, you will pay the brand name copay and the difference between the cost of the brand name prescription drug and the cost of the generic bioequivalent prescription drug, unless your physician has specified Dispense as Written.</p> <p>You will pay the following out of the formulary copayment:</p> <ul style="list-style-type: none"> • \$2 for bioequivalent prescription drug unit or refill. • 20% or \$10, whichever is higher, for out of formulary brand name prescription drug unit or refill.

Covered medications and supplies - Continued on next page

Covered medications and supplies <i>(Continued)</i>	You Pay
	<p>Note: If a generic bioequivalent does not exist, you will still have to pay the brand name copay.</p> <p>Note: If you choose a brand name prescription drug out of the formulary, for which a generic bioequivalent prescription drug exists, you will pay the brand name copay and the difference between the cost of the brand name prescription drug and the cost of the generic bioequivalent prescription drug, unless your physician has specified Dispense as Written.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Drugs available without a prescription or for which there is a nonprescription equivalent available</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs supplied by pharmacies located outside of Puerto Rico, the United States and its territories, except for emergencies</i> • <i>Drugs for treatment of infertility</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs that are experimental or investigational unless approved by the Federal Drug Administration (FDA)</i> 	<p><i>All Charges</i></p>
Mail Order Program	
<p>The program has the following characteristics:</p> <ul style="list-style-type: none"> • 90-day supply, including one (1) refill <p>Note: This program is only for maintenance medications. The exclusions and limitations mentioned above apply to this program. Please refer to Section 7 for instructions on how to use Pharmacare Express Mail Service Prescription Drug Program.</p>	<p>You will pay the following in-formulary copayments for the 90-day supply:</p> <ul style="list-style-type: none"> • \$4 for bioequivalent prescription drug • \$10 for preferred brand prescription drug • \$20 for brand name <p>Note: You will not pay shipping charges.</p>

Mail Order Program - Continued on next page

Mail Order Program (Continued)	You Pay
	<p>Note: If you choose a brand name prescription drug out of the formulary, for which a generic bioequivalent prescription drug exists, you will pay the brand name copay and the difference between the cost of the brand name prescription drug and the cost of the generic bioequivalent prescription drug, unless your physician has specified Dispense as Written.</p> <p>You will pay the following out of the formulary copayment for the 90-day supply:</p> <ul style="list-style-type: none"> • \$4 for bioequivalent prescription drug • 20% or \$20, whichever is higher, for out of formulary brand name prescription drug <p>Note: You will not pay shipping charges.</p> <p>Note: If you choose a brand name prescription drug out of the formulary, for which a generic bioequivalent prescription drug exists, you will pay the brand name copay and the difference between the cost of the brand name prescription drug and the cost of the generic bioequivalent prescription drug, unless your physician has specified Dispense as Written.</p>

Section 5 (g). Special Features

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

Special Features - Continued on next page

Section 5 (g). Special Features (Continued)

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

Section 5 (h). Dental benefits

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

If a non-Plan dentist is used, you pay a 30% coinsurance and any remaining difference between this Plan's payment of 90% of its established fee and the actual charge for services rendered in Puerto Rico. For care outside of Puerto Rico, the member will pay the 30% coinsurance and any remaining difference between 100% of this Plan's payment established fee and the actual charge. The following list shows the dental services covered by this Plan.

Note: We will pay for services provided by a non-Plan provider outside the service area only if the services are for an emergency or if they have been preauthorized. In general, we will only authorize care, equipment, or professional services that are not available from a Plan provider within the service area.

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

<p>Dental coverage is limited to:</p> <p>Diagnostic</p> <ul style="list-style-type: none"> • Periodic oral evaluation • Limited oral evaluation • Comprehensive oral evaluation • Periapical and bitewing X-rays (limited to six periapical X-rays and no more than two bitewing X-rays per calendar year) • Preventive Prophylaxis (adult and child) 	Nothing
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Dental benefits -- Continued on next page

Dental benefits (<i>Continued</i>)	You pay
Diagnostic (Continued): <ul style="list-style-type: none"> • Panoramic X-rays, up to 1 set every 3 years • Fluoride treatment, one every six month. 	30%
Restorative <ul style="list-style-type: none"> • Amalgam restorations • Plastic, porcelain or composite (anterior and posterior tooth) • Other restorative services (pin retention per tooth, in addition to restorations) • Sedative filling 	30%
Adjunctive General Services <ul style="list-style-type: none"> • Application of desensitizing medicament • Gingival curettage, surgical (emergency treatment), for one or two teeth in the same quadrant • Treatment of complications (post-surgical-unusual circumstances, by report) 	30%
Endodontics <ul style="list-style-type: none"> • Pulp capping-direct (excluding final restoration) • Pulp capping-indirect (excluding final restoration) • Pulpal debridement in primary and permanent teeth for emergency purposes 	30%
Oral Surgery <ul style="list-style-type: none"> • Extractions • Surgical removal of erupted teeth • Surgical removal of residual tooth roots • Incision and drainage of abscess - intra-oral soft tissue • Surgical removal of impacted teeth 	30%
<i>Not covered: Other dental services not shown as covered.</i>	<i>All charges</i>

Section 5 (i). Point of service benefits

Facts about this Plan's POS option

At your option, within our service area (Puerto Rico) you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care, except for the benefits listed below under "What is not covered." Outside of our service area, only emergency care or care that has been preauthorized will be covered under the POS option. In general, we will only authorize coverage outside of our service area for care, equipment, or professional services that are not available from a Plan provider.

Point of Service (POS) Benefits

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

You can also receive services from a non-Plan hospital within our service area. A non-Plan hospital is any licensed institution that is not a Plan hospital and that is engaged primarily in providing bed patient with diagnosis and treatment under the supervision of physicians with 24-hour-a-day registered graduate nursing services. A non-Plan hospital does not have to accept Triple-S established fees as payment in full. You must pay any difference between the non-Plan hospital's charges and the amount paid to you by us. We reimburse you according to our established fee for non-Plan hospital inpatient admissions.

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. When services are rendered outside the service area, the Plan's payment is based on usual, customary and reasonable charges.

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

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

What is covered

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

Precertification

Read Section 3 for services requiring our prior approval.

What is not covered

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

Care, equipment or professional services provided out of our service area, unless they are precertified or are for an emergency.

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness or condition and we agree, as discussed under *What Services Require Our Prior Approval* on page 11.**

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

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

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

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

Submit your claims to:

Triple-S

P.O. Box 363628

San Juan, Puerto Rico 00936-3628

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

Deadline for filing your claim

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

When we need more information

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

Mail Service Prescription Drug Program

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

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

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

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

Section 8. The disputed claims process

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

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

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

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

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

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

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

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

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

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

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

Section 9. Coordinating benefits with other coverage

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

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

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

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

•What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

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

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

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

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

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

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

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

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

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

(Primary payer chart begins on next page.)

Section 9. Coordinating benefits with other coverage (Continued)

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

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and ...	Then the primary payer is...	
	Original Medicare	This Plan
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when...		
a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB (Ask your employing office which of these applies to you.)		✓
4) 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),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and...		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and...		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or	✓	
b) Are an active employee, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

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

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

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

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

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

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

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE and CHAMPVA

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

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Assignment of Benefits	A provision in a health benefits claim form by which the insured directs the insurance company to pay any benefits directly to the provider of care on whose charge the claim is based.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	<p>Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. Custodial care that lasts 90 days or more is sometimes known as Long term care. These activities include but are not limited to:</p> <ul style="list-style-type: none">• personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;• homemaking, such as preparing meals or special diets;• moving the patient;• acting as a companion or sitter;• supervising medication that can usually be self-administered; or• treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.
Experimental or investigational services	<p>This Plan considers factors which it determines to be most relevant under the circumstances, such as: published reports and articles in the authoritative medical, scientific, and peer review literature; or written protocols used by the treating facility or being used by another facility studying substantially the same drug, device, or medical treatment. This Plan also considers Federal and other governmental agency approval as essential to the treatment of an injury or illness by, but not limited to, the following: American Medical Association, U.S. Surgeon General, U.S. Department of Public Health, the Food and Drug Administration, or the National Institutes of Health.</p>

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

Medically necessary

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

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

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

Plan allowance

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

Us/We

Us and we refer to Triple-S.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

Section 11. FEHB facts (*Continued*)

Children's Equity Act

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

- Your enrollment ends, unless you cancel your enrollment, or

Section 11. FEHB facts (*Continued*)

- **When FEHB coverage ends** (Continued)

- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

- **Spouse equity coverage**

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

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

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

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

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

- **Converting to individual coverage**

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

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

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

Section 11. FEHB facts (*Continued*)

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

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

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

Long Term Care Insurance Is Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But...

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337)** (TDD for the hearing impaired: **1-800-843-3557**) or visiting www.ltcfeds.com to get more information and to request an application.

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

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Summary of benefits for the Triple-S Plan – 2003

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

Benefits	You Pay	Page
Medical services provided by physicians: <ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office..... 	Office visit copay:\$7.50 general practitioner; \$10 specialist, 25% for laboratory and diagnostic tests; nothing for X-rays.	14
Services provided by a hospital: <ul style="list-style-type: none"> • Inpatient..... • Outpatient..... 	Nothing Nothing	28 29
Emergency benefits: <ul style="list-style-type: none"> • In-area • Out-of-area 	Emergency room \$5; waived if precertified. Nothing for hospital. 10%	31-33
Mental health and substance abuse treatment.....	Regular benefits	34
Prescription drugs	In-formulary: \$2 for bioequivalent prescription drug unit or refill; \$5 for preferred brand prescription drug unit or refill; and \$10 for brand name unit or refill. Out of the formulary: \$2 for bioequivalent prescription drug unit or refill; 20% or \$10, whichever is higher, for out of formulary brand prescription drug unit or refill.	36
Dental Care	Nothing for diagnostic services; 30% all other services.	42
Vision Care	\$10 per office visit	20
Special features: • Flexible benefits option • 24 hours, 7 days a week call center • Blue Card Program • Centers of excellence for transplants/heart surgeries/etc • High risk pregnancies program • Blue Card Worldwide • Mental Health Management Program for Federal Employees • Pharmacare Express Mail Service Prescription Drug Program		40
Point of Service benefits -- Yes		35, 44

2003 Rate Information for Triple-S, Inc.

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

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

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

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Standard Option Self Only	891	\$71.78	\$23.92	\$155.51	\$51.84	\$84.93	\$10.77
Standard Option Self and Family	892	\$154.16	\$51.39	\$334.02	\$111.34	\$182.43	\$23.12