Triple-S Salud, Inc.

www.ssspr.com

Customer Service 787-474-5219 or 833-201-9256

TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico

2025

A Health Maintenance Organization with a Point of Service

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 9 for details. This plan is accredited. See page 15.

IMPORTANT
- Rates: Back Cover
- Changes for 2025: Page 17
- Summary of Benefits: Page 96

Serving:

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 17 for requirements.

Only Postal Employees and Annuitants may enroll in this plan.

Enrollment codes for this Plan:

For Residents in Puerto Rico

83A – Self Only
83C – Self Plus One
83B – Self and Family

For Residents in U.S. Virgin Islands

14A – Self Only
14C – Self Plus One
14B – Self and Family

PSHB

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-930

Important Notice

Important Notice for Medicare-eligible Active Employees from Triple-S Salud, Inc.

About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Triple-S Salud, Inc. prescription drug coverage for active employees is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means active employees and their covered family members do not need to enroll in an open market Medicare Part D plan and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your PSHB coverage as an active employee.

However, if you (as an active employee and your covered Medicare Part D-eligible family members) choose to enroll in an open market Medicare Part D plan, you can keep your PSHB coverage and your PSHB plan will coordinate benefits with Medicare.

Please be advised

If you lose or drop your PSHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov , or call the SSA at 800-772-1213 TTY 800-325-0778.

Additional Premium for Medicare's High Income Members
Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your PSHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return**. You do not make any IRMAA payments to your PSHB plan. Refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

You can get more information about open market Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, TTY 877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of Triple-S Salud, Inc. under contract (CS-1090 PS) between Triple-S, Inc. as a legal entity and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits (FEHB) law, as amended by the the Postal Service Reform Act, which created the Postal Service Health Benefits (PSHB) Program. Customer service may be reached at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Islands or through our website: www.ssspr.com. The address for Triple-S Salud, Inc. administrative offices is:

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

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. If you are a Postal Service annuitant and you are eligible for Medicare Part D, or a covered Medicare Part D-eligible family member of a Postal Service annuitant, your prescription drug benefits are provided under our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).

You do not have a right to benefits that were available before January 1, 2025, under the FEHB Program unless those benefits are also shown in this PSHB Plan brochure.

OPM negotiates benefits and rates for each plan annually. Benefits are effective January 1, 2025. Rates are shown at the end of this brochure.

Plain Language

All brochures are written in plain language to make them easy to understand. Here are some examples: All Postal Service Health Benefits (PSHB) brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee and each covered family member, "we" means Triple-S Salud, Inc.
- We limit acronyms to ones you know. OPM is the United States Office of Personnel Management. The FEHB Program is the Federal Employees Health Benefits Program administered by OPM and established under 5 U.S.C. chapter 89. The PSHB Program is the Postal Service Health Benefits Program established within the FEHB Program under 5 U.S.C. section 8903c. PSHB Plan means a health benefits plan offered under the PSHB Program. PSHB means Postal Service Health Benefits. If we use others, we tell you what they mean.
- Our brochure and other PSHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of healthcare for everyone and increases your Postal Service Health Benefits Program premium.

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

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

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan, or OPM representative.

- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999 from the U.S. Virgin islands and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE
877-499-7295
OR go towww.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/
The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.
You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

Do not maintain family members on your policy:

- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
- Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26)

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain PSHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, for example a member's gender identity or the fact that the covered benefit is sought in connection with gender-affirming care, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medication or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.

- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.

- www.ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.

- https://psnet.ahrq.gov/issue/national-patient-safety-foundation The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.

- www.bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.

- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your PSHB plan will incur costs to correct the medical error. You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct Never Events, if you use Triple-S Salud's preferred providers.

PSHB Facts

Coverage information

No pre-existing condition limitation	We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
Minimum essential coverage (MEC)	Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
Minimum value standard	Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.
Where you can get information about enrolling in the PSHB Program	See https://health-benefits.opm.gov/PSHB/ for enrollment information as well as: • Information on the PSHB Program and plans available to you • A health plan comparison tool Note: Contact the USPS for information on how to enroll in a PSHB Program Plan through the PSHB System. Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your PSHB coverage. These materials tell you: • When you may change your enrollment • How you can cover your family members • What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire • What happens when your enrollment ends • When the next Open Season for enrollment begins We do not determine who is eligible for coverage. You will be responsible for making changes to your enrollment status through the PSHB System. In some cases, your employing or retirement office may need to submit documentation. For information on your premium deductions, you must also contact your employing or retirement office. Once enrolled in your PSHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.
Enrollment types available for you and your family	Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

You enroll in a PSHB Program Plan and make enrollment changes in the PSHB System located at https://health-benefits.opm.gov/PSHB/. For assistance with the PSHB System, call the PSHBP Helpline at (844) 451-1261. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment request. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

Use the PSHB System if you want to change from Self Only to Self Plus One or Self and Family, and to add or remove a family member.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive benefits. Please, report immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26 through the PSHB System. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one PSHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another PSHB or FEHB plan.

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

Family Member Coverage

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member, as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

Children's Equity Act

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

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

- If you have no PSHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the PSHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for PSHB coverage, you must continue your PSHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

For annuitants who are required to be enrolled in Medicare Part B as a condition to continue PSHB coverage in retirement: If you enroll in Medicare Part B and continue PSHB coverage in retirement, the child equity law applies to you and you cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your child(ren) live as long as the court/administrative order is in effect. You cannot be compelled to enroll or remain enrolled in Medicare Part B to maintain your PSHB enrollment as a condition to satisfy a court/administrative order. However, if you do not enroll (or remain enrolled) in Medicare Part B as required to continue your PSHB coverage in retirement (notwithstanding an existing court/administrative order), you will not be able to continue your PSHB coverage in retirement.

Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP)

Our PDP EGWP is only available to Postal Service annuitants who are Medicare Part D-eligible and their covered Medicare Part D-eligible family members. Our PDP EGWP is not an open market Medicare Part D Plan. If you are an active Postal Service employee, or covered family member, and become eligible to enroll in Medicare Part D, you are not eligible to enroll in our PDP EGWP. Please, contact us for assistance at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY:866-215-1999) from the U.S. Virgin Island or visit our website at www.ssspr.com.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage and premiums begins on January 1. If you joined at any other time during the year, your employing or retirement office will tell you the effective date of coverage.

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

When you retire

When you retire, you can usually stay in the PSHB Program. Generally, you must have been enrolled in the FEHB and/or PSHB 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 PSHB coverage ends

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

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

Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

If you are eligible for coverage under spouse equity, you are only eligible to enroll in the PSHB Program. If you are not eligible for coverage under spouse equity and you are otherwise eligible for Temporary Continuation of Coverage (TCC), then you could enroll in TCC under the PSHB Program.

Upon divorce

If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must enter the date of the divorce or annulment and remove your ex-spouse in the PSHB System. We may ask for a copy of the divorce decree as proof. If you need to change your enrollment type, you must use the PSHB System. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). Former spouses eligible for coverage under the spouse equity law are not eligible to enroll in the PSHB Program. However, former spouses eligible for coverage under the spouse equity law may enroll in the PSHB Program. (Former Spouses seeking but not yet adjudicated as eligible for Spouse Equity may be entitled to TCC under a PSHB plan in the interim).

Former spouses not meeting the spouse equity requirements may be eligible for TCC under the PSHB Program provided you otherwise meet the eligibility requirements for TCC. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

Medicare PDP EGWP

When a Postal Service annuitant who is Medicare Part D-eligible or their covered Medicare-eligible family member opts out of or disenrolls from our PDP EGWP, they will not have our prescription drug coverage under this plan. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for additional information at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY:866-215-1999) from the U.S. Virgin Island or visit our website at www.ssspr.com.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your PSHB enrollment after you retire, if you lose your Federal job, or if you are a covered child and you turn 26.

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

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

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

Converting to individual coverage

You may convert to a non-PSHB 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 contact us in writing 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 contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the PSHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY:866-215-1999) from the U.S. Virgin Island or visit our website at www.ssspr.com.

Health Insurance Marketplace

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

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that PSHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Triple-S Salud, Inc. holds the following accreditations: URAC accreditation. To learn more about this plan's accreditation(s), please visit the following websites: www.ssspr.com. We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area.

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

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

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

Who provides my health care

Triple-S Salud, Inc. is an individual practice prepayment Plan. You can receive care from any Plan provider. A Plan provider is a doctor of medicine (M.D.) licensed to practice in the Commonwealth of Puerto Rico or in the U.S. Virgin Islands, who has agreed to accept the Triple-S Salud, Inc. established fees as payment in full for surgery and certain other services. If you use a non-Plan provider, you must pay in full for the services rendered and Triple-S Salud, Inc. will reimburse you based on the established fees. A non-Plan provider is any licensed doctor of medicine (M.D.) who is not a Plan provider. Non-Plan providers do not have to accept Triple-S Salud's established fees as payment in full. Most doctors practicing in Puerto Rico are Plan providers.

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

Benefits for services you receive in Puerto Rico or U.S. Virgin Islands are paid according to the "medical benefits schedule" of Triple-S Salud, Inc. in Puerto Rico and in the U.S. Virgin Islands. This is the schedule of established fees on which this Plan's payment of covered medical expense is based, when the services are rendered within the service area. When emergency services are rendered outside the service area, this Plan pays based on usual, customary and reasonable charges of the area where services were rendered or according to the Blue Cross Blue Shield local Plan's fees. When we precertify services that you receive outside the service area, we will pay for covered services according to: 1) the usual, customary and reasonable charges of the area where services were rendered; 2) the Blue Cross Blue Shield local Plan's fees; or 3) Triple-S Salud's established fees. The written precertification that we provide to you and the provider will indicate the allowance we will use. When you receive covered services outside the service area that are neither emergency nor precertified, we will reimburse 90% of Triple-S Salud's established fees, after any applicable copay or coinsurance. You are responsible up to the billed charges for these services.

For services received by an employee (not available for dependents) due to Temporary Duty Assignment (TDY), Triple-S Salud will pay based on usual, customary, and reasonable charges of the area where the services were rendered in the United States. This benefit is not available overseas. The Agency must provide an official letter notifying Triple-S Salud, Inc. of the assignment. Services will be covered for a period of up to a maximum of three months.

For services received by a dependent that is a full-time student in a recognized educational institution in the United States, Triple-S Salud, Inc. will pay based on usual, customary and reasonable charges of the area where the services were rendered. The dependent must present a certification from the recognized educational institution as proof of study. This is required to determine eligibility of full-time student and must have the following specifications: The document must have the official stamp of the institution and it must indicate the total credits as well as the start and end date of the period of classes. (For associates or bachelor's degree we consider 12 credits or more and for master's degree or graduate studies, 6 credits or more). Members must send us the updated evidence for each semester, quarter, or trimester, as applicable. The same benefit will apply to students entering TCC due to his/her age while they are full time students. Please send this request including your name and ID number directly to: servicioalcliente@ssspr.com

General features of our High Options

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care provider or by another participating provider in the network.

We have Point of Service (POS) benefits

Our HMO offers POS benefits. This means you can receive covered services from a non-plan provider (out-of-network). However, out-of-network benefits have higher out-of-pocket-costs than our in-network benefits. When you receive out-of-network services, we pay 90% of the established fee for allowable charges. You are responsible for paying the non-plan provider up front for covered services and filing a claim for reimbursement. We will reimburse you directly for covered services unless the provider accepts assignment of benefits. You are responsible for all charges that exceed our payment. You may submit your reimbursement starting the date of service and you will have until December 31st of the consecutive year as the deadline to submit it. Example: If the services are received during 2024, you will have until 12/31/2025 to submit the reimbursement to us.

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 cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies). When you get services out-of-network, we reimburse members in Puerto Rico and in the U.S. Virgin Islands based on the "medical benefits schedule" and the member is responsible up to the billed charges for these services. When emergency services are rendered outside the service area, this Plan pays based on usual, customary and reasonable charges of the area where services were rendered or according to the Blue Cross Blue Shield local Plan's fees. When we precertify services that you receive outside the service area, we will pay for covered services according to: 1) the usual, customary and reasonable charges of the area where services were rendered; 2) the Blue Cross Blue Shield local Plan's fees; or 3) Triple-S Salud's established fees. The written precertification that we provide to you and the provider will indicate the allowance we will use. When you receive covered services outside the service area that are neither emergency nor precertified, we will reimburse 90% of Triple-S Salud's established fees, after any applicable copay or coinsurance. You are responsible up to the billed charges for these services.

Your rights and responsibilities

OPM requires that all PSHB plans provide certain information to their PSHB members. You may get information about us, our networks, and our providers. OPM's PSHB website www.opm.gov/healthcare-insurance/ lists the specific types of information that we must make available to you. Some of the required information is listed below:

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

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, Triple-S Salud, Inc. at www.ssspr.com. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Island, or write to P.O. Box 363628, San Juan, Puerto Rico, 00936-3628. You may also visit our website at www.ssspr.com.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website Triple-S Salud, Inc. at www.ssspr.com. to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is limited to: Puerto Rico and U.S. Virgin Islands.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other healthcare services out of our service area unless the services have prior plan approval.

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

Section 2. Changes for 2025

This is the first year for the Postal Service Health Benefits Program (PSHBP). This Section is not an official statement of benefits. For that, go to Section 5. Benefits.

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 PSHB System enrollment confirmation.

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 787-474-5219 (TTY: 787-792-1370 from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Islands, or write to us at Triple-S Salud, Inc. (Triple-S Salud), Customer Service Department, 1441 Roosevelt Avenue, San Juan, Puerto Rico 00920. You may also request replacement cards through our website: www.ssspr.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, if you use our point-of-service program, you can also get care from non-Plan providers, but it will cost you more. If you use our Open Access program, you can receive covered services from a participating provider without a required referral from your primary care provider or by another participating provider in the network.

Balance Billing Protection

PSHBCarriers must have clauses in their in-network (participating) provider agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount.? If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

Plan providers

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to national standards.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

This plan provides Care Coordinators for complex conditions and can be reached 787-706-2552 option 3 for assistance.

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 to get covered care

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

Primary care

Your primary care provider can be a family practitioner or internist, for example. Your primary care provider will provide most of your healthcare or give you a referral to see a specialist.

If you want to change primary care providers or if your primary care provider leaves the Plan, call us. We will help you select a new one.

Specialty care

Your primary care provider will refer you to a specialist for needed care. When you receive a referral from your primary care provider, you must return to the primary care provider after the consultation, unless your primary care provider authorized a certain number of visits without additional referrals. The primary care provider must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care provider gives you a referral. However, you may see.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care provider will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.

Your primary care provider will create your treatment plan. The provider may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. If they decide to refer you to a specialist, ask if you can see your current specialist.

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.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, 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.
- If you have a chronic and disabling condition and
  - lose access to your specialist because your coverage changed from the FEHB to the PSHB and your health plan does not participate in the PSHB; or
  - lose access to your specialist because we drop out of the Postal Service Employees Health Benefits (PSHB) Program and you enroll in another PSHB program plan; or:
  - lose access to your specialist because we terminate our contract with your specialist for other than cause; or
  - lose access to your specialist because we reduce our service area and you enroll in another PSHB 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 primary care provider or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are hospitalized when your enrollment begins

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Islands. If you are new to the PSHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the PSHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your primary care provider arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services*.

"You must get prior approval for certain services. Failure to do so will result in a denial of service.

Inpatient hospital admission

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

Other services

Your primary care provider has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. We call this review and approval precertification. Call us at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Islands.

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

- Services outside the Service Area, except emergencies; we will precertify services outside the service area, which will include payment determination, for those services that are not available in Puerto Rico;
- Chemotherapy drugs, radiation therapy, and genetic testing;
- Rental and purchase of durable medical equipment (DME);
- Skilled Nursing Facility;
- Organ and tissue transplants (see Note below);
- Lithotripsy;
- Osteotomy;
- Mammoplasty;
- Growth hormone therapy;
- Drugs identified with a precertification in the list of drugs;
- Positron Emission Tomography (PET AND PET-CT);

- Septoplasty;
- Rhinoplasty;
- Blepharoplasty;
- Office surgeries to be performed at hospitals;
- Surgical treatment of morbid obesity (bariatric surgery);
- Prosthetic tracheostomy speaking valve;
- Tracheo-esophageal voice prosthesis;
- Insulin pumps and/or their supplies;
- Implant replacement;
- Treatment for lymphedemas, when the treatment is other than any physical complication after a mastectomy procedure; and,
- Infertility services

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

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

The referral can be sent thru fax 787-625-8650 / 787-774-4824 or by e-mail at manejocasos@ssspr.com to the Case Management Department. All organ/tissue services require our prior approval for each transplant phase.

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

First, your physician, your hospital, you, or your representative, must call us at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Islands. before admission or services requiring prior authorization are rendered.

Next, provide the following information:

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

Non-urgent care claims

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

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

Urgent care claims

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Islands. You may also call Postal Service Insurance Operations (PSIO) at 202-936-0002 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Islands. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

Concurrent care claims

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

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

Emergency inpatient admission

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

Maternity care

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

If your treatment needs to be extended

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

What happens when you do not follow the precertification rules when using non-network facilities

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

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.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 787-474-5219 (TTY: 787-792-1370 from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Islands.

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

To reconsider a non-urgent care claim

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

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

1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3. Write to you and maintain our denial.

To reconsider an urgent care claim

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

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

To file an appeal with OPM

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

Note: If you are enrolled in our Medicare PDP EGWP and do not agree with our benefit coverage decision you have the right to appeal. See Section. 8(a) for information about the PDP EGWP appeal process.

Section 4. Your Cost for Covered Services

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

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayments

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

Example: When you see your primary care provider, you pay a copayment of $10 per office visit, and when you go in the hospital, you pay $100 per admission.

Coinsurance

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

Example: In our Plan, you pay 50% of our allowance for infertility services and durable medical equipment

Differences between our Plan allowance and the bill

You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum

After your (copayments and coinsurance) total $6,600 for Self Only or $13,200 per person for Self Plus One, or $13,200 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

- Difference between our Plan allowance and the billed charges for a covered service or supply;
- Cost of non-covered services or supplies; and,
- Coinsurance you pay when you use non-Plan providers.

For members enrolled in our Plan's associated MA-PD or PDP EGWP, we are required to accumulate all members' actual out-of-pocket costs for Medicare-covered drugs, services and supplies toward the PSHB catastrophic maximum(s), unless specifically excluded below.

- the share of the cost of the drug paid by a Medicare drug plan
- the monthly drug plan premium
- drugs purchased outside the U.S. and its territories
- drugs not covered by the plan
- drugs that are excluded from the definition of Part D drugs, even in case where the plan chooses to cover them as a supplemental benefit (like drugs for hair growth)
- Over-the-counter drugs or most vitamins (even if they're required by the plan as part of step therapy)

If you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP), the prescription drug out-of-pocket maximum is $2,000. After this maximum is met, we pay 100% of all eligible covered prescription drug benefits.

Carryover

If you changed to this PSHB Plan during Open Season from a plan with a catastrophic protection benefit the effective date of the change is January 1, and covered expenses that apply to this plan's catastrophic protection benefit starts on January 1.

Note: If you change PSHB plans during Open Season the effective date of your new PSHB plan is January 1 of the next year, and a new catastrophic protection accumulation starts on January 1. If you change plans at another time during the year, you must begin a new catastrophic protection accumulation under your new plan.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

For detailed information of Glossary of Medical Terms and Health Insurance please refer to https://salud.grupotriples.com/en/glossary-of-terms/

A surprise bill is an unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.ssspr.com or contact the health plan at 787-474-5219.

Section 5. Benefits - High Option

Page 102 and page 103 is a benefits summary.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- 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 coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).
- If you use a non-plan provider within the service area, you pay for services rendered and the plan will reimburse 90% of the plan's established fee, after any applicable copay or coinsurance. Please refer to Section 1 under Who provides my health care for more information on emergency services rendered outside the service area.
- **YOU OR YOUR PLAN PROVIDER MUST GET PRECERTIFICATION FOR SOME MEDICAL SERVICES AND SUPPLIES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • General practitioner's office visit within our Salus Clinics	Network: Nothing
Professional services of physicians • In physician's office • Second surgical opinion • Office medical consultations	Network: $7.50 per office visit to your general practitioner or specialist physician Out-of-network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
• In an urgent care center or emergency room • During a hospital stay • In a skilled nursing facility – precertification required - (refer to Section 3)	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
• At home	Network: $15 per physician visit Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Not covered: • *Private nursing care, except for treatment of mental illness*	*All charges*

Benefit Description	You pay
Telemedicine	**High Option**
• Unlimited online virtual consults through Teleconsulta MD: www.triplessalud.mytelehealth.com/landing.htm	Network: $0 per consult Out-of-Network: All charges Note: Available 7 days a week from 6am-10pm
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis	Network: $1.00 per laboratory Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
• Polysomnography • Genetic amniocentesis • Non-invasive vascular and cardiovascular tests • EEG	Network: 20% Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
• Pathology • Non-routine Pap test • X-ray • Non-routine Mammogram • Nuclear medicine tests • Hepatobiliary ductal system imaging (HIDA) • Cat Scans (CT)/Magnetic resonance (MRI, MRA) • Ultrasound, including Biophysical Profile • Invasive cardiovascular tests	Network: Nothing Out-of-Network: 10% of the allowable charges, plus any difference between our allowance and the billed amount
Preventive care, adult	**High Option**
Routine physical every 12 months: We cover a comprehensive range of A and B rated preventive care services for adults as recommended by the United States Preventive Services Task Force (USPSTF). Members over age 21 may obtain covered preventive services through our network Preventive Centers. **The following preventive services are covered at the time interval recommended at each of the links below:** • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at https://www.hrsa.gov/womens-guidelines.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
• To build your personalized list of preventive services go to https://health.gov/myhealthfinder	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Screening mammogram, including digital tomosynthesis: • From age 35 through 39, one during this five-year period • From age 40 through 64, one every calendar year At age 65 and older, one every two consecutive calendar years	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total cholesterol, lipid panel test, HIV, colorectal cancer screening including colonoscopy screening for members 40 and over.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
• Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Immunizations such as Pneumococcal, influenza, shingles, tetanus/Tdap, and human papillomavirus (HPV) including members ages 27 to 45 for high-risk members. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at:https://www.cdc.gov/vaccines/sched Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
• Electrocardiogram (EKG), once per year • Spirometry, once per year • Hemoglobin A1c, once per year • CBC, once per year • PSA, once per year • Thyroid, once per year	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
• Transportation Services to and from our Preventive Centers, up to 4 trips	Network: Nothing Out-of-Network: Not covered
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy, • Family centered programs when medically identified to support obesity prevention and management by an in-network provider.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
Note: • Please refer to Educational classes and programs information shown in Section 5(a). • When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) or 5(f)(a), if applicable for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See section 5(b) for Surgery requirements and cost share.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Preventive care, children	**High Option**
Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org Children's immunization's endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at https://www.cdc.gov/vaccines/schedules/index.html	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
You can also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	
Obesity counseling, screening, and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy, • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. Note: • Please refer to Educational classes and programs information shown in Section 5(a).	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**High Option**
• When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes • Delivery • Screening and counseling for prenatal and postpartum depression	Network: $0 copay for office visits when enrolled in Maternal Program during the first trimester $7.50 per office visits Nothing for delivery Nothing for circumcision Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
• Breastfeeding and lactation support, supplies and counseling for each birth • Electric breast pump for mothers who have given birth within the last 3 months, limited one per birth. • Services for high risk pregnancies - Prenatal in-home support service up to 16 hours, maximum four hours per day - Blood pressure monitor - Glucometer - Postnatal in-home support when enrolled in the Maternal Program during the first trimester • service up to 16 hours, maximum four hours per day • within one month of giving birth • Note: Call the Triple-S Salud Department of Disease Management (Prenatal Care Program) at 787-749-4949, extension 832-2042 to coordinate your electric breast pump, prenatal blood pressure monitor and/or glucometer, or schedule your In-Home Support service. Breast pumps, prenatal glucometer and blood pressure monitor do not require precertification and must be coordinated through the TSS Prenatal Care Program.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; see page 20 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. • We will extend your inpatient stay if medically necessary.	

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**High Option**
• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	
Family planning	**High Option**
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes: limited to: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms Note: See additional Family Planning and Prescription drug coverage Section 5(f) or 5(f)(a), if applicable. Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process. For more information on our 24 response time surgical contraceptive exception process, please visit: https://salud.grupotriples.com/en/health-insurance-plans/triple-s-salud-for-federal-employee/. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	Nothing
Voluntary male sterilization	Network: $10 per office visit Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*

Benefit Description	You pay
Infertility services	**High Option**
Triple-S Salud defines infertility as a disease or condition characterized by the inability to impregnate or conceive; a person's inability to reproduce either as an individual or with the person's partner for a period of 12 months or more (6 months for members over age 35). Cases of infertility can be determined based on a patient's medical history, physical findings, or diagnostic testing. Diagnosis and treatment of infertility, benefits include services such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Assisted reproductive technology (ART) procedures, such as - In vitro fertilization (IVF) - Embryo transfer, gamete intra-fallopian transfer (ZIFT) - Gamete Intra-Fallopian Transfer (GIFT) Note: You must obtain precertification for these services, see Section 3. Note: See additional Family Planning and Prescription drug coverage Section 5(f) or 5(f)(a), if applicable.. Note: Artificial insemination covers up to three cycles per year for members with female reproductive organs aged over 35. ART services have an annual maximum of $15,000.	Network: $7.50 per office visit Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Not covered: *• After voluntary sterilization* *• Cost of donor sperm or cost of donor egg* *• Surrogacy*	*All charges*
Allergy care	**High Option**
• Testing and treatment	Network: $7.50 per office visit Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
• Allergy serum • Allergy vaccine	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Not covered: *• Provocative food testing and sublingual allergy desensitization*	*All charges*

Benefit Description	You pay
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: Treatment will be subject to a peer review. See Oncology Analytics in Section 5(h). Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on pages 42 through 46. • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: Growth hormone is covered under the prescription drug benefit. We will only cover GHT when we precertify the treatment. You or your Plan provider should call 787-774-6081 (TTY 787-792-1370) from Puerto Rico or 800-716-6081 (TTY 866-215-1999) from the U.S. Virgin Islands, for precertification. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See Services requiring our prior approval in Section 3.	Network: $7.50 per office visit Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Respiratory and inhalation therapy up to a maximum of 20 sessions per year. We may extend coverage for services that exceed the visit limit if we determine the services are medically necessary through the precertification process.	Network: $10 for respiratory therapy session Out-of-network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Adaptive behavior assessment and treatment for Autism Spectrum Disorder • Behavior identification assessment • Observational and Exposure behavioral follow-up assessment • Adaptive behavior treatment • Group and Family adaptive behavior treatment Note: Services are subject to Triple-S Salud's protocols.	Network: $7.50 per office visit Out-of-network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Cardiac Rehabilitation Up to 36 therapies per year, subject to Triple-S Salud's protocol	Network: Nothing Out-of-network: Nothing up to our established fee and all charges thereafter Note: If the Cardiac rehabilitation provider accepts assignment of benefits you will not have to pay up front; if not, you should pay the provider’s claim and Triple-S Salud, Inc. will reimburse you up to the established fees.
Not covered: *• Services not shown as covered*	*All charges*

Benefit Description	You pay
Physical and occupational therapies	**High Option**
• Physical therapy - rendered by qualified physical therapists supervised by a physician specialized in physical therapy; - up to 60 therapies per condition, if significant improvement can be expected Note: We may extend coverage for services that exceed the visit limit if we determine the services are medically necessary through the precertification process.	Network: $7.50 per office evaluation or $10 for therapies Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
• Occupational therapy - rendered by certified occupational therapists - up to 60 therapies per condition, if significant improvement can be expected Note: Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. We may extend coverage for services that exceed the visit limit if we determine the services are medically necessary through the precertification process.	$10 per therapy session Note: For occupational therapy, you should pay the provider's claim and seek reimbursement from us. Occupational therapists are not plan providers and do not have to accept the established fees as payment in full.
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Aquatic therapy and non-therapeutic massages*	*All charges*
Speech therapy	**High Option**
Speech therapy rendered by certified speech therapist up to 60 therapies per condition. We may extend coverage for therapy that exceeds the limit if we determine the services are medically necessary through the precertification process.	$10 per office visit and/or speech therapy plus all charges that exceed our established fees Note: For speech therapy you should pay the provider's claim and seek reimbursement from us. Speech therapists are not Plan providers and do not have to accept the established fees as payment in full.
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an plan physician or audiologist • Tympanometry Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
• External hearing aids, up to a maximum of $1,000 every two years for one or both ears combined (see Section 5(a) Orthopedic and prosthetic devices)	Nothing, up to the allowance covered. Note: Members must pay any difference between our allowance and the billed amount
Not covered: • *Supplies*	*All charges*

Benefit Description	You pay
Vision services (testing, treatment, and supplies)	**High Option**
• In addition to medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (that include the written lens prescription) may be obtained from Plan providers. • Monofocal Intraocular lenses during cataract removal • Eye exam to determine the need for vision correction for children (see preventive care) Note: See Preventive care, children for eye exams for children.	Network: $7.50 per office visit Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
• Optometrist services	Network: $7.50 per office visit Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
• One pair of eyeglasses or contact lenses annually for members up to age 21.	Network: Nothing up to contracted fee. Member pays any balance exceeding contracted fee. Out-of-Network: Covered by reimbursement up to contracted fee. Member pays any balance exceeding contracted fee.
Not covered: • *Corrective lenses and fitting of contact lenses* • *Eye exercises and orthoptics* • *Multifocal Intraocular Lens* • *Radial keratotomy and other refractive surgery* • *Supplies*	*All charges*
Foot care	**High Option**
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. • Podiatric services	Network: $7.50 per office visit to a general practitioner, podiatrist or a specialist Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Not covered: • *Treatment of weak, strained or flat feet* • *Routine foot care such as cutting, trimming, or removal of corns, calluses, the free edge of toenails, treatment of fungal infected nail, foot cleaning and bathing, application of creams and similar routine treatment of conditions of the foot, except as stated above.*	*All charges*

Benefit Description	You pay
Orthopedic and prosthetic devices	**High Option**
• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Surgically implanted breast implant following mastectomy	Network: Nothing Out-of-Network 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
• Internal prosthetic devices (implants), such as artificial joints, pacemakers, and cochlear implants, requires prior approval • Prosthetics for lower and upper limbs, and orthotics, up to a maximum of $5,000 in combination, per year, requires prior approval • Repair of externally worn prosthetic devices • Prosthetic tracheostomy speaking valve, requires prior approval • Lumbosacral supports, requires prior approval • Tracheo-esophageal voice prosthesis, requires prior approval • External Hearing aids, up to a maximum of $1,000 every two years for one or both ears combined Note: *For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5 (c) Services provided by a hospital or other facility, and ambulance services.*	Network: 20%. Nothing for hearing aids, up to the allowance covered. Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount Note: Members must pay any difference between our allowance and the billed amount for hearing aids.
Not covered: *• Orthopedic and corrective shoes* *• Arch supports* *• Diabetic Shoes* *• Heel pads and heel cups* *• Certain Lumbosacral supports* *• Corsets, trusses, elastic stockings, support hose, and other supportive devices* *• Artificial eyes* *• Prosthetic sleeve or sock* *• Implant and prosthetic devices unless medically necessary* *• Testing and examinations for hearing aids*	*All charges*
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Hospital type beds • Wheelchairs • Walkers • Blood glucose monitors • Iron lungs • Other respiratory equipment • Ostomy supplies • Tracheostomy supplies	Network: 25% Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**High Option**
• Basic Continuous positive airway pressure device (CPAP) equipment (full face and nasal masks) and supplies • Insulin pumps and/or their supplies for patients with uncontrolled diabetes who require multiple daily injections of insulin and demonstrate wide fluctuations in glucose levels (see note below) • Specialized medical foods for members with Phenylketonuria (PKU) according to Triple-S Salud's medical policy • Blood pressure monitor for high-risk members Note: You must obtain a precertification from us. Refer to Section 3. Note: In order to be eligible for the coverage of an insulin pump, you must enroll and participate in our Disease Management Program. Note: Members must enroll and participate in our Hypertension Program to be eligible for this benefit. The blood pressure monitor will be coordinating through the program.	Network: 25% Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Strips and lancets: • Members diagnosed with Diabetes Type 1; • Diabetes Type 2 members enrolled in Medicare Part A and B Note: In order to be eligible for the 100% coverage of strips and lancets when diagnosed with Diabetes Type 2, you must enroll in Medicare Part A and Part B.	Network: Nothing Out-of-Network: 10%of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Not covered: *• Crutches* *• Other durable medical equipment not shown above*	*All charges*
Home health services	**High Option**
• Home healthcare ordered by a Plan physician (who will periodically review the program for continuing appropriateness and need) and provided by nurses or home health aides. • Services include oxygen therapy, intravenous therapy and medications	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.* • *Homemaker services.*	*All charges*

Benefit Description	You pay
Chiropractic	**High Option**
• One initial evaluation visit and one follow up visit if required per condition' • Manipulations of the spine and extremities, up to 20 manipulations per year • X-rays of the neck and spine	Network: Nothing Out-of-network: 10% of the allowable charges plus any difference between our allowance and the billed amount Note: If the chiropractor accepts assignment of benefits you will not have to pay up front; if not, you should pay the provider's claim and Triple-S Salud will reimburse you up to the established fees.
Not covered: • *Massages, dietary management, ultrasound*	*All charges*
Nutrition	**High Option**
• Nutritionists' services, up to six (6) visits per year.	Network: Nothing Out-of-Network: Nothing up to our established fee and all charges there after
Educational classes and programs	**High Option**
Coverage is provided for: • **Disease Management & Health Educational Programs**: Health education is an essential component in the prevention of diseases and will allow you to enjoy quality of life. Our various programs are focused on the most common chronic conditions and offer guidance on clinical treatments provided by your physician. We offer you information on how to care for your condition via educational workshops by phone with nursing professionals and/or health educators and with educational material by mail. For more information, call the Department of Education and Disease Management from Triple-S Salud at 787-749-4949, extension 832-2042. Among the various programs available are: - **Diabetes Progra**m: Members 18 years and over will receive orientations on diabetes, the emotional aspects of the condition, effects of exercise & nutrition, use of medications, and complications, among others. - **Hypertension Program**: Members ages 18 years and older will learn its signs and symptoms, how to modify lifestyles, and how to keep their blood pressure under control. - **Chronic Obstructive Pulmonary Disease (COPD) Program**: Members ages 40 and over will receive counseling on their condition, the use of prescription drugs, signs and symptoms, the importance of medical monitoring to help, and how to adopt healthy lifestyles to avoid complications and enjoy a better quality of life. - **Heart Failure Program**: Members aged 18 years and will receive guidance on how to prevent complications and improve your quality of life by learning the important steps needed to improve their health.	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
- **Prenatal Program:** We provided expecting members with education focused on the importance of early, prenatal care and risk factors. Pregnant members will receive educational brochures and virtual classes with information of the different stages of pregnancy and care for the newborn. For more information, see Section 5(a): Medical Services and Supplies Provided by Physicians and Other Health Care Professionals under Maternity Care. - **Tobacco Cessation Program**: Triple-S Salud offers you an educational and health promotion program to help you quit tobacco, including individual/group/telephone counseling, and over the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. See Section 5(f): Prescription Drug Benefit. - **Adult Obesity Management / Childhood Weight Control Program**: This program includes orientations and education about adopting good dietary habits, choosing healthy foods, reading nutritional labels, and food choices when eating out, among other topics. This program has been developed for enrollees with a body mass index (BMI) of 30.0 kg/m2 and above, who also meet established criteria for participation. When the enrollee takes part in the program, he/she will receive nutritional interventions by a duly certified and trained dietitian-nutritionist. The educational program includes six educational sessions in a group setting, one telephone-based educational intervention, and monthly coaching. The program's general objective is to offer enrollees access to education on nutrition through a dietitian-nutritionist who will guide them in the self-management of obesity, through dietary-habit modification and the promotion of physical activity. We also have a program with focus on childhood obesity. This multicomponent, family centered program is part of intensive behavioral interventions (behavior change counseling for healthy diet and physical activity) for children. - **Healthy Living Program for Diabetics**: This program is designed to provide a common framework of clinical strategies for diabetic members in our Salus Clinic. To ensure care as established by the guidelines, we established a protocol of medical visits, nutritional guidance, health education and clinical laboratories needed for diabetic members. Members are expected to achieve control and significantly reduce complications of their condition through education, clinical care and self-care developed with this program.	Nothing

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.
- If you use a non-plan provider within the service area, you pay for services rendered and the plan will reimburse 90% of the plan's established fee, after any applicable copay or coinsurance. Please refer to Section 1 under Who provides my health care for more information on emergency services rendered outside the service area.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical assistants • Lithotripsy procedure • Treatment of burns • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. Note: For female surgical family planning procedures see Family Planning Section 5(a) Note: For male surgical family planning procedures see Family Planning Section 5(a)	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount Note: See Section 5(c) Services provided by a hospital or other facility, and ambulance services for outpatient surgical facility copay Note: For insertion of internal prosthetic devices, member pays nothing if provided by a Plan provider. For all out-of-network services, you should pay the provider's claim and seek reimbursement from us. We will reimburse you 90% of our established fees.
• Surgical treatment of severe obesity (bariatric surgery) – This Plan uses the following criteria:	Network: Nothing

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
- Patients with a body mass index (BMI) of greater than 40 kg/m2 or greater than 35 kg/m2 in conjunction with severe comorbidities such as cardiopulmonary complications, severe diabetes or obstructive sleep apnea - BMI is calculated using the following formula: Weight (kg) ÷ height (m2) = BMI	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount Note: See Section 5(c) Outpatient hospital or ambulatory surgery center for copay.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; (see Foot care)*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see Prosthetic devices) 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. • Gender Affirming Surgery - Vaginoplasty - Labioplasty - Clitiroplasty - Vulvoplasty - Penectomy - Orchietomy - Breast Augmentation - Hysterectomy - Urethra reconstruction - Metoidioplasty - Phalloplasty - Colpectomy	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount Note: See Section 5(c) Outpatient hospital or ambulatory surgery center for copay.

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**High Option**
- Vaginectomy - Scrotoplasty - Vulvectomy - Mastectomy Note: Services will be covered subject to Triple-S Salud's medical policies and with prior authorization.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount Note: See Section 5(c) Outpatient hospital or ambulatory surgery center for copay.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury.*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, performed only when medically necessary, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount Note: See Section 5(c) Services provided by a hospital or other facility, and ambulance services for outpatient surgery facility copay.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to Services requiring our prior approval in Section 3 for precertification procedures. • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver	Network: Nothing Out-of-Network: All charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• Lung: single/bilateral/lobar • Pancreas	Network: Nothing Out-of-Network: All charges
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to Services requiring our prior approval in Section 3 for precertification procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Network: Nothing Out-of-Network: All charges
Blood or marrow stem cell transplants (Hematopoietic Stem Cell Transplant - HSCT) The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome	Network: Nothing Out-of-Network: All charges

Organ/tissue transplants - continued on next page

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

Organ/tissue transplants - continued on next page

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

Organ/tissue transplants - continued on next page

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

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- For maximum benefits plan physicians 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 in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS**. Please refer to Section 3 to be sure which services require precertification.
- Refer to Section 3 for more information on the Inpatient Value Care Hospital Network available to you.
- If you use a non-plan provider within the service area, you pay for services rendered and the plan will reimburse 90% of the plan's established fee, after any applicable copay or coinsurance. Please refer to Section 1 under Who provides my health care for more information on emergency services rendered outside the service area.

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets NOTE: The Inpatient Value Care Hospital Network is available with concierge services for your convenience. Refer to Section 3 for information on services available to you. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowable charges and the billed amount
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and x-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowable charges and the billed amount
• Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowable charges and the billed amount
Not covered:	*All Charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
• Custodial care, rest cures, domiciliary or convalescent care. *• Non-covered facilities, such as nursing homes, schools* *• Personal comfort items, such as telephone, television, barber services, guest meals and beds* *• Private nursing care* *• Hospitalization for non-covered surgery or procedures*	*All Charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Pathology services • Administration of blood and blood plasma, and other biologicals • Blood or blood plasma, if not donated or replaced • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Network: $25 facility copay when outpatient surgery is performed Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
• Pre-surgical testing	Network: Nothing for x-rays, $1.00 per laboratory; 20% for polysomnography, genetic amniocentesis, non-invasive vascular and cardiovascular tests, including electrocardiogram and EEG Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Not covered: *• Outpatient hospital or facility charges you incur for a non-covered surgery or procedure*	*All Charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Skilled nursing facility (SNF): Unlimited medically appropriate care, including bed, board and general nursing care; drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan provider. You or your Plan provider must obtain authorization from your Plan before a Skilled Nursing Facility confinement, as discussed on pages 18 through 19.	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Not covered: *• Custodial care, rest cures, domiciliary or convalescent care*	*All Charges*

Benefit Description	You pay
Hospice care	**High Option**
Supportive and palliative care to members with a projected life expectancy of six months or less due to a terminal medical condition, covered in the home Note: Services require a precertification and is subject to Triple-S Salud's protocol. Hospice care focuses on the palliation of pain, anxiety, suffering and other symptoms of chronic and terminal illness attending all the emotional and spiritual needs and those of their families. The length of hospice covered services will not exceed 120 days.	Network: Nothing, covered under Case Management. Out-of-Network: All charges
Not covered: *• Independent Nursing* *• Homemaker services*	*All Charges*
Ambulance	**High Option**
• Local professional ambulance service when medically appropriate	Nothing Note: You should submit the provider's claim and seek reimbursement from us.
• Air ambulance services within the service area (Puerto Rico and U.S. Virgin Islands)	Nothing up to $50,000 per occurrence.
Not covered: *• Air ambulance outside of Puerto Rico and U.S. Virgin Islands.*	*All Charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

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

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area

We have a 24 hour toll free number available to obtain professional medical advice regarding your condition, call 800-255-4375. Or, you can contact your general practitioner physician.

You can visit a network urgent care center if you have a disease, injury or condition serious enough that you can reasonably seek immediate medical attention but is not so serious where you require a visit an emergency room. Urgent care centers are usually available during extended hours, including weekends and nights.

In extreme emergencies, when you have acute symptoms of sufficient severity – including severe pain, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. When you call the 24 hour toll free number and receive a recommendation or a registration number, the $25 copay is waived and you pay only $10 copay. If the emergency results in admission to a hospital, you pay nothing for the inpatient admission.

Emergencies outside our service area

You can contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness through Blue Cross and Blue Shield Plan providers. When non-Plan providers are used this Plan pays 90% of usual, customary and reasonable charges for the area in which the emergency services are rendered, after any applicable copay or coinsurance. You pay all remaining charges.

- With your authorization, this Plan will pay benefits directly to non-Plan providers of your emergency care upon receipt of their claims. Non-Plan physician claims should be submitted on the CMS 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to this Plan along with an explanation of the services and the identification information from your ID card.
- Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with this Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on pages 70 through 72.

Benefit Description	You pay
Emergencies within our service area	**High Option**
• Emergency care at a doctor’s office	$7.50 copay
• Emergency care at a hospital emergency room	$25; if we recommend the visit $10
• Emergency care at a an urgent care center	Network: $10 copay Out-of-Network: 10% of the allowable charges plus any difference between our allowable charges and the billed amount
• Emergency care as an inpatient at a hospital, including doctors' services.	Nothing
Not covered: *• Elective care or non-emergency care*	*All Charges*
Emergency outside our service area	**High Option**
• Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors’ services Note: See Section 5(h) Wellness and other special features for information on the Blue Card Program.	10% of our allowance Note: When using Non-plan providers, you should submit the provider’s claim and seek reimbursement from this Plan. Plan reimburses you 90% of usual, customary and reasonable charges for the area in which emergency services are rendered or according to the Blue Cross Blue Shield local Plan’s Non-plan providers' fees, after any applicable copay or coinsurance. When using Plan providers, the plan will pay providers 90% of usual, customary and reasonable charges for the area in which emergency services are rendered or according to the Blue Cross Blue Shield local Plan’s fees, after any applicable copay or coinsurance.
• Emergency care in Sanitas Urgent Care Medical Centers in Florida	Network: $50 copay Out-of-Network: 10% of our allowance Note: When using Non-plan providers, you should submit the provider’s claim and seek reimbursement from this Plan. Plan reimburses you 90% of usual, customary and reasonable charges for the area in which emergency services are rendered or according to the Blue Cross Blue Shield local Plan’s Non-plan providers' fees, after any applicable copay or coinsurance. When using Plan providers, the plan will pay providers 90% of usual, customary and reasonable charges for the area in which emergency services are rendered or according to the Blue Cross Blue Shield local Plan’s fees, after any applicable copay or coinsurance.

Benefit Description	You pay
Ambulance	**High Option**
• Local professional ambulance service when medically appropriate. Note: See 5(c) Services provided by hospital or other facility, and ambulance services for non-emergency service.	Nothing Note: You should submit the provider's claim and seek reimbursement from us.
• Air ambulance services within the service area (Puerto Rico and US Virgin Islands)	Nothing up to $50,000 per occurrence
Not covered: *• Air ambulance outside of the service area.*	*All Charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans 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.
- You or your mental health provider should call 800-660-4896 to coordinate services for your treatment plan. This toll-free telephone number is available 24-hours a day and 7 days a week, to provide you with assistance in obtaining mental and/or substance abuse care.
- If you use a non-plan provider within the service area, you pay for services rendered and the plan will reimburse 90% of the plan's established fee, after any applicable copay or coinsurance. Please refer to Section 1 under Who provides my health care for more information on emergency services rendered outside the service area.

Benefit Description	You pay
Professional services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Note: To coordinate your services and ensure you are receiving the appropriate care, you or your Plan provider must notify us at the beginning of your ambulatory care. You or your Plan doctor should call 800-660-4896 to register and for assistance.	Network: Your cost-sharing responsibilities are no greater than for other illnesses or conditions. Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders including detoxification, treatment and counseling • Electroconvulsive therapy • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Network: $7.50 per office visit and/or therapy Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount

Benefit Description	You pay
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	Network: Nothing for X-rays and $1.00 per laboratory; 20% for some diagnostics tests. See Lab, X-ray and other diagnostic tests (Section 5a). Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
• Psychological tests if performed by a qualified psychologist	Plan reimburses you up to the established fees. You pay the difference between our allowance and the billed amount.
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services *Note: Please see Important things you should keep in mind about these services at the beginning of this section.*	Network: Nothing Out-of-Network: 10% of the allowable charges, plus any difference between our allowance and the billed amount
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Not covered: • *Services not described in this section.*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- If you use a non-Plan pharmacy, this Plan will pay 75% of this Plan's established fees for prescription drugs and you pay all remaining charges.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at a network pharmacy, a non-network pharmacy, a non-network pharmacy or by mail (see Triple-S Salud Pharmacy Mail Order Program). We pay a higher level of benefits when you use a network pharmacy. – or – You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication
- **We use a formulary.** We cover non-formulary drugs prescribed by a Plan doctor. If your physician believes a preferred brand product is necessary or there is no generic available, your physician may prescribe a preferred brand product from the formulary list. Our drug list includes preferred drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (TTY: 866-215-1999) from the U.S. Virgin Islands.
- **We have a managed formulary.** If your provider believes a name brand product is necessary or there is no generic available, your provider may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (TTY: 866-215-1999) from the U.S. Virgin Islands.
- **These are the dispensing limitations.** Federal Drug Administration (FDA) guidelines are used by this Plan to manage the pharmacy coverage. These include dosing, generic medications and new drug classifications, among others. We cover non-controlled prescription drugs dispensed within twelve months (with 5 refills) of a doctor, dentist or podiatrist's original prescription not to exceed the normal monthly 30-day supply. The pharmacy network will not dispense any order too soon after the last one was filled. If this is your case, the pharmacy will contact the Plan to obtain an authorization. Some drugs require precertification. The List of Drugs identifies the drugs that require precertification with a PA. Also, the pharmacy will contact the Plan to obtain an authorization for dose changes and for charges over $750 per dispensed prescription. Some drugs will be dispensed by Specialty Pharmacies only; CVS Caremark Specialty Pharmacy, Walgreens Specialty Pharmacy, Puremed Pharmacy and Alivia Specialty Pharmacy, in order to verify that these drugs are appropriately prescribed and dispensed. To get a list of these drugs call 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (TTY: 866-215-1999) from the U.S. Virgin Islands. When you are planning a trip and need a prescription drug refill in advance, you must show the pharmacy the prescription, along with the airline tickets, to allow the pharmacy to contact the Plan to obtain an authorization.
- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a name brand. If you receive a name brand drug when a FDA approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

- **Why use generic drugs.** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs. You can save money by using generic drugs since you pay nothing. However, you and your Plan physician have the option to request a name brand if a generic option is available, but it will cost you. Using the most cost-effective medication saves money.
- **When you do have to file a claim. You must file a claim whenever you use a non-network pharmacy.** The Plan reimburses 75% of its established fees for prescription drugs and you pay the remaining charges. Submit your itemized bill and/or receipts to us. Also read Section 7 Filing a claim for covered services for required information.

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Medications prescribed to treat obesity • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered. • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction - limited to six (6) pills per month for men age 18 years and over. • Drugs to treat gender dysphoria- Hormonal Therapy • Vitamins only if they include the legend: "Federal law prohibits dispensing without a prescription" including prenatal vitamins. Note: Intravenous fluids and drugs for home use, implantable drugs, and some injectable drugs are covered under the Medical and Surgical Benefits (also covered under the Medical and Surgical Benefits provided as part of a home health service program).	You will pay the following copayments for drugs in the List of Drugs obtained from a Plan pharmacy: • Tier 1: Generic prescription drugs - $2.00 for unit or refill • Tier 2: Preferred brand prescription drugs - $20 for unit or refill • Tier 3: Non-preferred brand name drugs - 20% or $20, whichever is higher, up to $125 maximum out of pocket for unit or refill • Tier 4: Preferred Specialty/biotech drugs - 25% or $200 whichever is the lowest for unit or refill • Tier 5: Non-Preferred Specialty/biotech drugs - 30% or $300 whichever is the lowest for unit or refill
Generic copay waiver drugs: • Antihypertensives - Only includes ACE inhibitors, ARBs and Direct Renin Inhibitors • Oral Antidiabetics - Covered oral antidiabetics medications except injectables • Antihyperlipidemics - Only includes statins • Naloxone	Network: Nothing Note: Applies only to generic drugs. For brand copayment or coinsurance, refer to Tier 2 and Tier 3.
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below.	Network: Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. For surgical contraceptive exception process, that include the 24-hour response time, please visit: https://salud.grupotriples.com/en/health-insurance-plans/for-federal-employee/ If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. Note: For additional Family Planning benefits see Section 5(a) Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and programs in Section 5(a)	Network: Nothing
• Reimbursement for over-the-counter contraceptives can be submitted in our online page in www.ssspr.com Note: Over-the-counter contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider. Please refer to the pharmacy formulary for a complete list. Note: For Family Planning and Prescription drug coverage, please refer to the pharmacy formulary for a complete list.	Network: Nothing
• FDA approved tobacco cessation drugs (over-the-counter and prescription), including nicotine patches Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)	Network: Nothing
Preventive care medications to promote better health as recommended by ACA. The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a healthcare professional and filled at a network pharmacy. • Aspirin (81 mg) for adults ages 50-75 used with a 10% 10-year cardiovascular risk for the primary prevention of cardiovascular disease and Colorectal cancer • Folic acid supplements for women of 400 & 800 mcg, for women of childbearing age • Iron supplements for children from 4 months to 21 years with risk of anemia • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-5 • Breast cancer preventive medications such as Tamoxifen or Raloxifene • Statin preventive medication for adults ages 40-75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater	Network: Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
Note: To receive this benefit a prescription from a doctor must be presented to the pharmacy.	Network: Nothing
Mail Order and 90 Day Extended Supply Program These programs have the following characteristics: • 90-day supply, including one (1) refill • Not all drugs are subject to this program Note: Tier 4 and Tier 5 are not available under Mail Order or 90 Day Extended Supply Programs because specialty/biotech drugs are dispensed only by specialty pharmacies.	You will pay the following copayments for drugs in the List of Drugs: • Tier 1: Generic prescription drugs - $4.00 for unit or refill • Tier 2: Preferred brand prescription drug - $40 for unit or refill • Tier 3: Non-preferred brand name drugs - 20% or $60, whichever is higher, up to a $375 maximum out of pocket for unit or refill Note: You will not pay shipping charges
Not covered • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them* • *Nonprescription medications unless specifically indicated elsewhere or medications for which there is a nonprescription equivalent available (Except: Prilosec OTC 20 mg, Nexium, Claritin and its generics; and Zaditor and its generics that are covered with no copayment, when a physician prescribes them)* • *Medical supplies such as dressings, antiseptics, lancets and strips* • *Drugs supplied by pharmacies located outside of Puerto Rico, U.S. Virgin Islands, the United States and its territories, except for emergencies* • *Drugs to enhance athletic performance* • *Drugs that are experimental or investigational unless approved by the Federal Food and Drug Administration (FDA)* • *Hormone therapy for non-approved Federal Food and Drug Administration (FDA) conditions*	*All charges*
Preventive medications	**High Option**
The following are covered: Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.
Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a our pharmacy network in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections.	

Preventive medications - continued on next page

Benefit Description	You pay
Preventive medications (cont.)	**High Option**
For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/.	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications*	*All charges*

Section 5(f)(a). PDP EGWP Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- These prescription drug benefits are for members enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).
- If you are a Postal Service annuitant and their covered Medicare-eligible family member, you will be automatically group enrolled in our PDP EGWP. Contact us for additional information at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY:866-215-1999) from the U.S. Virgin Island or visit our website at www.ssspr.com.

Note: Notify us as soon as possible if you or your eligible family member is already enrolled in a Medicare Part D Plan. Enrollment in our PDP EGWP will cancel your enrollment in another Medicare Part D plan.

There are advantages to being enrolled in our PDP EGWP:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, you have a pharmacy network that may include pharmacies that are out-of-network or excluded for those enrolled in our standard non-PDP EGWP Prescription Drug Program.

We cover drugs, medications, and supplies as described below and on the following pages.

- 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.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused drugs, medications, and supplies.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage.
- If you choose to opt out of or disenroll from our PDP EGWP, see Section 9 for additional PDP EGWP information and for our opt-out and disenrollment process. Contact us for assistance with the PDP EGWP opt out and disenrollment process at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Islands.

Warning: If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage.

If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Islands.

Note:If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll during Open Season or for a QLE. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Islands.

Each new enrollee will receive a description of our PDP EGWP Summary of Benefits, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. Your prescribers must have Medicare-approved prescriptive authority.
- **Where you can obtain prescription drugs.** You may fill prescriptions at any network pharmacy. For assistance locating a PDP EGWP network pharmacy, visit our website athttps://salud.grupotriples.com/en/health-insurance-plans/triple-s-salud-for-federal-employee/, or call us at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Islands.
- **We have a managed formulary.** Your provider may prescribe drugs that are subject to additional review to determine they are medically necessary. You may view our formulary on our website athttps://salud.grupotriples.com/en/health-insurance-plans/triple-s-salud-for-federal-employee/, or call us at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Islands.
- **These are the dispensing limitations.** Federal Drug Administration (FDA) guidelines are used by this Plan to manage the pharmacy coverage. These include dosing, generic medications and new drug classifications, among others. We cover non-controlled prescription drugs dispensed within twelve months (with 5 refills) of a doctor, dentist or podiatrist's original prescription not to exceed the normal monthly 30-day supply. The pharmacy network will not dispense any order too soon after the last one was filled. If this is your case, the pharmacy will contact the Plan to obtain an authorization. Some drugs require precertification. The List of Drugs identifies the drugs that require precertification with a PA. Also, the pharmacy will contact the Plan to obtain an authorization for dose changes and for charges over $750 per dispensed prescription. Some drugs will be dispensed by Specialty Pharmacies only. To get a list of these drugs call 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (TTY: 866-215-1999) from the U.S. Virgin Islands. When you are planning a trip and need a prescription drug refill in advance, you must show the pharmacy the prescription, along with the airline tickets, to allow the pharmacy to contact the Plan to obtain an authorization.
- **A generic equivalent will be dispensed if it is available** unless your physician specifically requires a brand name drug. If you receive a brand name drug when an FDA approved generic drug is available, and your physician has not specified Dispense as Written for the brand name drug, you have to pay the difference in cost between the brand name drug and the generic.
- **Why use generic drugs.** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs. You can save money by using generic drugs since you pay nothing. However, you and your Plan physician have the option to request a name brand if a generic option is available, but it will cost you. Using the most cost-effective medication saves money.
- **When you do have to file a claim.** The Plan reimburses 75% of its established fees for prescription drugs and you pay the remaining charges. Submit your itemized bill and/or receipts to us. Also read Section 7 Filing a claim for covered services for required information.
- If we deny your claim and you want to appeal, you, your representative, or your prescriber must request an appeal following the process described in Section 8(a). Medicare PDP EGWP Disputed Claims Process. The PDP EGWP appeals process has 5 levels. If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions in the decision letter on how to move to the next level of appeal.

PDP EGWP Catastrophic Maximum

The prescription drug out-of-pocket maximum is $2,000. After this maximum is met, we pay 100% of all eligible covered prescription drug benefits.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Medications prescribed to treat obesity • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered. • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction - limited to six (6) pills per month for men age 18 years and over. • Drugs to treat gender dysphoria- Hormonal Therapy • Vitamins only if they include the legend: "Federal law prohibits dispensing without a prescription" including prenatal vitamins. Note: Intravenous fluids and drugs for home use, implantable drugs, and some injectable drugs are covered under the Medical and Surgical Benefits (also covered under the Medical and Surgical Benefits provided as part of a home health service program).	You will pay the following copayments for drugs in the List of Drugs obtained from a Plan pharmacy: • Tier 1: Generic prescription drugs - $2.00 for unit or refill • Tier 2: Preferred brand prescription drugs - $20 for unit or refill • Tier 3: Non-preferred brand name drugs - 20% or $20, whichever is higher, up to $125 maximum out of pocket for unit or refill • Tier 4: Preferred Specialty/biotech drugs - 25% or $200 whichever is the lowest for unit or refill
Generic copay waiver drugs: • Antihypertensives - Only includes ACE inhibitors, ARBs and Direct Renin Inhibitors • Oral Antidiabetics - Covered oral antidiabetics medications except injectables • Antihyperlipidemics - Only includes statins • Naloxone	Network: Nothing Note: Applies only to generic drugs. For brand copayment or coinsurance, refer to Tier 2 and Tier 3.
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. For surgical contraceptive exception process, that include the 24-hour response time, please visit: https://salud.grupotriples.com/en/healthinsurance-plans/for-federal-employee/ If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	Network: Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
Note: For additional Family Planning benefits see Section 5(a) Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)	Network: Nothing
• Reimbursement for over-the-counter contraceptives can be submitted in our online page in www.ssspr.com Note: Over-the-counter contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider. Please refer to the pharmacy formulary for a complete list.	Network: Nothing
• FDA approved tobacco cessation drugs (over-thecounter and prescription), including nicotine patches Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)	Network: Nothing
Preventive care medications to promote better health as recommended by ACA. The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a healthcare professional and filled at a network pharmacy. • Aspirin (81 mg) for adults ages 50-75 used with a 10% 10-year cardiovascular risk for the primary prevention of cardiovascular disease and Colorectal cancer • Folic acid supplements for women of 400 mcg, for women of childbearing age • Iron supplements for children from 4 months to 21 years with risk of anemia • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-5 • Breast cancer preventive medications such as Tamoxifen or Raloxifene • Statin preventive medication for adults ages 40-75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater Note: To receive this benefit a prescription from a doctor must be presented to the pharmacy.	Network: Nothing
Mail Order and 90 Day Extended Supply Program These programs have the following characteristics: • 90-day supply, including one (1) refill • Not all drugs are subject to this program	You will pay the following copayments for drugs in the List of Drugs: • Tier 1: Generic prescription drugs - $4.00 for unit or refill • Tier 2: Preferred brand prescription drug - $40 for unit or refill • Tier 3: Non-preferred brand name drugs - 20% or $60, whichever is higher, up to a $375 maximum out of pocket for unit or refill.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
	• Tier 4: Specialty Drugs - 25% or $200 whichever is the lowest for unit or refill Note: You will not pay shipping charges
Not covered • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them* • *Nonprescription medications unless specifically indicated elsewhere or medications for which there is a nonprescription equivalent available (Except: Prilosec OTC 20 mg, Nexium, Claritin and its generics; and Zaditor and its generics that are covered with no copayment, when a physician prescribes them)* • *Medical supplies such as dressings, antiseptics, lancets and strips* • *Drugs supplied by pharmacies located outside of Puerto Rico, U.S. Virgin Islands, the United States and its territories, except for emergencies* • *Drugs to enhance athletic performance* • *Drugs that are experimental or investigational unless approved by the Federal Food and Drug Administration (FDA)* • *Hormone therapy for non-approved Federal Food and Drug Administration (FDA) conditions*	*All charges*
Preventive medications	
The following are covered: • Preventive Medications with a USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.
Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from our pharmacy network in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/	Network: Nothing

Preventive medications - continued on next page

Benefit Description	You pay
Preventive medications (cont.)	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your PSHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your PSHB Plan. See Section 9 Coordinating benefits with other coverage.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- If you use a non-Plan dentist, you pay for services rendered and the Plan will pay 90% of the Plan's established fees after any applicable copay or coinsurance when services are received within the service area; or the Plan's established fees when services are rendered outside the service area after any applicable copayment or coinsurance. You pay all remaining charges. In U.S. Virgin Islands, the dentist will submit the claim directly to us and we will pay up to Plan's established fees for the U.S. Virgin Islands.
- Plan dentist means a duly authorized dentist with a regular license issued by the designated entity of the government of Puerto Rico, and who is a bona fide member of the "Colegio de Cirujanos Dentistas de Puerto Rico", who has signed a contract with Triple-S Salud to render dental services, or has a license rendered by the U.S. Virgin Islands Health Department, who has signed a contract with Blue Cross Blue Shield to render dental services. Non-Plan dentist means a duly authorized dentist with a regular license, who has not signed a contract with Triple-S Salud or Blue Cross Blue Shield of the U.S. Virgin Islands to render dental services.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Network: 25% Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount
Dental benefits	**High Option**
Dental coverage is limited to: Diagnostic • Periodic oral evaluation (D0120) • Limited oral evaluation (D0140) • Comprehensive oral evaluation (D0150) • Periapical and bitewing X-rays, limited to six periapical X-rays and no more than two bitewing X-rays per calendar year (D0220, D0230, D0270, D0272) • Preventive Prophylaxis, adult and child limited to one every six months (D1110, D1120) • Fluoride treatment, one every six months for children under 19 (D1208)	Network: Nothing Out-of-Network: 10% of the allowable charges plus any difference between our allowance and the billed amount

Dental benefits - continued on next page

Benefit Description	You pay
Dental benefits (cont.)	**High Option**
• Fluoride treatment, one every six months for enrollees over 19 years of age (D1208) • Panoramic X-rays, up to 1 set every 3 years (D0330)	Network: 30% Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Restorative • Amalgam restorations (D2140 - D2161) • Plastic, porcelain or composite, anterior and posterior tooth (D2330 - D2335, D2391, D2392 - D2394) • Other restorative services, pin retention per tooth in addition to restorations (D2951) • Sedative filling (D2940)	Network: 30% Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Adjunctive General Services • Application of desensitizing medicament (D9910) • Treatment of complications, post-surgical, unusual circumstances, by report (D9930)	Network: 30% Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Endodontics • Pulp capping-direct, excluding final restoration (D3110) • Pulp capping-indirect, excluding final restoration (D3120) • Pulpal debridement in primary and permanent teeth for emergency purposes (D3221)	Network: 30% Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Oral Surgery • Extractions (D7140) • Surgical removal of erupted teeth (D7210) • Surgical removal of residual tooth roots (D7250) • Incision and drainage of abscess - intra-oral soft tissue (D7510) • Surgical removal of impacted teeth (D7220 - D7240)	Network: 30% Out-of-Network: 10% of the allowable charges after any applicable copay or coinsurance, plus any difference between our allowance and the billed amount
Not covered: *• Other dental services not shown as covered.*	*All charges*

Section 5(h). Wellness and Other Special Features

Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24 hours, 7 days a week call center	Through **Teleconsulta** , members can have immediate access to the advice of professional nurses to help them decide whether to go to the emergency room immediately, visit or call their physician or follow self-care instructions to feel better. Nurses use scientifically based algorithms developed by physicians of all specialties to reach a recommendation for the member. Call us at 800-255-4375, toll free. We will be glad to assist you.
Blue Card Program	Triple-S Salud, Inc. is an independent concessionaire of the Blue Cross and Blue Shield Association. As in other Blue Cross and Blue Shield Plans, Triple-S Salud, Inc. participates in a program called the BlueCard Program. This program is of benefit for insured members who receive covered emergency or precertified services outside the service area of Triple-S Salud, Inc. through program plan providers. When services are received outside the area and claims for such services are processed through the BlueCard Program, the amount (coinsurance, co-payment or deductible) paid for these services will be determined based on the arrangements as an estimate amount equivalent between the local Blue Cross or Blue Shield Plan of the area with its participating providers. The negotiated fee may be a discount of invoiced charges equivalent to an average of the savings that the area Blue Cross or Blue Shield Plan expects to receive from all or a specific group of its participating providers. The BlueCard Program is available to all members insured with a Blue Cross and Blue Shield Association Plan. When you need emergency or precertified hospital and medical services in any state out of the service area, you can receive them through the Plan providers of this Program. Call 800-810-2583 or 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (TTY: 866-215-1999) from U.S. Virgin Islands for additional information. Remember that you are responsible for paying the applicable copays or coinsurances related to out of area care according to the terms of your coverage.

Blue Card Worldwide	Blue Card Worldwide is available to all members insured with a Blue Cross and Blue Shield Association Plan. When you need emergency hospital and medical services out of the service area and the United States of America, you can receive them through the Plan providers of this Program in other countries. Call 800-810-2583 for additional information.
High risk pregnancies	Educational program for pregnant women that offers virtual workshops on prenatal care, childbirth, and breastfeeding. By participating in the program, you will enjoy benefits such as as $0 copay for prenatal and postnatal visits, up to 16 hours of postpartum in home-support, and a free electric breast pump. In addition, women with high-risk pregnancies will receive up to 16 hours of prenatal in-home support, a glucometer, and a blood pressure monitor.
Centers of Excellence for transplants/heart surgery/ etc.	We offer you the benefit of the Blue Distinction Centers for Transplants (BDCT) which is a cooperative effort among the Blue Cross and/or Blue Shield Plans, Blue Cross and Blue Shield Association and Participating Institutions to facilitate the provision of quality care in a cost-effective manner from leading institutions for six transplant types: heart, single or bilateral lung, combination heart-bilateral lung, liver, simultaneous pancreas-kidney, and bone marrow/stem cell (autologous/allogeneic). Call 800-981-4860 or 787-749-4949 extensions 4361 or 4312 for additional information.
Telexpreso	Automatic interactive voice response unit that allows the member to access information and make transactions without a direct intervention of a Customer Service Representative. Through this system the member verifies benefits, asks for a duplicate ID card and verifies the status of a claim, among other services. Call us at 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 888-716-6081 (TTY: 866-215-1999) from the U.S. Virgin Islands.
Medication Therapy Management Program	We offer a Medication Therapy Management Program at no additional cost to members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. This program was developed for us by a team of pharmacists and doctors. We use this Medication Therapy Management Program to help us provide better coverage for our members. For example, this program helps us make sure that our members are using appropriate drugs to treat their medical conditions and helps us identify possible medication errors. We may contact members who qualify for this program. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you don't need to pay anything extra to participate. If you are selected to join a Medication Therapy Management Program, we will send you information about the program, including information about how to access it.
Health Risk Assessment (HRA) tool	We developed an HRA tool that evaluates lifestyles, risk factors, and existing conditions, among others. It will help us have a clear profile of our insured population and help us determine where to direct our health education and prevention strategies. The HRA will also help enrollees do a health-assessment to find out where they are in term of compliance with preventive tests, the changes they need to make, and to gain greater awareness to prevent future health problems. Once you complete your HRA, you will receive an Exercise Kit that includes a backpack with a water bottle, pedometer, wrist band, and jump rope. Register today at our website www.ssspr.com. **Stay active, Stay healthy!**
Preventive Care Centers	Get your medical checkups in a single visit. You have more obligations every day but less time to accomplish them and healthcare is no exception. The time it takes you to visit the doctor, get routine checkups and manage your existing conditions-in addition to the amount you spend on copays- are obstacles on your path to health. Triple-S Salud, Inc. brings you the Preventive Care Program. Members 21 years and older may receive all of their preventive services in one place!

	All around our Island you will find eight Preventive Care Centers located at: Arecibo, Bayamón, Caguas, Carolina, Guaynabo, Mayaguez, Ponce, and San Sebastian. In these facilities you will be able to receive services that include Evaluations, such as: medical history, physical exams, depression screening, high-risk behaviors, and health education; Tests, such as: CBC, cholesterol, Pap (cervical cancer), chlamydia, gonorrhea, syphilis, HIV, glycated hemoglobin, vision; Medical Referrals, such as: Mammograms, vaccines, bone density test, colonoscopy, sigmoidoscopy, and much more. Recommended tests and medical orders are based on clinical guidelines or medical criteria.
Oncology Analytics	Oncology Analytics is a comprehensive oncology benefits management program which provides clinical decision support on oncology drugs, radiation therapy, molecular and genetic testing. Partnering with Oncology Analytics allows Triple-S to provide you with a higher quality of service by having clinical decision support by hematologists, medical and radiation oncologists, recommended protocols for efficacy, toxicity, and affordability and a user-friendly web-based application using the latest national guidelines. Providers receive the clinical decision support necessary to make optimal treatment decisions for the most effective, affordable and least toxic care available. This optimizes outcomes and cost of care. Having access to evidence-based guidelines along with clinical depth and breadth of a clinical team ensures that you receive the highest quality value-based treatment decisions. Oncology Analytics applies evidence-based approach to preauthorization of chemotherapy drugs, radiation therapy, genetic testing and Pet CT, to reduce under-treatment, over treatment and inappropriate treatment of cancer patients.
Triple S En Casa	Mobile application that will give access to send prescriptions electronically, buy medicine through the application and receive the order in your house or place of preference. For additional information, download the application into your mobile device or contact us at 888-525-4842.
Triple S Contigo Professional Counseling	A part of the approach to continue treating mental health conditions, the program will provide help for members, including: • 24 hours Call Center fully attended by mental health professionals • Immediate access to direct clinical face to face or virtual services • Visits to EAP professionals, ten (10) visits per situation, per year • FHC Emotional Connect-Teleheatlh: confidential way to timely access services to mental health specialist for counseling through videoconference • Rehab Program • Crisis Intervention

Section 5(i). Point of Service Benefits

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

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

You can also receive services from a non-Plan hospital. A non-Plan hospital is any licensed institution that is not a Plan hospital and that is engaged primarily in providing bed patient with diagnosis and treatment under the supervision of physicians with 24-hour-a-day registered graduate nursing services. A non-Plan hospital does not have to accept Triple-S Salud, Inc. established fees as payment in full. You must pay any difference between the non-Plan hospital's charges and the amount paid to you by us. We reimburse you according to our established fee for non-Plan hospital inpatient admissions within our service area, or for services outside the service area that are neither an emergency nor precertified. Please refer to Section 1, How this plan works, for more information on point of service 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
•Prescription drugs
•Organ/tissue transplants
•All exclusions that appear in Sections 5 and 6

Non-PSHB Benefits Available to Plan Members

The benefits on this page are not part of the PSHB contract or premium, you cannot file an PSHB disputed claim about them, and they are not available for residents in the U.S. Virgin Islands. Fees you pay for these services do not count toward PSHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 787-474-5219 (TTY: 787-792-1370) or visit the website at www.ssspr.com.

Triple-S Salud Medicare Advantage Plans: Triple-S Medicare Advantage plans focus on the health and well-being of Medicare beneficiaries, including seniors 65 and older and people with disabilities age 21 and older. You can choose among several options. These Plans cover all Medicare Parts A and B benefits and offer other benefits not covered by the Traditional Medicare Plan.

Triple-S Medicare Advantage plans offer you various options that include Plans from $0 to low premium, low copayments for the majority of the services obtained within the Plan network, and Plans with Part D extended prescription drug coverage.

With any of our products you will enjoy:

- $0 and/or low copayments and coinsurances when you obtain most of the services through our Plan providers
- You choose your doctors and providers. With several of our Plans you don’t need referrals to visit any physician or to receive any covered services
- Teleconsulta, our 24 hours, 7 days health orientation line
- Our Total Wellness Program for members with diabetes, hypertension, asthma, and chronic heart failure
- Alternative Medicine Coverage
- Medicare Prescription drug (Part D) Plans with no initial annual deductible. Services can be accessed through over 1,000 pharmacies in Puerto Rico and over 55,000 in the United States.

If you have Medicare Parts A and B, reside permanently in Puerto Rico and do not have end stage renal disease, you are eligible! Triple-S Salud, Inc. helps offer peace of mind for Medicare beneficiaries residing in Puerto Rico by offering more services than traditional Medicare for little additional cost or no cost at all. For more information visit any of our Service Centers throughout the Island or visit our webpage at www.ssspr.com. Prospective members can also call toll free at 877-207-8777 and TTY/TDD should call 800-383-4457, Monday through Saturday from 8:00 a.m. to 5:00 p.m.

Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency services/accidents).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the PSHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Extra care and research costs of clinical trials;
- Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel;
- Drug detection tests for employment purposes;
- Services or supplies we are prohibited from covering under the Federal Law; and
- All services related to anti-aging therapy (aesthetics).

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, 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, coinsurance, or deductible.

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 and hospital benefits

In most cases, providers and facilities file claims for you. Provider must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 787-474-5219, or at our website at www.ssspr.com.

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

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the provider or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

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

Submit your claims to:

Triple-S Salud, Inc.

PO Box 363628

San Juan, PR 00936-3628

Prescription drugs

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 Salud, Inc.

PO Box 363628

San Juan, PR 00936-3628

Other supplies or services	**Submit your claims to:** **Triple-S Salud, Inc.** **PO Box 363628** **San Juan, PR 00936-3628**
Deadline for filing your claim	Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance) and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website. If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) and you disagree with our **pre-service or post-service** decision about your prescription drug benefits, please, follow Medicare's appeals process outlined in Section 8a. Medicare PDP EGWP Disputed Claims Process.

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

Reminder: If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D PDP EGWP you may appeal an adverse pre-service or post-service determination through Medicare's appeals process. See Section 8(a).

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing Triple-S Salud, Inc., 1441 Roosevelt Avenue San Juan, Puerto Rico 00920 or calling 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201.9256 (TTY: 866-215-1999) from the U.S. Virgin Islands.

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

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

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

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

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 Salud, Grievances and Appeals Department, PO Box 11320, San Juan, Puerto Rico 00922-9905; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

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

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

a) Pay the claim or

b) Write to you and maintain our denial or.

c) Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

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

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Postal Service Insurance Operations (PSIO), 1900 E Street, room 3443, NW, Washington, DC 20415.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM’s review within 60 days. There are no other administrative appeals.

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Islands. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's PSIO at (202) 936-0002 between 8 a.m. and 5 p.m. Eastern Time.

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

Reminder: If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D PDP EGWP you may appeal an adverse pre-service or post-service determination through Medicare's appeals process. See Section 8a.

Section 8(a). Medicare PDP EGWP Disputed Claims Process

When a claim is denied in whole or in part, you may appeal the denial. Our Plan follows the Medicare Part D appeals process.

What if I don't agree with this decision?

You have the right to ask for an independent review (appeal) of our decision. If your case involves an exception request and your physician or other prescriber did not already provide your plan with a statement supporting your request, **your physician or other prescriber must provide a statement to support your exception request and you should attach a copy of this statement to your appeal request.** If you want to appeal our decision, you must request your appeal in writing by mail or electronically within 60 calendar days after the date of this notice. You must submit your written your written request to the independent reviewer at one of the following address:

United States Postal Service (USPS): For Mail sent by courier such as FedEx or UPS

C2C Innovative Solutions, Inc.
P.O. Box 44166
Jacksonville, FL 32231-4166

C2C Innovative Solutions, Inc.
301 W. Bay St. Suite 1110
Jacksonville, FL 32202

Fax Numbers:

For Standard Appeals: (833) 710-0580

For Expedited Appeals: (833) 710-0579 **Phone**: (833)919-0198

Part D QIC Portal Address: https://www.c2cinc.com//Appellant-Signup

Who May Request an Appeal?

You, your prescriber, or someone you name to act for you (your representative) may request an appeal. If someone request an appeal for you, he or she must send proof of his, her right to represent you with the request form. Proof could be or a power or attorney a court order, or an Appointment of Representation form. If the person appealing is your prescriber or is authorized under state law to act for you, an Appointment of Representation is not needed.

There Are Two Kinds of Appeals. You Can Request:

Expedited (72 hours)

You can request an expedited (fast) appeal for cases that involve coverage, if you or your doctor believes that your health could be seriously harmed by waiting up to 7 days for a decision. If your request to expedite is granted, the independent reviewer must give you a decision no later than 72 hours after receiving your appeal (the timeframe may be extended in limited circumstances).

- **If the doctor who prescribed the drug(s)** asks for an expedited appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 7 days could seriously harm your health, **the independent reviewer will automatically expedite the appeal.**
- If you ask for an expedited appeal without support from a doctor, the independent reviewer will decide if your health requires an expedited appeal. If you do not get an expedited appeal, your appeal will be decided within 7 days.
- Your appeal will not be expedited if you've already received the drug you are appealing.

Standard (7 days)

You can request a standard appeal for a case involving coverage or payment. The independent reviewer must give you a decision no later than 7 days after receiving your appeal (the timeframe may be extended in limited circumstances).

When the Independent Reviewer Can Extend the Timeframe for Making a Decision – The timeframe may be extended if your case involves an exception request and we have not received the supporting statement from your doctor or other prescriber supporting the request. The timeframe also may be extended when the person acting for you files an appeal request but does not submit proper documentation of representation. In both situations, the independent reviewer may toll (or stop the clock) for up to 14 days to get this information.

You can call us at: 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U. S. Virgin Islands to learn how to name your representative.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

For more information about your appeal rights, call us or see your Evidence of Coverage.

If your appeal relates to a decision by us to deny a drug that is not on our list of covered drugs (formulary) or if you are asking for an exception to a prior authorization (PA) or other utilization management (UM) requirement, your prescribing doctor or other prescriber must submit a statement with your appeal request indicating that all the drugs on any tier of our formulary (or the PA/UM requirement) would not be as effective to treat your condition as the requested drug, or would harm your health.

How Do I Request an Appeal?

You, your prescriber or your representative should mail or fax your written appeal request to:

United States Postal Service (USPS):	**UPS / FedEx ONLY**:
C2C Innovative Solutions, Inc.	C2C Innovative Solutions, Inc.
Part D Drug Reconsiderations	Part D Drug Reconsiderations
P.O. Box 44166	301 W. Bay St., Suite 1110
Jacksonville, FL 32231 – 4166	Jacksonville, FL 32202

Fax Numbers:

Standard Appeals: (833) 710-0580 **Expedited Appeals:** (833) 710-0579

QIC Appeals Portal: https://www.c2cinc.com/Appellant-Signup

What Happens Next? If you appeal, the independent reviewer will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can appeal to an administrative law judge (ALJ) if the value of your appeal is at least $130. If you disagree with the ALJ decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

Contact Information:

If you need information or help, call us at:

Toll Free: You can call us at: 787-474-5219 from Puerto Rico or 833-201-9256 from the U.S. Virgin Islands

TTY/TDD: 787-792-1370 from Puerto Rico or 866-215-1999 from the U.S. Virgin Islands

Other Resources To Help You:

Medicare Rights Center

Toll Free: 1-888-HMO-9050 (1-888-466-9050)

Elder Care Locator

Toll Free: 1-800-677-1116

1-800-MEDICARE (1-800-633-4227)

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.ssspr.com.

Medicare Part D and MA-PD plans are subject to Medicare Secondary Payer (MSP). Medicare Secondary Payer (MSP) means **the carrier or Part D sponsor pays for healthcare services first**, making that insurer the primary payer. The secondary payer covers some or all of the remaining costs that the primary payer leaves unpaid. In addition, Part D plan sponsors must coordinate payment and coverage with certain state programs that provide prescription drug assistance; other prescription drug plans, including Medicaid, GHPs, Federal Employee Health Benefits (FEHB), military coverage; and other plans or programs providing prescription drug coverage. To support the required benefit coordination, Part D sponsors may request information on third-party insurance from beneficiaries.

Please see Section 4, *Your Costs for Covered Services*, for more information about how we pay claims.

TRICARE and CHAMPVA

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

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

Workers' Compensation

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

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

Medicaid

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

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

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

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

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

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

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

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some PSHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your PSHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.gov or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your PSHB plan so that your plans can coordinate benefits. Providing your PSHB information may reduce your out-of-pocket cost.

Clinical trials

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

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

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

When you have Medicare

For more detailed information on "What is Medicare?" and "When do I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

Important Note: Subject to limited exceptions, Postal Service annuitants entitled to Medicare Part A and their eligible family members who are entitled to Medicare Part A are required to enroll in Medicare Part B to maintain eligibility for the PSHB Program in retirement.

If you are required to enroll in Medicare Part B and fail to do so at your first opportunity, you may be disenrolled (annuitants) and/or your family members removed from coverage.

For more information on these requirements, please contact 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Islands.

The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.
When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Islands, or see our website at www.ssspr.com.

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

- Medical services and supplies provided by physicians and other healthcare professionals.

We do not waive any costs if the Original Medicare Plan is your primary payor.

Please review the following examples which illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description: Deductible
High Option You pay without Medicare: $1,000
High Option You pay with Medicare Part B: $0

Benefit Description: Catastrophic Protection Out-of-Pocket Maximum
High Option You pay without Medicare: $5,000 self only/$10,000 family
High Option You pay with Medicare Part B: $5,000 self only/$10,000 family

Benefit Description: Part B Premium Reimbursement Offered
High Option You receive without Medicare: NA
High Option You receive with Medicare Part B: Up to $120

Benefit Description: Primary Care Provider
High Option You pay without Medicare: 15% or $25
High Option You pay with Medicare Part B:$0

Benefit Description: Specialist
High Option You pay without Medicare: 15% or $40
High Option You pay with Medicare Part B: $0

Benefit Description: Inpatient Hospital
High Option You pay without Medicare: 15% per admission
High Option You pay with Medicare Part B: $0

Benefit Description: Outpatient Hospital
High Option You pay without Medicare: 15% or $150 per visit
High Option You pay with Medicare Part B: $0

Benefit Description: Incentives offered
High Option You receive without Medicare: NA
High Option You receive with Medicare Part B: Plan will insert applicable incentives offered when member has Part B: gym discounts, hearing aid discounts, etc.

You can find more information about how our plan coordinates benefits with Medicare in the summary of benefits included in our website at www.ssspr.com.

Tell us about your Medicare coverage

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

Medicare Advantage (Part C)

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

This Plan and another plan's Medicare Advantage plan: You may enroll in another non-PSHB plan's Medicare Advantage plan and also remain enrolled in our PSHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended PSHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant, you can suspend your PSHB coverage to enroll in a Medicare Advantage plan, eliminating your PSHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

Medicare prescription drug coverage (Part D)

When we are the primary payor, we process the claim first. If you (as an active employee eligible for Medicare Part D or their covered Medicare Part D-eligible family member) enroll in any open market Medicare Part D plan and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by that Medicare Part D plan and consider them for payment under the PSHB plan.

Note: If you are a Postal Service annuitant or their covered Medicare-eligible family member enrolled in our Medicare Part D PDP EGWP, this does not apply to you because you may not be enrolled in more than one Medicare Part D plan at the same time. If you opt out of or disenroll from our PDP EGWP you do not have our PSHB Program prescription drug coverage and we are not a secondary payor for prescription drug benefits.

Medicare Prescription Drug Plan (PDP) Drug Plan Employer Group Waiver Plan (EGWP)

If you are enrolled in Medicare Part A and/or Part B, and are not enrolled in Medicare Advantage Prescription Drug Plan (MAPD), you will be automatically group enrolled into our Medicare PDP EGWP. Our PDP EGWP is a prescription drug benefit for Postal Service annuitants and their covered Medicare-eligible family members. This allows you to receive benefits that will never be less than the standard prescription drug coverage that is available to members with non-PDP EGWP prescription drug coverage. But more often you will receive benefits that are better than members with standard non-PDP EGWP prescription drug coverage. **Note: You have the choice to opt out of or disenroll from our PDP EGWP at any time and may obtain prescription drug coverage outside of the PSHB Program.**

When you are enrolled in our Medicare PDP EGWP for your prescription drug benefits you continue to have our medical coverage.

Members with higher incomes may have a separate premium payment for their Medicare Part D Prescription Drug Plan (PDP) benefit. Please refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to an additional premium.

For people with limited income and resources, Extra Help is a Medicare program to help with Medicare prescription drug plan costs. Information regarding this program is available through the Social Security Administration (SSA) online at www.ssa.gov, or call the SSA at 800-772-1213 TTY 800-325-0778. You may also contact 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Islands.

The PDP EGWP opt out process:

If you were automatically group enrolled into our PDP EGWP, you have the choice to opt out of this enrollment at any time. For additional information about how to opt out, contact us at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Island.

The PDP EGWP disenrollment process:

When you are enrolled in our PDP EGWP, you may choose to disenroll at any time, contact us at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Island.

Warning:If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage.

Note:If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll when and if you are eligible. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Island.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have PSHB coverage on your own as an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have PSHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Postal Service and your position is excluded from the PSHB (your employing office will know if this is the case) and you are not covered under PSHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Postal Service and your position is not excluded from the PSHB (your employing office will know if this is the case) and...		
• You have PSHB coverage on your own or through your spouse who is also an active employee		✓
• You have PSHB coverage through your spouse who is an annuitant	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a Postal employee receiving Workers' Compensation		✓*
8) Are a Postal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30-month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30-month coordination period)**		✓
• Medicare based on ESRD **(after the 30-month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have PSHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical trials cost categories

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

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

See Section 4, page 22

Copayment

See Section 4, page 22

Cost-sharing

See Section 4, page 22

Covered services

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

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. Custodial care that lasts 90 days or more is sometimes known as Long term care. These activities include but are not limited to:

	• personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing; • homemaking, such as preparing meals or special diets; • moving the patient; • acting as a companion or sitter; • supervising medication that can usually be self-administered; or • treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.
Experimental or investigational services	This Plan considers factors which it determines to be most relevant under the circumstances, such as: published reports and articles in the authoritative medical, scientific, and peer review literature; or written protocols used by the treating facility or being used by another facility studying substantially the same drug, device, or medical treatment. This Plan also considers Federal and other governmental agency approval as essential to the treatment of an injury or illness by, but not limited to, the following: American Medical Association, U.S. Surgeon General, U.S. Department of Public Health, the Food and Drug Administration, or the National Institutes of Health.
Healthcare professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.
In-Network/Network/ Plan provider	In-network, network or plan providers are the Doctors, group of doctors, other health professionals, hospitals and other health care facilities that have an agreement with us to accept our payment and any copayment or coinsurance as a full payment. We have made some arrangements with these providers so they can offer services covered by our plan to our enrollees.
Infertility	Triple-S Salud defines infertility as a disease or condition characterized by the inability to impregnate or conceive; a person's inability to reproduce either as an individual or with the person's partner for a period of 12 months or more (6 months for members over age 35). Cases of infertility can be determined based on a patient's medical history, physical findings, or diagnostic testing. Infertility
Medical necessity	Services, drugs, supplies, or equipment provided by a hospital or covered provider of health care services that the Plan determines: • are appropriate to diagnose or treat the patient's condition, illness or injury; • are consistent with standards of good medical practice in the United States; • are not primarily for the personal comfort or convenience of the patient, the family, or the provider; • are not a part of or associated with the scholastic education or vocational training of the patient; and • in the case of inpatient care, cannot be provided safely on an outpatient basis. The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug, or equipment does not, in itself, make it medically necessary.
Medicare Part A	Part A helps cover inpatient hospital stays, skilled nursing facility care, hospice care, and some health care.
Medicare Part B	Part B covers medically necessary services like doctors' services and tests, outpatient care, home health services, durable medical equipment, and other medical services.
Medicare Part C	Part C is a Medicare Advantage plan that combines the coverage of Medicare Part A and Part B. Part C typically also covers additional benefits like, dental, vision, and hearing services. Some Part C plans also include Medicare Part D coverage.

Medicare Part D	Medicare Part D plans provide coverage for prescription drugs. Private insurers contract with CMS on an annual basis for the right to offer Part D plans. Part D can be offered as a standalone Prescription Drug plan (PDP) or as part of a Medicare Advantage Prescription Drug plan (MAPD).
Medicare Part D EGWP	A Medicare Part D Employer Group Waiver Plan (EGWP) is a type of Medicare prescription drug plan that can be offered to employees and retirees of certain companies, unions, or government agencies, which allows for flexibility and enhanced coverage of traditional Medicare pharmacy benefits. Examples of Medicare Part D EGWPs are Medicare Advantage Prescription Drug (MAPD) plan EGWPs that include both health and drug benefits, as well as Prescription Drug Plan (PDP) EGWPs, which only cover the prescription drug benefit.
Out-of-Network/Non-Plan provider	Doctors, group of doctors, other health professionals, hospitals and other health care facilities who do not have an active contract with Triple-S Salud, Inc. to accept our payment and any copay or coinsurance as a full payment.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: the Plan allowance in our service area, Puerto Rico and U.S. Virgin Islands, is the medical benefits schedule, the fees Plan providers have agreed to accept as payment in full. The Plan allowance outside of the service area is the usual, customary and reasonable charge.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Precertification	Advanced authorization from Triple-S Salud, Inc. for the payment of any of the benefits and coverage under this policy and its riders, in cases Triple-S Salud, Inc. deems necessary. Some of the objectives of the precertification are: evaluate if the service is medically necessary, evaluate the adequacy of the service location, verify the eligibility of the insured for the requested service, and its availability in Puerto Rico. Precertifications will be evaluated based on the precertifications policies that Triple-S Salud,Inc. has set forth through time. Triple-S Salud, Inc. will not be liable for payment of services that have been rendered or received without this authorization from Triple-S Salud, Inc.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Surprise bill	An unexpected bill you receive for: • emergency care – when you have little or no say in the facility or provider from whom you receive care, or for • non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for

- air ambulance services furnished by nonparticipating providers of air ambulance services.

Us/We Us, We and Plan refer to Triple-S Salud, Inc.

You You refers to the enrollee and each covered family member.

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

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

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

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 787-474-5219 (TTY: 787-792-1370) from Puerto Rico or 833-201-9256 (TTY: 866-215-1999) from the U.S. Virgin Islands. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Index

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

Summary of Benefits for Triple-S Salud, Inc. - High Option Plan 2025

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this PSHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.ssspr.com.

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.

We only cover services provided or arranged by Plan physicians, expect in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Network: $7.50 office visit copay for PCP or $7.50 specialist; Nothing for X-rays and $1.00 per laboratory Out-of-Network: 10% of our allowance plus any difference between allowance and billed amount	29-30
Services provided by a hospital: • Inpatient	Network: Nothing Out-of-Network: 10% of our allowance plus any difference between allowance and billed amount	50-51
Services provided by a hospital: • Outpatient	Network: $25 facility copay for outpatient surgery Out-of-Network: 10% of our allowance plus any difference between allowance and billed charge	51
Emergency benefits: • Network	Network: Emergency room $25; if we recommend the visit $10. Nothing for hospital. Urgent care in network urgent centers $10 copay	54
Emergency benefits: • Out-of-Network	10% plus all charges that exceed our allowance	54
Mental health and substance use disorder treatment**:**	In-Network: Regular cost-sharing. Out-of-Network: Benefits are limited	56-57
Prescription drugs: • Retail pharmacy - up to a 30-day supply	• Tier 1: generic prescription drugs, $2.00 for unit or refill. • Tier 2: preferred brand prescription drug, $20 for unit or refill. • Tier 3: non-preferred brand name drugs, 20% or $20, whichever is higher, $125 maximum out of pocket for unit or refill. • Tier 4: Preferred Specialty/biotech drugs, 25% or $200, whichever is the lowest for unit or refill • Tier 5: Non-Preferred Specialty/biotech drugs, 30% or $300, whichever is the lowest for unit or refill	59

High Option Benefits	You pay	Page
Prescription drugs: • Mail Order and 90 Day Extended Supply Programs - up to a 90-day supply of certain maintenance drugs	• Tier 1: generic prescription drugs, $4.00 for unit or refill • Tier 2: preferred brand prescription drug, $40 for unit or refill • Tier 3: non-preferred brand name drugs, 20% or $60, whichever is higher, $375 maximum out of pocket for unit or refill	61
Prescription drugs: • Specialty drugs	• Tier 4: Preferred Specialty/biotech drugs - 25% or $200 whichever is the lowest for unit or refill • Tier 5: Non-Preferred Specialty/biotech drugs - 30% or $300 whichever is the lowest for unit or refill	59
Medicare PDP EGWP:	• Tier 1: generic prescription drugs, $4.00 for unit or refill • Tier 2: preferred brand prescription drug, $40 for unit or refill • Tier 3: non-preferred brand name drugs, 20% or $60, whichever is higher, $375 maximum out of pocket for unit or refill • Tier 4: Specialty - 25% or $200 whichever is the lowest for unit or refill	65
Dental care:	Nothing for diagnostic services; 30% all other services.	69-70
Vision care:	$7.50 per office visit	38
Special features:	Flexible benefits option · Teleconsulta · Blue Card Program · Blue Card Worldwide · Centers of Excellence for transplants · Telexpreso · Medication Therapy Management Program · Health Risk Assessment (HRA) tool · Preventive Care Centers · Oncology Analytics	71-73

2025 Rate Information for High Option Benefits for Triple-S Salud, Inc.

To compare your PSHB health plan options please go to https://health-benefits.opm.gov/PSHB/

To review premium rates for all PSHB health plan options please go to **www.opm.gov/healthcare-insurance/pshb/premiums/**

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
High Option Self Only	14A	$225.74	$75.25	$489.11	$163.04
High Option Self Plus One	14C	$506.86	$168.95	$1,098.20	$366.06
High Option Self and Family	14B	$516.95	$172.32	$1,120.07	$373.35

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
High Option Self Only	83A	$161.52	$53.84	$349.96	$116.65
High Option Self Plus One	83C	$362.68	$120.89	$785.81	$261.93
High Option Self and Family	83B	$369.89	$123.30	$801.44	$267.14