ESTADO LIBRE ASOCIADO DE
PUERTO RICO
Administración de Seguros
de Salud de Puerto Rico (ASES)

PUERTO RICO GOVERNMENT HEALTH PLAN MCO CONTRACT

APPENDIX (1)

APPLICABLE LAW AND REGULATIONS

ASES
Administración de Seguros de Salud de Puerto Rico

Applicable Commonwealth Laws and Regulations:

- Act 72 of September 7, 1993, as amended, knows as "Puerto Rico Health Insurance Administration Law"
- Puerto Rico Insurance Code and its applicable regulations
- Act 81 of May 14, 1912; known as "Organic Law for the Puerto Rico Health Department"
- Act 194 of August 25, 2000, as amended, known as "The Declaration of Patient's Rights and Responsibilities"
- Act 408 of October 2, 2000, as amended, known as "Puerto Rico Mental Health Law"
- Act 11 of April 11, 2011 as amended, known as "Organic Law of the Office of the Patient Advocate"
- Act 247 of September 3, 2004, as amended, known as the "Puerto Rico Pharmacy Law"
- Act 139 of August 1, 2008, as amended, known as "Law for the Medical Licensing and Discipline Board"
- Act 109 of June 28, 1974, as amended, known as "Law for the Puerto Rico Public Services Commission"
- Act 225 of July 23, 1974, as amended, known as "Law for Ambulance Services"
- The Public Services Commission's Regulations for ambulance services in Puerto Rico, Regulation No. 6737 of December 1, 2003
- Act 86 of August 16, 1997, known as "Law for the Residents of Culebra and Vieques"
- Act 227 of August 12, 1999, known as "Law for the Commission Implementation of the Suicide Prevention Public Policy"
- Act 243 of November 10, 2006, known as "Law to establish the public policy concerning the use of the Social Security Number for identification and the protection of its confidentiality"
- Act 84 of June 18, 2002, known as "Code of Ethics for Contractors, Suppliers and Applicants for Economic Incentives from the Executive Agencies of the Commonwealth"
- Act 12 of July 24, 1985, as amended, known as the "Government Ethics Law"

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- Act 458 of December 29, 2000, as amended, known as "Law to Prohibit the Adjudication of Auctions to convicts of Fraud, Embezzlement or Illegal Misappropriation of Public Funds"
- Act 70 of August 12, 1988, as amended, known as the "Puerto Rico Uniform Administrative Proceeding Law"
- Act 111 of September 7, 2005, as amended, known as the "Law to Inform Citizens of the Security of Data Banks"
- Act 126 of October 31, 2013, known as the "Law for the Protocol of Interagency Services for the Elderly Population Living in Infrahuman Conditions".

Applicable Federal Laws and Regulations:

- Puerto Rico Health Department's State Plan ("Medicaid State Plan" and CHIP State Plan")
- Title XIX of the Medical Assistance Program ("Grants to States for Medical Assistance Programs")
- Title XXI of the Social Security Act, Children's Health Insurance Program, ("CHIP")
- Federal rules and Regulations as established by the Center for Medicare & Medicaid Services ("CMS") and the Checklist for Managed Care Contract Approval" including, but not limited to: 42 CFR 422.208 and 210 (Physician incentive plans); 422.560-422.626; 42 CFR 438 (manage care) including subsections 56, 60, 66, 206(b), 214, 242, 42 CFR 431 (fair hearings and appeals); 42 CFR 455 fraud and abuse reporting; 42 CFR 447 (timely claim payment); 45 CFR 74.53 (retention requirements for records); 42 CFR 433 Subpart D, 42 CFR 447.20 and 42 CFR 434 (third party liability); 42 CFR 435.911 and 435.914; 42 CFR 431.52-53 (ambulance services); 42 CFR 405.2402; 42 CFR Part 455.104; 42 CFR Part 455.106; and 42 CFR 447.20 and 42 CFR 434.6 (a)(9)
- Davis-Bacon Act, 40 U.S.C. 276a et seq.
- The Social Security Act, including Titles VI,VII,XIX and XXI
- Copeland Anti-Kickback Act, 40 U.S.C 276c
- Fair Labor Standards Act of 1938, 29 U.S.C 201 et seq.
- Clean Air Act, 42 U.S.C. 7401 et seq.
- Federal Water Pollution Control Act as Amended, 33 U.S.C. 1251 et seq.

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- Federal Rehabilitation Act of 1973
- Byrd Anti-Lobbing Amendment, 31 U.S.C. 1352
- The Clinical Laboratory Improvement Amendments of 1988
- The Health Insurance Portability and Accountability act of 1996 (HIPAA)
- Omnibus Budget Reconciliation Act of 1981, P.L. 97-38
- Debarment and Suspensions, 45 CFR 74 and Executive Orders 12549 and 12689
- Americans with Disabilities Act, 42 USC 12101 et seq.
- Medicare Modernization Act of 203, P.L. 108-173
- Mental Health Parity and Addiction Equity Act of 208, P.L. 110-343
- Patient Protection and Affordable Care Act, P.L. 111-148.

Medicaid Laws, regulations and requirements pertaining only to the Medicaid population.

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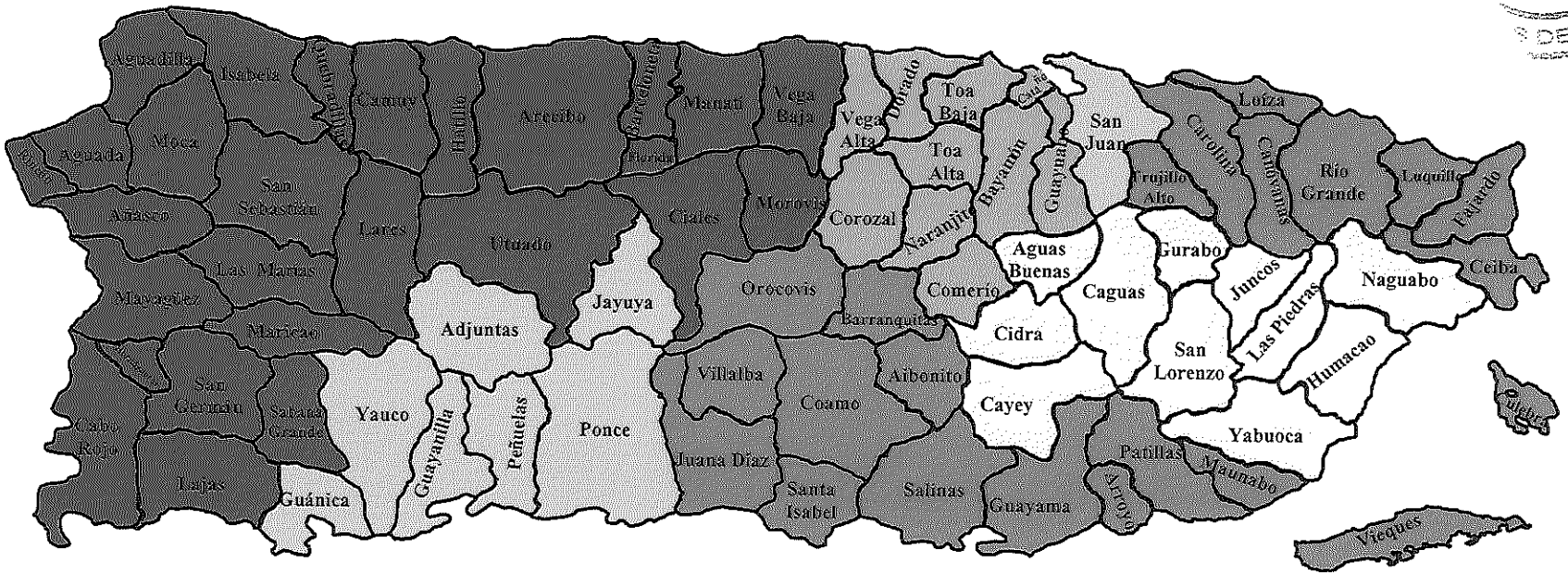
APPENDIX (2)

MAP OF GEOGRAPHICAL SERVICE REGIONS

ASES
Administración de Seguros de Salud de Puerto Rico

Puerto Rico Health Isurance Administration
Geographic Regions
2014



West Region
Physical & Behavioral Health: Triple-S
Pharmacy Services: MC-21

North Region
Physical & Behavioral Health:
First Medical Health Plan
Pharmacy Services: MC-21

Metro North Region
Physical & Behavioral Health: Triple-S
Pharmacy Services: MC-21

San Juan Region
Physical & Behavioral Health:
First Medical Health Plan
Pharmacy Services: MC-21

North East Region
Physical & Behavioral Health:
MMM Multi Health, LLC
Pharmacy Services: MC-21

South West
Physical & Behavioral Health:
Molina Healthcare of PR, Inc.
Pharmacy Services: MC-21

South East Region
Physical & Behavioral Health:
PMC Medicare Choice, LLC
Pharmacy Services: MC-21

East Region
Physical & Behavioral Health:
Molina Healthcare of PR, Inc.
Pharmacy Services: MC-21

***Virtual Region**
Physical & Behavioral Health: First Medical Health Plan
Pharmacy Services: MC-21

* **Virtual Region:** The Service Region for the MiSalud Program that is comprised of children who are in the custody of ADFAN, as well as certain survivors of domestic violence referred by the Office of the Women's Advocate, who enroll in the MiSalud Program. The Virtual Region encompasses services for these Enrollees throughout Puerto Rico.

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APPENDIX (3)

ASES UNIVERSAL BENEFICIARY GUIDELINES

ASES
Administración de Seguros de Salud de Puerto Rico

ASES
Administración de Seguros de Salud de Puerto Rico

_____, 2015

Dear Enrollee:

Greetings and welcome to the Government Health Plan of Puerto Rico!

The Health Insurance Administration (ASES, its Spanish acronym) has developed this Uniform Guide for you to be informed on the use of the benefits provided by the Government Health Plan (GHP). This way you can have available the information you need regardless of the company that provides your healthcare.

The GHP offers the broadest benefit coverage through a coordinated care model. Under the GHP model you will be able to move freely within the preferred network and visit your specialists, sub-specialists, laboratories, x-rays and other health care providers without the need for referral and without co-pays. Your Primary Medical Group (PMG) and the Health Plan will inform you who are the providers that compose the preferred network.

You have the opportunity to choose a Primary Medical Group (PMG) and a Primary Care Physician (PCP) and if you do not choose you will be assigned a PMG and PCP in your area. They will keep a complete clinical record on your health conditions, allergies, medications. All of the services offered will comply with the strictest quality and cost-effective standards required by the health industry and federal and Commonwealth regulations.

We ask that you keep your address and personal information updated by contacting the Medicaid Program Office in which you submitted your eligibility application. You must also attend your re-certification appointments so that you do not lose your health care benefits.

Visit your PCP for the necessary tests for your cholesterol, sugar, and blood pressure. Visiting your PCP can also help to early detect diseases such as cardiovascular diseases, diabetes and cancer.

We invite you to make good use of this benefit offered by the Government of Puerto Rico, whose aim is to safeguard your health.

Cordially,

Ricardo A. Rivera Cardona
Director Ejecutivo

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CONTACT US

Health Advocate Office

Toll-free	**1-800-981-0031**
Metro Area	**787-977-1100**

Puerto Rico Health Insurance Administration

Toll-free 1-800-981-2737

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LANGUAGE

This Guide is provided in Spanish and English for your benefit. If any member of your family is enrolled in the Government Health Plan and the person has problems reading or has a disability such as blindness and needs special services to be able to receive the information provided in this Guide, the person may request help from your Health Plan. Your Health Plan must have different formats for the information to make them available to the Enrollees.

If the information provided in this Guide is confusing or if you need to clarify any questions, you may contact your Health Plan for assistance. Information is a vital component of the commitment of the Government Health Plan with you, our Enrollees. You may contact your Health Plan at the telephone numbers found on the back of your Government Health Plan ID card.

DEFINITIONS

Abuse: The excessive and improper use of a product, service or benefit, which results in unnecessary or excessive costs for the health care system.

Access: The guarantee that the Enrollee will be able to receive all the medically necessary services included in the Government Health Plan coverage without any barriers.

Administrative Referral: Written Authorization issued by your Health Plan for the Enrollee to receive the required service, if medically necessary, when the PCP or other PMG physician does not provide a Referral within the required time period.

Advance Directives: Written or verbal instructions, such as wills or powers-of attorney related to decisions about services and health care expressed by the person in advance in case an event occurs and he/she may be unable to make such decisions.

Ancillary Services: All those supplementary services provided to the Patient to assist in the diagnosis and Treatment of illness or injury. Examples of these services include laboratory, radiology, therapies, etc.

Authorization: A written document through which a person freely and voluntarily authorizes another person or provider to represent, him/her, apply, use and disclose health information for medical or Treatment purposes or to initiate an action such as a Grievance. It may also be used to annul a previous authorization.

Auto Enrollment: Automatic enrollment in the Health Plan of a Medicaid certified eligible person once the Health Plan is notified of such eligibility.

CHIP: *Children Health Insurance Program*, a federal program that provides medical Service Coverage to low-income children under age 18 through health plans qualified to offer coverage under this program.

Coinsurance: A percentage of the cost of a health service which the Enrollee must pay after receiving the service.

Commonwealth Population: The Commonwealth Population is comprised of the following: (i) Certain persons who are between twenty-two (22) and sixty-four (64) years of age, inclusive of the age limits, and who do not qualify for either Medicaid or CHIP; (ii) Police officers of the Commonwealth and their Dependents; (iii) Surviving spouses of deceased police officers;(iv) Survivors of domestic violence referred by the Office of the Women's Advocate; and (v) Veterans.

Complaint: An informal claim on the quality of care, customer service or Treatment received by providers, personnel of your Health Plan, or PMG. It does not include disputes involving medical services, coverage or payment for services.

Consultation: An opinion a health professional requests to another health professional on a matter related to the health condition of a Patient.

Coordinated Care: Is the service provided to Enrollees by doctors who are part of the preferred network of providers in your Primary Medical Group. The Primary Care Physician is the leading provider of services and is responsible to periodically evaluate your health and coordinate all medical services you need.

Coordination of Benefits: The order in which health services are paid when the person has more than one medical plan. One of the plans is considered the primary plan and the other the secondary plan or secondary payer.

Copayment: An established fixed amount that is the Enrollee's contribution to the expense for a medical service he/she receives.

Covered Services: Those services and benefits included in the Government Health Plan coverage.

Deductible: A fixed amount pre-determined by ASES, which the Enrollee must pay when he/she receives, health services.

ELA Puro: An option available to public employees so they can maintain medical coverage when they lose eligibility in the Medicaid Program and the enrollment for other health plans contracted under Law 95 has ended. This coverage is the same as the coverage of the Government Health Plan.

Enrollee: A person who after being certified as eligible under the Medicaid Program has completed the enrollment process with the Health Plan and for whom the Health Plan has issued the ID card that identifies the person as a Government Health Plan Enrollee.

Federal Population: CHIP and Medicaid eligible individuals.

Good Cause: Refers to situations that allow Enrollees to change his/her PCP or Primary Medical Group. These are: 1) The Enrollee moved outside the Region, 2) For reasons of moral or religious nature, the Health Plan does not perform the services the Enrollee needs, 3) The Enrollee need services that can be provided at the same time and not all services are available; failure to receive all the services as ordered may expose the Enrollee to unnecessary risk, 4) Other acceptable reasons include, but are not limited to, poor quality of care, lack of Access to services covered or lack of providers with experience to provide the health care the Enrollee needs. ASES will determine if the reason constitutes a Good Cause.

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Grievance: A formal claim made by the Enrollee in writing, by telephone or by visiting your Health Plan or the Health Advocate Office, requesting a solution be granted when a service has been denied or allowed on a limited basis. A service; reduction, suspension or termination of a previously authorized service; total or partial denial of payment for a service; not having received services in a timely manner; when your Health Plan has not acted on a situation according to the established terms, refusal of your Health Plan let the Enrollee exercise his/her right to receive services outside the network

Health Plan: The managed care organization that is providing services in the GHP program. There is one health plan per region.

HIPAA (Health Insurance Portability and Accountability Act): The law that includes regulations for establishing safe electronic health records that will protect the privacy of a person's medical information and prevent the misuse of this information.

Hospital: A facility that provides medical-surgical services to hospitalized Patients.

Identification (ID) Card: A card your Health Plan delivers to you once the Auto Enrollment is completed or you complete the subscription process, which identifies the Enrollee by name and contract number, and includes information on coverage, Copayments, customer service and health advice telephone numbers.

Medical Record: Detailed collection of data and information on the Treatment and care the Patient receives from a health professional.

Medicare Beneficiary: Persons aged 65 or more, who are disabled or have renal disease, who have Medicare Parts A coverage for Hospital services or Parts A and B for Hospital, ambulatory and medical services.

Medicaid: Program that provides health insurance for people with low or no income and limited resources, according to federal regulations.

Primary Care Physician (PCP): A licensed medical doctor (MD) who is a provider and who, within the scope of practice and in accordance with Puerto Rico Certification and licensure requirements, is responsible for providing all required primary care to Enrollees. The PCP is responsible for determining services required by Enrollees, provides continuity of care, and provides Referrals for Enrollees when Medically Necessary. A PCP may be a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

Patient: Person receiving Treatment for his mental and physical health.

Post-Stabilization Services: Covered Services, relating to an Emergency Medical Condition or Psychiatric Emergency, that are provided after an Enrollee is stabilized, in order to maintain the stabilized condition or to improve or resolve the Enrollee's condition.

Preauthorization: Permission your Health Plan grants in writing to you, at the request of the PCP, Specialist or sub-specialist, to obtain a specialized service.

Prescription: Original written order issued by a duly licensed health professional, ordering the dispensing of a product, drug or formula.

Preferred Provider Network: Health Professionals duly licensed to practice medicine in Puerto Rico contracted by your Health Plan for the Enrollee to use as the first option. Enrollees can access these providers without Referral or co-payments if they belong to their Primary Medical Group.

Primary Medical Group: Health Professionals grouped to contract with your Health Plan to provide health services under a Coordinated Care model.

Referral: Written authorization a PCP issues to an Enrollee to receive services from a Specialist, sub-specialist or facility outside the preferred network of the Primary Medical Group.

Semi-Private Room: Hospital room with two beds.

Service Coverage: All the services offered to the Government Health Plan Enrollees under the Basic, Special, Mental, Dental and Pharmacy Coverages.

Special Coverage Registry: A form your Health Plan fills out at the request of the PCP when the Enrollee is diagnosed with one or more of the conditions that are part of the Special Coverage, for the Patient to receive Treatment and services directly from Specialists or sub-specialists without the need of a Referral.

Specialist: A health professional licensed to practice medicine and surgery in Puerto Rico that provides specialized medical and complementary services to the primary physicians. This category includes: cardiologists, endocrinologists, neurologists, surgeons, radiologists, psychiatrists, ophthalmologists, nephrologists, urologists, physiatrists, orthopedists, and other physicians not included in the definition of PCP.

Second Opinion: Additional Consultation the Enrollee makes to another physician with the same medical specialty to receive or confirm that the initially recommended medical procedure is the Treatment indicated for his condition.

Treatment: To provide, coordinate or manage health care and related services offered by health care providers.

Urgency: A medical condition that poses no risk of imminent death that can be treated in the doctor's office or in the facilities with extended hours and not in emergency rooms. An Urgency can become an emergency if not properly dealt with at the right time.

Waste: Is the overutilization of services, misuse of resources or other practices that, directly or indirectly, result in unnecessary costs.

HIPAA

The Health Insurance Administration (ASES) and the Health Plans are committed to maintain the confidentiality of your information. We may use and share information related to your Treatment, payment for medical services and everything related to health care within the strictest standards of confidentiality. With your written authorization we may provide your information to others for any purpose.

If you are interested in more information about the privacy practices or have questions or concerns, contact the Health Plan of the Region to which you belong.

IMPORTANT:
As a member of the Government Health Plan, you authorize the Federal Government, ASES, and the Health Advocate Office, the Health Plans or their representatives, to see your medical records to assess the quality, convenience, cost and promptness of services you receive.

IMPORTANT INFORMATION ON YOUR HEALTH PLAN

The Government Health Plan

Now, the new Government Health Plan of Puerto Rico offers more services and benefits. It also offers a Preferred Provider Network within the Primary Medical Group of your choice, which you can visit freely without the need for Referrals or paying Copayments.

Under the Government Health Plan you do not need the countersignature of the Primary Care Physician on the Prescriptions ordered by Specialists or sub-specialists within the Preferred Provider Network of your Primary Medical Group. You can freely choose dentists and pharmacies of your choice, among those contracted by the Government Health Plan.

In addition, you can receive mental health services within the same facility of Primary Medical Group. The Government Health Plan offers physical and mental health integrated services, so you can receive these services in one place.

Additional information including provider guidelines and information on the structure and operations of the GHP and physician incentive plans is available to you upon request. Please contact your Health Plan if you would like additional information.

Who is eligible to enjoy the services and benefits of the Government Health Plan?

The persons eligible under Law 72 of September 7, 1993, are:

- American citizens.
- Persons with low or no income.
- Population of Federal Medicaid Program: persons over age 65, persons that are blind or disabled and pregnant women.
- Children under the CHIP Program.
- Government employees, retirees and their dependents whose payroll is processed by the Treasury Department.
- Members of the Police Department of Puerto Rico, their widows, widowers and children that survive them.

- Veterans.
- Children under State custody through the Family and Children Administration (ADFAN, for its acronym in Spanish).
- Survivors of domestic violence through the Women's Advocate Office.

The Medicaid program will determine whether you are eligible for the Government Health Plan of Puerto Rico. Once you are certified eligible for Medicaid, they will give you form MA-10 entitled "Notice of Action Taken on Application and/or Re-Assessment" which indicates that you have been certified eligible. The MA-10 form includes the dates of your eligibility period. The Medicaid Program will also give the welcome letter to the Government Health Plan, from the Health Plan in your region.

You will receive your ID card by mail within five (5) business days after being certified eligible for Medicaid. If you do not receive the card during that period and you need medical services, you can show the MA-10 form to the contracted service provider with a contract with the Government Health Plan to show that your name is on the MA-10, that it is signed and you are authorized to receiving services.

Coordination of Benefits

As establish on Law 72 September 7, 1993, the Puerto Rico Government Health Plan, became the secondary payer to other healthcare plans that members are enrolled in. If you are currently enrolled in other healthcare plans, your responsibility is to provide ID Cards for each of your healthcare plans. Through this process, you agree to coordinate services and it will be your responsibility for the payment of the Deductible of the Government Health Plan.

AUTO-ENROLLMENT

As of July 1, 2011, every new beneficiary, who is eligible to the Government Health Plan of Puerto Rico, will be automatically enrolled and insured. This means you no longer have to visit your Health Plan to select your Primary Medical Group or your primary physician.

Auto-Assignment

Your Health Plan will send you the ID cards and information regarding the Primary Medical Group and Primary Care Physician assigned to you in order for you to access medical services immediately. You must receive your ID card by mail within 5 business days from the date you were certified as eligible. If you do not receive your card within this period, you must contact ASES Customer Service at 1-800-091-2737 or your Health Plan's Customer Service at [xxx], If you do not agree with the assigned Primary Medical Group and/or Primary Care Physician, you have the right to request a change within 90 days from the date you received your ID card.

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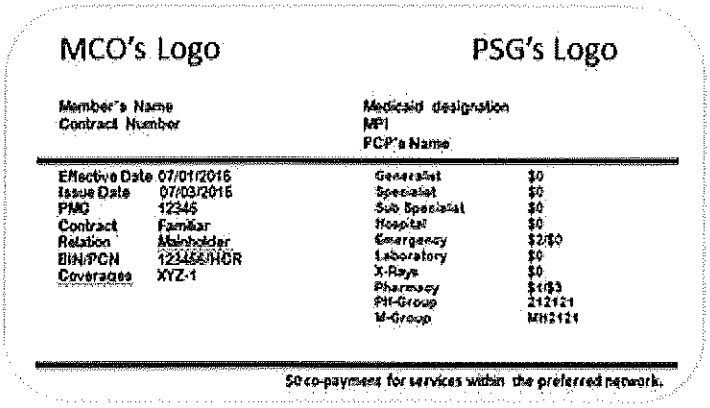
THIS IS YOUR ID CARD OF THE GOVERNMENT HEALTH PLAN



On the front of the card, you will find the following information:

- Your name and both last names;
- Your contract number;
- The group to which you belong;
- Your coverages; and
- Your Copayments and Coinsurances.

Be sure that:

- You take your ID card with you when you visit your physicians, request laboratory or X- rays services or need health services.
- They give you your ID card back after you receive medical services.
- Each insured person in your family even if he/she is a baby, has his/her own ID card.
- You keep your card in a safe place to avoid losing and having to wait for a new card.

On the back of your ID card you will find the toll-free numbers for the call center of the Government Health Plan, Customer Service and the Mental Health Crisis helpline.

If you lose your card, you may request a duplicate by visiting your Health Plan's Service Centers or by calling Customer Service at the number that appears on the back of your card.

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IMPORTANT:

No Hospital can refuse emergency services for not having the Government Health Plan card. Under EMTALA you have the right to receive adequate emergency services, including evaluation and Treatment of an emergency condition or delivery in Hospital Emergency Rooms.

DISENROLLMENT

You may request Disenrollment from your Health Plan without cause during the ninety (90) calendar days following the Effective Date of Enrollment with the Health Plan or the date that the Health Plan sends you notice of the Enrollment, whichever is later. You may request Disenrollment without cause every twelve (12) months thereafter.

You may request Disenrollment from the Government Health Plan for cause at any time. The following constitute cause for Disenrollment by the Enrollee:

1. The Enrollee moves to a Service Region not administered by the Health Plan, or outside of Puerto Rico;
2. The Enrollee needs related services to be performed at the same time, and not all related services are available within the General Network. The Enrollee's PCP or another Provider in the Preferred Provider Network have determined that receiving service separately would subject the Enrollee to unnecessary risk;
3. Poor quality of care; or
4. Lack of Access to Covered Services, or lack of Providers experienced in dealing with the Enrollee's health care needs.

ASES shall make the final decision on Enrollee requests for Disenrollment. An Enrollee wishing to request Disenrollment must submit an oral or written request to ASES or to the Health Plan. If the request is made to the Health Plan, the Health Plan shall forward the request to ASES, within ten (10) Business Days of receipt of the request, with a recommendation of the action to be taken.

The following are acceptable reasons for the Health Plan to request Disenrollment:

1. The Enrollee's continued enrollment in the Government Health Plan seriously impairs the ability to provide services to either this particular Enrollee or other Enrollees;
2. The Enrollee demonstrates a pattern of disruptive or abusive behavior that is not caused by a presenting illness;
3. The Enrollee's use of services constitutes Fraud, Waste or Abuse (for example, the Enrollee has loaned his or her Enrollee ID Card to other persons to seek services);
4. The Enrollee has moved out of Puerto Rico or out of the Health Plan's Service Regions;

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5. The Enrollee is placed in a long-term care nursing facility or intermediate care facility for the developmentally disabled;
6. The Enrollee's Medicaid or CHIP eligibility category changes to a category ineligible for the Government Health Plan; or
7. The Enrollee has died or has been incarcerated, thereby making him or her ineligible for Medicaid or CHIP or otherwise ineligible for the Government Health Plan.

If you are disenrolled from your Health Plan, you will lose access to services under the Government Health Plan.

RE-ENROLLMENT

If you are a Medicaid or CHIP member or member of the Commonwealth Population and you lose eligibility for the GHP for a period of less than two (2) months, you will be re-enrolled in your Health Plan.

FRAUD, WASTE AND ABUSE

What is Fraud?

Fraud affects adversely insured beneficiaries, health plans and professionals and entities that render health services. Fraud refers to any intentional and deliberate act to deprive another of property or money through deception or any other unfair action. It is done with the purpose of deceiving or making false misrepresentation with the purpose of obtaining a personal benefit or to benefit another person.

You have the responsibility of reporting any situation you understand may involve fraud against the Medicaid Program. Some examples of fraud are:

- Billing for medical services or procedures not actually performed.
- Billing for supplies or medications not dispensed.
- Lending an ID card to someone who is not entitled to it (misrepresentation) to obtain clinical services or medications.
- Billing for a more costly payment than the one actually performed to obtain a higher payment.
- Submitting false documents to obtain reimbursements.
- Billing for the same service more than once.
- Providing false information in a health enrollment form.
- Billing for the dispensing of full Prescription when the Prescription was actually filled partially.
- Receiving services rendered by a provider that has been excluded from the Medicaid Program.
- Receiving reimbursement for services that are not medically necessary or that do not comply with the health care professional standards.

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It is important that any illegal or fraudulent action be reported immediately to your Health Plan's Complaint Unit, the Patient's Advocate Office or to ASES at the telephone numbers or email addresses included in page [5] of this Handbook.

What is Abuse?

Abuse is the excessive and improper use of a product, service or benefit, which results in unnecessary or excessive costs for the health care system.

Some examples are:

- Overuse of services that are not medically necessary, such as the constantly using the emergency room instead of going to the Primary Care Physician.
- Excess in the orders for diagnostic tests that do not have a medical justification.
- Waiving health plan Copayments or Coinsurances to attract customers.

What is Waste?

Waste is the overutilization of services, misuse of resources or other practices that, directly or indirectly, result in unnecessary costs.

Some examples are:

- Prescribing high cost medications instead of similar generic or lower cost medication.
- Billing errors due to inefficient billing systems.
- Inflated prices on services or devices.

What can I do to avoid Fraud, Waste and Abuse?

- Protect your ID card information: never provide information on your Health Plan to strangers or to callers by phone.
- Learn the terms of your coverage and keep a copy of the medical studies to avoid duplicating services. If you visit a doctor, keep a copy of your laboratory results and other tests performed and have on hand a list of the medications you are taking. In this way you will not have to repeat tests that will consume time and money.
- Verify the information before signing any insurance enrollment form or health service form.
- Request and review the quarterly summary of the services you receive. You may request the summary of services directly to the Health Plan that provides you the Government Health Plan Services.

How can I report situations on Fraud, Waste and/or Abuse?

If you have information or suspicion that you have been a victim of health plan fraud, you may contact your Health Plan through the call center of the Government Health Plan at the numbers that appear on the back of your ID card. You may also contact the Health Advocate Office at 787-977-0909 or, ASES at 1-800-981-2737 or by visiting your Health Plan, the Patient's Advocate Office, ASES Offices or Customer Service Centers.

For more guidance on this matter you can access the orientation on Fraud, Waste and Abuse section on the ASES website at www.ases.pr.org. From this section of the website you can download the incident referral document which you can use to report any situation on Fraud, Waste and/or Abuse. Additionally, this section contains the contact information of all the agencies you can call to report any situation on Fraud, Waste and/or Abuse. Upon completing ASES's incident referral document you have the option of indicating that you do not want to be contacted and/or remain anonymous. Similarly, you can also access your Health Plan's website which also contains a Fraud, Waste and Abuse orientation section with all the previously described information.

Your call or written communication will be handled confidentially and your Government Health Plan Coverage will not be affected by this referral. If the investigation shows that Fraud, Waste or Abuse was committed, the case will be referred to the corresponding authorities.

PRIMARY MEDICAL GROUP AND PRIMARY CARE PHYSICIAN

Can I change my Primary Medical Group or the Primary Care Physician?

Yes, you may change your Primary Medical Group or your Primary Care Physician either by visiting your Health Plan's Service Center or by calling your Health Plan's Customer Service Line at [xxx-xxx-xxxx].

Changes to the Primary Medical Group and Primary Care Physician – You will only be able to change within the first 90 days following the date in which you received your Government Health Plan ID card. After this 90-day period, you may only change your Primary Medical Group and your Primary Care Provider once a year. If there is a Good Cause, you may change your Primary Medical Group or your Primary Care Physician at any time.

The following events are considered a Good Cause for a change:

1. You move out of the region;
2. For moral or religious reasons, the provider does not render the services you need;
3. You need services that must be rendered at the same time and the services are unavailable. Not receiving all the services as ordered may put you at risk unnecessarily.
4. Other acceptable reasons include, but are not limited to:
   a. Bad quality of services;
   b. Lack of Access to Covered Services; and
   c. Lack of providers with experience to take care of your health care needs.

ASES will determine if the reason is a Good Cause.

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Changing the Primary Care Physician and the Primary Medical Group, (referred in previous paragraph) must be made during the first 5 days of the month, so the change becomes effective the next month (e.g. If you make the change on January 5, the change will be effective on February 1). However, if you change after the first 5 days of the month, the change will be effective on the subsequent month. (e.g. If you make the change on January 6, it will be effective on March 1).

To change the Primary Care Physician within the same Primary Medical Group, you only have to choose the new Primary Care Physician within same Primary Medical Group you have now and the change will be effective on the following month.

IMPORTANT:
The Medicaid Program is the only office authorized to make changes on your personal information and your residential address. You must notify the Medicaid Program of any changes such as changes in address, family group, marital status, your income, corrections to names, and dates of birth, among others.

Your Health Plan must keep you informed when a Primary Care Physician. Specialist or Sub-specialist is no longer available to be your medical service provider, so you can choose a new Primary Care Physician, Specialist or Sub-Specialist. You must receive the notice sent by your Health Plan within 15 days from the date your Health Plan was informed that the provider will not continue providing services. The notice the Health Plan provides to you will give you the instructions for you to be able to choose a new physician among those in your Primary Medical Group.

Choosing the Primary Medical Group and the Primary Care Physician

Remember that you have the freedom to choose the Primary Medical Group and the Primary Care Physician you want. If you do not agree with the assigned PMG and/or PCP made by your Health Plan, you can change. **The Primary Medical Group and the Primary Care Physician you choose must render services with the region to which you belong.**

You must choose a Primary Care Physician for each insured member in your family. The Primary Care Physicians you use for you and your dependents may be different, but they must belong to the same Primary Medical Group.

If you are a woman, you may choose a gynecologist/obstetrician in addition to any other Primary Care Physician. If you are pregnant, your Primary Care Physician will be your gynecologist/obstetrician during your pregnancy. When your pregnancy ends you will go back to receive care from the Primary Care Physician you chose: a Generalist, Internist, or Family Practitioner. Your gynecologist will still be your other Primary Care Physician to meet your gynecological situations. You may choose a pediatrician for your baby or one will be assigned to you.

IMPORTANT:
Remember, you must register your baby in the Medicaid Program before he is 90 days of age. You must bring with you the birth certificate.

RECERTIFICATION OF ELIGIBILITY

Once the Medicaid Program (PAM, for its acronym in Spanish) of the Health Department certifies you as eligible, you must attend all the appointments to all reevaluation appoints, so you don't lose your eligibility. If you lose eligibility you will lose the benefits of the Government Health Plan, because you will not have the benefits of your Health Plan. Your Health Plan will send you a letter at 90 days, 60 days and 30 days before your eligibility ends as a reminder that you must visit the Medicaid Office in your hometown to recertify your eligibility.

If you miss your recertification appointment, you must immediately call the Medicaid Program Call Center at the toll-free number 1-885-400-4224 or visit your Medicaid Office located in your hometown to request a new appointment.

You must notify the Medicaid Program of any changes in address, income level, dependents, corrections to your address or name, or changes in marital status (married, divorced widower, etc.).

If you are pregnant, when you have your baby, you must visit the Medicaid Program Office and submit the birth certificate to enroll the baby in the Government Health Plan. If you do not comply with this requirement, the baby will lose the right to receive services under the Government Health Plan of Puerto Rico. It is possible that with the arrival of this new baby you can obtain more benefits if your level of poverty changes.

IMPORTANT:
Remember, it is your responsibility to keep appointments and update your information and mailing address with the Medicaid office in order to receive communications related to your recertification. If you do not receive the notification from your Health Plan, it is your responsibility to request the reevaluation appointment.

PUBLIC EMPLOYEE

If you are a public employee or a retiree from the Government of Puerto Rico and your payroll is process by the Treasury Department, you may enroll in the Government Health Plan during the open enrollment period to choose public employees health insurance plans. If you choose the Government Health Plan, the employer contribution will go to ASES and you will pay the difference, if any.

You can also visit the Medicaid Program for them to evaluate your case and, if found eligible and medically indigent, you will not have to pay the difference, if any, between the premium and the employer contribution as it will be paid with government funds.

Medical indigence is granted for a period of 12 months. Your plan will send you a letter 90 days, 60 days, and 30 days prior to the end of your eligibility period, reminding you that your eligibility is about to end and that you must visit your Medicaid Program Office located in your town of residence and request the reevaluation of your case.

In case of public employees that are married, they may enroll in the Government Health Plan combining both employer contributions (known as joint enrollment) for your eligibility. Your employer will provide the contributions to ASES, while you remain active and eligible under the Medicaid Program.

If after the evaluation, it is determined that you are no longer eligible to the Government Health Plan as medically indigent, you can enroll in the Government Health Plan as ELA Puro until the new health plan open enrollment period for public employees or you may enroll in any other health insurance plans contracted for public employees. It is your choice!

IMPORTANT:
Remember to attend your eligibility reevaluations on time, so you do not lose your Government Health Plan benefits.

What can I do if my eligibility in GHP is cancelled?

If the Medicaid Program determined that you are no longer eligible to the Government Health Plan, and you are an employee or retiree of the Government of Puerto Rico, you have the right to enroll in the Government Health Plan under ELA Puro within the 30 days following the date in which you lost your eligibility. In this way, you will not lose your medical coverage until the new government employee open enrollment period and you can choose any of the health plans contracted, including enrolling in the Government Health Plan.

If you are not an employee or retiree of the Government of Puerto Rico and you lose your eligibility, you may enroll in a Pago Directo Plan by submitting an application with your Health Plan. You must complete the formalities within 30 days from the date your eligibility to the Government Health Plan was cancelled.

How can I enroll in another of the plans contracted for government employees?

If you decide to join another plan from among the plans contracted for government employees according to Law 95, which is not the Government Health Plan, before you enroll in the new plan you will have to go to the Medicaid Program Office in your hometown to cancel your eligibility. The cancellation of your Government Health Plan coverage will be effective on the first day of the month following the date in which you requested your cancellation under the Medicaid Program.

If you do not cancel your eligibility to the Medicaid Program, ASES will continue receiving you employer contribution and you will have to pay the total premium of the Private Plan you chose.

IMPORTANT:
Remember that for you to be able to enroll in another plan, you must have lost your eligibility and may only enroll in another plan during the open health insurance enrollment period for the employees of the Government of Puerto Rico established by ASES.

Can the members of the Police Department of Puerto Rico enroll in the Government Health Plan?

The members of the Police Department of Puerto Rico, their spouses and children may also enroll in the Government Health Plan of Puerto Rico and the Police Department of Puerto Rico will transfer to ASES their employer contribution.

You must visit the Medicaid Program Office located in your town of residence to be certified under the Medicaid Program. This benefit will remain valid even if the member of the Police Department dies under any circumstance and as long as the widow does not re-marry and the children are under age 26 and are not married.

WHAT IS COORDINATED CARE?

The Government Health Plan uses a Coordinated Care model in which your health is under the care of a Primary Care Physician, who will be responsible to evaluate the beneficiary periodically and coordinate all the health services the person may need. Under this model your Primary Care Physician will keep an updated record of all the services you receive.

YOUR PRIMARY MEDICAL GROUP AND YOUR PRIMARY CARE PHYSICIAN

What is a Primary Medical Group?

Primary Medical Group (PMG) – is composed of several physicians who have joined to provide the services you need to keep you healthy. What was known as IPA, now it is known as PMG. Within this Group, there are physicians with different specialization which have been classified as Primary Care Physicians, among which there are:

- General Practitioners
- Family Physicians
- Pediatricians
- Gynecologists/Obstetricians
- Internists

Besides these five categories of Primary Care Physicians, under the new model of the Government Health Plan you will also have Specialists, sub-specialists, laboratories, X-rays facilities and Hospitals, among others, to form what we call the Preferred Providers Network of the Primary Medical Group. You have the freedom to visit the physicians and providers that are part of the Preferred Network without the need of a Referral or Copayment.

IMPORTANT:

Routine physical exams shall be provided for Enrollees age twenty-one (21) and over within thirty (30) calendar days of the Enrollee's request for the service.

Routine physical exams for minors less than twenty-one (21) years of age - an initial health and screening visit shall be provided to all newly enrolled Medicaid and CHIP Eligible children within ninety (90) calendar days and within twenty-four (24) hours of birth to all newborns; and, after the initial checkup, annually.

Routine evaluations for Primary Care shall be provided within thirty (30) calendar days, unless the Enrollee requests a later time.

Covered Services shall be provided within fourteen (14) calendar days following the request for service.

Specialist Services shall be provided within thirty (30) calendar days of the Enrollee's original request for service.

Dental services shall be provided within sixty (60) calendar days following the request, unless the Enrollee requests a later date.

Behavioral Health Services shall be provided within fourteen (14) calendar days following the request, unless the Enrollee requests a later date.

Diagnostic laboratory, diagnostic imaging and other testing appointments shall be provided consistent with the clinical Urgency, but no more than fourteen (14) calendar days, unless the Enrollee requests a later time.

Appointment for urgent situations – as long there is not a risk of death or damage to the body or body organs, they must be obtained within a period of 24 hours.

These conditions must be treated at the medical office or offices with extended business hours, not at emergency rooms.

What is a Preferred Providers Network?

They are a group of Specialists, sub-specialists and health service facilities with a contract with your Health Plan to provide services under your Primary Medical Group. As long as you visit your Primary Medical Group Preferred Network, you will not have to wait for a Referral or pay Copayments.

The information below tells about some physicians and providers, without limiting to these specializations that **may belong** to the Primary Medical Group of your choice:

- Specialists and sub-specialists (including but not limited to Cardiologists, Orthopedists, Rheumatologists, Endocrinologists, Urologists, Gastroenterologist, Oncologists, Physiatrists).

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- Ancillary Service providers: physical therapists, nutritionists, speech pathologists, among others.
- Clinical laboratories.
- Specialized diagnostic tests.
- Imaging centers.
- Cardiovascular surgery and catheterism centers.
- Hospitals.
- Urgency rooms.
- Emergency rooms.

Another benefit you will now have under the Government Health Plan is that you will no longer need the countersignature of your Primary Care Physician on the Prescriptions ordered by any other physician that is not your Primary Care Physician, **as long as the physician ordering the Prescription is part of the Preferred Network of your Primary Medical Group.**

For laboratory and X-rays services you will need an order from the prescribing physician, but not the Authorization of your Primary Care Physician, as long as you **receive the services at a laboratory or X-rays that belongs to the Preferred Provider Network of your Primary Medical Group.**

The preferred networks will guarantee Access, quality and availability of the health services to be rendered to beneficiaries.

Are all my Specialists within the Preferred Network of my Primary Medical Group?

In case that the Specialist or sub-specialist that you need is not part of the Preferred Network of your Primary Medical Group, your Primary Care Physician must give you a Referral so you can visit the Specialists or sub-specialists outside the Preferred Network of your Primary Medical Group and you will have to pay corresponding Copayments. Your Primary Care Physician will be the one to coordinate the visits to physician and providers of medical services outside the Preferred Network of Providers of your Primary Medical Group.

You may visit Specialists or sub-specialists from your Health Plan's General Network of Providers as long as your Primary Care Physician gives you the corresponding Referral and coordinates the visit, which will be subject to the applicable Copayments.

The Health Plan must cover FQHC services out-of-network at no cost to you for as long as FQHC services are unavailable in the Health Plan's Preferred and General Network of providers. The out-of-network FQHC services require a Referral from your PCP and there is no applicable Copayment. If you wish to visit a Specialist or sub-specialist that does not belong to the Preferred Network of your Primary Medical Group, when there is a physician with the same specialty in the Preferred Network of the Primary Medical Group, you will also need a Referral from your Primary Care Physician and you will be responsible of paying the corresponding Copayment.

Referrals to visit a Specialist or other health provider, for either the general network or out of network services, must be provided during the same visit with the PCP but no later than 24 hours of the Enrollee's request.

Authorizations or Preauthorizations for services must be provided within 72 hours. If life or health could be endangered by a delay in Accessing services, Prior Authorizations must be provided as expeditiously as the Enrollee's health requires, and no later than twenty-four (24) hours from the Service Authorization Request.

Non-compliance with these terms will be a reason to submit a Complaint. Nevertheless, if you are in the Special Coverage Registry you will not need Referrals from your Primary Care Physician, as long as the Treatment you are going to receive corresponds to your Special Coverage diagnosis.

IMPORTANT:

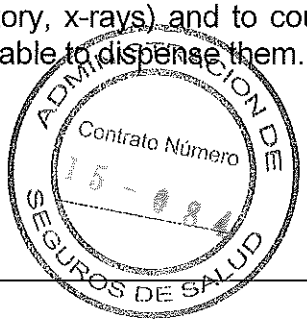
Your Primary Care Physician is the only authorized provider to give you the referrals you need for your health condition. The Administrator, the Medical Director or the Board of the Primary Medical Group cannot issue or authorize the referral.
If your Primary Care Physician does not provide you with the referral, you can request an Administrative Referral from your Health Plan by submitting a Complaint. Your Health Plan evaluates the Complaint or Grievance before proceeding with the final determination.

Your Health Plan will mail to you the Directory of the Providers of the Primary Medical Group and General Network. This information is also available on your Health Plan's website.

What is your Health Plan's General Network?

They are the Specialists, sub-specialists and health services facilities your Health Plan has contracted to provide support to the Primary Medical Groups. This General Network of your Health Plan will be available to provide those services you cannot obtain through the Preferred Network of your Primary Medical Group, as long as your Primary Care Physician gives you a Referral.

To be able to receive services from your Health Plan's General Network, you must obtain a Referral from your Primary Care Physician and pay the corresponding Copayments. Prescription drugs or other service orders issued by your Health Plan's General Network will need the countersignature or Authorization of your Primary Care Physician. That is, you will always have to go back to your Primary Care Physician for him/her to authorize the service ordered (laboratory, x-rays) and to countersign the Prescription of the medications for the pharmacy to be able to dispense them.



Will I need the Countersignature on the Prescriptions of Medications?

No participating pharmacy of the Government Health Plan can request the countersignature of the Primary Care Physician on Prescriptions ordered by Specialists or sub-specialists that belong to the Preferred Network of the Primary Medical Group.

If the Prescription of medications is from a Specialist or sub-specialist that belongs to your Health Plan's General Network or the Preferred Network of another Primary Medical Group that is not the Primary Medical Group you chose, you will need the countersignature of Primary Care Physician for the Prescription to be dispensed.

Remember, you must visit the Specialists and sub-specialists within the Preferred Network of your Primary Medical Group, so you will not need the countersignature of your Primary Care Physician.

IMPORTANT:
Remember to use the Specialists and sub-specialists within the Preferred Network of your Primary Medical Group, so you do not need the countersignature of your Primary Care Physician on your Prescriptions.

KNOW THE RESPONSIBILITY OF YOUR PRIMARY CARE PHYSICIAN

Your Primary Care Physician is responsible to:

- Perform medical assessments relevant to your health.
- Provide, coordinate and manage all health services and Treatments that you and your family need.
- Provide preventive health services to keep you healthy.
- Provide care when you feel or are sick.
- Tell you when he believes it is necessary that you visit a Specialist or sub-specialist.
- Provide Referrals when necessary, if you should visit a Specialist or sub-specialist outside of the Preferred Network of Primary Medical Group or when you want a Second Opinion.
- Coordinate visits to Specialists or sub-specialists outside the Preferred Network of the Primary Medical Group.
- Provide the Prescriptions for your medications or the orders for your Treatments.
- Keep your Medical Record updated with all the information on your health conditions, medications, Treatments, etc.
- Consult with other health professionals about your diagnosis and Treatment.

Call or visit your Primary Care Physician every time you need medical services.

HOW TO OBTAIN INFORMATION ABOUT PARTICIPATING PHYSICIANS

Your Health Plan will mail you the Directory of Participating Physicians and Providers that are part of the Preferred Network of your Primary Medical Group, which also includes the Medical Groups that belong to the Region. You will also receive the Directory of your Health Plan's General Network Physicians and Providers. These Directories will also be available in the Primary Medical Groups and at your Health Plan's Service Centers. The directories provide the following information about the physicians:

- Medical Specialty
- Name
- Address
- Telephone numbers
- Office days and business hours

You can contact your Health Plan to receive information on the providers available in your Region at the telephone numbers that appear on the back of your ID card, calling the Government Health Plan call center, going to your Health Plan's office or through your Health Plan's website. You may also contact your Primary Medical Group, which will provide information on the providers that belong to your Primary Medical Group.

When you contact your Health Plan, you can request additional information on your providers such as, where the physician studies, what did he studied, certifications of specialties the physician has, as well as all the information required to practice medicine.

THESE ARE YOUR RIGHTS

- You have the right to demand to be kept informed and receive information about:
  - your Health Plan,
  - health care facilities,
  - health care professionals,
  - health services covered, and
  - Access to contracted services;
- The right to be treated with respect and with due regard for your dignity and privacy;
- Select freely your Primary Medical Group, your Primary Care Physician, laboratory, X-rays, Hospital, Specialist and sub-specialists available within the Preferred Network of Primary Medical Group;
- Contact your Primary Care Physician or Specialist, freely and under strict confidentiality;
- Be free to receive emergency services 24 hours a day, 7 days a week;

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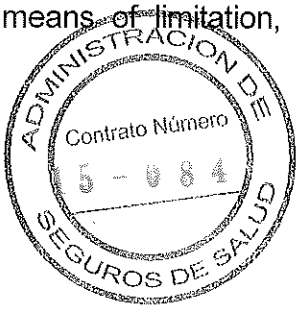
- Receive information about Treatment alternatives and options available and, that these alternatives and options be presented to you in a manner appropriate to your condition and ability to understand;
- Participate in decisions regarding your health care, including the right to refuse Treatment;
- Request a Second Opinion if you are interested in confirming a diagnosis or Treatment plan;
- Express with Advance Directives, either verbally or in writing, your wish as to what Treatment and services you want to be provided or do not want to be provided if you become unable to make such decisions;
- Be free from any form of restraint or seclusion used as a means of limitation, discipline, convenience or retaliation;
- Receive copies of your Medical Records;
- Receive high quality services;
- Continuity of health care;
- Access to adequate health services;



- Filing Complaints and appeals, when you understand that your rights have been violated by denial of, limitation of or, improper collection for services;
- Not to be discriminated against for any reason;
- Have the freedom to choose the pharmacy or dentist of your preference among those contracted by your Health Plan;
- Choose an Authorized Representative to be involved as appropriate in making care decisions;
- Provide informed consent;
- Be free from harassment by your Health Plan or its Network Providers with respect to contractual disputes between the Health Plan and its Providers;
- Participate in understanding physical and behavioral health problems and developing mutually agreed upon Treatment goals;
- Not be held liable for:
    - The Health Plan's debt in the event of insolvency;
    - Covered Services provided to you for which ASES does not pay the Health Plan;
    - Covered Services provided to you for which ASES or the Health Plan does not pay the provider that furnished the services;
    - Payments of Covered Services under a contract, Referral or other arrangement to the extent that those payments are in excess of the amount you would owe if the Health Plan provided the services directly; and
- Only be responsible for cost-sharing or co-pays as permitted by the Puerto Rico which are applicable to you.

THESE ARE YOUR RESPONSIBILITIES

- Inform yourself about the Government Health Plan Coverage, its limits and exclusions.
- Give your physician all your health-related information.
- Inform your doctor of any changes in your health.
- Follow the medical Treatment as recommended by your Primary Care Physician, Specialist or sub-specialist.
- Inform your physician when you do not understand an instruction or does not clearly understand what you are being inform.
- Inform your physician when there is a reason why you cannot comply with the recommended Treatment.
- Recognize when you need to make changes to your lifestyle to benefit your health.
- Participate in any decision regarding your health.
- Communicating either verbally or in writing any Advance Directive you want to be fulfilled regarding your decision on medical Treatment for the extension of your life.
- Maintain appropriate behavior, so your behavior does not affect or does not allow other Patients to receive necessary medical care.
- Maintain an appropriate behavior, so your behavior does not affect the operation of your Health Plan's Service Centers or prevent other beneficiaries from receiving the services provided at the Service Centers.
- Provide all the information on other health insurance plans you may have.
- Inform ASES of any fraud or improper action related to the services, providers and health facilities.

QUALITY AND PERFORMANCE INDICATORS

Puerto Rico Health Insurance Plan developed a series of quality and performance indicators as part of its quality improvement process. The quality and performance indicators are part of its Clinical and Mental Health Quality Program. The focus areas in the Clinical Quality Program are:

- Prenatal care services provided by your doctors;
- Health education on wellness and prevention programs;
- Care management support on severe acute medical condition;
- Disease Management support on chronic medical condition such as diabetes or hypertension;
- Education and support to your doctors to provide a better medical care; and
- Scorecard on preventive benefits level achieved by your Health Plan.

Some of the focus areas in the Mental Health Program are:

- Prenatal care services provided by your provider, such as:

- Screening for alcohol and tobacco for pregnant women
- Smoking cessation counseling and Treatment

- Screening of postpartum depression;
- Care Management for Enrollees diagnosed with serious mental illness or serious emotional disability; and
- Education and support to your provider to provide a better mental health care.

In addition, a series of service satisfaction indicators are measured on a yearly basis. You may be asked to participate on a survey that helps your Health Plan improve the quality of care and services delivered to you. Among the quality of service measures reported by your Health Plan are the following:

- How easy is it for you to receive the medical care that you need?
- How quickly did you receive the medical care?
- How is the customer service provided by your Health Plan?
- How easy is it for you to receive your Prescription drugs?
- How easy do you get the information you need about your medication drugs?
- How well does your doctor communicate with you?

For more information regarding Quality and Performance indicators please contact your Health Plan customer service to request it.

UTILIZATION MANAGEMENT POLICIES AND PROCEDURES

Utilization management is an evaluation of medical information to see if the service requested or recommended by your provider is necessary according to certain rules, known as clinical criteria or guidelines. The utilization management decisions are made by trained health professionals.

Your Health Plan offers clinical support through specialized programs that facilitate the Access and adequacy of services with the guarantee that services offered meet the highest standards of quality. These programs are: Disease Management, Preauthorization of Services and Case Management. Your Primary Care Physician (PCP) may decide to refer you to these programs if he/she believes you may benefit from them. For Covered Services that need Preauthorization, your Health Plan evaluates and issues a precertification of service once the care needs for the service is confirmed. If you have a chronic condition, such as Asthma, Diabetes, Hypertension or Congestive Heart Failure, you may benefit from participating in the Health Plan's Disease Management Program. When your health conditions require Treatment and management considered complex, or Treatments needs to be provided in the home setting, your Primary Care Physician may refer you to the Case Management Program for assistance and coordination of your care needs. For more information please contact your Health Plan's Customer Service.

The Health Plan also has a staff of trained mental health professionals to make decisions concerning utilization management. Some of the services that require an evaluation (Preauthorization) by the utilization management department staff before you get them are:

- Hospitalizations at a psychiatric Hospital;
- Partial hospitalizations;
- Some medications; and
- Some specialized Treatments (e. g. electroconvulsive therapy).

For more information please contact your Health Plan's Customer Service.

EMERGENCIES AND URGENCIES

How do I know when it is an emergency?

"It is a medical or Behavioral Health condition that manifests itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who has average knowledge of medicine and health would reasonably expect the absence of immediate medical attention to result in placing a person's health in serious jeopardy, serious impairment of bodily functions or serious dysfunction of any bodily organ or part, serious harm to self or other due to an alcohol or drug abuse emergency, serious injury to self or bodily harm to others. In case of a pregnant woman that has contractions it may be that there is not enough time to transfer her to any facility before delivery or, that transferring her to a facility, may seriously jeopardize her health or the health of the unborn child.

When can I receive emergency services?

You just have to arrive at any emergency room throughout Puerto Rico. You do not need Referrals or Preauthorization for emergency services.

You can also call the Government Health Plan at the toll-free number listed on the back of your Government Health Plan ID card. When you contact the call center of the Government Health Plan for information and medical advice, you will be provided a code, so you do not have to pay Copayments if you had to go to an ER. No Co-Payment will be imposed on a Medicaid or CHIP Eligible Enrollee for Treatment of an Emergency Medical Condition or Psychiatric Emergency (regardless of whether the Enrollee uses the Medical Advice Service and gets the code or not).

And then, what is an Urgency?

A medical condition that poses no risk of imminent death that can be treated in the doctor's office or in the facilities with extended hours and not in emergency rooms. An Urgency can become an emergency if not properly dealt with at the right time.

How can I receive Urgency services?

Visit or call your Primary Care Physician. If you have an Urgency or a question about your health, you may call toll-free to the Government Health Plan hotline for medical information and advice. The telephone to this hotline, which is available 24 hours a day, 7 days a week, appears on the back of your Government Health Plan ID card.

How can I receive services outside business hours from my Primary Care Physician, the Primary Medical Group or the Preferred Network of Providers?

You must consult the Directory of Providers your Health Plan provided you, to learn about the business hours of your physicians. In addition, the Directory gives you the number for the Government Health Plan call center, so you can receive information and advice regarding your health condition as well as how to obtain services on extended hours.

If you understand that it is necessary to go to an emergency room, nobody can stop that right. When you use the Government Health Plan call center for information and medical advice, they will provide you a code, so you do not have to pay Copayments if you need to go to an emergency room. They will have to give you the code, regardless of your condition. No Co-Payment will be imposed on a Medicaid or CHIP Eligible Enrollee for Treatment of an Emergency Medical Condition or Psychiatric Emergency (regardless of whether the Enrollee uses the Medical Advice Service and gets the code or not).

WHAT IS AN ADVANCE DIRECTIVE?

An Advance Directive is a written legal document which allows you to instruct your attending physician on your Treatment preferences in case there is a moment that you lose your capacity to approve the Treatment. The written document that states the Advance Directive is known as a living will.

The instructions regarding your Treatment may be stated before a lawyer, who will prepare a legal document with your instructions or before your attending physician with two witnesses, of legal age and legal capacity, who are not relatives.

Your physician can provide you information on how you can exercise your right to Advance Directives. In case you are confined in a Hospital, the staff from the Hospital Administration Office can provide you the necessary information and the forms you must you fill out to validate your Advance Directives. You may also contact the Senior Citizens Advocate Office at 787-721-6121, who provides information booklets on this topic.

For any Complaints concerning Advance Directives, you can file directly them with ASES or with the Puerto Rico Office of the Patient Advocate.

COMPLAINTS, GRIEVANCES AND APPEALS

What is a Complaint?

A Complaint is an expression of dissatisfaction about any matter that is resolved at the point of contact rather than through filing a formal Grievance (see below for what is a Grievance). Complaints are not Actions; please see below for what is an Action.

For example, you can make a Complaint for incidents related to, but not limited to:

- Problems getting an appointment, or having to wait a long time for an appointment; or
- Disrespectful or rude behavior by doctors, nurses or other Health Plan clinic or Hospital staff.

How can you file a Complaint?

You can call, write or visit your Health Plan's Service Centers for them to take your Complaint. Your physician, a relative or a person authorized by you, can file the Complaint on your behalf. Your Health Plan's staff can provide help to you to file your Complaint.

You or your authorized representative must file a Complaint within fifteen (15) calendar days after the date of occurrence that initiated the Complaint. The Health Plan shall resolve your Complaint within seventy-two (72) hours of receipt of the initial Complaint, whether orally or in writing. If the Complaint is not resolved within this timeframe, the Complaint shall be treated as a Grievance.

What is a Grievance?

A Grievance is a formal expression of dissatisfaction about any matter other than an Action that is documented and investigated by the plan. Grievances are not Actions; please see below for what is an Action.

The Grievance can be presented in writing, by telephone or by visiting any of your Health Plan's Service Centers or the Health Advocate Office (OPS, for its acronym in Spanish). For example, you can file a Grievance for incidents related to, but not limited to:

- The quality of care or services provided
- Access to care or services
- Aspects of interpersonal relationships such as rudeness of a provider or employee,
- Misinformation provided by the Health Plan or providers
- Failure to respect the Enrollee's rights
- Preauthorization requests
- Network provider changes
- Referrals
- Hazardous environment conditions

How can you file a Grievance?

You can call, write or visit your Health Plan's Service Centers to file a Grievance. Your physician, a relative or a person authorized by you, can file the Grievance on your behalf.

You have up to ninety (90) calendar days from the date of the occurrence to file a Grievance with the Health Plan. The Health Plan shall acknowledge receipt of your Grievance in writing to you (and the provider, if the provider filed the Grievance on your behalf) within ten (10) business days of receipt.

The Health Plan shall provide written notice of how the Grievance is resolved as promptly as your health condition requires, but in any event, within ninety (90) calendar days from the day the Health Plan receives the Grievance.

What is an Action?

An Action is a decision that your Health Plan makes that may affect the services you receive, specifically, an Action is:

- The denial or limited Authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service; or
- The failure to provide services in a timely manner.

What is a Notice of Action?

A Notice of Action is a written notice provided by the Health Plan to you notifying you of an Action (as defined above). The Notice of Action must contain the following information:

- The Action the Health Plan has taken or intends to take;
- The reasons for the Action;
- Your right to file an Appeal through the Health Plan's internal Grievance System and the procedure for filing an Appeal;
- Your right to request an Administrative Law Hearing after exhaustion of the Health Plan's Grievance System;
- Your right to allow a Provider to file an Appeal or an Administrative Law Hearing on behalf of you, upon written consent;
- The circumstances under which expedited review is available and how to request it;
- Your right to continue receiving Benefits and Covered Services pending resolution of the Appeal with the Health Plan or during the Administrative Law Hearing; and
- How you can request that Benefits be continued and the circumstances under which you may be required to pay the costs of these services.

The Health Plan shall mail the Notice of Action within the following timeframes:

- For termination, suspension, or reduction of previously authorized Covered Services, at least ten (10) calendar days before the date of Action or no later than the date of Action except in the event of one of the following exceptions:
    1. The Health Plan has factual information confirming the death of an Enrollee.
    2. The Health Plan receives a clear written statement signed by the Enrollee that he or she no longer wishes to receive services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information.
    3. The Enrollee's whereabouts are unknown and the post office returns the Health Plan's mail directed to the Enrollee indicating no forwarding address.
    4. The Enrollee's Provider prescribes a change in the level of medical care.
    5. The Health Plan may shorten the period of advance notice to five (5) calendar days before the date of Action if the Health Plan has facts indicating that Action should be taken because of probable Enrollee Fraud and the facts have been verified, if possible, through secondary sources.
- For denial of payment, at the time of any Action affecting the Claim.
- If the Health Plan extends the timeframe for the Authorization decision and issuance of Notice of Action the Health Plan shall give you written notice of the reasons for the decision to extend if you did not request the extension. The Health Plan shall issue and carry out its determination as expeditiously as your health requires and no later than the date the extension expires.

What can I do if I do not agree with the Notice of Action?

If you do not agree with your Health Plan's determination included in the Notice of Action, you have the right to appeal the determination before your Health Plan or the Health Advocate Office (OPS, for its acronym in Spanish) within sixty (60) calendar days from the date of the Notice of Action.

What is an appeal?

An appeal is a formal request that you file with your Health Plan or the Health Advocate Office when you do not agree with the determination (Notice of Action) or with the Health Plan's denial of a service, procedure, study, collection or payment. Once you receive the Notice of Action from your Health Plan, you have a period of sixty (60) Calendar days to file your appeal with your Health Plan.

Who will hear your Appeal?

Your Appeal will be evaluated by a team of experts (specific for your health condition) that did not take part in the determination or in the Notice of Action. This is to ensure the appeal process is fair, transparent and dependable.

How much time will they take to make a determination on my Appeal?

If the Appeal does not adversely affect your health and/or does not put your life at risk, you must receive the determination of your appeal within a period that does not exceed forty-five (45) calendar days. However, if your health condition requires an expedited determination; you will receive an answer within a period of three (3) business days or less.

Your Health Plan can request a 14-day extension to send its determination, as long as this extension request benefits the beneficiary (you) or because you need more time to find evidence or data that may benefit your case.

Remember that if during the appeal process you request a continuation of services, you may be required to pay the cost of services furnished while the Appeal is still pending. This would be the case if the final decision is adverse to you.

What is an Administrative Law Hearing?

An Administrative Law Hearing is an appeal process that is available to you after you exhaust your Health Plan's Complaint, Grievance and Appeals processes described above for an Action that your plan takes.

How can you request an Administrative Law Hearing?

If you are not satisfied with the outcome after you have gone through your Health Plan's Complaint, Grievance and Appeal procedures for an Action, you can request an Administrative Law Hearing to ASES or the Health Advocate Office, or both, in a period not to exceed thirty (30) calendar days from the date of the notice of disposition of the Appeal that your Health Plan sends you.

The Administrative Law Hearing resolution will be ninety (90) calendar days of the date you file an Appeal with your Health Plan (not including the days it took you to file for an Administrative Law Hearing) for standard resolutions. For expedited resolution, the Administrative Law Hearing resolution will be within three (3) business days from ASES's receipt of a request for a hearing for a denial of service.

Before the Administrative Law Hearing, you and your authorized representative, or a representative of a deceased Enrollee, if applicable, can ask to look at and copy the documents and records your Health Plan will use at the Administrative Law Hearing or that you may otherwise need to prepare your case for the hearing. Your Health Plan shall provide such documents and records at no charge to you.

If you receive an unfavorable decision at the Administrative Law Hearing, you may appeal the decision to the Court of Appeals of Puerto Rico.

TIME TO SOLVE COMPLAINTS, GRIEVANCES AND APPEALS

Below are timeframes your Health Plan has to address and resolve Complaints, Grievances, Appeals and ASES has to resolve issues brought before an Administrative Law Hearing:

- The Health Plan must resolve Complaints within 72 hours of receipt whether orally or in writing. If it is not resolved in 72 hours, it becomes a Grievance.
- The Health Plan must send a written notice to Enrollees within ten (10) business days or receiving a Grievance.
- The Health Plan must provide a written notice on the resolution of the Grievance as quickly as your health requires but no later than ninety (90) calendar days from the day the Health Plan receives the Grievance.
- If the Health Plan denies a service Authorization request, it must provide a written Notice of Action to you and your provider.
- You or your provider on your behalf can appeal the Notice of Action no later than sixty (60) calendar days after receiving the Notice of Action.
- The determination on standard Appeals must be sent to the affected parties within a period that does not exceed 45 days. Your Health Plan may request a 14-day extension, as long as it is for your benefit.
- Determination on expedited Appeals will always depend on your health condition and may not exceed three (3) business days. The Health Plan may request a 14-day extension as long as it is for your benefit.
- You may request an Administrative Law Hearing before ASES thirty (30) days from the date you received notification of determination on the appeal.
- The Administrative Law Hearing resolution will be ninety (90) calendar days of the date you file an Appeal with your Health Plan (not including the days it took you to file for an Administrative Law Hearing) for standard resolutions. For expedited resolution, the Administrative Law Hearing resolution will be within three (3) business days from ASES's receipt of a request for a hearing for a denial of service.

DENTAL SERVICES

Dental services are free choice services and do not need Referrals, that is, you can visit the dentist whenever you need dental services. You can visit your dentist as you have always done, as long as they are participating dentists of the Government Health Plan.

The information on participating dentists is included in the Directory of Contracted Providers which your Health Plan will mail to you and which is available at your Health Plan's website. Dentists are not part of the Preferred Networks.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15 - 0 8 4

MENTAL HEALTH SERVICES

How can I receive mental health services or services against drug dependence?

Mental health services and services against substance abuse will be provided through your Health Plan. To receive these services you do not need a Referral from your Primary Care Physician, you may request these services for yourself when you feel it is necessary.

The Government Health Plan offers integrated mental health and physical health services. Under the Government Health Plan you can receive mental health services at the same facility where you visit your Primary Care Physician; and primary care health services at the same facility where you visit your mental health provider.

This means that when either your Primary Care Physician or your mental health provider detects that you need mental or physical health services, he/she does not have to send you to another office to receive the services. The psychologist and/or social worker will be physically at your PMG at least sixteen (16) hours per week during regular business hours.

In the same way, a PCP will be physically present at your mental health clinic at least sixteen (16) hours per week at Ambulatory Clinics and twelve (12) hours per week at Addiction Services Units. Psychiatric Hospitals will have at least a PCP on call on a daily basis. Hospitalization Units will have at least one collocated PCP two (2) days per week for four (4) hours and Stabilization Units will have one PCP for Consultation (on call) on a daily basis.

When you fill out your enrollment form at your Health Plan's Service Centers, among the materials you will receive there will be detailed information about the mental health services providers for your Region and how to obtain them when you need them. In addition, the Directory of Providers provided by your Health Plan will indicate the address and telephone numbers of the providers that render mental health services in your Region. For additional information regarding the services and benefits, you may refer to the Mental Health Coverage Section this Guide offers.

You may also contact the Government Health Plan helpline if you do not know where to go. The Government Health Plan helpline will provide you all the information you need or you may contact your Health Plan at the numbers that appear on the back of your card.

PREVENTIVE SERVICES

Your Government of Puerto Rico Health Plan offers you a variety of services under preventive services.

What are preventive services?

They are health care services offered to help you keep your health in optimal condition. If you have any condition, preventive services will help you have better knowledge of your condition, so you can keep it under control and will help prevent your health from getting worse. These services not only will help you understand your condition, but also will tell you what to do to keep yourself healthy. Refer to the Preventive Service Coverage found in this Guide, so you find out all the services covered under the Government Health Plan.

To keep your health in optimal conditions you should:

- Maintain healthy nutrition.
- Exercise, such as walking, at least 30 minutes 4 to 5 days a week.
- Avoid being overweight.
- Be calm and in peace.
- Take a few minutes daily to relax. This will help you reduce stress.
- Get enough rest.
- Do not smoke.
- Do not use drugs or alcohol.
- Visit or consult your doctor whenever you feel sick.

Your Health Plan will provide the preventive services and additional services as required by the Government Health Plan. The Health Plan will provide you information in booklets that will be a part of these guidelines.

HIV-AIDS

If you are diagnosed with the Acquired Immunodeficiency Syndrome or the Human Immunodeficiency Virus (HIV), your Primary Care Physician must request that you be included in the Special Coverage Registry. Once the Health Plan includes you in the Special Coverage Registry, they will mail you a letter authorizing you to receive services under the Special Coverage. This letter will include information on the effective date and the expiration of this coverage.

This letter will allow you to Access all the services and Treatments for your condition without Referrals, countersignatures on your Prescriptions or Service orders for laboratory, X-rays services, among others, from your Primary Care Physician.

There are certain medications for your HIV/AIDS condition that will be provided by the Health Department, which may be acquired through the following Immunology Centers and Pharmacies:

Centers for the Prevention and Treatment of Communicable Diseases (CPTET, for its acronym in Spanish)
Updated as of June 2014

REGION	*MEDICAL DIRECTOR*	*TELEPHONE/FAX*	*ADDRESS*
ARECIBO	Dr. Evelyn Reyes García Director Internist	(787) 878-7895 Fax. (787) 881-5773 Fax. Medical Director Office Fax. (787) 878-8288 Tel. (787) 879-3168	Antiguo Hosp. Distrito Carretera 129 hacia Lares #627 Ave. San Luis Arecibo, PR 00612-3666
BAYAMON	Dr. Odette García Viña Director Dr. Fco. Bellaflores Internist	(787) 787-5151 Ext. 2224, 2475 (787) 787-5154 (d) Fax. (787) 778-1209 (787) 787-4211	Antigua Casa de Salud Hosp. Regional Bayamón Dr. Ramón Ruíz Arnau, Ave. Laurel Santa Juanita Bayamón, PR 00956
CAGUAS **CLINICA SATELITE HUMACAO**	Dr. Gloria Morales Director General Medicine	(787) 653-0550 Ext. 1142, 1150 Fax (787) 746-2898 (787) 744-8645 (787) 640-0980 (787) 852-0665	Hosp. San Juan Bautista PO Box 8548 Caguas, PR 00726-8548 Centro Comercial Humacao Ave. Font Martelo 100 Humacao, PR
CAROLINA	Dr. Milton Garland Director Internist	(787)757-1800 Ext. 454, 459 Diirecto y Fax. (787)257-3615	Hospital UPR Dr. Federico Trilla P. O. Box 6021 Carolina, PR 00984-6021 Carretera 3, Km. 8.3
CLETS	Dr. Hermes García Director	(787)754-8118 © (787)754-8128 (directo) (787)754-8127 Fax. (787)754-8199	P. O. Box 70184 San Juan, PR 00936-8523 Calle José Celso Barbosa Centro Médico de PR Bo. Monacillos, San Juan
FAJARDO	Dr. Arturo Hernández Director General Medicine	(787)801-1992 (787)801-1995 Fax. (787)863-5437	Calle San Rafael # 55 Fajardo, PR Urb. Monte Brisas I Suite 69 Calle E Fajardo, PR 00738
MAYAGUEZ	Dr. Ramón Ramírez Ronda Director Infectologist	(787)834-2115, 2118 Ext. 4634 Fax Regional Director (787)806-3440	Centro Médico de Mayagüez Hospital Ramón Emeterio Betances Suite 6 Ave. Hostos 410 Antigua Casa de Salud Mayagüez, PR 00680
PONCE	Dr. Gladys Sepúlveda Director Infectologist	(787)259-4731 (787)259-4046, (787)842-8626 Fax (787)259-3998 Fax pharmacy (787)843-2188	Departamento de Salud Región Ponce Antiguo Hosp. Distrito Ponce Dr. José Gándara Carretara Estatal 14 Bo. Machuelo Ponce, PR 00731
NIVEL CENTRAL	Dr. Greduvel Durán Executive Director Services Director OCASET	(787)765-2929 Ext. 4026, 4027 Fax (787)274-5523	P.O. Box 70184 San Juan, PR 00936 Ant. Hosp. Psiquiatría Pabellón 1, primer piso, 4ta. Puerta - Terrenos de Centro Médico, Río Piedras

IMPORTANT:

The Special Coverage is authorized for a specific time period. When this period expires, your physician must justify any extension that is medically necessary for your condition and will have to request your registration in the Special Coverage again.

HEPATITIS-C

If you are diagnosed with Hepatitis C, once laboratory tests are performed confirming that you have been infected with this disease, all the services and Treatments will be provided through the Health Department. Your Primary Care Physician must inform your diagnosis to your Health Plan's Disease Management Program, for your Health Plan to provide you information and coordinate your enrollment in the Hepatitis C Program of the Health Department.

This is your Benefits Coverage

The Government Health Plan offers a broad Service Coverage with minimum exclusions. Your services will not be reduced, limited or will be excluded because you had a preexisting conditions before enrolling in the Government Health Plan. You will not have to comply with a waiting period to receive any of the Covered Services. Services will be covered from the moment Medicaid grants your eligibility. Services will be provided if medically necessary. Medically necessary means:

Services related to (i) the prevention, diagnosis, and Treatment of health impairments; (ii) the ability to achieve age-appropriate growth and development; or (iii) the ability to attain, maintain, or regain functional capacity. Additionally, Medically Necessary services must be:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect your medical condition;
- Compatible with the standards of acceptable medical practice in the community;
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for your convenience or the convenience of the Provider or Hospital; and
- Not primarily custodial care (for example, foster care).

In order for a service to be Medically Necessary, there must be no other effective and more conservative or substantially less costly Treatment, service, or setting available.

The information that follows details all the services covered.

Preventive Services

- Vaccines – Provided by the Health Department. The Government Health Plan will cover the administration of the vaccines following the dates established in the schedule provided by the Health Department.
- Healthy Child Care - during the child's first 2 years of life.
- Healthy Child Care - One comprehensive annual assessment performed by a certified health professional. This annual assessment supplements the services for children and young adults is provided during the period established in the schedule of the American Academy of Pediatrics and Title XIX (EPSDT).
- Vision test.
- Hearing exam, including the newborn hearing screening before they are released from the Hospital nursery.
- Nutritional evaluations and tests.
- Laboratory tests and all the diagnostic and screening tests according to the beneficiary's age, sex and health condition.
- Prostate and gynecologic cancer screening according to the accepted medical practices, including Papanicolau, mammography and PSA tests when medically necessary and according to the age of the beneficiary.
- Puerto Rico public policy sets the age of 40 years as a starting point for mammograms and breast cancer screening.
- Sigmoidoscopy and colonoscopy to detect colon cancer in adults aged 50 or more, classified by risk group, according to the accepted medical practices.
- Education on physical, nutritional and oral health.
- Reproductive Health Counseling (Family Planning). Such services shall be provided voluntarily and confidentially, including circumstances where the Enrollee is under age eighteen (18). Family planning services will include, at a minimum, the following:
    - Education and counseling necessary to make informed choices and understand contraceptive methods;
    - Pregnancy testing;
    - Diagnosis and treatment of sexually transmitted infections;
    - Infertility assessment;
    - At least one of every class and category of FDA-approved contraceptive medication as specified in ASES's preferred drug list (PDL); and
    - At least one of every class and category of FDA-approved contraceptive method as specified by ASES.
    - Other FDA approved contraceptive medications or methods when it is Medically Necessary and approved through a Preauthorization or through an exception process and the prescribing provider can demonstrate at least one of the following situations:
        - Contra-indication with drugs that are in the PDL that the Enrollee is already taking, and no other methods available in the preferred drug list that can be used by the Enrollee.

- History of adverse reaction by the Enrollee to the contraceptive methods covered as specified by ASES; or
- History of adverse reaction by the Enrollee to the contraceptive medications that are on the preferred drug list.

- Syringes for the administration of medications at home.
- Health certificates covered under the Government Health Plan (any other health certificates are excluded).
- Health Certificates that include tests for sexually transmitted diseases (VDRL) and tuberculin tests. The certificate must have the seal of the Health Department with a Copayment that will not exceed $5.00. The PR Department of Health charges a nominal administrative fee of $5.00 for the certificate. This is not a co-payment to receive the service or the results.
- Any certification for the Government Health Plan beneficiaries related to the Medicaid and CHIP Program eligibility (e.g. Medications History) will be provided to the beneficiary free of charge.
- Any Copayment that applies to necessary procedures and laboratory tests for the issuance of a Health Certificate will the responsibility of the beneficiary.
- Annual physical exam and follow-up to diabetic Patients according to Treatment guidelines for the Treatment of diabetic Patients and the protocols of the Health Department.

Dental Services

You may visit the dentist of your choice that accepts the Government Health Plan. Covered dental services will be identified using the codes published by the American Dental Association (ADA) for the procedures established by ASES. The services that follow are covered under the Government Health Plan:

- Preventive services for children.
- Preventive services for adults.
- Restorative services.
- A comprehensive oral exam.
- A periodic oral evaluation every 6 months.
- Limited oral evaluation- problem focused.
- Intraoral X-rays complete series, including bitewings, every 3 years.
- One intraoral/periapical first film.
- Up to a maximum of 5 additional intraoral/periapical X-rays a year.
- Bitewing single film a year.
- One Bitewings double film a year.
- One set of panoramic film every 3 years.
- Prophylaxis – adult, every 6 months.

- Prophylaxis – children, every 6 months.
- Topical fluoride application for children under age 19, every 6 months.
- Topical application of sealant, per tooth, on posterior teeth for beneficiaries up to 14 years old. Includes deciduous molars up to 8 years of age when it is medically necessary because of a tendency to cavities. This service is limited to one lifetime Treatment.
- Resin composite restorations.
- Amalgam restoration.
- Pediatric therapeutic pulpotomy.
- Stainless steel crowns for primary teeth followed by a pediatric therapeutic pulpotomy.
- Root canals.
- Palliative Treatment.
- Oral surgery.

Diagnostic Testing Services

- High tech laboratories.
- Clinical laboratories including, but not limiting to, any laboratory order with the purpose of diagnosing the disease, even if the diagnosis is an excluded condition or disease.
- X-rays.
- Radiotherapy.
- Electrocardiograms.
- Pathology.
- Arterial blood gases.
- Electroencephalograms.

Ambulatory Rehabilitation Services

- Physical therapy – a minimum of 15 physical therapy Treatments a year per condition, per beneficiary, when prescribed by an orthopedist or a physiatrist; unless Preauthorization of an additional fifteen (15) Treatments is indicated by an orthopedist, physiatrist or chiropractor.
- Occupational therapy – unlimited.
- Speech therapy – unlimited.

Medical and Surgical Services

- Visits to primary care providers, including Primary Care Physicians and nursing services.
- Treatments by Specialists and sub-specialists, without Referral, if they belong to the Preferred Provider Network of your Primary Medical Group.

- Treatments by Specialists and sub-specialists outside the Preferred Provider Network of the Primary Medical Group with a Referral of the Primary Care Physician you chose.
- Physician home visits when it is medically necessary.
- Respiratory therapy, without limits.
- Anesthesia services, except epidural anesthesia.
- Radiological services.
- Pathology services.
- Surgery.
- Use of ambulatory surgery facilities.
- Diagnostic services for cases of learning disabilities.
- Practical nurse services.
- Voluntary sterilization for men and women of appropriate age after being previously informed on the consequences of the medical procedure. The physician must have the written consent of the Patient.
- Prosthesis: includes the supply of all body extremities including therapeutic ocular prosthesis, segmented instrument tray and spinal fusion in scoliosis and vertebral surgery.
- Ostomy equipment for Patients ostomized ambulatorily.
- Blood, plasma and their derivatives.
- Services to Patients with chronic kidney disease in the first two levels (levels 3 to 5 are included in the Special Coverage).
- Breast reconstruction surgery after a mastectomy because of cancer.
- Treatments and surgery in cases of morbid obesity.
- Abortions are covered in the following instances: (i) life of the mother would be in danger if the fetus is carried to term; (ii) when the pregnancy is a result of rape or incest; and (iii) severe and long lasting damage would be caused to the mother if the pregnancy is carried to term, as certified by a physician.
- Durable medical equipment (DME) is covered on a case-by-case basis with Preauthorization as Medically Necessary. Mechanical respirators and ventilators with oxygen supplies are covered without limits as required by local law to Enrollees under age twenty-one (21).)

Ambulance Services

- Sea, air and land transportation will be covered within Puerto Rican territory limits in cases of emergency. These services do not require Preauthorization or precertification.

Non-Emergency Transportation Services (NEMT)

- Each Municipality in Puerto Rico has a variety of free transportation services available to assist you in getting to your medical appointments. You can access the

service by contacting your local Municipal office or your Health Plan and asking about how to obtain transportation services the transportation.

- The Health Plans and some providers do offer transportation for members with certain conditions through case management. If you need the help of a case manager and you do not have one, call your Health Plan.

Maternity and Prenatal Services

- Women have the freedom to choose a gynecologist/obstetrician among the providers of the Primary Medical Group or from your Health Plan's General Network or any gynecologist/obstetrician, subject to the final coordination with the provider. The different interventions until the confirmation of the pregnancy are not part of this coverage.
- Pregnancy tests.
- Pre-natal services.
- Services of the physician and an obstetric nurse during a normal delivery, c-section and in any other complication that may arise.
- Maternity hospitalization or for pregnancy secondary conditions, when medically recommended.
- Hospitalization of at least 48 hours for the mother and the newborn in case of a vaginal delivery and of 96 hours in case of c-section.
- Anesthesia, except epidural anesthesia.
- Use of incubator, unlimited.
- Nursery room care for the newborn.
- Circumcision and dilatation services for the newborn.
- Transportation of the newborn to tertiary facilities.
- Assistance of a Pediatrician during a c-section or high risk delivery.

Emergency Room Services

You do not need a Preauthorization or a precertification to receive these services.

- Visits, medical attention, routine emergency room necessary services.
- Services for trauma.
- Use of emergency room and surgery.
- Necessary and routine emergency room services.
- Respiratory services, without limitations.
- Treatment by a Specialist or a sub-specialist when requested by the emergency room physician.
- Anesthesia, excluding epidural anesthesia.
- Surgical supplies.
- Clinical laboratory tests.

- X-rays.
- Drugs, medications and intravenous solutions to be used in the emergency room.
- Blood, plasma and their derivatives, without limitations.

Emergency services outside Puerto Rico will be covered only for the Federal Population according to non-participating providers' fees in Puerto Rico.

Post-Stabilization Services

- Post-Stabilization Services are services that are provided after the Enrollee is stabilized to maintain or improve the Enrollee's condition after experience an emergency medical condition or psychiatric emergency for one hour while awaiting responses on a Preauthorization request.
- The attending Emergency Room physician or other treating Provider shall be responsible for determining whether the Enrollee is sufficiently stabilized for transfer or discharge. That determination will be binding for the Health Plan with respect to its responsibility for coverage and payment.
- An Enrollee who has been treated for an Emergency Medical Condition or Psychiatric Emergency shall not be held liable for any subsequent screening or Treatment necessary to stabilize the Enrollee.

Hospitalization Services

- Semi-Private Room, available 24 hours a day, year round.
- Isolation room for medical reasons.
- Nursery.
- Meals, including specialized nutrition services.
- Regular nursing services.
- Use of specialized rooms such as surgery room, recovery room, Treatment and delivery room, without limitations.
- Drugs, medications and contrast agents, without limitations.
- Materials such as bandages, gauze, plaster bandages or any other therapeutic dressing materials.
- Therapeutic and maintenance care services, including the use of the necessary equipment to render the service.
- Specialized diagnostic tests such as electrocardiograms, electroencephalograms, arterial blood gases, and other specialized test available at the Hospital and necessary during the beneficiary's hospitalization.
- Supply of oxygen, anesthesia and other gases, including their administration.
- Respiratory therapy, without limitations.
- Rehabilitation services while the Patient is confined in the Hospital, including physical, occupational and speech therapy.
- Blood, plasma and their derivatives, without limitations.

Mental Health Services

- Evaluation, screening and Treatment to individuals, couples, families and groups.
- Ambulatory services rendered by psychiatrists, psychologists and social workers.
- Hospital and ambulatory services for substance abuse and alcoholism.
- Intensive ambulatory services.
- Emergency and crisis intervention services available 24 hours a day, 7 days a week.
- Detoxification services for beneficiaries that use illegal drugs, have had suicidal attempts or accidental poisoning.
- Administration of and Treatment with Buprenorphine (requires Preauthorization).
- Clinics for injectable extended-release medications.
- Escort, professional assistance and ambulance services when the services are necessary.
- Prevention services and secondary education.
- Pharmacy coverage and Access to medications within 24 hours.
- Laboratory tests that are medically necessary.
- Treatment for Patients diagnosed with Attention Deficit Disorder (ADD) with or without hyperactivity (ADHD). This includes, but is not limited to, visits to neurologists and tests related to the Treatment of this diagnosis.
- Consultations and coordination with other Agencies.
- Substance abuse Treatment.

Mental Health Hospitalization Services

- Partial hospitalization services for cases referred by a psychiatrist for primary phase diagnosis and Treatment, according to the parity provisions of Law 408 of October 2, 2000.
- Hospitalization that presents a mental pathology that is not drug abuse when referred by a psychiatrist for primary phase diagnosis and Treatment, according to the parity provisions of Law 408 of October 2, 2000.

Pharmacy Services

- The GHP has Prescription drug coverage for the Physical and Mental Health needs of beneficiaries established in the Preferred Drug List (PDL).
- The pharmacy benefit coverage is generic-bioequivalent mandatory as general rule.
- Copayments are required for prescribed medication covered by the GHP.
- No co-payments will be charged to Medicaid and CHIP children under eighteen (18) years of age, and pregnant women. .
- Medications included in the Master Formulary are covered through the exception processes.

- Pharmacy Management Program: Program of 90 days dispensing for Patients with chronic conditions: Providers can prescribe a 90-day supply for certain medications. This program allows the beneficiary to pay one (1) co-payment for a 90-day supply of medications instead of paying three (3) co-payments (1 co-payment per month).

Services Excluded from the Basic Coverage

The following services are excluded from Basic Coverage; if you have any questions about the list or regarding your coverage please call your Health Plan.

- Services to Patients not eligible to the Government Health Plan.
- Services for non-covered illnesses or trauma.
- Services for automobile accidents covered by the Administration of Compensation for Automobile Accidents (ACAA, for its acronym in Spanish).
- Accidents on the job that are covered by the State Insurance Fund Corporation.
- Services covered by another insurance or entity with primary responsibility (third party liability).
- Specialized nursing services for the comfort of the Patient when they are not medically necessary.
- Hospitalizations for services that can be rendered on an outpatient basis.
- Hospitalization of a Patient for diagnostic services only.
- Expenses for services or materials for the Patient's comfort such as telephone, television, admission kits, etc.
- Services rendered by Patient's relative (parents, children, siblings, grandparents, grandchildren, spouse, etc.).
- Organ and tissue transplants, except skin, bone and corneal transplants.
- Weight control Treatments (obesity or weight increase for aesthetic reasons).
- Sports medicine, music therapy and natural medicine.
- Cosmetic surgery to correct physical appearance defects.
- Services, diagnostic tests ordered or provided by naturopaths, and iridologists.
- Health Certificates except for (i) venereal disease research laboratory tests, (ii) tuberculosis tests and (iii) any certification related to the eligibility for the Medicaid program.
- Mammoplasty or plastic reconstruction of breast for aesthetic purposes only.
- Outpatient use of fetal monitor.
- Services, Treatment or hospitalization as a result of induced, non-therapeutic abortions or their complications. The following are considered induced abortions (code and description):
  - ✓ 59840 – Induced abortion – dilation and curettage;
  - ✓ 59841 – Induced abortion – dilation and expulsion;
  - ✓ 59850 – Induced abortion – intra-amniotic injection;
  - ✓ 59851 – Induced abortion – intra-amniotic injection;

- ✓ 59852 - Induced abortion – intra-amniotic injection;
- ✓ 59855 - Induced abortion – by one or more vaginal suppositories (e.g. prostaglandin) with or without cervical dilation (e.g. laminate) including admission and visits, expulsion of the fetus and afterbirth;
- ✓ 59856 - Induced abortion – by one or more vaginal suppositories (e.g. prostaglandin) with dilation and curettage or evacuation; and
- ✓ 59857 - Induced abortion – by one or more vaginal suppositories (e.g. prostaglandin) with hysterectomy (failed medical evaluation).

- Rebetron or any other prescribed medication for Hepatitis C Treatment, both Treatment and medications are excluded from the Health Plan coverage. The medications as well as the Treatment will be provided by the Hepatitis Program of the Health Department. For additional information refer to the Hepatitis Section previously mentioned in this Handbook.
- Medications delivered by a provider that does not have a pharmacy license, with the exception of medications that are traditionally administered in a doctor's office such as an injection.
- Epidural anesthesia services.
- Services that are not reasonable or necessary according to the regulations accepted in the practice of medicine. Services rendered in excess to those normally required for diagnostics, prevention, diseases, Treatment, injury or organ system dysfunction or pregnancy condition.
- Mental health services that are not reasonable or necessary according to the accepted regulations for the practice of medical Psychiatry or the services rendered in excess to those usually required for the diagnostic, prevention and Treatment of a mental illness.
- Educational tests, educational services.
- Peritoneal dialysis or hemodialysis services (Covered under the Special Coverage).
- New or experimental procedures not approved by ASES to be included in the Basic Coverage.
- Custody, rest and convalescence once the disease is under control or in irreversible terminal cases (hospice care for Members under 21 is part of basic coverage).
- Services covered under the Special Coverage.
- Services received outside the territorial limit of the Commonwealth of Puerto Rico, except for emergency services for Medicaid or CHIP beneficiaries.
- Judicial order for evaluations for legal purposes.
- Travel expenses, even when ordered by the Primary Care Physician are excluded.
- Eyeglasses, contact lenses and hearing aids (for members over age 21).
- Acupuncture services.
- Procedures for sex changes, including hospitalizations and complications.
- Treatment for infertility and/or related to conception by artificial means including tuboplasty, vasovasectomy, and any other procedure to restore the ability to procreate.

- Expenses incurred for the Treatment of conditions resulting from services not covered under the GHP (maintenance Prescriptions and required clinical laboratories for the continuity of a stable health condition, as well as any emergencies which could alter the effects of the previous procedure, are covered).

Special Coverage Services

Enrollees with special health care needs caused by serious illnesses may be enrolled into Special Coverage Registry to receive Special Coverage services.

Your Primary Care Physician, the personnel designated by the Primary Medical Group or the case coordinator of the Primary Medical Group can instruct you on the conditions that qualify for the special coverage. Any of them can help you to be included in the Special Coverage by sending all the necessary information on your medical condition your Health Plan.

Once enrolled in special coverage, Enrollees have the freedom to choose the providers for these services among the providers in the Preferred Provider Network of the Primary Medical Group or your Health Plan's General Network, differential diagnostic interventions up to the verification of the final diagnosis are not part of the Special Coverage.

Medications, laboratory test, diagnostic test and other related procedures specified in this coverage as necessary for ambulatory Treatment or convalescence are part of this coverage and do not require the Preauthorization of the Primary Care Physician or of your Health Plan. Your Health Plan must identify the Enrollees included under this coverage to facilitate Access to the contracted services. The Government Health Plan Special Coverage will be activated when the Enrollee reaches the limit of any other Special Coverage the Enrollee may have under any other plan.

The purpose of this coverage is to facilitate the effective management of beneficiaries with special health condition that require specialized medical attention. This coverage will become effective when the diagnosis is confirmed through the results of tests or procedures performed.

The benefits under this coverage are:

- Coronary disease services and intensive care, without limitations.
- Maxillary surgery, with a Referral.
- Neurosurgical and cardiovascular procedures, including pacemakers, valves and any other instrument or artificial device (requires Preauthorization).
- Peritoneal dialysis, hemodialysis and related services (requires Preauthorization).
- Clinical and pathological laboratory test that must be sent outside Puerto Rico for their processing (requires Preauthorization).
- Neonatal intensive care unit services, without limitations.

- Treatment with radioisotopes, chemotherapy, radiotherapy and cobalt.
- Gastrointestinal conditions, allergies and nutritional evaluation for autistic Patients.
- The following procedures and diagnostic tests, when medically necessary (require Preauthorization):
    - ✓ Computerized tomography;
    - ✓ Magnetic resonance tests;
    - ✓ Cardiac catheterisms;
    - ✓ Holter Test;
    - ✓ Doppler Test;
    - ✓ Stress Test;
    - ✓ Lithotripsy;
    - ✓ Electromyography;
    - ✓ Tomography test (SPECT);
    - ✓ Ocular Pletismography test (OPG);
    - ✓ Impedance Pletismography (IPG);
    - ✓ Other neurological cerebral-vascular and cardiovascular tests, invasive or non-invasive;
    - ✓ Nuclear Medicine tests;
    - ✓ Diagnostic Endoscopies; and
    - ✓ Genetic Studies.
- Physical therapy – up to 15 additional Treatments per condition per beneficiary a year, when ordered by an Orthopedist, Physiatrist or Chiropractor (requires Preauthorization from your Health Plan).
- General Anesthesia.
    - ✓ General anesthesia for dental Treatment to children with special needs.
- Hyperbaric chamber.
- Immunosuppressive drugs and laboratory tests required for the maintenance Treatment of Patients who have been operated to receive any transplant, which assure the stability of the beneficiary's health and the emergencies that may arise after this surgery.
- Treatment for the following conditions after being confirmed by the results of laboratory tests and the diagnosis has been established:
    - ✓ Positive HIV Factor and Acquired Immunodeficiency Syndrome (AIDS) – Ambulatory and hospitalization services are included. You do not need a Referral or Preauthorization from your Health Plan or the Primary Care Physician for the visits and Treatment at the Immunology Regional Clinics of the Health Department;
    - ✓ Tuberculosis;
    - ✓ Leprosy;

- ✓ Lupus;
- ✓ Cystic fibrosis;
- ✓ Cancer;
- ✓ Hemophilia;
- ✓ Aplastics Anemia;
- ✓ Reumatoid Artritis ;
- ✓ Autism;
- ✓ OBG Obstetricians;
- ✓ Post Organ Transplantation; and
- ✓ Children with special needs, including the conditions described in the Manual of Diagnosis for Children with Special Needs of the Health Department, Office of Health Protection and Promotion, Habilitation Division (the manual) which is part of this part of this document, except:
  - o Asthma and diabetes, which are included in the Disease Management Program,
  - o Psychiatric disorders, and
  - o Intellectual disabilities, behavior manifestations will be managed by the mental health providers under the basic coverage, with the exception of a catastrophic disease.

- Scleroderma.
- Multiple Sclerosis and Amiotrofic Sclerosis Lateral (ALS).
- Services for the Treatment of conditions resulting from self-inflicted damage or as a result of a felony committed by a beneficiary or negligence.
- Chronic renal disease in levels 3, 4 and 5. (Levels 1 and 2 are included in the Basic Coverage). The following is a description of the stages of chronic renal disease:
  - o **Level 3** - FG (glomerular filtration - ml / min. bu 1.73 m ² per unit of body area) between 30 and 59, a moderate decrease in kidney function
  - o **Level 4** - TFG between 15 and 29, a serious decrease in kidney function
  - o **Level 5** - TFG under 15, renal failure with probability of dialysis or kidney transplantation.
- The medications required for the ambulatory Treatment of Tuberculosis and Leprosy are included under the Special Coverage. Medications required for the ambulatory Treatment or hospitalization for beneficiaries diagnosed with AIDS or that are HIV positive are covered under the Special Coverage, except protease inhibitors, which will be provided by the Clinics for the Prevention and Treatment of Sexually Transmitted Diseases (CPTEST, for its acronym in Spanish).

Services excluded from the Special Coverage

Exclusions and limitations under the Basic Coverage are not covered under the Special unless expressly included in the Special Coverage.

Medicare Coverage Services

For Medicare Parts A and B Beneficiaries, the following factors will be considered to determine the coverage to be offered:

- Beneficiaries eligible to Part A:
  - ✓ They will be offered the regular Government Health Plan coverage, excluding the benefits covered by Part A until they reach their limit. In other words, once you reach the benefit limit of Medicare Part A coverage, the Government Health Plan will be activated.
  - ✓ Part A Deductibles are not included.
  - ✓ The payment of Deductibles for the regular coverage will be according to the payment capacity table provided to all the Government Health Plan beneficiaries.
- Beneficiaries eligible to Parts A/B:
  - ✓ They are offered the regular the Government Health Plan pharmacy and dental coverage.
  - ✓ Part A Deductibles are not included.
  - ✓ Part B Deductibles and Copayments will be included.
- Dual eligible (Medicare and Medicaid eligible) may not be simultaneously enrolled in the Government Health Plan and in a Medicare Platino plan, for the reason that the Platino plan already included GHP benefits. In addition, as an Enrollee in the plan, the dual eligible may access Covered Services only through the PMG, not through the Medicare Provider List.

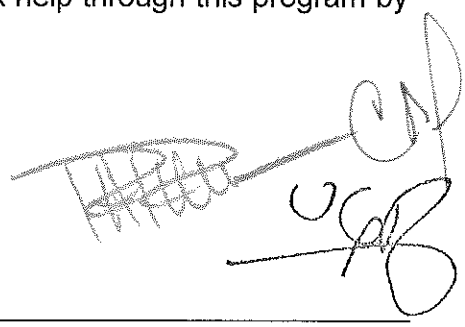
DISEASE MANAGEMENT

Chronic Disease Management

Your Health Plan has programs that will help you control your chronic diseases, such as Diabetes Mellitus, Hypertension, and Congestive Heart Failure (CHF), Obesity, Kidney Failure and Bronchial Asthma. To benefit from these programs you may call your Health Plan. Your Health Plan has a nursing and nutritionist staff available to manage your condition in coordination with the Primary Care Physician.

Case Management

Your Health Plan has a Case Management Program, which is designed to help you with the coordination of medically necessary services for high cost conditions or catastrophic diseases. This program has a staff of nurses, social workers and nutritionists to assist you. You physician, the Hospital staff, your family or you may seek help through this program by calling your Health Plan.



THESE ARE YOUR COPAYMENTS AND COINSURANCES

CO-PAYS & CO-INSURANCE - Effective on July 1st, 2013								
Services	Federal		CHIPS	Población Estatal				ELA*
	100	110	230	300	310	320	330	400
HOSPITAL	HOSPITAL		HOSPITAL	HOSPITAL				HOSPITAL
Admissions	$0	$3	$0	$3	$5	$6	$20	$50
Nursery	$0	$0	$0	$0	$0	$0	$0	$0
EMERGENCY ROOM (ER)	EMERGENCY ROOM (ER)		EMERGENCY ROOM (ER)	EMERGENCY ROOM (ER)				EMERGENCY ROOM (ER)
Emergency Room (ER) Visit	$0	$0	$0	$1	$5	$10	$15	$20
Non-emergency visit to a hospital emergency room.	$3.80	$3.80	$0	$15	$15	$15	$15	$20
Trauma	$0	$0	$0	$0	$0	$0	$0	$0
AMBULATORY VISITS TO	AMBULATORY VISITS TO		AMBULATORY VISITS TO	AMBULATORY VISITS TO				AMBULATORY VISITS TO
Primary Care Physician (PCP)	$0	$1	$0	$0	$1	$2	$2	$3
Specialist	$0	$1	$0	$1	$1	$3	$4	$7
Sub-Specialist	$0	$1	$0	$1	$1	$3	$5	$10
Pre-natal services	$0	$0	$0	$0	$0	$0	$0	$0
OTHER SERVICES	OTHER SERVICES		OTHER SERVICES	OTHER SERVICES				OTHER SERVICES
High-Tech Laboratories**	$0	50¢	$0	$1	$1	$2	$3	20%
Clinical Laboratories**	$0	50¢	$0	$1	$1	$2	$3	20%
X-Rays**	$0	50¢	$0	$1	$1	$2	$3	20%
Special diagnostic Tests**	$0	$1	$0	$1	$2	$2	$6	40%
Therapy – Physical	$0	$1	$0	$1	$2	$2	$3	$5
Therapy – Respiratory	$0	$1	$0	$1	$2	$2	$3	$5
Therapy – Occupational	$0	$1	$0	$1	$2	$2	$3	$5
Vaccines	$0	$0	$0	$0	$0	$0	$0	$0
Healthy Child Care	$0	$0	$0	$0	$0	$0	$0	$0
DENTAL	DENTAL		DENTAL	DENTAL				DENTAL
Preventive (Child)	$0	$0	$0	$0	$0	$0	$0	$0
Preventive (Adult)	$0	$1	$0	$0	$1	$2	$3	$3
Restorative	$0	$1	$0	$0	$1	$5	$6	$10
PHARMACY***	PHARMACY***		PHARMACY***	PHARMACY***				PHARMACY***
Generic (Children 0-18)	$0	$0	$0	$0	$0	$0	$0	$5
Generic (Adult)****	$1	$1	N/A	$1	$2	$3	$5	$5
Brand (Children 0-18)	$0	$0	$0	$0	$0	$0	$0	$10
Brand (Adult)****	$3	$3	N/A	$3	$4	$5	$7	$10
Services	Federal		CHIPS	Población Estatal				ELA*
	100	110	230	300	310	320	330	400

*Code 400 in ELA column refers to the population that subscribes as public employees of the Puerto Rico Government.

** Apply to diagnostic tests only. Copays do not applied to tests required as part of a preventive service.

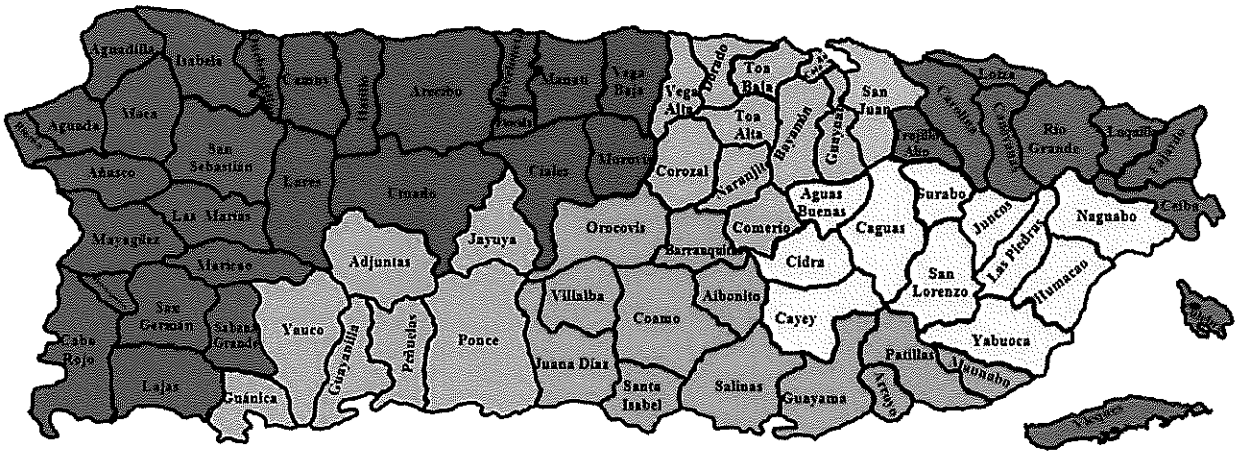
***Copays apply to each drug included in the same prescription pad. Pharmacy exception (children 0- 18) does not apply to 400 ELA employees.

****Co-pays for children 0-18 years of age are not applicable for Medicaid, Commonwealth medically indigent eligible, and for children 0-18 enrolled in the CHIP Program in group ages 0-18. Co-pays may apply to children ages over 18 years old as well as to adults.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número

ASES

Puerto Rico Health Isurance Administration
Geographic Regions



West Region North Region Metro North Region San Juan Region North East Region

South West South East Region East Region

ESTADO LIBRE ASOCIADO DE
PUERTO RICO
Administración de Seguros
de Salud de Puerto Rico (ASES)

PUERTO RICO GOVERNMENT HEALTH PLAN MCO CONTRACT

APPENDIX (4)

CPTET CENTER AND HIV/AIDS ORGANIZATION

ASES
Administración de Seguros de Salud de Puerto Rico

Estado Libre Asociado de Puerto Rico
Departamento de Salud
Secretaría Auxiliar de Salud Familiar, Servicios Integrados y Promoción de la Salud
Oficina Central para Asuntos del SIDA y Enfermedades Transmisibles
División de Servicios VIH/SIDA: Preventivos y de Cuidado de Salud
Programa Ryan White Parte B

REGIÓN ARECIBO	
Clínica	Farmacia
CPTET Arecibo / Clínica de Inmunología Tel. (787) 817-2677 / 878-7895 Fax. (787) 881-5773 Dirección Física: Antiguo Hospital de Distrito, Carr. 129 Hacia Lares Dirección Postal: PO Box 397 Arecibo,PR 00613 Director Médico: Dra. Evelyn Reyes MC: Lourdes Castro	Farmacia García Tel. (787) 898-3975 / 820-5158 Fax. (787) 820-9048 Dirección Física: Calle Vidal Félix #121 Hatillo, P.R. 00659 Dirección Postal: PO Box 67 Hatillo PR 00659 Farmacéutico: Lic. Daniel Mahíques Nieves
Centro de Salud de Lares, Inc. Ryan White Parte C Tel. (787) 897-2727 / 2155 /1720 /1730 Fax. (787) 897-2155 / 2725 Dirección Física: Carr. 111 KM 1.9 Ave. Los Patriotas Dirección Postal: PO Box 379 Lares, P.R. 00669 Director: Sr. Gonzálo Maldonado R.N. MC: Elsie Camacho MC: Zulma Román	Farmacia In House Tel. (787) 897-3610 / 897-3023 Tel. (787) 897-2727 / 2155 / 1720 Cel. (787) 414-1304 Fax: (787) 897-2725 Dirección Física: Carr. 111 KM 1.9 Ave. Los Patriotas Dirección Postal: PO Box 379 Lares, P.R. 00669 Farmacéutico: Lic. Mayra Vélez E mail: rw_csl@hotmail.com Contacto: Domingo Carrero
*Sucursales Adscritas al Centro de Salud de Lares, Inc.	
*Centro de Salud de Quebradillas Tel. (787) 895-2660 / 2670 Dirección Física: Calle Muñoz Rivera Esq. San Justo #114 Quebradillas, PR 00678 Dirección Postal: Apartado 1551 Quebradillas, PR 00678 Administrador: Sr. Daniel González Rivera MC: Marilyn Acevedo E mail: cdtquebradillas@hotmail.com	Farmacia In House Tel. (787) 895-2512 Fax. (787) 895-2512 Dirección Física: Calle Muñoz Rivera Esq. San Justo #114 Quebradillas, PR 00678 Dirección Postal: Apartado 1551 Quebradillas, PR 00678 Contacto: Vanessa Pérez Farmacéutico: Lic. Hilda Torres

ADMINISTRACIÓN DE SEGUROS DE SALUD
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Estado Libre Asociado de Puerto Rico
Departamento de Salud
Secretaría Auxiliar de Salud Familiar, Servicios Integrados y Promoción de la Salud
Oficina Central para Asuntos del SIDA y Enfermedades Transmisibles
División de Servicios VIH/SIDA: Preventivos y de Cuidado de Salud
Programa Ryan White Parte B

REGIÓN ARECIBO	
Clínicas	Farmacias
*Camuy Health Services, Inc. Tel. (787) 898-2290 / 262-6603 Fax. (787) 262-1210 / 3789 Dirección Física: Ave. Muñoz Rivera #63, Camuy PR 00627 Dirección Postal: PO Box 660 Camuy, PR 00627-0660 Director: Lcdo. Eddie Pérez MC: Zaida González	Farmacia In House Tel.(787)898-2660 Ext.227 Fax.(787)262-4822 Dirección Física: Ave. Muñoz Rivera #63, Camuy PR 00627 Dirección Postal: PO Box 660 Camuy, PR 00627-0660 Farmacéutico: Lcda. Luz del Alba Ramírez E mail: camuy660@coqui.net
*Corporación de Servicios Médicos Primarios y Prevención de Hatillo Tel. (787) 898-3935 / 4190 Fax. (787) 262-3984 Dirección Física: Ave. Dr. Susoni #121 Hatillo Dirección Postal: PO Box 907 Hatillo, PR 00659 Director: Armando Legarreta MC: Wanda León	Farmacia In House Tel. (787) 898-5764 Fax. (787) 262-3984 Dirección Física: Ave. Dr. Susoni #121 Hatillo Dirección Postal: PO Box 907 Hatillo, PR 00659 Contacto: Leticia Reyes Farmacéutico: Lic. Carmelo Nistal E mail: hatipa19@libertypr.net
*Ciales Primary Health Care Services Tel. (787) 871-0601 / 0602 / 0603 Fax. (787) 871-3960 Dirección Física: Carr. 149 k.m. 12.3 Ciales Dirección Postal: PO Box 1427 Ciales, PR 00638 Director Médico: Gladys Rivera Estela MC: Iraida Marero Contacto: Carmen Sandoval Santiago	Farmacia In House Tel. (787) 871-0601 Ext. 210 Fax: (787) 871-3960 Dirección Física: Carr. 149 k.m. 12.3 Ciales PR 00638 Dirección Postal: PO Box 1427 Ciales, PR 00638 Contacto: Janet Maldonado Villalobos Farmacéutica: Lcda. Aixa Bou E mail: cphcsinc@yahoo.com
*Hospital General de Castañer Tel. (787) 829-5010 / 2055 /7500 /5600 Fax. (787) 829-2913 / 2166 / 4668 Dirección Física: Carr. 135 k.m. 64.2 Castañer Dirección Postal: PO Box 1003 Castañer, PR 00631 Contacto: Doris Bengoechea	Farmacia In House Tel. (787) 829-5010 Ext. 233 / 289 Fax. (787) 829-1479 Dirección Física: Carr. 135 k.m. 64.2 Castañer Dirección Postal: PO Box 1003 Castañer, PR 00631 Farmacéutica: Lcda. Yivet Aquino E mail: hospitalcastaner@hotmail.com

ADMINISTRACIÓN DE SEGUROS DE SALUD
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REGIÓN BAYAMÓN	
Clínica	Farmacia
Salud Integral en la Montaña, Inc. (SIM) Oficina Central Tel. (787) 869-5900 / 5960 / 5950 x. 225, 251 Fax: 1 (787) 869-6120 Dirección Física: Carr. 152 Naranjito a Barranquitas Dirección Postal: PO Box 515 Naranjito, PR 00719 Directora: Sandra V. García Gerente Servicios Clínicos: Nelly Vargas MC: Maritza Rolón Madeline Figueroa E mail: mfigueroa@sim.pr.com	Oficina Central Tel. (787) 869-5900 Ext. 252 Contacto: Sra. Lourdes Chevere *Directora de Farmacias incluyendo las 5 clínicas Farmacéutico: Lcda. Sandra V. García E mail: sgarcia@sim.pr.com
*Centro de Salud Integral de Naranjito Tel. (787) 869-1290 Ext. 2203, 2237, 2204 Fax: (787) 869-1800 Dirección Física: Carr. 164 Sector el Desvío, Barrio Achiote, Naranjito PR 00719 Dirección Postal: PO Box 525 Naranjito PR 00719 Directora: Maritza Ortiz Berríos MC: Maritza Rolón Nieves MC: Judith Rosa	Farmacia In House Tel. (787) 869-1290 Ext. 2208, 2238 Fax: (787) 869-1800 Dirección Física: Carr. 164 Sector el Desvío, Barrio Achiote, Naranjito PR 00719 Dirección Postal: PO Box 525 Naranjito PR 00719 Farmacéutico: Lcda. Marienilda La Santa
*Centro de Salud Integral de Barranquitas Tel. (787) 857-2688 Fax: (787) 857-1730 / 3440 Dirección Física: Calle Barceló #3, Barranquitas, PR 00794 Dirección Postal: PO Box 728 Barranquitas, PR 00794 Directora: Lourdes MC: Carmen Carro	Farmacia In House Tel. (787) 857-2688 Ext. 225 Fax. (787) 857-1730 Dirección Física: Calle Barceló #3, Barranquitas, PR 00794 Dirección Postal: PO Box 728 Barranquitas, PR 00794 Farmacéutico: Lcda. Lourdes Chéverez

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
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REGIÓN BAYAMÓN	
Clínica	Farmacia
*Centro de Salud Integral de Comerío Tel. (787) 875-3375 / 2750 Fax: (787) 875-4230 / 2769 Dirección Física: Calle Georgetti, Carr. 167 Dirección Postal: PO Box 418 Comerío PR 00782 Director: Angel robles Diretcor Médico: Fernando Roura Contacto: Jannette Gailé	Farmacia In House Tel. (787) 875-3375 Fax. (787) 875-4230 Dirección Física: Calle Georgetti, Carr. 167 Dirección Postal: PO Box 418 Comerío PR 00782 Farmacéutico: Lcda. Helen Feshold
*Centro de Salud Integral de Corozal Tel. (787) 859-2560 / 2470 Fax: (787) 859-5390 Dirección Física: Carr. 159 Sector El Desvio, Corozal PR 00783 Dirección Postal: PO Box 739 Corozal PR 00783 Director Médico: Michael Fusile Nelson MC: Daysi Alvino Martínez MC: Leidy Rivera Santiago	Farmacia In House Tel. (787) 859-2560 / 215 Fax. (787) 859-5390 Dirección Física: Carr. 159 Sector El Desvio, Corozal PR 00783 Dirección Postal: PO Box 739 Corozal PR 00783 Contacto: Lcda. Hairilys Vázquez
*Centro de Salud Integral de Orocovis Tel. (787) 867-6010 Fax. (787) 867-5210 Dirección Física: Ave. Luis Muñoz Marín, Carr. 155, Orocovis PR 00720 Dirección Postal: PO Box 2105 Orocovis PR 00720 Directora: Maritza Rolón Nieves Director Médico: Ada L. Santos Santos MC: Elba Miranda	Farmacia In House Tel. (787) 867-6010 Fax. (787) 867-6008 Dirección Física: Ave. Luis Muñoz Marín, Carr. 155, Orocovis PR 00720 Dirección Postal: PO Box 2105 Orocovis PR 00720 Farmacéutico: Lcda. Brenda Ortiz

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-98-20

REGIÓN DE BAYAMÓN	
Clínica	Farmacia
CPTET Bayamón Clínica de Inmunología Tel. (787) 798-1580 / 5154 Tel. (787) 780-6690 Hospital Cuadro Tel. (787) 787-5151 Ext. 2112,2224,2534,2510 Fax. (787) 269-7740 ETS. (787) 786-4211 Pediátrico: (787) 786-6940 Contacto:(787) 313-2573 Zuley Huguet E mail: zhuguet@salud.gov.pr Dirección Física: Hospital Universitario Dr. Ramón Ruiz Arnau, Ave. Laurel, Santa Juanita Bayamón, P.R. 00956 Dirección Postal: Hospital Universitario Dr. Ramón Ruiz Arnau, Ave. Laurel, Santa Juanita Bayamón, P.R. 00956 Coordinador: Dr. Calos León Valiente	Farmacia Caridad Tel.(787) 785-3055 / 269-3140 Fax: (787) 740-5445 Fax. (787) 269-0022 Dirección Física: Barrio Hato Tejas Carr.862 Km 1.9 Bayamón, PR 00954 Dirección Postal: PO Box 4218 Bayamón, PR 00954 Farmacéutico: Lic. Linnette Rivera E mail: lynnettepr@hotmail.com ADMINISTRACION DE SEGUROS DE SALUD Contrato Número 15-08
Centro de Epidemiología de Bayamón Tel. (787) 787-9831 Fax. (787) 269-5230 / (787) 785-2387 Dirección Física: Calle Isabel 2da Esq. Degetau Sotano, Antiguo CDT Bay. Pueblo Dirección Postal: PO Box 1588 BAyamón, P.R. 00961 Directora: Deborath Medina, Marisel Cruz MC: Alma Ortiz, Rocío Román, David Ayala	Farmacia Plaza III Tel. (787) 785-0000 Fax: (787) 785-2387 Dirección Física: Calle Barbosa # 57 Bayamón PR 00961 Dirección Postal: Calle Barbosa # 57 Bayamón PR 00961 Contacto: Lcda. Mayda Rodríguez
Casa Joven del Caribe Tel. (787) 870-1911 Cel. (787) 630-3571 Fax. (787) 796-2832 870-1911 Dirección Física: Carr. # 820 Bo. Marzán Sector Río Lajas, Toa Alta Dirección Postal: PO Box 694, Dorado, P.R. 00646 Director: Rev. Samuel Agosto López MC: Felicita Santiago, Betzaida Rivera	Farmacia Plaza III Tel. (787) 785-0000 Fax: (787) 785-2387 Dirección Física: Calle Barbosa # 57 Bayamón PR 00961 Dirección Postal: Calle Barbosa #57 Bayamón, PR 00961 Contacto: Lcda. Mayda Rodríguez

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REGION DE CAGUAS	
Clínicas	Farmacia
CPTET Caguas Clínica de Inmunología Tel. (787) 744-3141 Ext.1142 ETS. (787) 744-8645 Fax. (787) 746-2898 Dirección Postal: San Juan Bautista Medical Center PO Box 5729 Caguas, P.R. 00726 Contactos: Norma Sánchez, Nancy del Valle Coordinador: Dr. Milton Garland Pediátrico Tel. (787) 744-3141 Ext.1158 / 1563 Tel. (787) 282-6300 / 8509 Tel. (787) 649-3930 Manejadora de Caso: Ivette Peña Enfermera: Juanita Gómez Ext. 1153 Infectólogo: Armando Torres Nieves	Farmacia Arleen Tel. (787) 746-5952 / 745-2838 Fax. (787) 744-3397 Dirección Física: Carr 172 tercera sección de Villa del Rey Caguas, PR 00725 Dirección Postal: PO Box 5986 Caguas, PR 00726 Contacto: Sra. Adria Farmacéutico: Lic. Roberto Peirats Cel. (787) 379-0116 Farmacéutico: Lic. Arleen Hernández E-mail: farmaciaarleen@gmail.com
Clínica Satélite de Humacao Tel. (787) 640-0980 Dirección Física: Centro Comercial de Humacao Ave. Font Martelo # 100 Humacao, P.R. 00792	Farmacia Central Tel. (787) 852-0520 Fax. (787) 850-5500 Dirección Física: Calle Noya Hernández # 12 Este, Humacao PR 00791 Dirección Postal: PO Box 669 Humacao 00792 Contacto: Lic. Julio Garriga E-mail: julioegarriga@hotmail.com
Gurabo Community Health Center/Gurabo Family Medicine Center Programa SIVIF Tel. (787) 737-1131/ 630-5564 Fax.(787) 737-2365 Tel.(787) 737-2377 SIVIF Fax. (787) 737-2377 Dirección Física: Ramal 941 Sección Oscar Dávila, Gurabo PR Dirección Postal: Apartado 1277 Gurabo, PR	Farmacia In House Tel. (787) 737-4449 Fax: (787) 737-1242 Dirección Física: Carr 941 Salida Barrio Jaguas Gurabo, PR Dirección Postal: Apartado 1277 Gurabo, PR 00778 Farmacéutico: Noemí Rivera

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00778 Contacto: Denisse Figueroa E mail: dfigueroa@sivif.com	
REGIÓN DE CAGUAS	
Clínica	Farmacia
Proyecto CIS Hospital Ryder Memorial Ryan White Parte C Tel. (787) 852-0768 Ext. 4716, 4717, 4609, 4276 Fax. (787) 656-0735 850-1444 Dirección Física: Ave. Font Martello #355 (Salida de Humacao a Las Piedras) Dirección Postal: PO Box 859 Humacao, P.R. 00792 Contactos: Carmelo Rivera Awilda, Felicita de Jesús	Farmacia In House Tel. (787) 852-0768 Ext. 4730, 4724, 4466, 4467, 4718 Fax: (787) 850-1444 Dirección Física: Ave. Font Martello #355 (Salida de Humacao a Las Piedras) Dirección Postal: PO Box 859 Humacao, P.R. 00792 Contactos: Lcda. Carmen Ortíz Lcda. Cristina Marrero Lcda. Lilliam Sepúlveda Lcda. María Carradero
*Corporación de Servicios de Salud y Medicina Avanzada (COSSMA) Humacao Tel. (787) 852-2551 / 2595 Fax: (787) 850-1218 Dirección Física: Calle Ulises Martínez # 50 Humacao, PR 00791 Contacto: Bárbara Rodríguez	Farmacia In House Tel. (787) 852-2551 Fax. (787) 937-0062 Dirección Física: Calle Ulises Martínez # 50 Humacao, PR 00791 Dirección Postal: PO Box 1330, Cidra, P.R. 00739 Farmacéutico: María de L. García
*Corporación de Servicios de Salud y Medicina Avanzada (COSSMA) San Lorenzo Tel. (787) 736-3655 / 3646 Fax: (787) 937-0059 Dirección Física: Calle Muñoz Rivera #186, San Lorenzo, P.R. 00754 Dirección Postal: Calle Muñoz Rivera #186, San Lorenzo, P.R. 00754 Contacto: Wanda Nieves	Farmacia In House Tel. (787) 736-3655 Ext.1115 Fax: (787) 937-0064 Dirección Física: Calle Muñoz Rivera # 186, San Lorenzo, P.R. 00754 Dirección Postal: PO Box 1330, Cidra, P.R. 00739 Farmacéutico: Dra. Ilia Huertas

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REGIÓN DE CAGUAS	
Clínica	Farmacia
*Corporación de Servicios de Salud y Medicina Avanzada (COSSMA) Cidra Tel. (787) 739-8182 / 8183 Dirección Física: Ave. Industrial El Jíbaro Lote #2 Carr. 172 Km. 13.5 Dirección Postal: Apartado 1330 Cidra, PR 00739 Contacto: Yesenia Velázquez E mail: cossma@cossmapr.org Internet page: www.cossmapr.org Sra. Isolina Miranda: imiranda@cossmapr.com	Farmacia In House Tel. (787) 739-8182 Ext. 1228 Fax: (787) 714-1444 Dirección Física: Ave. Industrial El Jíbaro Lote #2 Carr. 172 Km. 13.5 Dirección Postal: Apartado 1330 Cidra, PR 00739 Farmacéutico: Lcda. Lidian Rosario
*Corporación de Servicios de Salud y Medicina Avanzada (COSSMA) Yabucoa Tel. (787) 893-3060 / 3055 Fax: (787) 266-6292 Dirección Física: Calle Muñoz Rivera #15 Yabucoa, PR Contacto: Diana Mulero	Farmacia No tienen

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REGIÓN FAJARDO	
Clínica	Farmacia
CPTET Fajardo Clínica de Inmunología Tel. (787) 801-1992 / 1995 Tel. (787) 863-5437 Fax. (787)801-6767 Dirección Física: Urb. Monte Brisa Calle Rafael #55 Fajardo, P.R. 00738 Coordinador: Dr. Arturo Hernández Estrella Contacto: Rafaela Díaz	Farmacia Denirka Tel. (787) 863-7788 / 860-7788 Fax. (787) 863-1422 Dirección física: Avenida General Valero # 305 Fajardo, PR 00738 Dirección Postal: PO Box 850 Fajardo, PR 00738 Contacto: Vanessa Hernández Contacto: Lic. Gil Nieves E-mail: gilnieves@hotmail.com

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Estado Libre Asociado de Puerto Rico
Departamento de Salud
Secretaría Auxiliar de Salud Familiar, Servicios Integrados y Promoción de la Salud
Oficina Central para Asuntos del SIDA y Enfermedades Transmisibles
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REGION DE MAYAGÜEZ	
Clínica	Farmacia
CPTET Mayagüez Clínica de Inmunología Tel.(787) 834-2115 / 2118 Fax. (787) 265-2850 / 834-2370 Dirección Física: Centro Médico al lado de Salud Mental, Carr. #2 Dirección Postal: PO Box 400 Mayagüez, P.R. 00680 Contacto: Damariz Ruiz, Marianita Torres Coordinador: Ramón Ramírez Ronda	Farmacia In House Tel. (787) 834-2116 / 2115 / 2118 Cel. (787) 546-5527 Sonia Cel. (787) 644-3277 Janette Torres Cel. (787) 233-8080 Sandra Dirección Física: Centro Médico al lado de Salud Mental, Carr. #2 Dirección Postal: PO Box 400 Mayagüez, P.R. 00680 Farmacéutico: Lic. Janette Torres Contactos: Sonia Vargas, Sandra Rivera
Centro de Salud de Migrantes Región Oeste Programa SSIMA Serv. Salud Integrado Ryan White Parte C Tel.(787) 805-2900 / 805-2920 Ext. 294 Fax.(787) 805-4750 Clínica:(787) 834-1470 ADM: (787) 834-1924 Fax.(787) 805-4750 Dirección Física: Calle Ramón E. Betánces #392 Sur Mayagüez, PR 00680 Dirección Postal: PO Box 7128 Mayagüez, PR 00681-7128 Contacto: Wanda Acosta Director: Reynaldo Serrano	Farmacia In House Tel.(787) 805-2900 / 920 Ext. 237 Fax:(787) 265-4245 Dirección Física: Calle Ramón E. Betánces #392 Sur Mayagüez, PR 00680 Dirección Postal: PO Box 190 Mayagüez PR 00681-7128 Contacto: Lcda. Juliana Torres Contacto: Lcda. Lilliam Torres Farmacia Clínica Satélite de San Sebastián Tel.(787) 896-1665 Tel. (787) 896-6975 Fax. (787) 896-4570 Dirección Física: Carr. 119 k.m. 35.2 Bo. Piedras Blancas San Sebastián PR Contacto: Lcda. Grisel A. Cabá Farmacia Clínica Satélite de Guánica Tel.(787) 821-4511 / 821-3377 / 821-2144 Fax.(787) 821-4511 Dirección Física: Calle Montalva #23 Ensenada Guánica, PR 00647

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	Dirección Postal: Calle Montalva #23 Ensenada Guánica, PR 00647 Farmacéutico: Lcda. Wanda Torres
REGION DE PONCE	
Clínica	Farmacia
Centro Ararat Tel. (787) 284-5884 / 5887 Fax. (787) 284-5874 Dirección Física: 8169 Condominio San Vicente, Suite 204, Ponce, P.R. Dirección Postal: PO Box 7793 Ponce, P.R. 00732 Contacto:Juan Rivera, Madeline Torres E mail: jrivera@centroararat.org Administrador: Iván Meléndez Rivera	Farmacia El Apotecario Tel. (787) 844-2135 / 290-4654 Fax. (787) 844-2135 Dirección Física: Ave.Tito Castro #625 Carr. 14 Frente a Farmacia El Amal La Rambla, Ponce Dirección Postal: PMB 381 Ave. Tito Castro #609, Ponce, PR 00716 Contacto: Lcdo. Ricardo Cintrón
Centro de Salud Fam. Dr. Julio Palmieri Programa Ryan White Parte C Tel. (787) 271-3779 / (787) 839-4150 Fax. (787) 271-3779 MC: Ilka Santiago Dirección Física: Esq. Valentina Calle Morse, Arroyo Dirección Postal: PO Box 450 Arroyo, P.R. 00714 Contacto: Dra. Antonia Márquez	Farmacia In House Tel. (787) 839-4150 Ext. 234 Fax: (787) 839-3989 Dirección Física: Esq. Valentina – Calle Morse, Arroyo, PR 00714 Dirección Postal: PO Box 450 Arroyo, P.R. 00714 Farmacéutoco: Lcda. Doris Porrata
Consejo de Salud de la Comunidad CDT Playa de Ponce Programa Ryan White Parte C Tel. (787) 843-9393 Ext. 258, 262 Fax. (787) 843-0899 / 841-0077 Dirección Física: Ave. Hostos 1034 Ponce, P.R. 00716 Dirección Postal: PO Box 220 Ponce, P.R. 00715 - 0220 Contacto: Dra. Awilda García	Farmacia In House Tel. (787) 843-9370 Fax. (787) 843-9395 Dirección Física: Ave. Hostos 1034 Ponce, P.R. 00716 Dirección Postal: PO Box 220 Ponce, P.R. 00715 - 0220 Contacto: Lcda. Hilda Torres
CPTET Ponce Clínica de Inmunología Tel. (787) 259-4046 / 259-4731 ETS. (787) 848-2000 Fax. (787) 259-3998 / 842-1943 Dirección Física: Antiguo Hospital de Distrito de	Farmacia In House Tel. (787) 843-2188 Fax. (787) 842-1943 Dirección Física: Antiguo Hospital de Distrito de Ponce Carretera Estatal Bo. Machuelo #14 Ponce, P.R. 00717

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Ponce Carretera Estatal Bo. Machuelo #14 Ponce, P.R. 00717 Coordinadora: Dra. Gladys Sepúlveda	Farmacéutico: Lic Jorge López Vega
REGIÓN DE PONCE	
Clínica	Farmacia
Clínica Especial de la Salud Tel. (787) 260-9446 Cuadro: (787) 837-2185 Ext. 2296, 2297, 2298 Fax. (787) 260-2943 Dirección Física: Calle Hostos #23 Juana Díaz Dirección Postal: Apartado 1409 Juana Díaz, P.R. 00795 Director: Carlos Ortíz Torres	Farmacia Sonia Tel. (787) 837-2666 Fax: (787) 837-4602 Dirección Física: Calle Comercio #61 Juana Díaz, PR 00795 Dirección Postal: Calle Comercio #61 Juana Díaz, PR 00795 Farmacéutico: Lcda. Sonia Muñoz De Toro
Centro de Ambulantes Cristo Pobre Inc. Tel. (787) 841-7149 Fax. (787) 844-5656 Dirección Física: Calle Guadalupe Esq. Unión #100 Ponce, P.R. Dirección Postal: PO Box 334651 Ponce, P.R. 00733-4651 Contacto: Irma Valentín Administrador: Juan de Dios Videau	Farmacia El Apotecario Tel. (787) 844-2135 / 290-4654 Fax. (787) 844-2135 Dirección Física: Ave.Tito Castro #625 Carr. 14 Frente a Farmacia El Amal La Rambla, Ponce Dirección Postal: PMB 381 Ave. Tito Castro #609, Ponce, PR 00716 Contacto: Lcdo. Ricardo Cintrón
Centro de Servicios de Salud de Patillas Tel. (787) 839-4320 / 839-4360 Fax. (787) 271-0004 Dirección Física: Calle Riefhkol # 99 Patillas, PR 00723 Dirección Postal:PO Box 697 Patillas, PR 00723 Contacto: Sra. Carmen Carro	Farmacia In House Tel. (787) 839-4320 Ext. 241 / 247 Fax. (787) 839-4337 Dirección Física: Calle Riefhkol # 99 Patillas, PR 00723 Dirección Postal:PO Box 697 Contacto: Lic. Anette Alvarado E mail: pphsc_inc.com
Proyecto Amor que Sana, Inc. Oficinas Administrativas Tel. (787) 844-8081 Fax. (787) 844-8117 Tel./Fax. (787) 259-2882 Manejo de Caso Dirección Física: Traditional Plaza 7033 Méndez Vigo y Aurora Ponce, PR 00717-1250 Dirección Postal: Traditional Plaza 7033 Méndez Vigo y Aurora Ponce, PR 00717-1250	Farmacia El Apotecario Tel. (787) 844-2135 / 290-4654 Fax. (787) 844-8117 Dirección Física: Ave. Tito Castro #625 Carr. 14 (Frente a la Farmacia El Amal) La Rambla, Ponce, PR 00716 Dirección Postal: PMB 381 Ave. Tito Castro #609 Ponce, PR 00716 Contacto: Lcdo. Ricardo Cintrón

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Contacto: Héctor Torres Director: Juan A. Panelli	

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Clínica	Farmacia
Centro Latinoamericano de Enfermedades Transmisibles (CLETS) Tel. (787) 754-8123 / 8118 Fax. (787) 754-8127 Dirección Física: Barrio Monacillos Paseo Celso Barbosa Centro Médico San Juan, P.R. 00936 Dirección Postal: PO Box 70184 San Juan PR 00936 Director: Dr. Hermes García	Farmacia In House Tel. (787) 754-8118 Fax: (787) 754-8127 Dirección Física: Barrio Monacillos Paseo Celso Barbosa Centro Médico San Juan, P.R. 00936 Dirección Postal: PO Box 70184 San Juan PR 00936 Farmacéutico: Lic. Lourdes Fornés
Concilio de Salud Integral de Loíza Tel. (787) 876-3130 / 2042 Ext. 261 Fax. (787) 256-1900 Dirección Física: Carr. 188 Intersección # 187 Loíza Dirección Postal: Apartado 509, Loíza P.R. 00772 Contacto: Juan C. Castellanos	Farmacia In House Tel. (787) 876-2005 Fax. (787) 876-6613 / 1120 / 1900 Dirección Física: Carr. 188 Intersección # 187 Loíza Dirección Postal: Apartado 509, Loíza P.R. 00772 Contacto: Lcda. Irma Alvárez
CPTET Carolina Clínica de Inmunología Tel. (787) 757-1800 Fax. (787) 257-3615 Dirección Física: Ave. 65 de Infabntería KM 8.4 al lado de Plaza Carolina Dirección Postal: Hospital Universitario de Carolina, PO Box 6021, Carolina P.R. 00984-6021 Coordinadora: Dra. Adiana Zayas	Farmacia Hospital UPR Tel. (787) 757-1800 Ext. 227 Fax: (787) 750-4214 Dirección Física: Ave. 65 de Infabntería KM 8.4 al lado de Plaza Carolina Dirección Postal: Hospital Universitario de Carolina, PO Box 6021, Carolina P.R. 00984-6021 Farmacéutico: Lic. Juan Villegas
Iniciativa Comunitaria Tel. (787) 250-8629 / 8680 / 8690 Fax. (787) 753-4454 Dirección Física: Calle Quisqueya #61 Esq. Chile, Hato Rey P.R. 00918 Dirección Postal: PO Box 366535 San Juan, P.R. 00936-366535	Farmacia San Rafael Tel. (787) 724-3307 Fax: (787) 721-4165 Dirección Física: 851 Lafayette Esq. San Rafael, Urb. Hipódromo Pda. 20 Santurce PR Dirección Postal: 851 Lafayette Esq. San Rafael, Urb. Hipódromo Pda. 20 Santurce PR

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Contacto: Jonathan Fernández Director: Dr. José Vargas Vidot E mail: iniciator@hotmail.com	00909 Contacto: Rafael Díaz
REGIÓN SAN JUAN	
Clínica	Farmacia
Municipio de San Juan Programa Más Salud: Sida con Salud Tel. (787) 723-2424 Ext. 239 / 243 /294 Fax. (787) 724-5104 Dirección Física: Ave. Fernández Juncos 1306 Pda. 19 Santurce, P.R. 00908 Dirección Postal: PO Box 13694 San Juan, P.R. 00908 Contacto: Dr. Luis Martínez Gerente: Lcda. Sonia Collazo	Farmacia In House Tel. (787) 723-2424 Ext. 4071 Fax: (787) 721-7596 Dirección Física: Ave. Fernández Juncos 1306 Pda. 19 Santurce, P.R. 00908 Dirección Postal: PO Box 13694 San Juan, P.R. 00908 Contacto: Lcda. Laura Del Carmen Rivera
Nuevo Puerto Rico CoNCRA Programa Ryan White Parte C Tel. (787) 753-9443 / 9463 Ext. 32 Fax. (787) 753-2894 / 9463 Dirección Física; Urb. García Ubarry Calle Brunbaugh #162 San Juan, PR 00925 Dirección Postal: PO Box 20850 San Juan, P.R. 00928-9463 Contacto: Manuel Quiñones, Magaly Nieves Directora: Rosaura López Director Médico: Ext. 11	Farmacia García Tel. (787) 898-3975 / 820-5158 Fax. (787) 820-9048 Dirección Física: Calle Vidal Félix #121 Hatillo, P.R. 00659 Dirección Postal: PO Box 67 Hatillo PR 00659 Farmacéutico: Lic. Daniel Mahíques Nieves
Proyecto CEMI Tel. (787) 766-0025 / 0030 Tel. (787) 771-4740 / 753-5913 SIDA Pediátrico Tel. (787) 274-5762 Dirección Física: Recinto de Ciencias Médicas Edificio Biomédico II Piso I, Río Piedras, PR 00935 Contacto: Janice Pérez	ADMINISTRACION DE SEGUROS DE SALUD Contrato Número 15 - 0 0 4
Proyecto ACTU Tel. (787) 767-9192 /9193 /9194 /9195 Fax. (787) 754-8002 Dirección Física: Recinto de Ciencias Médicas UPR	

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Edificio Biomédico II al lado de medicina nuclear, Río Piedras,PR 00935 Contacto:Silvia Dávila / sdavila@rcm.upr.edu	
REGIÓN SAN JUAN	
Clínica	Farmacia
Proyecto GAMMA Tel. (787) 759-9595 Fax: (787) 767-4798 Dirección Física: ,Centro Cardiovascular de PR Proyecto GAMMA, Piso 8 Oficina 814 San Juan Dirección Postal: Universidad de Puerto Rico RCM Proyecto GAMMA, PO Box 365067 San Juan PR 00936-5067 Contacto: Dra. Irma L. Febo, Contacto: Iraida Salabarria	

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