Triple-S Salud, Inc.

www.ssspr.com

Customer Service 787-774-6081 or 800-716-6081

TRIPLE-S SALUD

2027

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 FEHB Facts page 7 for details. This Plan is accredited. See How This Plan Works page 12.

Serving: All of Puerto Rico and U.S. Virgin Islands

Enrollment in this plan is limited. You and your dependents must live in our geographic service area to enroll. See page 14 for requirements.

Postal Employees and Annuitants are no longer eligible for this plan. (unless currently under Temporary Continuation of Coverage).

Enrollment Codes for this Plan:

For Residents in Puerto Rico and U.S. Virgin Islands

891 Self Only

893 Self Plus One

892 Self and Family

IMPORTANT
- Rates: Back Cover
- Changes for 2027: Page 15
- Summary of Benefits: Page 89

Special Notice: Enrollees formerly in enrollment code 85 U.S. Virgin Islands will merge into enrollment code 89 unless the enrollees select another FEHB plan during Open Season.

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-016

Important Notice from Triple-S Salud, 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 meets the Centers for Medicare & Medicaid Services (CMS) requirements to be considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB Plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

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

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug Plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www. socialsecurity.gov, or call the SSA at 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 FEHB 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 FEHB 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 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

Table of Contents 1
Introduction 3
Plain Language 3
Stop Health Care Fraud! 3
Discrimination is Against the Law 5
Preventing Medical Mistakes 5
FEHB Facts 7
- Coverage information 7
- No pre-existing condition limitation 7
- Minimum essential coverage (MEC) 7
- Minimum value standard 7
- Where you can get information about enrolling in the FEHB Program 7
- Enrollment types available for you and your family 7
- Family member coverage 8
- Children's Equity Act 9
- When benefits and premiums start 9
- When you retire 10
- When FEHB coverage ends 10
- Upon divorce 10
- Temporary Continuation of Coverage (TCC) 10
- Converting to individual coverage 10
- Health Insurance Marketplace 11

Section 1. How This Plan Works 12
- Who provides my health care 12
- We have Open Access benefits 13
- We have Point-of-Service (POS) benefits 13
- How we pay providers 13
- Your rights and responsibilities 13
- Your medical and claims records are confidential 14
- Service Area 14

Section 2. Changes for 2027 15
- Changes to this Plan 15

Section 3. How You Get Care 16
- Identification cards 16
- Where you get covered care 16
- Plan providers 16
- Plan facilities 16
- Inpatient Value Care Hospital Network 16
- Other Providers 17
- What you must do to get covered care 17
- Primary care 17
- Specialty care 17
- Hospital care 17
- If you are hospitalized when your enrollment begins 17
- Balance Billing Protection 18
- You need prior Plan approval for certain services 18

- Inpatient hospital admission 18
- Other Services....18
- How to request precertification for an admission or Other services 19
- Non urgent care claims 19
- Urgent care claims 20
- Concurrent care claims 20
- Emergency inpatient admission....20
- Maternity care....20
- If your treatment needs to be extended....21
- What happens when you do not follow the precertification rules when using non-network providers 21
- Circumstances beyond our control 21
- If you disagree with our pre-service claim decision....21
- To reconsider a non-urgent care claim....21
- To reconsider an urgent care claim 21
- To file an appeal with OPM....21

Section 4. Your Costs for Covered Services 22
- Cost-sharing....22
- Copayment....22
- Coinsurance 22
- Differences between our Plan allowance and the bill....22
- Your catastrophic protection out-of-pocket maximum for coinsurance and copayments 22
- Carryover....22
- When Government facilities bill us 23
- Important Notice About Surprise Billing – Know Your Rights....23
- The Federal Flexible Spending Account Program - FSAFEDS 23

Section 5. Benefits 24
Non-FEHB Benefits Available to Plan Members....69
Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover....70
Section 7. Filing a Claim for Covered Services....71
Section 8. The Disputed Claims Process....73
Section 9. Coordinating Benefits with Medicare and Other Coverage....76
- When you have other health coverage....76
- TRICARE and CHAMPVA 76
- Workers' Compensation....76
- Medicaid 76
- When other Government agencies are responsible for your care 77
- When others are responsible for injuries 77
- When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage....77
- Clinical Trials 77
- When you have Medicare 78
- The Original Medicare Plan (Part A or Part B)....78
- Tell us about your Medicare coverage....79
- Medicare Advantage (Part C) 79
- Medicare prescription drug coverage (Part D) 80

Section 10. Definitions of Terms We Use in This Brochure 82
Index....86
Summary of Benefits for the Triple-S Salud, Inc. Plan - 2027 89
2027 Rate Information for Triple-S Salud, Inc. 91

Introduction

This brochure describes the benefits of Triple-S Salud, Inc. under contract (CS-1090) between Triple-S Salud, Inc. and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 787-774-6081 from Puerto Rico or 800-716-6081 from the U.S. Virgin Islands or through our website: www. ssspr.com. If you are deaf, hearing impaired or speech impaired, you can contact our Customer Service at TTY: 787-792-1370 from Puerto Rico or TTY: 866-215-1999 from the U.S. Virgin Islands. If you need ASL providers see our website at 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. Brochures are available in Spanish. You can get a copy by calling 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-981-3241 (TTY: 866-215-1999) from the U.S. Virgin Islands.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2027, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each Plan annually. Benefit changes are effective January 1, 2027, and changes are summarized on page 15. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member, “we” means Triple-S Salud, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB Plans’ brochures have the same format and similar descriptions to help you compare Plans.

Stop Health Care Fraud!

Fraud increases the cost of healthcare for everyone and increases your Federal Employees Health Benefits Program premium.

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

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

- Do not give your Plan identification (ID) number over the 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 claims 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 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (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 to www. opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

Do not maintain as a family member on your policy:

- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
- Your child age 26 or over (unless 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 FEHB enrollment.

- If you have any questions about the eligibility of a family member, 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 FEHB benefits, trying to or obtaining services or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

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, sex, pregnancy, or genetic information. We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information.

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, 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 the pharmacist about your 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.
- Understanding both the generic and brand names for all of your medication(s) is important. This helps ensure you do not receive double dosing from taking both a generic and a brand of the same medication. It also helps you avoid 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, be it in person, by phone, or by mail. 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 reaction 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 medications.
- 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 FEHB 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.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

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

- **Minimum value standard**

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

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and Plans available to you
  - A health Plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

  We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for 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 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 FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child under reaches age 26. 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 FEHB Plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB Plan.

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

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described 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 FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll 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 FEHB 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 FEHB 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 FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a Plan that 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.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed Plans or Plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new Plan or option, your claims will be processed according to the 2027 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. **However**, if your prior plan left the FEHB Program at the end of 2026, you are covered under that Plan's 2026 benefits until the effective date of your coverage with your new Plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

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

When you lose benefits

- **When FEHB coverage ends** — You will receive an additional 31 days of coverage, for no additional premium, when:
  - Your enrollment ends, unless you cancel your enrollment, or
  - You are a family member who is no longer eligible for coverage.

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

  You may be eligible for spouse equity coverage or assistance with enrolling in a conversion policy (a non-FEHB individual policy).

- **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 contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. 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 FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices, visit 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 FEHB enrollment.

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

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

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

  Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a 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 FEHB Program coverage.

- **Converting to individual coverage** — You may convert to a non-FEHB individual policy if:
  - Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);

- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must 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 FEHB 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 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (TTY:866-215-1999) from the U.S. Virgin Islands, 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 FEHB Plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Triple-S Salud, Inc. holds the URAC accreditation. To learn more about this plan's accreditation(s), please visit the following website: www. ssspr.com. We require you to see those 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. Contact us for a copy of our most recent provider directory or visit the following website: www. ssspr.com/postal for a digital version or searching platform.

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

Benefits offered under this Plan may be modified by Triple-S Salud, Inc. to authorize payment for treatment methods or therapies not expressly provided for but not prohibited by law or rule if otherwise that method or therapy is as cost effective as providing benefits to which the enrollee otherwise is entitled.

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

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

Who provides my health care

Triple-S Salud, 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

We have Open Access benefits

Our HMO offers Open Access benefits within our service area. 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 2026, you will have until 12/31/2027 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 FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www. opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Triple-S 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 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (TTY: 866-215-1999) from the U.S. Virgin Islands, or write to P.O. Box 363628, San Juan, Puerto Rico, 00936-3628. You may also visit our website Triple-S Salud, Inc. 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 and your dependents must live in our Service Area. This is where our providers practice. Our service area is limited to: Puerto Rico and U.S. Virgin Islands.

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

Section 2. Changes for 2027

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

Changes to this Plan

- Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. See Section "2027 Rate Information for Triple-s Salud Inc., page 117.
- The Dental benefit will no longer cover Restorative, Adjunctive General Services, Endodontics, and Oral Surgery. See Section 5(g) Dental Benefit, page 63.
- We will no longer provide an exception process for members who are mid-treatment within a surgical and/or hormonal regimen for diagnosed gender dysphoria. Counseling services for possible or diagnosed gender dysphoria will continue to be covered when provided by a licensed mental health provider. See Section 5(e).
- We will eliminate the $10 visit copay and $25 facility copay for In-network voluntary male sterilization services. See Section 5(a) Family Planning, page 32.
- We will increase the Pap Smear test benefit to once every 12 months with no in-network member cost sharing. See Section 5(a), Preventive care, adult, page 39.
- We will add coverage for the Peak Flow Meter as Durable Medical Equipment for members with COPD or Asthma, subject to a doctor's prescription. There is 25% cost-sharing for in-network providers, limited to one unit per member per. See Section 5 (a), Durable Medical Equipment, page 41.
- We will remove the member cost-sharing for listed in-network services provided by SALUS Clinics and SALUS Urgent Care Centers. Members will pay nothing for the following services: Generalist, Specialist, Laboratory Test, Non-Invasive vascular test, Cardiovascular test, Podiatrist visits and foot care routine visits. See Section 5(a), page 26-27 and 36, and Section 5(d), page 53.
- We're adding new access to Telehealth Services through MiConsulta MD Carestation with no member cost share for virtual visits. See page 27.
- We will add coverage for Acupuncture for Chronic Low Back Pain with no member cost for in-network and 10% coinsurance for out of services; up to 12 visits in 90 days. See section 5(a), page 39.
- We will add coverage for a Board Certified Lactation Consultants. See Section 5(a) Maternity care, page 31.
- We have enhanced the Obesity Program: Our program connects you with a dedicated representative who will help you to navigate through the range of services designed to help you lose weight and maintain a healthy lifestyle. You don't have to pay to participate in the Obesity Program, *but some cost-sharing applies for medical services or medication.* These services include:
  - Intensive Behavioral Therapy: Work with a healthcare provider to develop healthy habits and Up to 18 visits per year; $7.50 copay per visit.
  - Nutrition Support: Get personalized guidance on healthy eating and nutrition. Up to six (6) visits; $0 copay per visit.
  - Anti-Obesity GLP-1 Drugs: If other methods haven't worked, we can provide access to medication, with guidance and support. We will increase the member cost share to 50% cost-sharing applies for GLP-1 drugs, refers to section 5(f).
  - Specialty Obesity Care: If you need more specialized care, we have clear pathways for escalation to ensure you get the help you need.
  - Behavioral Support: Access to counseling and support to help you stay on track.

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Your ID card does not have an expiration date to ensure the continuity of services and to avoid waiting for a new one. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (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 at www.ssspr.com.

Where you get covered care

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

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.

Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information.

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.

Inpatient Value Care Hospital Network

Triple-S's personnel is located at the hospitals in this network in order to provide you with educational material and coordinate services for you, such as:

- Admission process
- Precertifications
- Post discharge physician visits

To know which in-network hospitals provide these services, refer to your provider directory.

Other Providers

Non-Plan Providers are physicians, medical groups or providers who do not have an active contracts with Triple-S but they are health professionals and providers of services which are covered by this plan. We reimburse members based on our established fees.

You may refer to Section 1, *How this plan works*, under How we pay providers, for more information on reimbursement of non-plan providers.

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 physician will provide most of your healthcare, or refer you to a specialist.

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

Specialty care

Your general practitioner physician will refer you to a specialist for needed care.

Here are other things you should know about specialty care:

- If you are seeing a specialist and your specialist leaves the Plan, call us. We will provide you a list of specialists within your area. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- You may continue seeing your specialist for up to 90 days if you are undergoing treatment for a chronic or disabling condition and you lose access to your specialist because:

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

Contact us at 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-981-3241 (TTY: 866-215-1999) from the U.S. Virgin Islands 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.

Note: If you lose access to your specialist because you changed your carrier or plan option enrollment, contact your new plan.

Hospital care

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

If you are hospitalized when your enrollment begins

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (TTY: 866-215-1999) from the U.S. Virgin Islands. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

Balance Billing Protection

FEHB Carriers 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.

You need prior Plan approval for certain services

Since your network physician arranges inpatient hospitalization and most referrals to specialists, the pre-service claim approval process only applies to care shown under Other services or out-of-network care when you self-refer.

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 we evaluate the medical necessity and the number of days for the proposed hospital stay to treat your condition.

Other Services

Your general practitioner physician may refer you for most services. For certain services, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. We call this review and approval precertification. Call us at 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (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 through 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 Other services

When you remain within our network, network providers will take care of precertification for you. When you seek out-of-network care, your physician, your hospital, you or your representative, must call us at 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (TTY: 866-215-1999) from the U.S. Virgin Islands before admission or services requiring precertification are rendered.

Next, provide the following information:

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

- **Non urgent care claims**

For non-urgent care claims, we will tell the physician and/or facility the care that we approve for services that must have prior approval. 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 the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (TTY: 866-215-1999) from the U.S. Virgin Islands. You may also call OPM's Health Insurance 2 at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (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 emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

Maternity care

You do not need 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 providers

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

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 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (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.

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.

Section 4. Your Costs for Covered Services

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

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., coinsurance, and copayments) for the covered care you receive.
Copayment	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your Network specialist, you pay a copayment of $10 per office visit.
Coinsurance	Coinsurance is the percentage of our negotiated fee that you must pay for your care. Example: In our Plan, you pay 20% of our allowance for certain diagnostic tests.
Differences between our Plan allowance and the bill	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 for coinsurance and copayments	After your (copayments and coinsurance) reaches the out-of-pocket maximum you do not have to pay any more for covered services, with the exception of certain cost sharing for the services below which do not count toward your catastrophic protection out-of-pocket maximum. Your out-of-pocket maximum for services rendered during the 2027 calendar year is: Self Only $6,600 in network Self Plus One $13,200 combined but will not exceed $6,600 per member Self and Family $13,200 combined but will not exceed $6,600 per member Your out-of-pocket maximum may differ if you changed plans at Open Season. The following services do not count toward your out-of-pocket maximum and you must continue to pay for these services: • Difference between our Plan allowance and the billed charges for a covered service or supply; • Cost of non-covered services or supplies; and, • Coinsurance you pay when you use non-Plan providers.
Carryover	If you changed to this Plan during Open Season from a Plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that Plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1. 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.

In addition, your health plan adopts and complies with the surprise billing laws of Law 134 of September 1, 2020 "Law for the Protection of Patients against Surprise Medical Bills" of Puerto Rico.

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 787-774-6081.

The Federal Flexible Spending Account Program - *FSAFEDS*

- **Healthcare FSA (HCFSA)** – Reimburses an FSA participant for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, over-the-counter drugs and medications, vision and dental expenses, and much more) for their tax dependents, and their adult children (through the end of the calendar year in which they turn 26).
- **FSAFEDS** offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP Plans. This means that when you or your provider files claims with your FEHB or FEDVIP Plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. Benefits

See page 15 for how our benefits changed this year. Page 89 is a benefits summary. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. Benefits 24
Section 5(a). Medical Services and Supplies Provided by Physicians and Other Health Care Professionals 26
- Diagnostic and treatment services 26
- Telehealth 27
- Lab, X-ray and other diagnostic tests 27
- Preventive care, adult 27
- Preventive care, children 30
- Maternity care 30
- Family planning 32
- Infertility services 32
- Allergy care 33
- Treatment therapies 34
- Physical and occupational therapies 35
- Speech therapy 35
- Hearing services (testing, treatment, and supplies) 35
- Vision services (testing, treatment, and supplies) 36
- Foot care 36
- Orthopedic and prosthetic devices 37
- Durable medical equipment (DME) 38
- Home health services 39
- Chiropractic 39
- Nutrition 40
- Educational classes and programs 40

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals 42
- Surgical procedures 42
- Reconstructive surgery 43
- Oral and maxillofacial surgery 44
- Organ/tissue transplants 44
- Anesthesia 48

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services 49
- Inpatient hospital 49
- Outpatient hospital or ambulatory surgical center 50
- Extended care benefits/Skilled nursing care facility benefits 50
- Hospice care 51
- Ambulance 51

Section 5(d). Emergency Services/Accidents 52
- Emergency within our service area 53
- Emergency outside our service area 53
- Ambulance 54

Section 5(e). Mental Health and Substance Use Disorder Benefits 55
- Professional services 55
- Diagnostics 56
- Inpatient hospital or other covered facility 56
- Outpatient hospital or other covered facility 56

Section 5(f). Prescription Drug Benefits....57
- Covered medications and supplies....59

Section 5(g). Dental Benefits....63
- Dental Benefits....63

Section 5(h). Wellness and Other Special Features....65
- Flexible benefits option....65
- 24 hours, 7 days a week call center....65
- Blue Card Program....65
- Blue Cross Blue Shield Global Core....65
- Centers of Excellence for transplants/heart surgery/etc....66
- Telexpreso....66
- Medication Therapy Management Program....66
- Health Risk Assessment (HRA) tool....66
- Preventive Care Centers....66
- Oncology Analytics....67

Section 5(i). Point of Service Benefits....68
Non-FEHB Benefits Available to Plan Members....69
Summary of Benefits for the Triple-S Salud, Inc. Plan - 2027....89

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, Your costs for covered services for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU OR YOUR PLAN 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.
- 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 in-network 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
Diagnostic and treatment services	**High Option**
Professional services of physicians • General practitioner's office visit • In physician's office • Second surgical opinion • Office medical consultations • Initial examination of a newborn child	Network: $7.50 per office visit to your general practitioner or specialist physician $0 copay for services rendered in SALUS Clinics. Out-of-network: 10% coinsurance. In-network cost-sharing applies, 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% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
At home	Network: $15 per physician visit Out-of-Network: 10% coinsurance. In-network cost-sharing applies, 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
Telehealth	**High Option**
TelehealthServices • Unlimited online virtual consults through Teleconsulta MD: www.triplessalud.mytelehealth.com/landing.htm • Available 7 days a week from 6am-10pm **MiConsulta MD CareStation** • Visit our CareStation and connect with a doctor virtually and receive and evaluation, diagnosis, and prescription on the spot. Visit our website to find your nearest location, hours and availability: https://salud.grupotriples.com/en/miconsulta-md	Network: $0 copay Out-of-Network: Not Covered
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as*:* • Blood tests • Urinalysis	Network: $1.00 per laboratory $0 copay for services rendered in SALUS Clinics. Out-of-Network: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
• Polysomnography • Genetic amniocentesis • Non-invasive vascular and cardiovascular tests • EEG	Network: 20% coinsurance $0 copay for services rendered in SALUS Clinics. Out-of-Network: 10% coinsurance. In-network cost-sharing applies, 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% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
Preventive care, adult	**High Option**
Routine physical every calendar year: 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:	Network: Nothing Out-of-Network: 10% coinsurance. In-network cost-sharing applies, 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**
• U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, lipid panel test, HIV, colorectal cancer. For a complete list of screenings go to the 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 • To build your personalized list of preventive services go to www. health.gov/myhealthfinder	Network: Nothing Out-of-Network: 10% coinsurance. In-network cost-sharing applies, 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% coinsurance. In-network cost-sharing applies, 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% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
Routine use of adult immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and adopted by the Centers for Disease Control and Prevention (CDC) are covered. A recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention. For the current immunization schedule, visit https ://www. cdc.gov/vaccines/imz-schedules/index.html 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/imz-schedules/index.html • Routine exams limited to: - One routine eye exam every 12 months - One routine hearing exam every 12 months 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 and coinsurance.	Network: Nothing Out-of-Network: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
• Electrocardiogram (EKG), once per year • Spirometry, once per year • Hemoglobin A1c, once per year	Network: Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
• CBC, once per year • PSA, once per year • Thyroid, once per year • PAP Smear Test, once per year	Network: Nothing Out-of-Network: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
HIV Preexposure Prophylaxis (PrEP) • testing for HIV infection with an FDA-approved antigen/antibody immunoassay • testing for sexually transmitted infections • pregnancy testing when appropriate • kidney function and serologic testing for hepatitis B prior to initiating a tenofovir-containing therapy • lipid profile testing prior to initiating TAF/FTC	Network: Nothing Out-of-Network: 10% coinsurance. In-network cost-sharing applies, 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. Note: Please refer to Educational classes and programs information in Section 5(a) for more information of our Obesity Program. Note: When anti-obesity medication is prescribed see Section 5(f), if applicable. Note: When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity see Section 5(b).	Network: Nothing Out-of-Network: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*

Benefit Description	You pay
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 For preventive immunizations see guidance below. • Routine use of children's immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) schedule and adopted by the Centers for Disease Control and Prevention (CDC) are covered. A recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention. For the current immunization schedule, visit https ://www. cdc.gov/vaccines/imz-schedules/index.html • You may also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at: www.uspreventiveservicestaskforce.org 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 and coinsurance.	Network: Nothing Out-of-Network: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
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 in Section 5(a), page 40 for more information of our Obesity Program. Note: When anti-obesity medication is prescribed see Section 5(f). Note: When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity see Section 5(b).	Network: Nothing Out-of-Network: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Screening for gestational diabetes • Prenatal and Postpartum care • Delivery • Screening and counseling for prenatal and postpartum depression Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; see Section 3 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.	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% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.

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. • 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. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	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% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
• As part of your coverage, you have access to in-network board certified lactation consultants during prenatal and post-partum period, who provide personalized breastfeeding and lactation support through educational sessions and one-on-one counseling. These experts help mothers navigate feeding and pumping challenges, offering guidance before and after birth to promote a successful breastfeeding journey. Per birth, the member can coordinate with our contracted provider for one (1) initial session and up to five (5) subsequent sessions, administered through an office visit. • Electric breast pump for mothers who have given birth within the last 3 months, limited one per birth. • Services for high risk pregnancies: - Glucometer - Blood pressure monitor - Prenatal In-Home support service up to 16 hours, maximum 4 hours per day • Postnatal in-home support when enrolled in the Maternal Program during the first trimester - service up to 16 hours, maximum 4 hours per day - within one month of giving birth Note: Call the Triple-S Salud Department of Disease Management (Contigo Mama 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 Contigo Mama Program.	Network: Nothing Out-of-Network: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.

Benefit Description	You pay
Family planning	**High Option**
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories in the HRSA supported guidelines. This list includes: • Voluntary sterilization (male and female) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms Note: See additional Family Planning and Prescription drug coverage in Section 5(f), 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 describe below. For more information on our 24 hour response time surgical contraceptive exception process, please visit: https://salud.grupotriples.com/en/health-insurance-plans/triple-s-salud-for-federal-employee/. Once we have been contacted with exception request information sufficient for us to make a determination, you will receive a response within 24 hours or the next business day. Contraceptive exception requests are not subject to Section 8. The Disputed Claims Process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	Network: Nothing Out-of-Network: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*
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. Infertility to include services such as: • Artificial insemination (AI): • Intravaginal insemination (IVI) • Intracervical insemination (ICI) • Intrauterine insemination (IUI) Artificial Reproductive Technology (ART) treatments and procedures, including preservation, such as: • In vitro fertilization (IVF)	Network: $7.50 per office visit Out-of-Network: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**High Option**
• Embryo transfer, gamete intra-fallopian transfer (ZIFT) • Gamete Intra-Fallopian Transfer (GIFT) • Services and supplies related to ART procedures Note: See Section Fertility drugs. See Section 5(f) for Fertility drugs coverage. Note: You must obtain precertification for these services, see Section 3. Note: Artificial insemination covers up to three cycles per year for members with female reproductive organs aged over 35. Note: ART services have an annual maximum of $15,000 per policy year. You must pay the provider's claims and seek reimbursement form us for infertility services.	Network: $7.50 per office visit Out-of-Network: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
Iatrogenic Infertility Fertility preservation for iatrogenic infertility: • Procurement of sperm or eggs including medical, surgical, and pharmacy claims associated with retrieval, see 5 (f) for Fertility drug coverage. • Cryopreservation of sperm and mature oocytes; and • Cryopreservation storage costs for 1 year. Note: You must obtain precertification for these services, see Section 3. Note: You must pay the provider’s claim and seek reimbursement from us for infertility services.	Network: $7.50 per office visit Out-of-Network: 10% coinsurance. In-network cost-sharing applies, 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% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
• Allergy serum • Allergy vaccine	Network: Nothing Out-of-Network: 10% coinsurance. In-network cost-sharing applies, 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 44 through 48. • Dialysis - hemodialysis and peritoneal dialysis • Intravenous (IV) / Infusion **Therapy** - Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. We will only cover GHT when we precertify the treatment. You or your Plan 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% coinsurance. In-network cost-sharing applies, 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% coinsurance. In-network cost-sharing applies, 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% coinsurance. In-network cost-sharing applies, 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% coinsurance. In-network cost-sharing applies, 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 a Plan physician or audiologist • Tympanometry Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	Network: Nothing Out-of-Network: 10% coinsurance. In-network cost-sharing applies, 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:	*All charges*

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

Benefit Description	You pay
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**
• *Supplies*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• In addition to medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (that include the written lens prescription) may be obtained from Plan providers. • For cataract removal surgery, see Section 5(b). For Monofocal Intraocular lens benefit, See 5(a) Orthopedic and prosthetic devices for coverage information. • Eye exam to determine the need for vision correction for children (see preventive care)	Network: $7.50 per office visit Out-of-Network: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
• Optometrist services	Network: $7.50 per office visit Out-of-Network: 10% coinsurance. In-network cost-sharing applies, 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 or vision correction lens (Collamer Lens)* • *Radial keratotomy and other refractive surgery* • *Supplies*	*All charges*
Foot care	**High Option**
• Routine foot care performed by a Plan provider 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 $0 copay for services rendered in SALUS Clinics. Out-of-Network: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
Not covered: • *Treatment of weak, strained or flat feet*	*All charges*

Foot care - continued on next page

Benefit Description	You pay
Foot care (cont.)	**High Option**
• *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*
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% coinsurance. In-network cost-sharing applies, 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 • Monofocal Intraocular lens (implant), up to a maximum of $250 per eye. 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% coinsurance. In-network cost-sharing applies, 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*

Benefit Description	You pay
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of prescribed durable medical equipment prescribed by your physician, at our option, including repair and adjustment. Covered items include: • Oxygen • Hospital type beds • Wheelchairs • Walkers • Blood glucose monitors • Iron lungs • Other respiratory equipment • Ostomy supplies • Tracheostomy supplies • Basic Continuous positive airway pressure device (CPAP) equipment (full face and nasal masks) and supplies • Specialized medical foods for members with Phenylketonuria (PKU) according to Triple-S Salud's medical policy • Blood pressure monitor for high-risk members • Peak Flow Meter Note: To be eligible for coverage of a blood pressure monitor, you must enroll and participate in our Hypertension Program. Note: You must obtain a precertification from us. Refer to Section 3. Note: The peak flow meter is limited to one per year and does not require pre-certification.	Network: 25% Out-of-Network: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
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. Note: To be eligible for the coverage of an insulin pump, you must enroll and participate in our Disease Management Program.	Network: Nothing Out-of-Network: 10% coinsurance. In-network cost-sharing applies, 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% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
Not covered: • *Crutches* • *Other durable medical equipment not shown above*	*All charges*

Benefit Description	You pay
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% coinsurance. In-network cost-sharing applies, 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*
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% coinsurance. In-network cost-sharing applies, 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*
Acupuncture for Chronic Low Back Pain	**High Option**
Covered services include: Up to 12 visits in 90 days are covered under the circumstance of chronic low back pain. An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Not covered: pain associated with • Pain associated with surgery; and • pregnant	Network: $0 copay Out-of-Network: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.

Benefit Description	You pay
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**
Disease Management and 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 Program:** Members 18 years and over will receive orientations on diabetes, the emotional aspects of the condition, effects of exercise and 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. **Contigo Mama 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:** Our Obesity Program is designed to help you achieve healthier weight and improve your overall wellbeing. We understand that obesity is a complex issue that requires a comprehensive approach. **What You Can Expect** Our program offers a range of services to support your weight management journey, including:	Network: Nothing Network: Nothing for participating in the Obesity Program.

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
• **Intensive Behavioral Therapy**: Work with a healthcare provider to develop healthy habits and behaviors. Up to 18 visits per year. The copay for specialist visit applies per session. • **Nutrition Support**: Get personalized guidance on healthy eating and nutrition. Maximum of six (6) visits. • **Anti-Obesity GLP-1 Drugs**: If other methods haven't worked, we can provide access to medication, with guidance and support. A 50% cost-sharing applies, refers to section 5(f). • **Specialty Obesity Care**: If you need more specialized care, we have clear pathways for escalation to ensure you get the help you need. • **Behavioral Support**: Access to counseling and support to help you stay on track. You don't have to pay to participate in the Obesity Program, *but some cost-sharing applies for medical services or medication.* **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.	Network: Nothing Network: Nothing for participating in the Obesity Program.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOU OR YOUR PLAN PROVIDER 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**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Routine pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Cataract removal surgery • 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% coinsurance. In-network cost-sharing applies, 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 procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High**
• Surgical treatment of severe obesity (bariatric surgery) – This Plan uses the following criteria: - Patients with a body mass index (BMI) of greater than 40 kg/m2 or greater than 35 kg/m2 in conjunction with severe comorbidities such as cardiopulmonary complications, severe diabetes or obstructive sleep apnea - BMI is calculated using the following formula: Weight (kg) ÷ height (m2) = BMI	Network: Nothing Out-of-Network: 10% coinsurance. In-network cost-sharing applies, 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 condition of the foot (see Section 5(a) Foot care)*	*All Charges*
Reconstructive surgery	**High**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see Section 5 (a) 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.	Network: Nothing Out-of-Network: 10% coinsurance. In-network cost-sharing applies, 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. (See Section 5(d) Accidental injury)* • *Surgery for Sex-Trait Modification to treat gender dysphoria*	*All Charges*

Benefit Description	You pay
Oral and maxillofacial surgery	**High**
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% coinsurance. In-network cost-sharing applies, 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**
These **solid organ and tissue 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 • Lung: single/bilateral • 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	Network: Nothing Out-of-Network: All charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High**
- 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 - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, 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 • 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	Network: Nothing Out-of-Network: All charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High**
- Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Petroperitoneal, 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 - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	Network: Nothing Out-of-Network: All charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High**
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-myeloblative allogeneic, reduced intensity conditioning (RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia, up to 60 years of age - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma, up to 65 years of age - Sickle cell anemia • Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Breast Cancer - Childhood rhabdomyosarcoma - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma)	Network: Nothing Out-of-Network: All charges
Note: For all covered organ/tissue transplants, we cover the related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	Network: Nothing Out-of-Network: All charges
National Transplant Program (NTP)	Network: Nothing Out-of-Network: All charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High**
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**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Network: Nothing Out-of-Network: All charges
Not covered: • *Anesthesia performed for non-covered surgery or procedures*	*All Charges*

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- For maximum benefits Plan physicians should provide or arrange your care and you should be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- 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**
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% coinsurance. In-network cost-sharing applies, plus any difference between our allowance 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% coinsurance. In-network cost-sharing applies, plus any difference between our allowance 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% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
Not covered:	*All Charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High**
• *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**
• 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 Network: $0 copay for Voluntary Sterilization Out-of-Network: 10% coinsurance. In-network cost-sharing applies, 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% coinsurance. In-network cost-sharing applies, 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**
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% coinsurance. In-network cost-sharing applies, 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**
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**
• 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. 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 71 through 72.

Benefit Description	You pay
Emergency within our service area	**High**
• Emergency care at a doctor's office	$7.50 copay
• Emergency care at a hospital emergency room	$25
• Emergency care at an urgent care center	Network: $10 copay $0 copay for services rendered in Urgent SALUS Clinics. Out-of-Network: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance 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**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services. Note: See Section 5(h) *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

Emergency outside our service area - continued on next page

Benefit Description	You pay
Emergency outside our service area (cont.)	**High**
	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.
Ambulance	**High**
• 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 U.S. 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.
- **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.
- 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.

Benefit Description	You pay
Professional services	**High**
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% coinsurance. In-network cost-sharing applies, 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 • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Network: $7.50 per office visit and/or therapy Out-of-Network: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.

Professional services - continued on next page

Benefit Description	You pay
Professional services (cont.)	**High**
Inpatient hospital visit by a physician	Network: Nothing Out-of-Network: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
Diagnostics	**High**
• 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% coinsurance. In-network cost-sharing applies, 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**
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% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
Outpatient hospital or other covered facility	**High**
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% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
Not covered	**High**
• *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 page 59.
- 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 or state laws may prevent the pharmacy from accepting unused drugs.
- 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.

The exclusion for hormone treatments for Sex-Trait Modification for gender dysphoria only pertains to chemical and surgical modification of an individual's sex traits (including as part of "gender transition" services). **We do not exclude coverage for entire classes of pharmaceuticals**, e.g., GnRH agonists may be prescribed during IVF, for reduction of endometriosis or fibroids, and for cancer treatment or prostate cancer/tumor growth prevention.

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

Who can write your prescription. A licensed physician or dentist within our service area.

Where you can obtain them. You may fill the prescription at a 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.

We use a formulary. We cover non-formulary drugs prescribed by a Plan doctor. If your physician believes a brand name product is necessary or there is no generic available, your physician may prescribe a brand name drug from a formulary list. This list of brand name drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. Please see our online formulary and drug pricing search tools at the following www. ssspr.com. 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 or Drug List is a list of medicines that represents a previous evaluation of the Plan's Pharmacy and Therapeutics Committee regarding their efficiency, safety and cost effectiveness; that guarantees the therapy quality, minimizing inadequate utilization that could affect the patient's health. Please, refer to the Drug List to find out more information regarding benefit level descriptions, pharmacy terms, utilization edits, and special instructions. We reserve the right to choose those prescription drugs to be included in its Prescription Drug Coverage. In addition, any new prescription drug of an excluded therapeutic classification will also be considered an exclusion.

Benefits are provided to the member and member's covered dependents, for medications prescribed by a doctor or a dentist after applicable copays are paid.

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 will be dispensed if it is available. If you or your physician chooses the use of a brand name drug indicating in the prescription *Original* or *Dispense as Written* when a FDA approved generic drug exists, you have to pay the difference in cost between the brand name drug and the generic when the brand is not medically necessary. Triple-S Salud will pay up to the generic drug cost. If a generic is not manufactured, the brand name drug will be dispensed and you will pay the brand copay.

*Triple-S Salud Pharmacy Program is a Triple-S Salud product administered by Abarca Health LLC., a pharmacy services independent contractor.

Why use generic drugs? Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

You can save money by using generic drugs since you pay nothing. However, you and your Plan physician have the option to request a name brand if a generic option is available, but it will cost you. Using the most cost-effective medication saves money.

Step Therapy Program. In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B. This program will require the utilization of Over-The-Counter (OTC) drugs or Generic drugs before using other drugs to treat your medical condition. The "OTC First" portion includes Proton Pump Inhibitors (PPI), Non-sedating antihistamines, and Ocular allergies agents. The "Generic First" portion includes Cholesterol drugs-Statins, Osteoporosis-Oral Bisphosphonates, Allergies-Nasal Corticosteroids, Angiotensin receptor blockers (ARBs) for hypertension, Hypnotics, Pain Management drugs, ADHD, Asthma, Diabetes, and Antidepressants.

Specialty Pharmacy Program. Specialty products are medications for the treatment of chronic and high-risk conditions such as Cancer, Rheumatoid Arthritis, Multiple Sclerosis, Hemophilia, Hepatitis C, among others. They require special administration and/or management, given their complex composition. You must fill all specialty medication through our specialty pharmacies: CVS Caremark Specialty Pharmacy, Walgreens Specialty Pharmacy, Puremed Pharmacy and Alivia Specialty Pharmacy. Once you select your preferred pharmacy, you will receive an evaluation from personnel specialized in the management of chronic conditions in order to identify your specific needs or answer questions you may have regarding your medication. In addition, you will be able to coordinate the delivery of your medications to the location of your choice, you will also have access to pharmacy personnel and have the option to order refills or check on their status through a dedicated website for program participants. Pharmacy personnel will collaborate with your physician in the management of your condition and your drug therapy. For more information call 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (TTY: 866-215-1999) from the U.S. Virgin Islands.

Triple-S Salud Pharmacy Mail Order Program. You can get certain maintenance drugs through the mail, in the comfort of your home and up to a 90 day supply. To begin using the services of the Pharmacy Mail Order Program, submit your prescription drugs by internet at www. alliancerxwp.com/home-delivery and follow the instructions from the registration confirmation page to submit your prescriptions. For initial enrollment in the program your physician must write you two prescriptions:

- One prescription for a 30-day supply to be dispensed immediately by any participating pharmacy,
- One prescription for a 90-day supply, including one (1) refill. This prescription is the one to be dispensed by the Mail Order Pharmacy.

You may also request your prescription drugs by phone; 800-345-1985, 800-778-5427 (TTY 800-925-0178 in English, 877-220-6173 in Spanish), by fax: 800-332-9581 or by regular mail to: PO Box 29061 Phoenix, AZ 85038-9061. Opening hours are 24 hours / 7 days a week.

90-Day Extended Supply Program. This is a voluntary program that allows the member to obtain a 90-day supply of some maintenance drugs at retail pharmacies participating in the program. For more information call us at 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (TTY: 866-215-1999) if you call from U.S. Virgin Islands.

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

Benefit Description	You pay
Covered medications and supplies	**High**
We will cover prescription drugs based on a List of Drugs. We cover the following medications and supplies prescribed by a Plan physician or dentist and obtained from a Plan pharmacy: • Medications prescribed to treat obesity: A cost-sharing of 50% applies for GLP-1 drugs. See Section 5(a) Obesity Program for more information. • 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. • 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% 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.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High**
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 FEHB 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 our 24 hour contraceptive expedite exception process, when prescribed by a physician. • Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. • For additional information, please contact our Customer Service 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. Once we have been contacted with exception request information sufficient for us to make a determination, you will receive a response within 24 hours or the next business day. Contraceptive exception requests are not subject to Section 8. The Disputed Claims Process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. 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 additional Family Planning benefits see Section 5(a).	Network: Nothing
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
Opioid rescue agents are covered under this Plan with no cost sharing when obtained with prescription from our pharmacy 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 care medications to promote better health as recommended by ACA.	Network: Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High**
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 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% 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* • *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*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High**
• *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*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 *Coordinating benefits with other coverage.*
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- If you use a non-Plan dentist, you pay for services rendered and the Plan will pay 90% of the Plan's established fees after any applicable copay or coinsurance when services are received within the service area; or the Plan's established fees when services are rendered outside the service area after any applicable copayment or coinsurance. You pay all remaining charges. In 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
Dental Benefits	**High**
Accidental injury benefit We cover restorative services and supplies necessary to repair (but not replace) sound natural teeth, within a six-month period. The need for these services must result from an accidental injury. An injury caused by chewing is not considered an accidental injury.	Network: 25% Out-of-Network: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
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% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.
Not covered:	*All charges*

Dental Benefits - continued on next page

Benefit Description	You Pay
Dental Benefits (cont.)	**High**
• *Other dental services not shown as covered.*	*All charges*

Section 5(h). Wellness and Other Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24 hours, 7 days a week call center	Through **Teleconsulta** , members can have immediate access to the advice of professional nurses to help them decide whether to go to the emergency room immediately, visit or call their physician or follow self-care instructions to feel better. Nurses use scientifically based algorithms developed by physicians of all specialties to reach a recommendation for the member. Call us at 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 or co-payment) 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 Cross Blue Shield Global Core	Blue Cross Blue Shield Global Core 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.

Feature	Description
Centers of Excellence for transplants/heart surgery/etc.	We offer you the benefit of the Blue Distinction Centers for Transplants (BDCT) which is a cooperative effort among the Blue Cross and/or Blue Shield Plans, Blue Cross and Blue Shield Association and Participating Institutions to facilitate the provision of quality care in a cost-effective manner from leading institutions for six transplant types: heart, single or bilateral lung, combination heart-bilateral lung, liver, simultaneous pancreas-kidney, and bone marrow/stem cell (autologous/allogeneic). Call 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-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, you cannot file an FEHB disputed claim about them, and they are not available for residents in the U.S. Virgin Islands. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 787-774-6081 (TTY: 787-792-1370) or visit the website at www. ssspr.com.

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

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

With any of our products you will enjoy:

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

If you have Medicare Parts A and B, reside permanently in Puerto Rico and do not have end stage renal disease, you are eligible! Triple-S Salud, 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 we determine 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.*

We do not cover the following:

- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage;
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption;
- Services or supplies furnished or billed by a non-covered facility, except medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to plan limits;
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see Section 9) or doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see Section 9);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Chemical or surgical modification of an individual's sex traits through medical interventions (to include “gender transition” services)
- Extra care and research costs of clinical trials;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel;
- Drug detection tests for employment purposes;
- Services, drugs, or supplies you receive without charge while in active military service;
- Services or supplies we are prohibited from covering under the Federal Law;
- All services related to anti-aging therapy (aesthetics); and
- Any benefits or services required solely for your employment are not covered by this Plan.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

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

Medical, hospital and drug benefits

In most cases, providers and facilities file HIPAA compliant electronic claims for you. In cases where a paper claim must be used, the provider must file on the form CMS-1500, Health Insurance Claim Form. Facilities will file on the UB-04 form. For claims questions and assistance, call us at 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (TTY: 866-215-1999) from the U.S. Virgin Islands or visit us at our website at www.ssspr.com.

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

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

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

Submit your claims to:

Triple-S Salud, 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. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a 6-months limitation on the re-issuance of uncashed checks.

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.
Records	Keep a separate record of the medical expenses of each covered family member and maximum allowances apply separately to each person. Save copies of all medical bills. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.
When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	If you live in a country where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7, and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing Triple-S Salud, Inc., 1441 Roosevelt Avenue San Juan, Puerto Rico 00920 or calling 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (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 health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

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

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

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 Unit, PO Box 363628, San Juan, Puerto Rico 00936-3628; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4

Step	Description
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 in English to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 2, 1900 E Street, NW, Washington, DC 20415-3620. Send OPM the following information in English: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM 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 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (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 FEHB 2 at 202-606-3818 between 8 a.m. and 5 p.m. eastern time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a 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 Worker's Compensation programs if you are receiving Worker's Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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

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

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

Clinical Trials

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

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

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

When you have Medicare

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

- **The Original Medicare Plan (Part A or Part B)**

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

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (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 health care professionals.

Once the member reaches their out-of-pocket maximum for their coverage ($6,600 for Self Only, $13,200 for Self Plus One or Self and Family), Medicare remains the primary payer, and we will pay the entire remaining deductible or coinsurance from Medicare.

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
You pay without Medicare: $0
You pay with Medicare Part B: $0

Benefit Description: Catastrophic Protection Out-of-Pocket Maximum
You pay without Medicare: $6,600 Self Only $13,200 Self Plus One or Self and Family
You pay with Medicare Part B: $6,600 Self Only $13,200 Self Plus One or Self and Family

Benefit Description: Primary Care Provider
You pay without Medicare: $7.50
You pay with Medicare Part B: $0

Benefit Description: Specialist
You pay without Medicare: $7.50
You pay with Medicare Part B: $0

Benefit Description: Inpatient Hospital
You pay without Medicare: $0
You pay with Medicare Part B: $0

Benefit Description: Outpatient Hospital
You pay without Medicare: $25
You pay with Medicare Part B: $0

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 health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage Plans, contact Medicare at 800-MEDICARE (800-633-4227), (TTY: 877-486-2048) or at www.medicare.gov.

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

This Plan and our Medicare Advantage Plan: You may enroll in our Medicare Advantage Plan and also remain enrolled in our FEHB Plan. We will still provide benefits when our Medicare Advantage Plan is primary, even when you visit non Plan providers of our Medicare Advantage Plan (but they are network providers of Triple-S Salud, Inc. regular Plan servicing FEHB). If you enroll in our Medicare Advantage Plan, please tell us. We will need to know if you are enrolled in our Medicare Advantage Plan as soon as you subscribe to it, so we can correctly coordinate benefits with the FEHB Plan from the beginning of your Medicare Advantage coverage.

This Plan and another Plan's Medicare Advantage Plan: You may enroll in another Plan's Medicare Advantage Plan and also remain enrolled in our FEHB Plan. We will still provide benefits when your Medicare Advantage Plan is primary, even out of the Medicare Advantage Plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments or coinsurance. If you enroll in a Medicare Advantage Plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage Plan so we can correctly coordinate benefits with Medicare.

	Suspended FEHB coverage to enroll in a Medicare Advantage Plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage Plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage Plan premium.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage Plan's service area.
• **Medicare prescription drug coverage (Part D)**	When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB Plan.

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

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation	✓*	
9) Are a Federal 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 FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

Section 10. Definitions of Terms We Use in This Brochure

Assignment of Benefits

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 (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

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

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

Coinsurance

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.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Iatrogenic Infertility

Infertility that occurs in oncology patients as a result of medical treatments such as chemotherapy, radiation therapy, and surgery. We cover standard fertility preservation procedures for men and women as recognized by the American Society for Reproductive Medicine (ASRM) and/or American Society of Clinical Oncology (ASCO).

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.

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.

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.
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.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
SALUS Clinics	Clinics that provide access to their services exclusively to Triple-S Salud members. With zero copay.
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.
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 787-774-6081 (TTY: 787-792-1370) from Puerto Rico or 800-716-6081 (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.
Us/We/Plan	Us, We and Plan refer to Triple-S Salud, Inc.
You	You refers to the enrollee and each covered family member.

Index

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

Accidental injury.....42-48, 63-64
Allergy tests.....26-41
Allogeneic (donor) bone marrow transplant 42-48
Ambulance.....22-23, 26-54, 82-85
Anesthesia.....5-6, 42-51
Autologous bone marrow transplant...26-41
Biopsy.....42-48
Blood and blood plasma.....49-51
Casts.....49-51
Catastrophic protection.....22-23, 69, 76-81
Changes for 2027.....15
Chemotherapy.....16-21, 26-41, 65-67
  Oncology Analytics...26-41, 65-67, 89-90
Chiropractic.....26-41
Cholesterol tests.....26-41, 57-62, 65-67
Claims...3-4, 7-14, 16-23, 26-48, 52-54, 57-62, 65-67, 71-85
Coinsurance...12-14, 16-23, 26-67, 69, 71-72, 76-85
Colorectal cancer screening.....26-41
Congenital anomalies.....42-48
Contraceptive drugs and devices.....57-62
Crutches.....26-41
Cryopreservation.....26-41
Definitions.....26-64, 82-85, 89-90
Dental care.....89-90
Diagnostic services.....89-90
Donor expenses.....26-48
Dressings.....49-51, 57-62
Durable medical equipment.....16-21, 26-41
Effective date of enrollment.....16-21
Emergency...12-23, 26-56, 63-68, 82-85, 89-90
Experimental or investigational...57-62, 70, 82-85
Eyeglasses.....57-62, 70, 82-85
Family planning.....26-48, 57-62
Fecal occult blood test.....26-41
Fraud.....3-4, 7-11
General exclusions.....70
Hearing services.....26-41
Home health services.....26-41
Hospital...5-21, 26-56, 63-68, 71-85, 89-90
Iatrogenic Infertility.....26-41
Immunizations.....12-14, 26-41
Infertility.....15-21, 26-41, 82-85
Inpatient hospital benefits.....63-64
Insulin.....15-21, 26-41, 57-62
Magnetic Resonance Imagings (MRIs) 26-41
Mammogram.....26-41, 65-67
Maternity benefits.....16-21, 26-41
Medicaid.....76-81
Medically necessary...5, 16-21, 26-64, 70, 82-85
Medicare.....1, 26-64, 69, 71-72, 76-81
  Advantage.....69, 76-81
  Original.....16-21, 57-62, 71-72, 76-81
Members...1, 3-23, 26-51, 55-62, 65-67, 69, 76-85
  Family.....3-23, 26-48, 55-62, 71-85
  Plan.....1, 3-23, 26-85, 89-91
Mental Health/Substance Abuse Benefits 55-56, 89-90
Newborn care.....26-41
No Surprises Act (NSA).....22-23
Non-FEHB benefits.....69
Nurse.....5-11, 26-41, 49-51, 65-67, 76-85
  Registered Nurse.....26-41
Occupational therapy.....26-41
Office visits.....12-14, 26-41
Oral and maxillofacial surgery.....42-48
Out-of-pocket expenses.....22-23
Oxygen.....26-41, 49-51
Pap test.....26-41
Physician...12-14, 16-21, 26-62, 65-69, 71-85, 89-90
Point of Service (POS).....68
Precertification...12-14, 16-21, 26-51, 57-62, 68, 73-75, 82-85
Prescription drugs...26-41, 57-62, 65-68, 71-72, 89-90
Preventive care, adult.....26-41
Preventive care, children.....26-41
Preventive services.....26-41, 65-67
Prosthetic devices.....26-48, 76-81
Psychologist.....55-56
Radiation therapy.....16-21, 26-41, 65-67
Room and board.....49-51, 55-56
Second surgical opinion.....26-41
Skilled nursing facility care...16-21, 26-51, 82-85
Social worker.....55-56
Speech therapy.....26-41
Splints.....49-51
Subrogation.....76-85
Substance abuse.....55-56
Surgery.....5-6, 12-21, 26-51, 63-67, 89-90
  Oral.....16-21, 26-48, 57-64, 71-72
  Outpatient.....42-56, 76-85, 89-90
  Reconstructive.....42-48
Syringes.....57-62
Tabacco Cessation.....26-41, 57-62
Telehealth.....26-41
Temporary Continuation of Coverage (TCC) 3-4, 7-11
Transplants...16-21, 26-48, 65-68, 70, 89-90
Treatment therapies.....26-41
Vision care.....89-90
Wheelchairs.....26-41
X-rays...26-51, 55-56, 63-64, 76-85, 89-90

Notes

Notes

Summary of Benefits for the Triple-S Salud, Inc. Plan - 2027

- **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 FEHB 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, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	**Network**: $7.50 for PCP and Specialist $1.00 per laboratory $0 copay for services rendered in SALUS Clinics. $0 copays for X-rays **Out-of-Network**: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount	26-27
Services provided by a hospital: Inpatient	**Network**: Nothing **Out-of-Network**: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount.	49-50
Services provided by a hospital: Outpatient	**Network**: $25 facility copay for outpatient surgery **Out-of-Network**: 10% coinsurance. In-network cost-sharing applies, plus any difference between our allowance and the billed amount	50
Emergency benefits: Network	**Network**: Emergency room $25 Nothing for hospital. Urgent care $10 copay $0 copay for services rendered in Urgent SALUS Clinics.	52
Emergency benefits: Out-of-Network	10% plus all charges that exceed our allowance	52
Mental health and substance use disorder treatment	Regular cost-sharing	55-56
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% 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	59

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% up to $375 maximum out of pocket for unit or refill	61
Dental care	Diagnostic and Preventive services 0% coinsurance	63-64
Vision care	$7.50 per office visit $0 copay for services rendered in SALUS Clinics.	36
Special Features	Flexible benefits option · Teleconsulta · Blue Card Program · BCBS Global Core · Centers of Excellence for transplants · Telexpreso · Medication Therapy Management Program · Health Risk Assessment (HRA) tool · Preventive Care Centers · Oncology Analytics	65-67

2027 Rate Information for Triple-S Salud, Inc.

To compare your FEHB health plan options please go to www. opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www. opm.gov/FEHBpremiums or www. opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the monthly non-Postal column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Puerto Rico					
High Option Self Only	891	$183.17	$61.05	$396.86	$132.28
High Option Self Plus One	893	$411.28	$137.09	$891.11	$297.03
High Option Self and Family	892	$419.46	$139.82	$908.83	$302.94
Virgin Islands					
High Option Self Only	891	$183.17	$61.05	$396.86	$132.28
High Option Self Plus One	893	$411.28	$137.09	$891.11	$297.03
High Option Self and Family	892	$419.46	$139.82	$908.83	$302.94