Triple-S

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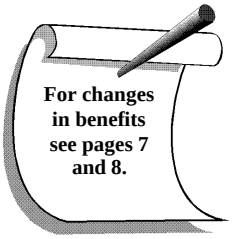
2001

A Health Maintenance Organization with a point of service product



Serving: All of Puerto Rico

Enrollment in this Plan is limited; see page 6 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

Federal Employees
Health Benefits Program

RI 73-016

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Introduction

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

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. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. 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 for 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, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on pages 7 and 8. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means Triple-S.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We encourage you to see those physicians, hospitals, and other providers that contract with us. These Plan providers can help you coordinate your health care services. 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 a 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 ususal, 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 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. The medical benefits schedule applies to Puerto Rico. When services are rendered outside the area this Plan pays usual, customary and reasonable charges.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. 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 FEDINFO@ssspr.com.

Service Area

To enroll with us, you must live or work 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. We will pay only for emergency care and hospitalization of authorized special cases if you receive care outside our service area. Special cases means care, equipment or professional services that are not available in our service area. We will not pay for any other health care services.

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 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling 787-749-4777, or checking our website http://www.ssspr.com . You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:

  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.

  This Plan will evaluate the patient safety initiatives to ensure you better health care. Our safety programs include:

  - Drug interaction program
  - Dose check program
  - Medication alerts to physicians and dentists by means of a monthly publication (Pharma News)
  - Disease management program for asthma
  - 24 hours x 7 days call center for Triage
  - Managed care model for mental health and substance abuse. We provide:
    - concurrent review
    - discharge planning
    - case management
    - disease management for depression
    - 24 hours x 7 days call center
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-Postal premium will increase by 7% for Self Only or 7% for Self and Family.
- We will cover prescription drugs based on a formulary. 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.

  You will pay the following in-formulary copayments:

  - $2 for generic bioequivalent prescription drug unit or refill;
  - $5 for preferred brand prescription drug unit or refill;
  - $10 for brand name unit or refill.

  You will pay 20% or $10, whichever is higher, for out of formulary prescription drug unit or refill.

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.

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.

What you must do

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

· Specialty care

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

Here are other things you should know about specialty care:

- If you are seeing a specialist and your specialist leaves the Plan, call us. We will provide you a list of specialists within your area. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

- terminate our contract with your specialist for other than cause; or
- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
- reduce our service area and you enroll in another FEHB Plan,

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

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

· Hospital care

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

If you are 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.

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. You or your Plan doctor must obtain our approval before sending you to a hospital. 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. But you or your Plan doctor must obtain authorization from this Plan before:

- Services outside the Service Area, except emergencies;
- Rental and purchase of durable medical equipment;
- Skilled Nursing Facility;
- Organ and tissue transplants;
- Genetic amniocentesis;
- CT Scans (including SPECT);
- Hepatobiliary ductal system imaging (HIDA);
- Magnetic resonance (MRI, MRA);
- Lithotripsy;
- Polysomnography;
- Speech and occupational therapy;
- All hospital admissions;
- Mandibular osteotomy;
- Mammoplasty;
- Mental health and substance abuse services 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 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 out-of-pocket maximum

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

- The stated copayments which 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; 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 exist.
- 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.

Section 5. Benefits -- OVERVIEW

(See pages 7and 8 for how our benefits changed this year and page 62 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.

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

IMPORTANT

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.
- Plan physicians must provide or arrange your care.
- 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 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 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.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • 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 • In an urgent care center or emergency room • During a hospital stay • In a skilled nursing facility – *precertification required (refer to Section 3)* • Initial examination of a newborn child covered under a family enrollment • Office medical consultations	$10 per office visit

Diagnostic and treatment services – Continued on next page

Diagnostic and treatment services *(Continued)*	**You pay**
• Second surgical opinion	Nothing
• Vaccines for pediatric and adult immunizations	$10 per office visit. Nothing for vaccines for pediatric and adult immunizations.
At home	$15 per physician visit. Nothing for nurse and health aids visit
Not covered: • *Private nursing care, except for treatment of mental illness*	*All charges*
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/Magnetic resonance (MRI, MRA) – *precertification required (refer to Section 3)* • Hepatobiliary ductal system imaging (HIDA) – *precertification required (refer to Section 3)* • Polysomnography – *precertification required (refer to Section 3)* • Genetic amniocentesis- *precertification required (refer to Section 3)* • Ultrasound • Non-invasive vascular and cardiovascular tests	25%. Nothing for X-rays.

Preventive care, adult	You pay
Routine screenings, such as: • Blood lead level • Total Blood Cholesterol • Colorectal Cancer Screening, including ••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.
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: • From age 35 through 39, one during this five year period • From age 40 through 64, one every one or two years • At age 65 and older, one every two consecutive calendar years	$10 per office visit. Nothing for X-ray.
Routine Immunizations, limited to: • 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	
• Childhood immunizations recommended by the American Academy of Pediatrics, such as • Diphtheria-tetanus-pertussis (Dtp) • Diphtheria-tetanus toxoids (Dt) • Measles, mumps and rubella (Mmr) • Varicella and varivax • Hemophilus influenza B	$10 per office visit. Nothing per vaccine or immunization.

Preventive care, children *(Continued)*	**You pay**
• Influenza • Tetanus toxoid • Hepatitis B	$10 per office visit. Nothing per vaccine or immunization.
• Examinations, such as: ••Eye exams to determine the need for vision correction. ••Ear exams to determine the need for hearing correction ••Examinations done on the day of immunizations • Well-child care charges for routine examinations, immunizations and care	$10 per office visit. Nothing per vaccine or immunization
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: ••You do not need to precertify your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby. ••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. Be sure to tell the hospital personnel that you are a Plan member so they can notify us. You or a family member should notify us within 48 hours unless it was not reasonably possible to notify us within that time. It is your responsibility to ensure that we had been timely notified. ••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. ••We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*

Family planning	You pay
• Voluntary sterilization • Surgically implanted contraceptives • Intrauterine devices (IUDs)	$10 per office visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling	*All charges*
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: ••*intravaginal insemination (IVI)* ••*intracervical insemination (ICI)* ••*intrauterine insemination (IUI)*	$10 per office visit
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* ••*in vitro fertilization* ••*embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Fertility drugs*	*All charges*
Allergy care	
Testing and treatment	$10 per office visit
Allergy vaccine	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on pages 26 and 27. • Respiratory and inhalation therapy up to a maximum of 20 sessions per year • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: – 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 *Services requiring our prior approval* in Section 3.	$10 per office visit and/or respiratory therapy session
Not covered: Services not shown as covered	*All charges*
Rehabilitative therapies	
Physical, occupational and speech therapy -- 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: • Physical therapy •• rendered by qualified physical therapists supervised by a physician specialized in physical therapy; • Occupational and speech therapy (precertification required. Refer to Section 3). •• rendered by certified speech therapists; and •• rendered by certified occupational therapists. Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.	$10 per office visit and/or physical therapy *For speech and occupational therapy you should pay the provider's claim and seek reimbursement from us.*

Rehabilitative therapies -- Continued on next page

Rehabilitative therapies *(Continued)*	**You pay**
Not covered: • *long-term rehabilitative therapy* • *exercise programs* • *cardiac rehabilitation*	*All charges*
Hearing services (testing and treatment)	
• Hearing testing performed by a Plan physician for adult and children (see *Preventive care, children*)	$10 per office visit
Not covered: • *hearing aids, testing and examinations for them* • *Timpanometry*	*All charges*
Vision services (testing and treatment)	
• 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.	$10 per office visit
• Lenses following cataract removal	$10 per office visit
• Eye exam to determine the need for vision correction for children (see preventive care)	$10 per office visit
Not covered: • *Eyeglasses or contact lenses, corrective lenses, frames, fitting of contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Optometrist services*	*All charges*
Foot care	
Routine foot care performed by a Plan doctor when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$10 per office visit

Foot care -- Continued on next page

Foot care *(Continued)*	**You pay**
Not covered: • *Treatment of weak, strained or flat feet* • *podiatric services*	*All charges*
Orthopedic and prosthetic devices	
• 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.	Nothing if provided by a Plan doctor or provider *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.*
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *artificial limbs and eyes; stump hose*	*All charges*

Durable medical equipment (DME)	You pay
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: • hospital type beds; • Non motorized wheel chairs • iron lungs; • oxygen equipment; and • other respiratory equipment 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.	$10 per office visit
Not covered: • *Motorized wheel chairs* • *Crutches* • *Walkers* • *Blood glucose monitors* • *Insulin pumps* • *Other durable medical equipment not shown above.*	*All charges*
Home health services	
• 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 aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.* • *homemaker services*	*All charges*

Alternative treatments	You pay
Not covered: • *chiropractic services* • *naturopathic services* • *hypnotherapy* • *biofeedback* • *osteopathic services* • *acupuncture* • *podiatric services*	*All charges*
Educational classes and programs	
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. • Asthma program – Addressed to enhance the quality of life of the asthmatic insured by teaching them self health care and illness management. • Pregnancy educational program – Provides education about pregnancy during prenatal, delivery and postnatal stages. Emphasizes risk factors that every women 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. They also provide counseling from health educators within the workplace. Individual education also includes the distribution of written literature.	Nothing

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

IMPORTANT

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.
- Plan physicians must provide or arrange your care.
- 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.

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.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information. • Lithotripsy procedure.	Nothing For insertion of internal prosthetic devices member pays nothing if provided by a Plan doctor or provider. *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.*

Surgical procedures -- Continued on next page

Surgical procedures *(Continued)*	**You pay**
• Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5 (a). • Treatment of burns 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.	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Surgical assistance*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: ••the condition produced a major effect on the member's appearance and ••the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) 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.	Nothing

Reconstructive surgery -- Continued on next page

Reconstructive surgery *(Continued)*	**You pay**
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, *performed only when medically necessary* limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas	Nothing

Organ and tissue transplants -- Continued on next page

Organ/tissue transplants *(Continued)*	**You pay**
• Liver • Lung: Single –Double • 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. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Ambulatory surgical center	Nothing

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

IMPORTANT

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.
- Plan physicians must provide or arrange your care and you must 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).
- **YOU OR YOUR PLAN DOCTOR MUST GET A PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.
- If you use a non-participating hospital, this Plan will reimburse $60 per day, except for hospitalization due to accidental injury or a medical emergency as shown on page 31.

Note: We will pay for services provided by a non-participating hospital outside the service area only 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.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing per inpatient admission to a Plan hospital. *Plan reimburses you up to $60 daily for an inpatient admission to a non-Plan hospital in the service area. You pay all charges over the $60 per day.*

Inpatient hospital -- Continued on next page

Inpatient hospital *(Continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • 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 • 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.	Nothing
Not covered: blood and blood derivatives not replaced by the member.	*All charges*

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 pages 10 and 11.	Nothing
Not covered: custodial care, rest cures, domicile or convalescent care.	*All charges*
Hospice care	
Not covered: Independent nursing, homemaker services, hospice care	*All charges*
Ambulance	
• Local professional ambulance service authorized by a Plan doctor when medically appropriate	*You should submit the provider's claim and seek reimbursement from us. We pay all charges. You pay nothing.*
• Air ambulance services within the Service Area will be rendered by a Plan provider.	Nothing
Not covered: Air ambulance outside of the Service Area.	*All charges*

Section 5 (d). Emergency services/accidents

IMPORTANT	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. • 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.	IMPORTANT

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 advise 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 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.

- Be sure to tell the emergency room personnel that you are a Plan member so they can notify this Plan. You or a family member should notify this Plan within 48 hours unless it was not reasonably possible to notify this Plan within that time. It is your responsibility to ensure that this Plan has been timely notified.

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

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

- 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.

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 page 47.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at emergency room and an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services.	$10 per office visit $5; if we precertify, the copayment is waived Nothing
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
• 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	*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. With your authorization, this Plan will pay benefits directly to non-Plan providers of your emergency care upon receipt of their claims.*
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*

Emergency outside our service area -- Continued on next page

Ambulance	You pay
• Local professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	*You should submit the provider's claim and seek reimbursement from us.*
• Air ambulance services within the Service Area will be rendered by a Plan provider	Nothing
Not covered: Air ambulance service outside of the Service Area	*All charges*

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

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- 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 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 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 Mental Parity Act by visiting our website at http://www.ssspr.com.

Benefit Description	You pay
Mental health and substance abuse benefits	
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. 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.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• 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
• Diagnostic tests	25% laboratory and diagnostic tests. Nothing for X-rays. See Lab, X-ray and other diagnostic tests (Section 5a).

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

Mental health and substance abuse benefits *(Continued)*	**You pay**
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about a treatment plan on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Precertification

To be eligible to receive these benefits you must follow your treatment plan and the following authorization process:

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

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause, or

- If changes to this plan's benefit structure for 2001 cause your out-of-pocket costs for your out-of-network provider to be greater than they were in contract year 2000.

If these conditions apply to you, we will allow you reasonable time to transfer your care to a network mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1, 2001, and this transitional benefit does not apply.

Limitation

We may limit your benefits if you do not follow your treatment plan.

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

Description	You pay
POS mental health and substance abuse benefits	
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 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 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.	
Special nursing care for each 8-hour period not to exceed 72 consecutive hours, when ordered by the attending psychiatrist.	*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.*
Psychological tests if performed by a qualified psychologist.	*Plan reimburses you up to $35 for a full battery of tests. You pay the remaining charges.*
Not covered: POS services we have not approved, half-way home, residential treatment and services related to a drug detection and rehabilitation program.	*All charges*

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- 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, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- If you use a non-Plan pharmacy, this Plan will reimburse you 75% of this Plan's established fees for prescription drugs and you pay all remaining charges.

IMPORTANT

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

- **Who can write your prescription.** A licensed physician or dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a network pharmacy or a non-network pharmacy. We pay a higher level of benefits when you use a network pharmacy.
- **We use a 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.

  Benefits are provided to the member and member's direct dependents who have this coverage, for medications included in the formulary when prescribed by a doctor or a dentist; after applicable copays are paid.
- **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.

  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.

  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.

  The member 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 he/she chooses a brand name prescription drug, for which a generic bioequivalent prescription drug exist. If a generic bioequivalent does not exist, you still have to pay the brand copay.
- **When you have to file a claim.**

  You must file a claim whenever you use a non-network pharmacy. Plan reimburses 75% of its established fees for prescription drugs and you pay the remaining charges. Submit your itemized bill and/or receipts to us. Also read Section 7 *Filing a claim for covered services* for required information.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician or dentist and obtained from a Plan pharmacy: 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 exists. Covered prescription drugs and accessories include: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Insulin • Disposable needles and syringes for the administration of covered medications • Contraceptive drugs and devices • Vitamins only if they include the legend: "Federal law prohibits dispensing without a prescription" • Smoking cessation drugs, including nicotine patches • 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). Here are some things to keep in mind about our prescription drug program: • A generic bioequivalent will be dispensed if it exists, 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. • 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 brochure, call 787-749-4777.	You will pay the following in-formulary copayments: • $2 for bioequivalent prescription drug unit or refill • $5 for preferred brand prescription drug unit or refill • $10 for brand name unit or refill. 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. You will pay the following out of the formulary copayment: • 20% or $10, whichever is higher, for out of formulary prescription drug unit or refill. Note: If a generic bioequivalent does not exist, you will still have to pay the brand name copay.

Prescription drugs benefits -- Continued on next page

Covered medications and supplies *(Continued)*	**You pay**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Nutrients and food supplements even if a physician prescribes or administers them* • *Drugs available without a prescription or for which there is a nonprescription equivalent available* • *Medical supplies such as dressings and antiseptics* • *Drugs supplied by pharmacies located outside of Puerto Rico, the United States and its territories* • *Medication for treatment of infertility or impotence* • *Drugs to enhance athletic performance* • *Drugs that are experimental or investigational unless approved by the Federal Drug Administration (FDA)* • *New drugs not approved by the plan's Pharmacy and Therapeutic Committee*	*All Charges*

Section 5 (g). Special Features

Feature	Description
24 hours, 7 days a week call center	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.
Blue Card Program	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.
Centers of excellence for transplants/heart surgery/etc	We offer you the benefit of the Blue Quality Centers for Transplant 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 of 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).
High risk pregnancies	Our pregnancy educational program provides education about pregnancy during prenatal, delivery and postnatal stages. Emphasizes risk factors that every women should know to have a healthy delivery and to avoid complications.
Blue Card Worldwide	Blue Card Worldwide is available to all members insured with a Blue Cross and Blue Shield Association Plan. When you need emergency hospital and medical services out of the service area or 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.

Section 5 (h). Dental benefits

IMPORTANT

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.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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.

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.

Dental coverage is limited to: Diagnostic • Periodic oral evaluation • Limited oral evaluation • Comprehensive oral evaluation • Periapical and bitewing X-rays (limited to six periapical X-rays and no more than two bitewing X-rays per calendar year) • Preventive Prophylaxis (adult and child) • Fluoride treatment, one every six month. Fluoride treatment is limited to members under 19 years of age.	Nothing

Dental benefits -- Continued on next page

Dental benefits	You pay
Restorative • 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 • 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 • Pulp capping-direct (excluding final restoration) • Pulp capping-indirect (excluding final restoration)	30%
Oral Surgery • Extractions • Surgical removal of erupted tooth • Surgical removal of residual tooth roots • Incision and drainage of abscess - intra-oral soft tissue • Surgical removal of impacted tooth	30%
Not covered: Other dental services not shown as covered.	*All charges*

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 up to $60 daily 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. The medical benefits schedule applies to 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 fee 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 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. 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 Section 5 of this brochure.

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 10.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits) outside our service area or eligible self-referred services (POS benefits) within our service area;
- 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; or
- Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.

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 out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to:

Triple-S

P.O. Box 363628

San Juan, Puerto Rico 00936-3628

Deadline for filing your claim

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

When we need more information

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

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	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Triple-S, P.O. Box 363628, San Juan, Puerto Rico 00936-3628; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, D.C. 20044-0436. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must provide 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.

6 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. 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 can call OPM's Health Benefits Contracts Division II 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 are covered or a family member is covered under another group health plan or have automobile insurance that pays medical 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.
- Part B (Medical Insurance). Most people pay monthly for Part B.

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

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

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

(Primary payer chart begins on next page.)

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

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

Primary Payer Chart		
A. When 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……	…….✓	
b) Are an active employee……	……..	……✓

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

- 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 pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 787-749-4777.

We waive some costs when you have Medicare -- When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows: If you are enrolled in Medicare Part A and Part B we will waive copays and coinsurance.

· 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 cover all Medicare Part A and B benefits. 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.

Suspended FEHB coverage and 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+Choice service area.

· Enrollment in Medicare Part B

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease 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 benefits. You must use our providers. If medical benefits provided under such law are exhausted, we will be financially responsible for services or supplies that are otherwise covered by us. We are entitled to be reimbursed by OWCP for services we provided that were later found to be payable by OWCP.

Medicaid

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

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

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.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include but are not limited to:

- personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;
- homemaking, such as preparing meals or special diets;
- moving the patient;
- acting as a companion or sitter;
- supervising medication that can usually be self-administered; or
- treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

Experimental or investigational services

This Plan considers factors which it determines to be most relevant under the circumstances, such as: published reports and articles in the authoritative medical, scientific, and peer review literature; or written protocols used by the treating facility or being used by another facility studying substantially the same drug, device, or medical treatment. This Plan also considers Federal and other governmental agency approval as essential to the treatment of an injury or illness by, but not limited to, the following: American Medical Association, U.S. Surgeon General, U.S. Department of Public Health, the Food and Drug Administration, or the National Institutes of Health.

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. 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:

- 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.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

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

When you lose benefits

When FEHB coverage ends

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

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

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. But, you may be eligible for your own FEHB coverage under the spouse equity law. 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.

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.

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

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.

Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital 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.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for a person who is not an eligible family member, or are no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Department of Defense/FEHB Demonstration Project

What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 open season for the year 2000. Open season enrollments will be effective January 1, 2001. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

DoD determines who is eligible to enroll in the FEHB Program. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

The demonstration areas

- Dover AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA

When you can join

You may enroll under the FEHB/DoD Demonstration Project during the 2000 open season, November 13, 2000, through December 11, 2000. Your coverage will begin January 1, 2001. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877/DOD-FEHB (1-877/363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during the 2000 and 2001 open seasons. Your coverage will begin January 1 of the year following the open season during which you enrolled.

If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2001 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

TCC eligibility

See Section 11, FEHB Facts; it explains temporary continuation of coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

Other features

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

Summary of benefits for the Triple-S Plan – 2001

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office.....	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: • Inpatient..... • Outpatient.....	 Nothing Nothing	 28 29
Emergency benefits: • 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: 20% or $10, whichever is higher, for out of formulary prescription drug unit or refill.	37
Dental Care.....	Nothing for diagnostic services; 30% all other services.	41
Vision Care.....	$10 per office visit	20
Special features: • 24 hours, 7 days a week call center • Blue Card Program • Center of excellence for transplants/heart surgeries/etc • High risk pregnancies • Blue Card Worldwide		40
Point of Service benefits -- Yes		36, 43

2001 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 special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and 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. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
All of Puerto Rico							
Self Only	891	$68.36	$22.79	$148.12	$49.37	$80.90	$10.25
Self and Family	892	$146.82	$48.94	$318.11	$106.04	$173.74	$22.02