Triple-S 2000

A Health Maintenance Organization with a Point of Service Product

Serving: All of Puerto Rico
Enrollment in this Plan is limited: see page 23 for requirements

Enrollment code:

891 Self only
892 Self and Family

Visit the OPM website at http://www.opm.gov.insure
and
this Plan's website at http://www.ssspr.com

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United States
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Introduction

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

This brochure describes the benefits you can receive from Triple-S under its contract (CS1090) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 5. Premiums are listed 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. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to Triple-S as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How to use this brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Health Maintenance Organizations (HMO). This Plan is an HMO with a Point of Service Product. Turn to this section for a brief description of HMOs and how they work.

2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.

3. How to get benefits. Make sure you read this section; it tells you how to get services and how we operate.

4. What to do if we deny your claim or request for service. This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.

5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.

6. General exclusions – Things we don't cover. Look here to see benefits that we will not provide.

7. Limitations – Rules that affect your benefits. This section describes limits that can affect your benefits.

8. FEHB facts. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. - Health Maintenance Organizations

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

You should join an HMO because you prefer this 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. Our providers follow generally accepted medical practice when prescribing any course of treatment.

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

Section 2. - How we change for 2000

Program-wide changes

- This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.
- If you have a chronic or disabling condition, and your provider leaves this Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves this Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program (See Section 3, How to get benefits, for more information).
- You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.
- If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.
- You pay a $7.50 copay per office visit to a Plan doctor general practitioner and $10 copay per office visit to a Plan doctor specialist, except for mental conditions and substance abuse as explained on Section 5. Benefits.

Clarifications regarding this Plan

- Authorization from this Plan is required before genetic amniocentesis, single photon emission computerized tomography (SPECT), hepatobiliary ductal system imaging (HIDA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), lithotripsy, computerized tomography and polysomnography.
- Authorization from this Plan is required before hospital admissions. Admissions due to an emergency, including normal and cesarean deliveries do not require prior authorization but must be notified to Triple-S on or before the following workday.
- Air ambulance services will not be covered if services are rendered outside of Puerto Rico.
- Breast prostheses and surgical bras, as well as their replacement are covered.
- New drugs not approved by the Plan's Pharmacy and Therapeutic Committee are not covered.
- FDA approved prescription drugs and devices for birth control are covered.

Section 3. - How to get benefits

What is this Plan's 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 the Commonwealth of Puerto Rico.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care or point-of-service benefits. 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 BlueCard 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.

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services, as explained on Section 5. Benefits.

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us, or you use point-of-service benefits. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

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.

What do I do if my primary care physician leaves this Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care.

What do I do if I'm in the hospital when I join this Plan?

First, call our Customer Service Department at 787/749-4777. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching 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 became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

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

What do I do if I am seeing a specialist when I enroll?

If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

What do I do if my specialist leaves this Plan?

Call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

But, what if I have a serious illness and my provider leaves this Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice.

This Plan will provide benefits for covered services only when services are medically necessary to prevent, diagnose or treat your illness or condition. Your Plan doctor will determine medical necessity but you must obtain authorization from this Plan before: services outside the Service Area, except emergencies, rental and purchase of durable medical equipment, Skilled Nursing Facility, organ and tissue transplants, hospitalization for certain inpatient dental procedures, genetic amniocentesis, single photon emission computerized tomography (SPECT), hepatobiliary ductal system imaging (HIDA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), lithotripsy, computerized tomography and polysomnography.

Magnetic Resonance Imaging (MRI), rehabilitation therapy and lithotripsy also require an authorization. Your provider will obtain the authorization.

Also, mental and substance abuse and hospital admissions require an authorization. You or your Plan doctor must obtain the required authorizations.

How do you decide if a service is experimental or investigational?

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.

Section 4. - What to do if we deny your claim or request for service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing,

2. Refer to specific brochure wording explaining why you believe our decision is wrong; and

3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;

2. Pay the claim;

3. Arrange for a health care provider to give you the service; or

4. Ask for more information.

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division II at (202) 606-3818 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

What if I have a serious or life threatening condition and you haven't responded to my request for service?

Call us at 787/749-4777 and we will expedite our review.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

- We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
- You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

- A statement about why you believe our decision is 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 us about the claim;
- Copies of all letters we sent you about the claim; and
- Your daytime phone number and the best time to call.

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

- Anyone enrolled in the Plan;
- The estate of a person once enrolled in the Plan; and
- Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our 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 or supplies.

What laws apply if I file a lawsuit?

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. - Benefits

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** a $7.50 copay for each office visit to a Plan doctor general prectitioner, a $10 copay for each office visit to a Plan doctor specialist and 25% of the fee schedule allowance for laboratory and diagnostic tests out of hospital, but no additional copayment for X-ray examinations. You must use a Triple-S participating laboratory and X-ray facility. Within the service area, house calls will be provided if, in the judgement of the Plan doctor, such care is necessary and appropriate; **you pay** a $15 copay for a doctor's house call and nothing for home visits by nurses and health aides. The physician may charge a differential to a member who requests a private room in the hospital if semiprivate rooms are available. The physician will bill the Plan on the basis of the established fees for such purposes and will charge the member any difference directly.

If you use a non-Plan doctor, **you pay** for services rendered and the Plan will reimburse you 1) 90% of the Plan's established fee when services are rendered within the service area, or 2) 90% of the usual, customary and reasonable charge of the area in which the services are rendered when services are rendered outside the service area. **You also pay** a $7.50 copay for each office visit to a non-Plan doctor general prectitioner, a $10 copay for each office visit to a non-Plan doctor specialist, a $15 copay per doctor's house call, and nothing for visits of nurses and health aides.

The following services are included:

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays. You or your Plan doctor must obtain authorization from your Plan before genetic amniocentesis, single photon emission computerized tomography (SPECT), hepatobiliary ductal system imaging (HIDA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), lithotripsy, computerized tomography and polysomnography, as discussed on Page 7.
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. Copays are waived for maternity care. The mother at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under this Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services
- Tuboplasty
- Diagnosis and treatment of diseases of the eye

What is covered

- Allergy testing and treatment, including testing and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints. This Plan pays 100% of the submitted charge when the implant device is provided and billed by a Plan doctor or provider. If the implant device is provided and billed by a non-Plan doctor, provider, or medical equipment supplier, this Plan will reimburse you 90% of the established fee.
- Breast prostheses and surgical bras, as well as their replacement.
- Cornea, heart, heart/lung, lung, kidney, kidney/pancreas and liver transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retro peritoneal and ovarian germ cell tumors. Transplants are covered when approved by this Plan. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan. You must obtain authorization from your Plan before an organ or tissue transplant, as discussed on Page 7.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Lenses following cataract removal
- Surgical treatment of morbid obesity
- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers.
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers.
- The medical management of mental conditions will be covered under this Plan's Medical and Surgical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits. Office visits for the medical aspects of treatment do not count toward the 40 outpatient Mental Conditions visit limit.

Limited benefits

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

Limited benefits

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two consecutive months per condition if significant improvement can be expected within two months. Physical therapy must be provided by or under the supervision of a doctor specializing in physical therapy and speech and occupational therapy must be referred by a Plan doctor to a provider certified to provide such therapy; you pay a $10 copay per outpatient session, and nothing per inpatient session. There are no participating Plan providers for speech therapy and occupational therapy. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. As discussed on page 6 of this brochure, you should pay the provider's claim and seek reimbursement from this Plan.

Diagnosis and treatment of infertility, is covered, (excluding drug treatment); **you pay** a $10 office visit copay. Artificial insemination is covered; **you pay** a $10 office visit copay; the cost of donor sperm is not covered. Fertility drugs are not covered. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization and embryo transfer, are not covered.

Respiratory therapy is covered for up to two sessions per day to a maximum of 20 sessions per year; **you pay** a $10 copayment per session.

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

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

What is not covered

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

What is not covered

- Assistance at surgery services
- Podiatric services
- Chiropractic services
- Homemaker services
- Cardiac rehabilitation

Hospital/Extended Care Benefits

What is covered

Hospital care

This Plan provides a comprehensive range of benefits with no dollar or day limit for a member who is hospitalized in a participating hospital. You or your Plan doctor must request an authorization from Triple-S before hospital admissions. Admissions due to an emergency, including normal and cesarean deliveries do not require prior authorization but must be notified to Triple-S on or before the following workday. **You pay** nothing per inpatient admission to a participating hospital in the service area. 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 14. **You pay** all remaining charges. **All necessary services are covered** including:

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

Outside the service area hospital benefits for special cases that require equipment, mode of treatment or specialist care are not available in Puerto Rico are covered by this Plan. However, Triple-S must approve the hospitalization of special cases in advance. (See page 14 for coverage provided for hospitalization due to accidental injury or medical emergency). Plan pays usual, customary and reasonable charges of the area in which hospital services are rendered. **You pay** any charges for services which are not a covered benefit of this Plan.

Extended Care

This Plan provides a comprehensive range of benefits in Plan facilities with no dollar or day limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility medically appropriate as determined by a Plan doctor and approved by this Plan. **You pay** nothing. All necessary services are covered including:

- Bed, board and general nursing care
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.

You must obtain authorization from your Plan before a Skilled Nursing Facility confinement, as discussed on Page 7.

Ambulance services

Benefits are provided for terrestrial or maritime ambulance transportation ordered or authorized by a Plan doctor. This is an indemnity benefit and is payable directly to you after you have paid the claim, except for air ambulance services rendered in Puerto Rico by a Plan provider.

Limited Benefits

Impatient dental procedures

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

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if this Plan doctor determines that outpatient management is not medically appropriate. See page 16 for non-medical substance abuse benefits.

What is not covered

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

Emergency Benefits

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 this Plan may determine are medical emergencies — what they all have in common is the need for quick action.

Emergencies within the service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system or 343-2550) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify 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.

Plan pays …

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

You pay …

$5 per hospital emergency room visit or urgent care center visit for services that are covered benefits of this Plan and any remaining charges. In case of emergencies within the service area, this Plan has available a 24 hour toll free number. Call **1-800-255-4375** for professional medical advise regarding your condition and to request an authorization. When you receive an authorization the $5 copay is waived. Also, if the emergency results in admission to a hospital, **you pay** nothing for the inpatient admission.

Emergencies outside the service area

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

If you need to be hospitalized, 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 a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

You pay … The copayments shown above for within-area benefits

What is covered

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

What is 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
- Air ambulance service outside of Puerto Rico

Filing claims for non-Plan providers

With your authorization, this Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to 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 8.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

To the extent shown below, this Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders. Non-Plan providers are under no obligation to accept the Triple-S established fees as payment in full. You pay all charges remaining for outpatient care above this Plan's established fee when non-Plan providers are used, in addition to the copays noted below. **You pay** only the copays noted below when Plan providers are used. For all other care under this benefit **you pay** all remaining charges after this Plan has paid benefits.

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

Outpatient Care

- For up to 40 full treatment visits per calendar year; **you pay** $5 per visit for visits 1-20, 50% of charges for visits 21-40-all charges thereafter.
- For up to 40 group therapy visits per calendar year; **you pay** $5 per visit-all charges thereafter.
- For collateral visits with immediate members of the patient's family (5 visits over age 18, 20 visits under age 18). **You pay** $5 per visit.

Inpatient Care

Hospital benefits, as shown on page 13 for up to 90 days each calendar year, in hospitals approved to render these services. Two days of partial hospitalization are equivalent to one full day of hospitalization. Your Plan doctor will request an authorization for any mental or substance abuse hospital admission.

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

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

In or out the hospital

- Psychological tests - if performed by a qualified psychologist, up to $35 for a full battery of tests.
- Electroshock therapy - up to 10 treatments in a calendar year
- Anesthetic for electroshock therapy - up to 10 treatments in a calendar year
- Electroencephalography

What is not covered

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

Substance Abuse

What is covered

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

What is not covered

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

Prescription Drug Benefits

What is covered

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

Covered medications and accessories include:

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

What is not covered

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

Other Benefits

Dental care

What is covered

This Plan provides the following dental coverage shown below; **you pay** 30% of this Plan's established fees for all services and nothing for oral examination, prophylaxis, fluoride treatment and x-ray services, if a Plan dentist is used. If a non-Plan dentist is used, **you pay** a 30% coinsurance and any remaining difference between 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. Coverage is limited to these items:

Diagnostic
- Periodic oral evaluation
- Limited oral evaluation
- Comprehensive oral evaluation
- Periapical and bitewing x-rays (limited to six periapical x-rays per calendar year and no more than two bitewing x-rays per calendar year)
- Preventive Prophylaxis (adult, child)
- Fluoride treatment, one every six month. Fluoride treatment is limited to members under 19 years of age.

Restorative
- Amalgam restorations
- Plastic, porcelain or composite (anterior and posterior tooth)
- Other restorative services (pin retention per tooth, in addition to restorations)
- Sedative filling
- Adjunctive General ServicesApplication 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)

Endodontics
- Pulp capping-direct (excluding final restoration)
- Pulp capping-indirect (excluding final restoration)
- Oral and Maxillofacial Surgery

Extractions
- Surgical removal of erupted tooth
- Surgical removal of residual tooth roots
- Incision and drainage of abscess - intra-oral soft tissue
- Impacted tooth

Accidental injury benefit

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

Definitions

Plan dentist: Means a duly authorized dentist with a regular license issued by the designated entity of the government of Puerto Rico, and who is a member "bona fide" of the "Colegio de Cirujanos Dentistas de Puerto Rico", who has signed a contract with Triple-S to render dental services.

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

What is not covered

Other dental services not shown as covered.

Vision care

What is covered

In addition to medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (that include the written lens prescription) may be obtained from Plan providers. **You pay** a $10 copay per office visit.

What is not covered

- Eye exercises
- Corrective lenses, eyeglasses, frames, contact lenses, fitting of contact lenses

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.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits) or eligible self-referred services
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Procedures, services, drugs and supplies related to sex transformations;
- Services or supplies you receive from a provider or facility barred from the FEHB Program; and
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. Limitations – Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, 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.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800/638-6833.

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. 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.

TRICARE

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. 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 determine they must provide;
- 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 the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

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

If you have a malpractice claim

If you have a malpractice claim because of services you did or did not receive from a plan provider, it must go to binding arbitration. Contact us about how to begin our binding arbitration process.

Section 8. FEHB FACTS

You have a right to information about your HMO

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 787/749-4777, or write to P.O. Box 363628, San Juan, P.R. 00936-3628. You may also contact us by fax at 787/749-4108, or visit our website at http:/www.ssspr.com or by e-mail at FEDINFO@ssspr.com.

Where do I get information about enrolling in the FEHB Program?

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
- The next Open Season for enrollment.

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.

When are my benefits and premiums effective?

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 January 1.

What happens when I 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, which is described later in this section.

What types of coverage are available for my family and me?

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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get 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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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.

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

Are my medical and claims records 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,
- 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.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan 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 former spouse coverage or Temporary Continuation of Coverage.

What is former spouse coverage?

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse 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 more information about your coverage choices.

What is TCC?

Temporary Continuation of Coverage (TCC). If you leave Federal service or if you lose coverage because you no longer qualify as a family member, you may be eligible for 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.

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an 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 if individual coverage is available. 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.

How can I get 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. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

Department of Defense/FEHB Demonstration Project

What is the Department of Defense (DoD) and FEHB Program Demonstration Project?

The national Defense Authorization Act for 1999, Public Law 105-261, established the DoD/FEHBP Demonstration Project. It allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years beginning with the 1999 Open Season for the year 2000. Open Season enrollments will be effective January 1, 2000. DoD and OPM have set-up some special procedures to successfully 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 FEHB. 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 eight 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.

Where are the demonstration areas?

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

When Can I Join?

Your first opportunity to enroll will be during the 1999 Open Season, november 8, 1999, through December 13, 1999. Your coverage will begin january 1, 2000. 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 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 1999, 2000, and 2001 Open Seasons. Your coverage will begin January 1 of the year following the Open Season that you enrolled.

If you become eligible for the DoD/FEHBP 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 2000 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHBP Demonstration Project”, on the OPM web site at www.opm.gov.

Am I eligible for Temporary Continuation of Coverage (TCC)?

See Section 10, FEHB Facts, for information about TCC. Under this 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/FEHBP 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/FEHBP Demonstration Project.

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

Do I have the 31-Day Extension and Right to Convert?

These provisions do not apply to the DoD/FEHBP Demonstration Project.

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 or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 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 they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in this Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for Triple-S - 2000

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure).

Benefits		Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing	13
	Extended Care	All necessary services, no dollar or day limit. **You pay** nothing	13
	Mental Conditions	Up to 90 days of inpatient care per calendar year. Two days of partial hospitalization are equivalent to one full day of hospitalization. **You pay** nothing per admission to a participating hospital	15
	Substance Abuse	Covered under Mental Conditions Benefits	16
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** a $7.50 copay per office visit to a Plan doctor general practitioner and $10 copay per office visit to a Plan doctor specialist (copay is waived for maternity care); and $15 per doctor's home visit	10-13
	Home Health Care	All necessary visits by nurses and health aides. **You pay** nothing	11
	Mental Conditions	Up to 40 outpatient visits per year. **You pay** a $5 copay per visit for visits 1-20, and 50% of charges for visits 21-40	15
	Substance Abuse	Covered under Mental Conditions Benefits	16
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. You pay a $5 copay to the hospital for each emergency room visit and any charges for services that are not covered benefits of this Plan. If you call the toll free number before reaching emergency room or urgent care center and receive an authorization, **you pay** nothing.	14
Prescription drugs		Prescribed drugs provided by a Plan pharmacy. **You pay** 20% coinsurance up to a maximum of $10 per brand name prescription unit or refill, or nothing per generic bioequivalent prescription unit or refill	17
Dental care		Accidental injury benefits; oral examinations, fluoride treatments, prophylaxis, x-rays, extractions, and fillings. **You pay** a percentage of charges as shown	18
Vision care		Refractions. **You pay** $10 per visit	19
Out-of-pocket maximum		Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments which are required for benefits when Plan providers are used	5

2000 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 most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee, but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
All of Puerto Rico									
Self Only	**891**	**$63.89**	**$21.30**	**$138.44**	**$46.14**	**$75.61**	**$9.58**	**$75.61**	**$9.58**
Self and Family	**892**	**$137.22**	**$45.74**	**$297.31**	**$99.10**	**$162.38**	**$20.58**	**$162.38**	**$20.58**