TRIPLE-S SALUD, INC.
1441 Roosevelt Avenue, San Juan Puerto Rico
Independent Licensee of the Blue Cross and Blue Shield Association

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Employer/Policy Holder: Payless ShoeSource

Sponsor: SP0003586

Effective date: January 01, 2018

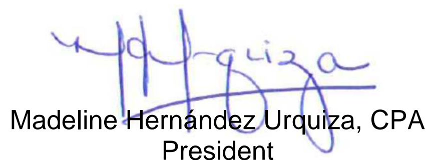
Triple-S Salud, Inc. (hereinafter "Triple-S Salud") ensures all of the active employees of the employer whose name appears in the group health plan contract, as well as their eligible dependents in accordance with the provisions of this policy/certificate of benefits (hereinafter, "the policy") and the payment policy established by Triple-S Salud, for medically necessary medical-surgical and hospitalization services, rendered while the policy is in force, that may result from injuries or illnesses of the insured member. This policy is not subject to risk evaluation and is issued taking into consideration the statements in the group insurance contract and the employer payment in advance of the corresponding premiums and according to the date on which the employer subscribed the group health insurance.

This policy is issued to *bona fide* residents of Puerto Rico, whose permanent residence is located within the Service Area, as defined in this policy, for a one-year term from the date on the insurance contract of the group health plan. This insurance may be renewed for equal, consecutive terms, through the payment of the corresponding premiums, for which the employer will be primary liable as the policyholder and the employee as insured member and user of the health insurance plan, as provided further below. All the terms of this coverage will begin and end at 12:01AM, Puerto Rico Official Time.

Triple-S Salud will not deny, exclude or limit the benefits of a covered person because of a preexisting condition, regardless of the age of the insured member. This policy is not a policy or supplement contract to the Federal Health Insurance Program for the Elderly (Medicare). Review the *Guide* to *Health Insurance for People with Medicare*, available through the insurance company.

Triple-S Salud complies with applicable federal laws of civil rights and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Signed on behalf of Triple-S Salud, by its President.



Madeline Hernández Urquiza, CPA
President

Keep this document in a safe place. It includes the benefits to which you are entitled as a member of Triple-S Salud. For any additional coverage subscribed by your employer, refer to any rider issued together with this policy, to have the complete information on the benefits included in your Health Plan.

CONTACTS

Customer Service Department

Our Customer Service Department is available whenever you have a question or concern about benefits or services that Triple-S Salud offers to the members subscribed in this policy. Also, they can answer your questions, help you to understand your benefits and will provide you information about our policies and procedures.

Customer Service Telephones	**787-774-6060 or 1-800-981-3241 (toll free)** **TTY Users call TTY 787-792-1370 or** **1-866-215-9999**
Call Center Business Hours	• Monday to Friday: 7:30 a.m. - 8:00 p.m. • Saturday: 9:00 a.m. - 6:00 p.m. • Sunday: 11:00 a.m. - 5:00 p.m.
Fax- Customer Service	**787-706-4014 / 787-706-2833**
Fax - Reimbursements	**787-749-4032**
Teleconsulta	**1-800-255-4375**
BlueCard	**1-800-810-2583** **www.bcbsa.com**
Customer Service Postal Address	**Triple-S Salud, Inc.** **Customer Service Department** PO Box 363628 San Juan, PR 00936-3628
Electronic Mail Address	**customerservice@ssspr.com**
Precertifications	**Triple-S Salud, Inc.** **Precertifications Department** PO Box 363628 San Juan, PR 00936-3628
Case Management Program	**787-277- 6544, 787-273-1110 extensions 4312, 4265, 4355 or 1-800-981-4860** **Fax: 787-744-4820**
Education and Disease Management Program (asthma, diabetes, cardiac failure, prenatal, hypertension, COPD (Chronic Obstructive Pulmonary Disease), Living without Smoke	**1-866-788-6770** **Monday to Friday: 8:00 a.m. – 4:30 p.m.**

Service Centers	
Plaza Las Américas (Second level across from *Relojes y Relojes*) Monday to Friday: 8:00 a.m.-7:00 p.m. Saturday: 9:00 a.m. – 6:00 p.m. Sunday: 11:00 a.m. – 5:00 p.m.	**Plaza Carolina** (Second level next to Sears) Monday to Friday: 9:00 a.m. – 7:00 p.m. Saturday: 9:00 a.m. – 6:00 p.m. Sunday: 11:00 a.m. – 5:00 p.m.
Caguas Angora Building Luis Muñoz Marín Ave., Troche St. corner Monday to Friday: 8:00 a.m. – 5:00 p.m.	**Arecibo** Caribbean Cinemas Building, Suite 101 Road #2 Monday to Friday: 8:00 a.m. – 5:00 p.m.
Ponce 2760 Maruca Ave. Monday to Friday: 8:00 a.m. – 5:00 p.m.	**Mayagüez** Road 114 Km. 1.1 Barrio Guanajibo Monday to Friday: 8:00 a.m. – 5:00 p.m.
Personas con necesidades especiales debido a: • **El inglés no es su lenguaje primario** • **Necesidades Especiales**	Esta información está disponible en español, libre de costo. Además, si necesita servicios de interpretación para hablar en otro idioma que no sea inglés o español, favor de comunicarse con Servicio al Cliente al 787-774-6060. Llame a Servicio al Cliente si necesita ayuda en otro idioma o formato. Si necesita ayuda para leer o entender un documento, le podemos ayudar. Los materiales impresos pueden estar disponibles en otros formatos. Usuarios TTY pueden llamar al 787-792-1370 de lunes a viernes de 7:30 a.m. - 8:00 p.m.; sábados de 9:00 a.m.- 6:00 p.m. y domingos de 11:00 a.m. - 5:00 p.m.
Persons with Special Needs	Call Customer Service if you need help in another language or format. If you want to speak in another language, or need help to read or understand a document, we can help you. Printed materials may be available in other formats. TTY users can call our Customer Service Department at TTY 787-792-1370 during the following hours: • Monday to Friday: 7:30 a.m. - 8:00 p.m. • Saturday: 9:00 a.m. - 6:00 p.m. • Sunday: 11:00 a.m. - 5:00 p.m.

Internet Portal	www.ssspr.com Our members have the option to register in our website. In this website, they may perform transactions such as: • Obtain information about their benefits • Health education information • Obtain a Coverage Certification • Request duplicates of the identification card • Address changes • Review reimbursement status • Review precertifications status • Obtain a student certification letter • Review their service history
Mobile Application, Triple-S Salud	In your Smartphone, through the Triple-S Salud application, you can locate participating providers easily and quickly. Download the application in your Apple or Android store. The functions of our application are the following: • *Coverage and Copayments* – The member can review his/her coverage and those of his/her dependents • *Your card always with you* – The policyholder can send his plan card and those of his/her dependents to his/her physician through e-mail. • *Medical Directory* - Find the closest health services provider. • *Acquire a plan* –Customers of individual plans can see the prices of our plans and acquire the one that best fits their need. • *Customer Service* –The member will have Triple-S Salud contact information at hand such as telephone numbers and addresses or he/she can send us an email directly from the application. **If you have not registered yet:** • **Download the application** • **If you have not registered yet in the Internet Portal, access the link "Register".**

IMPORTANT NOTICE FOR PEOPLE WITH MEDICARE

All the forms needed to exercise your rights are available at www.ssspr.com

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not a supplement insurance to Medicare

This insurance plan provides limited benefits, if you comply with the conditions of this policy for expenses related to the specific services listed in this policy. It will not pay your Medicare copayments or coinsurance and it is not a substitute to Medicare supplemental policy.

This insurance plan duplicates Medicare benefits when:

- Medicare also covers some of the services covered by this policy.

Medicare pays for extended benefits for services medically necessary regardless of the reason for which you may need them. These include:

- Hospitalization
- Medical services
- Other approved items and services

Before you purchase this Insurance

- ✓ Verify the coverage in all of the health insurance policies that you already have.
- ✓ For more information about Medicare and Medicare supplement insurance, review the Guide to Health Insurance for People with Medicare available through the insurance company.

For help in understanding your health insurance, please contact the Office of the Insurance Commissioner of Puerto Rico or a government senior insurance counseling program.

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ERISA NOTICE FOR PRIVATE EMPLOYEES

ERISA Coverage

Federal Employee Retirement Income Security Act (ERISA) rules benefits such as pension, health and disability plans; life insurance benefits, indemnity plans and prepaid plans to obtain legal services, education funds and apprenticeship plans, as well as child care centers operated by private employers. The Federal Labor Department is the entity that oversights compliance with this law.

The law does not require a private employer to provide particular benefits to the employees such as a health insurance plan. However, ERISA requires that once the private employer decides to offer such plans, they must meet certain minimum standards designed to protect the interests of the employees (participants) and their dependents.

Request from your employer a copy of the Summary Plan Description (SPD) and information on the additional benefits that it has available for its employees. The certificate of benefits issued by Triple-S Salud covers the health insurance plan benefit.

ERISA Scope

ERISA does not cover health plan of churches or the plans of the agencies, corporations and instrumentalities of the Government of Puerto Rico and its Municipalities. It does not either cover plans required and administered by local laws, such as employee compensation under the State Insurance Fund and Unemployment.

ERISA Requirements

ERISA generally sets forth that benefit plans must be maintained in a fair and financially sound manner. Private employers and the entities that manage and control employment benefits are required to the following:

- Manage the funds for the exclusive benefit of plan participants and plan members;
- Prevent conflicts of interests when investing or making decisions on the benefits;
- Report certain plan information to the government and the participants; and
- Comply with the lineaments that rule how and when plan funds must be invested.

As an insurer, Triple-S Salud does not manage or make decisions, administers, controls, invests or distribute the plan funds used to finance the health insurance plan. You must request the SPD to your employer to have further details.

Each plan must notify its participants the procedure to make the request for benefits and the standards with which he must comply to receive the benefits. For example, said standards may include the criteria to determine when a person is disabled and is entitled to receive disability benefits, how soon an employee can retire and request pension benefits, how soon an employee is granted benefits after he has paid the plan, and how soon a participant can claim the health plan benefits for an illness or injury to be covered. An employer or administrator (such as disability insurance or retirement investment company) cannot make significant changes to the plan without notifying it to the participants. Ask your employer for the SPD to get more details on the availability of these benefits.

Claim of Benefits

Under ERISA, claims must be handled with the regulatory deadlines. If the health insurance plan denies a benefit, the claimant must be informed in writing of the denial and must state the reasons that justify the denial. In addition, must orientate you on how to submit your case again for a fair reevaluation. We encourage you to read the section on Appeals to Adverse Benefits Determinations in this policy issued by Triple-S Salud for information on claims to the health plan.

For further information on ERISA, visit the webpage of the federal Department of Labor at www.dol.gov.

THE CHANGES IN THE PLAN EFFECTIVE IN THEIR NEW POLICY YEAR

Below, we present a summary of the changes in your plan for this new policy year. Review carefully the changes in the sections of the benefits of their different covers.

- We have added a new section "How Your Plan Works." This new section provides additional information on how it works your deck with Triple-S Salud and a guide on how to obtain any additional information with respect to its cover. This information does not change its cover with Triple-S Salud. For specific information, refer to the sections of the benefits of their different covers in the policy/certificate of benefits.

AMBULATORY MEDICAL-SURGICAL AND DIAGNOSTIC SERVICES IN AMBULATORY FORM

- The following services are covered for children under 21 years of age diagnosed with Diabetes Mellitus Type 1, as required by law 177 of August 13, 2016:
  1. Lancets, up to 150 for 30 days
  2. Test Strips, up to 150 for 30 days
  3. Insulin infusion pump and supplies for members under 21 years of age diagnosed with Diabetes Mellitus Type 1, as required by Law 177 of August 13, 2016. Requires precertification.

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ELIGIBILITY

WHO IS ELIGIBLE?

Each employer's active employee and his dependents will be eligible for the insurance provided by this policy. Triple-S Salud may verify the eligibility of the insured member to assure the necessary conditions are met to obtain the benefits this policy provides. Active employees and their spouses, aged sixty-five or older, who are benefiting from both parts of the Medicare Program, may be insured under the benefits of this policy.

Triple-S Salud will follow the rules of eligibility of the employer concerning consensual couples of the opposite sex or the same sex.

DATE OF COVERAGE

The employee and his/her eligible dependents (direct) will be insured on the effective date of this policy if the employee's individual health insurance application, including the eligible dependents, if any, was accompanied by other documents related to the recruitment and provided by Triple-S Salud through the employer's officer in charge or the employer's Benefits Administrator. After this date, the employee will not be able to enroll in the health plan until the next policy renewal date or if there is a special enrollment event.

Any new employee, who becomes eligible to this policy after the effective date of this policy, will have a waiting period that will not exceed 90 days from the date he was hired by the employer. The insurance application must include the document proving the eligibility date of the employee. The insurance in these cases will be effective on the next day after the 90-day waiting period. If enrollment is not requested, the employee may request enrollment on the next policy renewal date or if there is a special enrollment event.

CHANGES IN ENROLLMENT

Once the plan open enrollment period ends, the employee will not be able to disenroll while the policy is in force, unless he/she is terminated from employment, except in cases in which the employee understands that the existing coverage under his eligible group health plan is no longer an affordable coverage or it has been informed that its plan coverage does not provide a minimum actuarial value (60%) for the next renewal. Besides, the insured employee may not be able to make changes to his health plan or the employer request them, unless said changes are necessary as the result of any of the following events:

1. Death of any of the insured members: When any of the insured members die during the effectiveness of the policy, the request for termination of insurance must be submitted within thirty (30) days following the date of the death, which must be evidenced with the Death Certificate. The change will be effective on the first day of the month following the month in which the event took place.

2. Divorce of the insured employee: When the insured employee divorces during the effectiveness of the policy, the request for termination of the policy must be submitted within thirty (30) days following the date of the divorce, which must be evidenced with the Divorce Decree and its corresponding notification. The change will be effective on the first day of the month following the month in which the event took place.

3. When a child, according to the definition of direct dependent in this policy, loses eligibility as a dependent of the insured employee:

   a. When a child reaches age 26, the date of birth will be taken as the date of request for termination of insurance, except in case of disabled dependents, as provided in the definition of direct dependents. The change will be effective on the first day of the month following the month in which the event took place.

b. When a direct dependent joins the Armed Forces of the United States, the date of entry in the Armed Forces will be taken as the date of request for termination of insurance. The change will be effective on the first day of the month following the month in which the event took place.

A request for enrollment will be considered to be submitted when the person fills it out in all its parts and sends it through the employer's officer in charge of the staff or the Benefits Administrator. The same rule shall apply regarding any request for change in the plan, except when the insured member reaches the age limit for coverage or benefits, in which cases Triple-S Salud will be able to make the changes automatically. The employer's officer in charge of the staff or its Benefit Administrator will be responsible to send or deliver to Triple-S Salud, as soon as possible, all health insurance applications or requests for change received, the health plan ID cards of the persons terminated from insurance and a certified summary of all the new enrollment forms and requests for changes to be performed. Triple-Salud may confirm the insured member's eligibility to assure the necessary conditions are met to obtain the benefits this policy provides.

SPECIAL ENROLLMENT

An active employee and his/her eligible dependents (direct) may enroll under this policy at any moment during the policy year under the following conditions, terms and limitations:

1. Marriage of the insured employee: When the insured employee marries during the policy year, he/she may be able to enroll his/her spouse and those dependents that may become eligible by virtue of this marriage, as long as he or she submits the insurance enrollment form to Triple-S Salud within thirty (30) days from the date of the marriage, proves said marriage with the Marriage Certificate, and submits evidence to prove the eligibility of the new dependents, as applicable.

2. Birth, adoption, placement for adoption, or adjudication of custody or guardianship:

    a. When the insured employee procreates a biological child, legally adopts a child, or a child is placed in his home for adoption, or if the employee is awarded legal custody or guardianship of a minor, the insured employee may include the new dependent under this policy. The employee must evidence the event with the original birth certificate or the court resolution or ruling or the official document issued by the corresponding government agency or authority, as the case may be.

    b. In case of newborns that are biological children of the insured employee, the plan will cover the newborn from birth with the request for inclusion as a dependent and the submission of the original Birth Certificate. In these cases, if the request for enrollment as a dependent is not received, Triple-S Salud will cover the newborn under the health plan of the main insured of the newborn in case of individual contracts or the health plan of the insured employee or the spouse of the insured employee in case of family contracts for the first 30 days from the date of birth while the enrollment process of the child is completed.

    c. In case of recently adopted children, coverage will be from the first of the following dates:

        1. The date in which the child is placed in the home of the insured employee for adoption and stays in the home under the same conditions as the other dependents of the insured employee, unless the placement of adoption is interrupted before the child is legally adopted and the child is transferred from the home where he was placed;

        2. The date in which the order awarding custody of the child to the insured employee that has the intention of adopting the child is issued; or

        3. The effective date of the adoption.

    d. Coverage for newborn children, recently adopted children, or children placed for adoption will include health care services for injuries or illnesses including care and treatment for birth defects and anomalies that have been diagnosed by a physician and will not be subject to any exclusion for a preexisting condition.

    e. If to provide coverage for a newborn, the payment of a premium or a specific enrollment fee is required, the plan may require the insured employee to notify the birth and pay the required fee or premium no later than thirty (30) days from the date of birth.

    f. If the insured employee fails to provide the notice or pay the premium, the plan may choose to discontinue coverage for the dependent child beyond the 30-day term. In case of a newborn, who is a biological child of the insured employee, if the employee pays all the outstanding premiums within four months from the date of birth of the child, the child's coverage will be reinstated.

g. On the other hand, if the plan does not require the payment of a premium, it may request notice of the birth, but may not deny or refuse coverage if the insured employee does not provide said notice.

h. In cases of recently adopted children or children placed for adoption, the health insurance organization or insurer is required to provide the insured employee a reasonable notice on the following:

   1. If in order to provide coverage for a recently adopted child or a child placed for adoption, the payment of a premium or a specific enrollment fee is required, the plan may request the insured employee to give notice on the adoption or placement for adoption and pay the required premium or fee no later than thirty (30) days from the date in which coverage is required to begin.

   2. If the insured employee does not provide the notice or pays the payment required on the previous paragraph within the thirty (30)-day term, the plan cannot treat the adopted child or the child placed for adoption in a less favorable manner than other dependents, that are not newborns, for whom coverage is requested on a later date after the date the dependent became eligible for coverage.

i. When the insured employee has a family contract and the event of the adoption or placement for adoption does not involve the payment of an additional premium, the insured employee must give the plan notice on the event within thirty (30) days from the date of the adoption or placement for adoption and submit the corresponding evidence to validate the eligibility of the minor, compliance of the submitted documents with the legal requirements and the consequential issuance of the health plan ID card for the minor.

   In these cases, the plan will cover the services for these minors from the date of birth, adoption, or placement for adoption.

3. Special enrollment for loss of eligibility under another group health plan or termination of employer contributions toward the premiums of another group health plan

   An active employee and his eligible dependents (direct) may enroll in this policy during a special enrollment period if any of the following events takes place:

   a. In those cases in which by the time of the open enrollment period, the active employee did not enroll or did not enroll a dependent under the health plan of his present employer, because at that time he was enrolled in another health plan or had an extended coverage under COBRA from his former employer.

   b. Because his former employer contributed to the premiums of the health plan the employee had at that moment and the employer ceased entirely the contributions to the health plan the employee had at that moment.

   c. The other health plan the active employee had, terminated according to the eligibility requirements of said health plan, which include, separation, divorce, death, termination of employment or reduction in the number of employment hours.

   d. In case of birth, adoption, an awarding of custody or guardianship, the dependent may enroll in the plan. Refer to paragraph 2 in this Section for the rules and effective dates that apply in these cases.

   e. In case of marriage, if the eligible employee or his dependent were not enrolled in the plan at first, they may be able to enroll in it during the special enrollment period.

f. The eligible employee or his dependent loses the minimum coverage with the essential health benefits.

g. The previous policy was not cancelled for lack of payment or fraud by the member.

h. The person lost eligibility under the Puerto Rico Government Health Insurance Plan.

In all of these cases, the active employee as well as his eligible dependent shall be entitled to special enrollment under this policy within 30 days from the date in which the event took place. To be eligible for this special enrollment benefit, loss of eligibility under the other plan should not have arisen by reason of nonpayment of the plan premiums or from unilateral termination by the other plan because of fraud.

This special enrollment period benefits the active employee as well as his eligible dependents, who must meet the eligibility requirements contained in the terms of this policy when they request enrollment. In these cases, the employee will be responsible of submitting the cancellation or creditable coverage letter issued by the other health plan with the plan enrollment application, as provided by the law.

4. When an insured employee or one of his/her eligible dependents (direct) did not enroll in the employer health plan during the open enrollment period, because he was participating in the Medicaid Program or the Children's Health Insurance Program (CHIP) and later loses eligibility in any of this programs or becomes eligible to receive premium assistance under any programs. In these cases, the insured employee and his eligible dependents will be entitled to special enrollment and may request enrollment in the employer health plan within 60 days from the date of any of these events.

In those cases in which a non-custodian main member of minors listed as dependents under the policy, or when the member is of legal age, but is listed as eligible dependents under the policy, requests the payment of indemnification be paid directly to him/her because he/she paid for the covered medical services claimed, Triple-S Salud may issue the payment directly to the non-custodian parent or to the member.

DOMESTIC PARTNER

A Domestic Partner is defined as a person of the same or opposite sex who:

- is your sole domestic partner and such relationship is intended to remain so indefinitely;
- has resided with you for no less than one year and intends to do so indefinitely;
- is no less than 18 years of age and mentally competent;
- is not related by blood to a degree of closeness that would prohibit legal marriage;
- is not legally married to anyone nor has had another domestic partner within the prior 12 months;
- shares a close personal relationship with you and is jointly responsible for your common welfare and financial obligations and likewise. (Payless ShoeSource may, during any time period, in which domestic partnership is claimed, require evidence of such joint responsibility by requesting copies of three or more of the following types of documentation):
    a. Domestic partnership agreement;
    b. Joint mortgage, lease, or deed
    c. Joint ownership of a vehicle
    d. Joint checking account or credit account
    e. Designation of domestic partner as primary beneficiary on life insurance or retirement contract
    f. Durable property and health care powers of attorney
    g. Other legal or financial documentation evidencing joint responsibility
- has signed jointly with you, a Declaration Statement of Domestic Partnership.

CHILD OF A DOMESTIC PARTNER

A son of a couple of fact ("domestic partner"), is covered in this policy, according to the following requirements:

- includes any dependent child not married until the age of 26 years.
- Includes a dependent child married for 26 years or older, who is unable to be independent delays due to mental or physical handicap, which depends principally upon the employee for their livelihood.

HOW DOES YOUR PLAN WORK

Your coverage under this policy / certificate

Your employer (the "Policyholder") have acquired a policy of Triple-S Salud and maintain a contract with Triple-S Salud. You, as an employee of said employer, and your dependents have the right to the benefits described in this Policy/Certificate.

The benefits provided by this policy are included within the general classifications which follow. These benefits are subject to the terms and conditions specifically established for them, and are only offered for those members who permanently reside in the Service Area. Triple-S Salud is responsible for the payment of services provided to a member subject to the provisions of this policy and the conditions expressed below.

The benefits that this basic policy provides are not cumulative or are subject to waiting periods.

The policyholder and all his/her direct dependents will have similar benefits.

Free Choice Plan

You, as a member of Triple-S Salud, are enrolled in a Free Choice plan. This means that you can access your medical care freely within the Participants and Providers Network of Triple-S Salud without the need of a referral from a primary care physician or another physician.

However, we recommend that you always select a primary care physician to coordinate your services with other providers. This will help you identify the medical care you will need to coordinate with other medical specialists and providers of the Participants and Providers Network of Triple-S Salud that are part of the Directory.

You should always visit physicians and providers participating of the Triple-S Salud network so that your services are covered, except in cases of emergency as required by law.

There are also certain rules of the Triple-S Salud plan you should follow so that services are covered, such as: visit to certain providers to receive specific services, precertification for services before receiving them, use of the Drug Formulary, use of a first step therapy drug in the treatment of your condition, and use of physicians and providers in the network, among other rules.

It is important that you familiarize yourself with this Policy/Certificate. This document includes valuable information about your health coverage with Triple-S Salud.

Medically Necessary Services

Triple-S Salud covers the benefits described in this Policy/Certificate, provided they are medically necessary.

Medically necessary services are services or supplies that are necessary for the diagnosis or treatment of your disease, and that comply with the accepted standards of the medical practice.

Please refer to the Appeals section for your right to an appeal of an adverse determination about the benefits of a service deemed not medically necessary.

Medical-Surgical Services during a Hospitalization

Triple-S Salud is committed to pay, based on the fees established for such purposes, for the services covered in this policy that are provided to the member during periods of hospitalization. Only the services of physicians that are normally available in the hospital in which the member is hospitalized will be covered during any period of hospitalization.

No member under this policy, who is hospitalized in a semi-private or private hospital room will be required to pay any amount to a participating physician for the services covered by this policy that the physician renders. The payment of medical fees in these cases will be done by Triple-S Salud directly to the participating physicians based on the fees established for such purposes.

Inpatient Hospital Services

It is a requirement that the member to be admitted by reason of injury or illness, pays to the participating hospital, at the time of admission, the copayment or coinsurance established for the admission. In addition, you must pay copayments or coinsurance for hospital services that apply. This amount will not be refundable by Triple-S Salud.

For the calculation of any hospitalization period, the admission day is counted, but the day in which the patient is discharged by the physician in charge of the case is not counted. Triple-S Salud is not responsible for the services received by any member if he/she stays in the hospital after being discharged by the physician in charge of the case, nor shall be liable for any day or days of pass which are granted to the patient to leave the hospital during the same hospitalization period.

Hospitalization services will be extended in case of maternity or secondary conditions to the pregnancy, only if the member is entitled to the benefit of maternity**. As provided in the Law 248 of August 15, 1999, Law to Guarantee Adequate Care for Mothers and their Newborns during the Post-Partum Period, hospital admissions in the event of a delivery will be covered a minimum of 48 hours in the event of natural childbirth and 96 hours for cesarean delivery unless the physician, after consulting with the mother, orders the hospital discharge for the mother and/or newborn.**

When a member uses a private room at a participating hospital, Triple-S Salud will cover what it would have paid for a semi-private room. The hospital may charge the patient the difference between the normal cost of the private room and the fee established by Triple-S Salud for a semi-private room, except in cases where it is medically necessary and with prior notification to Triple-S Salud.

The other hospitalization costs of the member covered by this policy are included in the contract between the participating hospital and Triple-S Salud and therefore it may not charge any difference to the member. Please verify the table of benefits for any copayments or coinsurance additional to the one for hospital admission.

Participating Providers in our Network

We have a contract with physicians, facilities and providers across the Island to provide services to our members. It is important that you are aware of and access our Providers and Participants Directory at any time.

To find out if a physician or provider is part of our network:

- Verify in the Participants and Providers Directory of the Triple-S Salud Network you may have available.
- Visit our internet portal www.ssspr.com.
- **Access our mobile application** for your Smartphone (Android or Apple), **Triple-S Salud**. Once you complete the registration process, you can access the Provider Directory.

- Call Customer Service at the number listed on the back of the member identification card for questions of a specific provider.

If you want a printed copy or a CD of the Directory, please call Customer Service so that they provide you an updated copy.

Special Contracts for Management

Triple-S Salud may establish a particular contract with any provider for health conditions that require or for which Triple-S Salud requires specialized management in such cases. There are certain conditions which, due to their particular characteristics, require Triple-S Salud to closely review the utilization of the services to prevent insurance fraud or abuse of services. Triple-S Salud policies are aimed at achieving good administration in these particular cases, so as to ensure equal treatment for all members under similar conditions, at the same time ensure cost-effective management. This policy is not construed as an elimination or reduction of the benefits covered under this policy.

Compensation to Network Providers

The services provided by participating providers are paid based on the established fee for each of the services, in accordance with the contract between the Participant and Triple-S Salud. When requesting a service, the member is obligated to show the identification card of the plan that accredits him/her as a person eligible to receive services from the provider. This provides the coverage to which he/she is entitled.

If you need additional information about the fees or rates paid to a participating physician or provider for a specific service, please call Customer Service at the number listed on the back of the member identification card.

Services outside the Network in Puerto Rico

The services covered by this policy that are provided by non-participating physicians or providers of Triple-S Salud, are covered only in cases of emergency as required by law and will be paid directly to the provider based on the contracted fee that would have been paid to a participating provider, after the applicable copayment and/or coinsurance, as provided in the policy.

In the event that the member receives health care services after the emergency services or of post stabilization which would be covered under the health care plan, except for the fact that it is a non-participating provider, Triple-S Salud will reimburse the member based on what is lower between the cost incurred and the fee that it would have paid to a participating provider, after the applicable copayment and/or coinsurance as provided in the policy, as long as that there is a strong medical reason why the patient cannot be transferred to a participating provider.

Under other circumstances, non-participating providers are not covered by this policy. This means that you will be responsible for the total cost of the services received from non-participating providers.

Transition

When a provider is no longer in the Triple-S Salud Network

In case of cancellation of the provider (voluntary or involuntary) or the health plan ceases, the member shall be notified of such cancellation with at least 30 days before the effective date of the cancellation. In the event of cancellation, and subject to the payment of the premium, the member shall be entitled to continue receiving benefits for a 90-day transition period. If the member is hospitalized at the time of the date of cancellation and the discharge date has been scheduled before the termination date, the transition period will be extended 90 days after the date in which he/she is discharged.

In the case of a member during pregnancy and the cancellation occurs in the second trimester, the transition period will be extended until the discharge date of the member after the delivery or the discharge date of the newborn, whichever was last. In case of patients diagnosed with a terminal condition, before the date of termination of the plan and that continue receiving services for that condition before the date of termination of the plan, the transition period is extended during the time remaining of the life of the patient.

New members with an ongoing treatment

If the member is in an ongoing treatment with a non-participating provider when this Policy/Certificate coverage becomes effective, the member can receive covered services for the ongoing treatment with the non-participating provider for a maximum of 60 days from the effective date of the coverage with Triple-S Salud. This course of treatment must be for a disease or condition threatening the life or a condition or degenerative and debilitating disease. The members also may continue with the care of a non-participating provider if the member is in the second or third trimester of the pregnancy, when the coverage of this Policy/Certificate becomes effective. Members may continue with health care up to the date of delivery and any post-partum services directly related to it.

To continue receiving services from a non-participating provider under the circumstances described above, the provider must accept our fees as payment for such services. The provider must also agree to provide the necessary medical information related to the health care of the member and accept our policies and procedures, including those for ensuring the quality of health care, obtaining a precertification and a plan of treatment approved by the Plan. If the provider agrees with these conditions, the member will receive covered services as if they were provided by a participating provider. The member shall be liable only for copayments and coinsurance applicable to his/her coverage.

Your Right to participate in decision making about your treatment

You have the right to participate or that a person that you trust fully participates in the decisions about your health care. This means that you are entitled to receive all the necessary information and available treatment options, costs, risks and chances of success of these options so you can make your decision.

Your physician or health care service provider shall respect and abide by your decisions and treatment preferences.

Our plan may not impose gag clauses, penalties or any other type of clause that interferes with the communication between you and your physician. Your physician(s) or health professional(s) who coordinate your medical care must provide you with the medical order for laboratory tests, x-rays or drugs so you can choose the facility in which you will receive the services.

Emergency Services in Puerto Rico

Triple-S Salud covers emergency services for treatment of an emergency condition in a hospital or an independent emergency room.

"Medical emergency" means: A medical or behavior condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent person with an average knowledge of medicine and health, could infer that the absence of immediate medical attention could endanger seriously the health condition of the person affected by such a condition or, with respect to a member during pregnancy, the health of the member or the fetus, or in the case of a behavior disorder, can put the health condition of such person or others in serious danger; cause problems in the bodily functions of such person; cause serious dysfunction of any organ or part of the body of that person; or serious disfigurement.

For example, an emergency condition may include, but is not limited to, the following conditions:

- Severe pain in the chest

- Serious or multiple injuries
- Severe respiratory difficulty
- A sudden change in mental state (e.g., disorientation)
- Severe bleeding
- Pain or conditions that require immediate attention, such as the heart attack or suspected acute appendicitis
- Poisoning
- Seizures

Coverage of emergency services for the treatment of an emergency condition will be provided to the member regardless of whether the provider is a participating provider. The plan covers emergency services to treat an emergency condition outside the area. However, the plan will cover only those emergency services and supplies that are medically necessary and are performed to treat or stabilize the emergency condition of a member in a hospital.

Visits to a hospital emergency room

In the event that a member requires treatment for an emergency condition, seek immediate attention at the nearest hospital's emergency room or a facility's emergency room, or call the 9-1-1 System. Emergency services do not require precertification. However, only emergency services for treatment of an emergency condition are covered in an emergency room.

We do not cover the follow-up care or routine attention that are rendered in an emergency room of a hospital.

Emergency admissions in hospitals

In the event that a member was admitted as an emergency to the hospital, the member does not have to notify the plan about the admission, except if it is outside of Puerto Rico. In these cases, the member or any another person must notify the plan at the telephone number that appears on the back of the identification card within forty-eight (48) hours following the admission, or as soon as it is reasonably possible.

Emergency Services in the United States

The members have the right to emergency services coverage when they are in the United States.

Triple-S Salud will cover emergency services based on the contracted fees of the Blue Cross Blue Shield Plan of the area, if the provider rendering the services is a participant of the Blue Cross Blue Shield plans network.

If the member has an emergency and uses a non-participating provider, Triple-S Salud will pay:

1. the percent of the fee for non-participating providers established by the local Blue Cross Blue Shield Association plan

2. or the highest among the following three amounts (adjusted to the cost-sharing of the network of participating providers): negotiated fee with participating providers, the amount of the usual, customary and reasonable charge (UCR), or the amount that Medicare would pay.

Urgent Care

Urgent care is the care for an illness, injury, or condition serious enough so that a person may reasonably seek medical care immediately, but it is not so serious to visit an emergency room. Urgent care is usually available at extended hours, including weekends and evenings. Urgent care is covered by the plan:

- **In the network.** The Plan covers urgent care through a physician, medical services clinic or urgent care center.

- **Outside of the Network.** The Plan does not cover urgent care rendered through physicians or providers not participating in the network.

Precertification of Services

There are certain services and medications that require the prior approval of Triple-S Salud before the member can receive them. The member or the provider is responsible for requesting a precertification service. Please refer to the Sections on Precertifications, Procedure for Processing Precertifications and Preauthorizations for Prescription Drugs for a detailed list of services that require a precertification and the process that should be followed by the member or provider to obtain precertification from the plan.

For the services to be considered covered by the plan, the member must comply with the requirement of the prior precertification. In cases in which Triple-S Salud requires precertification or authorization prior to rendering the services, Triple-S Salud will not be responsible for the payment of such services, if they have been provided or received without this precertification or prior authorization by Triple-S Salud.

The member, physician and participating provider will be oriented on hospital admissions requiring precertification or notification within 24 hours or as soon as reasonably possible. Some studies, diagnostic and surgical procedures require a precertification by Triple-S Salud. The member, physician and participating provider will be oriented on the procedures to preauthorize. **Services received as a result of a medical emergency in an Emergency Room will not require precertification from Triple-S Salud.**

Obtain an Updated Copy of the Drugs Formulary

Your medications coverage under this policy is subject to a Drug List or Formulary.

Our Pharmacy and Therapeutics Committee consists of doctors, clinical pharmacists and other health professionals, who meet regularly to evaluate and select those medications that will be included in the List, following a rigorous clinical evaluation process.

This Drug List or Formulary is printed once a year, but regular revisions are made to include new medications after the Committee approves them.

We will notify changes to all members, physicians, dentists and participating pharmacies, no later than the effective date of the change. In the case of inclusion of new prescription medications in the Drug List or Formulary, we will notify them thirty (30) days prior to the effective date of inclusion.

Please call Customer Service if you want an updated copy of the List or Formulary.

Specialty Prescription Drugs Management Program

The Specialty Prescription Drugs Management Program is a program coordinated exclusively through participating pharmacies of the Exclusive Specialty Pharmacy Network of Triple-S Salud. The purpose of this program is to help members who have chronic and high risk conditions that require the administration of specialized medications to receive a fully integrated clinical management of the condition.

Some of the medical conditions or medications that require management through the Specialized Medications Management Program are the following:[1]

- ✓ Cancer (oral treatment)
- ✓ Antihemophilic Factor
- ✓ Crohn's Disease
- ✓ Erythropoietin (Deficiency in the blood cells)
- ✓ Cystic Fibrosis
- ✓ Hepatitis C
- ✓ Rheumatoid Arthritis
- ✓ Multiple Sclerosis
- ✓ Gaucher's Disease
- ✓ Pulmonary Hypertension
- ✓ Osteoporosis
- ✓ Osteoarthritis
- ✓ Psoriasis

Among the services that the program includes are the following:

- An evaluation that allows to identify particular needs that the patient may have with regard to the use of his/her medication.
- Clinical interventions that include, among others:
    - Coordination of patient's care with his/her physician
    - Personalized education for the patient and caregivers according to the condition
    - Management and coordination of preauthorization of medications
    - Monitoring of signs and symptoms of the condition
    - Monitoring of adherence to therapy
    - Appropriate utilization of medications
    - Optimization of dosage
    - Drug to drug interactions
    - Management of side effects
    - Coordination of refills
    - Assistance through staff specialized in the condition
    - Ease of delivery of medications at the patient's preferred address
    - Access to pharmaceutical personnel 24 hours per day, 7 days per week
    - Education material about the condition

For information on participating pharmacies of the Exclusive Specialty Pharmacy Network, please refer to the Participants and Providers Directory of Triple-S Salud, visit our internet website at www.ssspr.com or call Customer Service.

Programs for the Extended Supply of Maintenance Prescription Drugs

Triple-S Salud offers programs for 90-day supply on some maintenance medications. The members of Triple-S Salud will have the flexibility to select their preferred option to receive some maintenance medications through pharmacies participating of the Flex 90® Program or in the comfort of their own home by registering in the Express Pharmacy Program (Mail Order) of Triple-S Salud.

- **Flex90®:** This program of extended supply allows the member to obtain a 90-day supply of some maintenance medications through its participating pharmacies. The Program has over 900 pharmacies around the Island which include chains pharmacies (Walgreens, Kmart, Walmart, Sam's, Costco, Farmacias Plaza and community independent pharmacies).

- **Express Pharmacy Program of Triple-S Salud (Mail Order):** Under this program, the member will receive a 90-day supply of his/her maintenance prescription drugs in his home or another place of preference and may order refills of his medications by mail or by phone. In addition,

[1] Some medications to treat these conditions could be excluded from your pharmacy coverage.

shipping of the medications is free of charge and the member obtains savings in his copayments. **To receive information and register in the Mail Order Program please call 1-866-881-6221.**

Clinical Management

The benefits that this Policy/Certificate offers are subject to precertification, concurrent and retrospective reviews to determine when those services must be covered by the plan. The objective of these reviews is to promote the provision of medical care in a cost-effective way through the utilization review of the medical procedures and, in his case, the level or provider that will render the service. Covered services must be medically necessary to be deemed covered by the plan.

Case Management

The Case Management Program helps to coordinate services for members with health care needs due to serious, complex and/or chronic health conditions such as:

- HIV or AIDS
- Cerebrovascular Diseases
- Cancer in continuous chemotherapy treatment or terminal phase
- Degenerative diseases such as multiple sclerosis
- Premature babies with genetic defects
- Patients that depend of the mechanical ventilation
- Patients requiring intravenous antibiotics or hyperalimentation
- Organ and tissue transplants, including bone marrow
- High risk pregnancy
- Mental illness and substance abuse

Our program is confidential and voluntary. In addition, it will help the member who participates in the program to coordinate his benefits and educate him to satisfy his health care related needs.

A member can be referred to the program by a physician, social worker, hospital, discharge planner, a relative or on his own, as well as other sources.

Eligibility to participate in the program will depend on the existence of effective options for the treatment of the health condition of the member. These may include: home health services, durable medical equipment or admission to a specialized care center and other services.

If the member meets the criteria of the program and agrees to participate, a group of nurses, physicians and a social worker with extensive clinical experience, will evaluate the health needs of the member and will determine the available alternatives of care. Coordination is based on the recommendations of the primary care physician or physician of the member. When the member is accepted into the program, the case manager will coordinate services and will follow-up through phone calls and personal visits.

These programs are given free of charge to the member and do not change the services covered by the policy. For additional information please call 787-277-6544, 787-749-4949, extensions 4312, 4265, 4355 or 1-800-981-4860 only in Puerto Rico.

Your coverage when you participate in a Clinical Trial

If you participate in a clinical trial, below you will find what the plan covers and does not cover.

Remember, this applies when you have registered in a trial or study to treat a disease that threatens your life, for which there is not an effective treatment and you obtain the approval of the physician for your participation in the study, because it offers a potential benefit.

Our plan covers:

Routine medical expenses for the patient according to the categories of services covered, limits and other conditions set forth in the policy. These are costs that are normally available whether or not you are participating in a clinical trial. This includes services to diagnose and treat complications resulting from the study.

Our plan does not cover:

- Expenses for studies or clinical treatment research (clinical trials)
- Devices, experimental or investigative medications administered to be used as part of these studies
- Services or products that are provided for obtaining data and analysis, and not for the direct management of the patient
- Items or services without cost to the member that the sponsor of the research commonly offers.

Program for Management of Populations with Specific Diseases

This program offers guidance and follow-up to our members to optimize their quality of life and ensure adequate management of their health condition to avoid risks and prevent complications.

- **Diabetes Program:** Members receive educational orientations for diabetic members from 18 years of age and up. In the workshops and telephone calls, topics such as what is diabetes, emotional aspects, exercise, nutrition, medications and prevention of complications, among others, are discussed.

- **Asthma Program:** With the help of clinical management staff, educators and therapists, the members between the ages of 5 to 56 years who suffer from asthma receive information about their condition and factors that can cause asthma attacks, symptoms, warning signs and medications to establish strategies to control it.

- **Hypertension Program:** Members over the age of 18 suffering from hypertension (high or uncontrolled blood pressure) benefit from educational activities offered by this program. They learn what hypertension is, its signs or symptoms, lifestyle modification and how to control their blood pressure.

- **Heart Failure Program:** Members over the age of 19 years who suffer from cardiac failure (heart disease that causes the pumping of blood to the body to be abnormal) receive educational material and orientation from the nurses on how to take care of themselves and thus feel better. The members whose condition is not severe will be invited by the health educators for educational activities. This will help them manage their condition, prevent complications and improve their quality of life.

- **COPD Program:** Members over the age of 40 with the condition of COPD (Chronic Obstructive Pulmonary Disease) receive guidance about their condition, use of medications to control it, signs and symptoms of complications and the importance of medical follow-up. Our health professionals help the participants to become familiar with their condition and adopt healthy lifestyles to prevent complications and enjoy a better quality of life.

- **Prenatal Program:** The Prenatal Program educates members about the importance of early prenatal care and on risk factors that they must take into account. Members during their pregnancy receive educational brochures about the pregnancy and baby care. They also receive orientation by phone from a specialist in clinical management in the prenatal area and guidance in educational workshops offered by health educators.

- **"Living without Smoke" Program:** The program consists of offering guidance and general education about the effects of smoking on health and the benefits of modifying and/or eliminating this addiction. It is aimed at people who suffer from chronic conditions and those who want to stop this addiction. The Program is offered free of charge to members.

For more information on population management programs you can call 1-866-788-6770.

Preventive Centers Program

Through this program, you can obtain its services in the participating Centers, in the same visit without the need for long waits. The member shall coordinate the appointment with the participating Center of his interest, to receive the services provided in his policy in the Section of Preventive Services Coverage. It also includes an initial evaluation and subsequent to the tests performed.

The program is only available through facilities participating in the Program. Please refer to the Participants and Providers Directory of Triple-S Salud for a list of Preventive Centers participating in the program, visit our website www.ssspr.com, our mobile application or call Customer Service for information about a Center near you.

Triple-S Natural

Triple-S Natural is a program that allows you to receive medical services using a model of integrated medicine, which incorporates complementary techniques and treatments validated by the National Health Institutes of the United States and recognized international bodies.

The Triple-S Natural Program integrates the specialties of conventional and complementary medicine such as:

- **Conventional Primary Medicine:** Conventional healthcare offered by specialists in Family Medicine, Chinese Medicine and Acupuncture.

- **Integral and Complementary Health:** It is the use of conventional medicine, in conjunction with therapies, treatments, modalities and therapeutic approaches, both based on the scientific method, that are conducive to the optimal state of health of a person, even within the limitations that a health condition may present. Its objective is the prevention of the disease and before the occurrence of this, the coordinated intervention of this set of therapies that can re-establish the physical, mental and spiritual health of the person.

- **Medical Acupuncture:** Acupuncture uses as a basis the body's ability to regenerate and heal through the stimuli produced by the insertion and manipulation of needles or other instrumentation at certain points in the skin. These points have been clinically defined with therapeutic purposes.

- **Therapeutic Massage:** The massage has as a basis the conception of the human being as a total and sees the disease as the rupture of the constant flow of energy, nutrient and well-being that ensure the optimal state of health of the person. Through a combination of specialized techniques, the hands, elbows and some auxiliary instruments are used which facilitate the activation of the blood flow and energy needed for the reconstruction of the patient.

- **Naturopathic Medicine:** It is the system of care practiced by a Doctor of Naturopathy for the prevention, diagnosis and treatment of health conditions through the use of natural medicine, therapies and education to the patient to maintain and stimulate the intrinsic system of self-healing of each individual.

- **Bioenergetic Medicine (Pranic Healing):** Treatment of different health conditions by balancing the vital energy that surrounds or that our body has internally. This therapeutic method uses as a principle that the body has an energy that gives it life and which many scientists call

electromagnetic energy or bioenergy. The therapist provides energy to the patient with the primary purpose of improving the general state of the patient.

- **Botanical Medicine:** It is the use of plants or their derivatives, with medicinal properties, for the treatment of diseases. This has different forms of application, whether in the form of teas, infusions, capsules, injections, dyes, suppositories, compresses, baths or creams. It is also known as herbology or phytotherapy.

- **Aromatherapy**: It uses the therapeutic, psychological and physiological properties of pure essential oils through different methods of use as: inhalations, diffusers, compresses, aromatherapy massage and mud poultices (in specific zones) to achieve the balance between the body, the mind, the spirit and achieve health.

- **Music Therapy:** Uses the music for a therapeutic purpose. Specialty oriented to the opening of the channels of communication by means of the sound, the rhythm, the gesture, the movement and the silence, at a psychological, physical and cognitive level. Music therapy has a wide application to mental conditions, addictions, depression, hyper or hypoactivity, among others.

- **Hypnotherapy:** Medical treatment technique that uses a special state of sleep, and an active sleep where some of the active foci of the brain can be inhibited in a partial way, as opposed to the regular dream where the brain is inhibited in a generalized way to treat some emotional and physical conditions.

- **Traditional Chinese Medicine:** Group of healing techniques and methods that follow the principles of healing of the traditional Chinese medicine. This healing system has different modalities as the stimulation of the acupuncture points through different techniques such as needles, laser, electricity, heat (moxibustion), massages (acupressure), magnets, techniques of bleeding, injections, auriculotherapy, skull acupuncture, Chinese herbs, Oriental nutrition and feeding, Oriental massage and exercises (Qi gong, Tai-chi).

- **Chiropractic**: Is based in the concept that the vital energy of the human being passes through the spinal column and that any alteration in this energy flow causes the pathology that degenerates in disease. The chiropractor through spinal adjustment techniques, restores the normal flow of energy, up to the total or partial disappearance of the symptoms of the patient.
- **Reflexology**: It is a specialized technique that aims to offer treatment for various health conditions through the activation of acupressure points on feet and hands. Such technique has as basis the use of body maps with the acupuncture points of the traditional Chinese medicine.

- **Clinical Nutrition:** It is the extension of supplement food as vitamins and minerals orally or injecting to treat different diseases.

The member will be responsible to pay the established copayment which is presented in the table of benefits.

The program is only available through facilities participating in the Program. Please refer to the Participating Providers Directory of Triple-S Salud for a list of providers participating in the program, visit our website at www.ssspr.com, our mobile application or call Customer Service for a participating provider near you.

TELECONSULTA[2]

It is the Health Orientation Telephone Line, available **24** hours a day, **7** days a week 365 days a year.

Our members have phone access to medical information 24 hours a day, 7 days a week. This program is attended by qualified clinical personnel, which offer you help and guidance about your condition. These professionals assess the symptoms of the member to determine the most appropriate treatment.

If you feel **ill**, are **injured** or **need health advice**, the professional nurses will offer you advice so you decide if you should:

- Make a medical appointment,
- visit an emergency room,
- or they will give you indications to relieve the symptoms that you present in a safe and reliable way, in the comfort of your home.

Teleconsulta offers you as benefit that if the recommendation of the professional nurse is "visit an Emergency Room" you will be given a number; which will exonerate you or will reduce the copayment/coinsurance of the Emergency Room (available only in Puerto Rico and depends on what your policy / certificate of benefits stipulates). This does not apply to accidents cases. If a non-participating provider cannot process the number for the exemption or reduction of copayment/coinsurance on his system, the member will pay it and will request reimbursement to Triple-S Salud for the amount that would have been exempted or reduced.

The call to Teleconsulta is **free of charge** through **1-800-255-4375**. You can call from any point of the Island or from the United States. Look for the phone number on the back of your Health Insurance Card of Triple-S Salud, and remember when you call **Teleconsulta** to always have your Health Insurance card on hand.

Tool for Health Risk Assessment (HRA)

We have developed a tool (HRA) that evaluates lifestyles, risk factors and existing conditions, among others. This tool will help us to have a clear profile of our member population and will help us to determine where to direct our health education and prevention strategies.

The tool will also help the member to make a self-assessment to know where they are in terms of compliance with the preventive tests, the changes that they need to do, and have greater awareness to prevent health problems in the future. Register today on our portal www.ssspr.com and complete your questionnaire. Stay active, stay healthy!

Educational materials on the Internet Portal

Search Our Blog Section on our website www.ssspr.com for health and wellness information for members.

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[2] Teleconsulta is an exclusive service of Triple-S Salud for its members, which is managed by Axis Point Health, an independent contractor of telephone guidance and health information services.

Satisfaction Surveys

The opinion of our members counts.

Triple-S Salud periodically performs surveys to its members to measure their satisfaction with the plan at a general level and the care provided by the providers of its network. These studies are conducted with organizations independent to Triple-S Salud. The results of the survey are used by Triple-S Salud for its continuous efforts to improve the general experience of the member with the health plan, including the service experience and quality of care.

A summary of the results of the latest survey is available on our website www.ssspr.com. For detailed information and results of the most recent customer satisfaction survey, please call Customer Service.

Benefits not covered by the plan

Your physician could recommend you medical services, treatments or medications that your policy with Triple-S Salud does not cover. If you receive non-emergency services and your policy of Triple-S Salud does not cover them, you will be responsible for payment in full for the services provided or dispensed medications.

We recommend that you verify the Exclusions Sections in your policy/certificate of benefits before receiving the medical service, treatment or medication, as well as any rider that is added to verify if it is covered or not. Also, we recommend you to explore with your physician or service provider treatment alternatives that are covered under the plan to reduce your expenses or coverage options under programs with other organizations that can provide you additional help.

Previous Instructions or Advanced Directives

Advance directives or the prior declaration of will on medical treatments are legal documents that allow any person of age (21 years or older) in full use of his mental faculties, to express in writing his decisions about the care and medical treatment he wishes to receive in case of a health condition that would not allow him to express himself during the treatment. It also provides greater control about crucial matters in his quality of life, providing the essential information to the family, friends and doctors that they need to take care of him. It is legally required for physicians and other health professionals to follow the directives. In accordance with the provisions of law, you cannot be denied care or be discriminated based on whether you have signed or not an advance directive.

In the case of a disease that incapacitated you to communicate, the decisions regarding your health will be taken by another person and not always in accordance to what you would have desired.

According to the laws in Puerto Rico, the closest relative of legal age, taking the first place the spouse of the declarant, is considered the one that makes the decisions about acceptance or rejection of medical treatment. Hence it is important to take a few moments to write your advanced directives.

For more information on Advance Directives visit our internet portal at www.ssspr.com or call Customer Service at the number that appears on the back of the member card.

Informed decisions about your health care

You can play an active role in your health care. Clear and honest communication between you and your physician or service provider can help you both to make smart decisions about your health and your treatment. It is important to have an open dialogue about your symptoms, condition and concerns about your treatment. Here are some questions that you should ask your physician to ensure that you understand your diagnosis, treatment alternative and recovery.

- What is my diagnosis?
- What caused this problem?
- What is the adequate treatment? What are the estimated costs?
- When will I begin my treatment and how long will it last?
- What are the benefits of this treatment and how much success does it usually have?
- What are the risks and side effects associated with this treatment?
- Is there any food, medication or activity that I should avoid while I am following the treatment plan?
- What medications will I take before, during and after treatment?

Ask for a cost estimate. After your physician gives you all the details of your condition and treatment alternatives, call Triple-S Salud to confirm how much your disbursements will be for the treatment of your condition.

We can help you if you have a condition for which we can offer assistance and more cost-effective alternatives for you.

Maximize you plan benefits

Take advantage to the maximum of your health benefits according to the following recommendations:

Avoid using the emergency room for services which are urgent or routine and are not an emergency. The visit to the emergency room in these cases can result in higher costs for the health plan and higher disbursements for you compared to a medical visit. Please check the following examples:

Services that are not an emergency **You should call your physician or visit a clinic**	**Emergency** **Visit the closest emergency room or call the 9-1-1 System**
Mild throat pain Earache Mild cuts or scrapes Mild sprains or tears Fever under 103 F° Cold or flu	Broken bones or serious tears / Deep cuts or Uncontrolled bleeding / Poisoning / Severe burns / Chest pain or intense and sudden pain / Fever over 103 F° / Coughing or vomiting with blood / Sudden dizziness, weakness, loss of coordination or balance, or loss of consciousness / numbness of the face, arm or leg / Seizures / Difficulty to breathe / Sudden blurred vision or sudden or unusual headache

Remember, if you feel **sick**, are **injured**, or **need health advice**, **call Teleconsulta**. The nursing professionals will offer you advice to decide if you should:

- make a medical appointment,
- visit an emergency room,
- or they will give you indications to relieve the symptoms that you present in a safe and reliable way, in the comfort of your home

- Visit a general practitioner or primary care physician instead of visiting multiple medical specialists to diagnose and treat a condition properly.

  A general practitioner or primary care physician can be an Internal Medicine Specialist, Family Medicine Specialist, General Practitioner, Pediatrician, Gynecologist or Geriatrician. He will coordinate the necessary and preventive services according to your age and health condition in

addition to the necessary health care with the medical specialists and other providers of the Triple-S Salud network.

Your general practitioner or primary care physician will know all about your health and will keep a record of your health condition.

Remember that you do not need referrals to receive services covered from any provider of the Triple-S Salud network.

- Use generic medications as first choice provided that they are available for the treatment of your condition.

    - A generic medication is a copy of a brand medication whose patent has expired. The patent is what provides the pharmaceutical company the sole right to sell the medication while it is effective. When the patent expires, the companies can sell generic versions of the available brand medication.

    - A generic medication has the same use and works in the same way in the body than brand-name drugs. In addition, it has the same active ingredient, it is equal in dosage, safety and quality, by requirement of the Food and Drug Administration (FDA).

    - On the other hand, generic medications can mean savings for your wallet, since they cost much less than the brand name. In addition, copayments or coinsurance for generic medications are usually less. Please note that, if you are using a brand-name medication for which there is a generic available, you can be receiving the same benefits at a lower cost.

- Use Over the Counter (OTC) medications under the Triple-S Salud program that have $0 copayment. The list includes medications for stomach conditions, allergies and eye drops that have demonstrated to be safe and effective, and that also represent a lower cost for the health plan. Remember that you have to submit a prescription from the physician for the OTC medication.

- Evaluate with your physician the medications that are part of your treatment and are included in our Formulary or Drug List. Use the Preferred Drugs List which are cost-effective and already tested for the treatment of conditions. In addition, they have been selected by the Pharmacy and Therapeutics Committee for their effectiveness. You will have higher disbursements when using medications that are not preferred. Verify your coverage description and the table of benefits to see how much is your disbursement by concept of copayments and coinsurance.

- Use your coverage of preventive services to detect conditions in time.

  Our plan offers all the preventive services required by law without any cost for you. This means that you do not pay anything out-of-pocket for services like annual physical exams and preventive gynecological appointments, mammograms and other tests, vaccinations and much more. These are important steps to stay healthy, so you should take advantage of this to detect any health condition in time.

- Reduce your disbursements significantly using always providers from the network. Triple-S Salud provides a wide network of providers in and outside Puerto Rico. Remember that our plan covers non-participating providers only in emergency cases. This means that for services that are not emergency, you will be responsible for the total cost of the service received from the non-participating provider.

- If you have additional health insurance, report it to Triple-S Salud and your other plan so that you coordinate benefits between both plans. Please refer to the Coordination of Benefits Section below for more information on the rules to determine which plan will be primary.

Coordination of Benefits (COB)

When a member is covered by two or more plans, the rules for determining the order in which plans have to pay benefits, will be as follows:

a. 1) The primary plan will pay its benefits as if the secondary plan did not exist.

2) If the primary plan was a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan will pay its benefits as if it were the primary plan when the member receives services from a provider outside the panel, except in emergency cases or in cases of authorized referrals that are provided by the primary plan.

3) When there are multiple contracts that provide coordinated coverages and which are treated as the same plan for the purpose of this rule, this section shall apply only to the plan as a whole, and the coordination between contracts components shall be governed by their terms. If more than one contractor pays or provides benefits under the plan, the contractor that is designated as the primary payer within the plan will be responsible for the compliance of the whole plan with this section.

4) If a person is insured by more than one secondary plan, these rules will also apply to the order in which secondary plans will pay their benefits between one and the other. Each secondary plan shall take into consideration the benefits of the primary plan and the benefits of any other plan that has been appointed to pay first under these rules.

b. 1) Except for what is provided later in the paragraph (2), a plan that has not provided an order of coordination of benefits consistent with this section will be deemed as a primary plan, unless the provisions of both plans, regardless of what is indicated in this paragraph, establish that the plan that has provided an order of coordination of benefits is the primary.

2) A group coverage designed to complement a part of a basic benefits package can provide that the complementary coverage be the excess to any of other parts of the plan provided by the same contract or policy. An example of this are major medical expenses coverages and the coverages specifically designed to cover services provided by non-participating providers in a closed panel plan.

c. A plan may only take into account the benefits paid by another plan when under these rules is a secondary payer to the other plan.

d. Order of Determination of Benefits

Each plan will determine its benefits using the first of the following rules that apply:

1) Non-dependent or dependent

a) Except for what is provided in subparagraph (b) of this paragraph, the plan that covers a person as non-dependent (for example, the plan that covers a person as an employee, member, subscriber, policyholder, or retired) is the primary plan and the plan that covers the person as dependent is the secondary plan.

b) (i) If the person is a Medicare beneficiary and as result of the provisions of the Title XVIII of the Social Security Law and their regulations, Medicare is:

(I) Secondary to the plan that covers the person as a dependent; and

(II) Primary to the plan that covers the person as non-dependent

(ii) Then the order of benefits is reversed, in such way that the plan that covers the person as non-dependent will be secondary and the other plan that covers the person as dependent will be primary.

2) Dependent Child Covered under More than One Plan

Unless there is a court order that says otherwise, the plans that cover a dependent child will pay their benefits in the following order:

a) In the case of a dependent child whose parents are married or are living together even though they have never married:

(i) The plan of the parent whose birthday is the first in a calendar year will be the primary plan; or
(ii) If both parents have their birthday on the same day of the year, the plan that has covered one of the parents for the longest period of time will be the primary plan.

b) In the case of a dependent child whose parents are divorced or separated or are not living together although they have never married:

(i) If a court order provides that one of the parents will be responsible for the medical expenses of the dependent child or to provide the child with a health plan, and the plan of said parent has knowledge of the that decree, that plan will be primary. If the parent with this responsibility does not have a medical plan that covers the expenses of the dependent child, but the spouse of that parent has such a plan, the plan of the spouse of the parent with responsibility will be the primary plan. This provision shall not apply with respect to any year in which services were paid or supplied before this plan is aware of the relevant court order.

(ii) If a court order provides that both parents are responsible for the medical expenses of the dependent child or to provide him a medical plan, the rules established in subparagraph (a) of this paragraph will determine the order of the benefits.

(iii) If a court order provides that the parents have joint custody without specifying that one of them will be responsible for the medical expenses of the dependent child or to provide a health plan, the rules established in subparagraph (a) of this paragraph will determine the order of the benefits.

(iv) If there is not a court order assigning responsibility to one of the parents for medical expenses of the dependent child or to provide a health plan, then the order of benefits will be determined as follows:

I. The plan that covers the custodial parent;

II. The plan that covers the spouse of the custodial parent;

III. The plan that covers the non-custodial parent; and finally

IV. The plan that covers the spouse of the non-custodial parent.

c) For a minor covered as dependent under more than one plan of people that are not parents of said minor, the order of the benefits will be determined under subparagraphs (a) or (b) of this paragraph, as applicable, as if such people were the parents of said minor.

d)

i. For a dependent child who is covered under the plan of one or both parents and also has his own coverage as a dependent under the plan of a spouse, the rule of paragraph (5) applies.

ii. For the coverage of the minor dependent child under the plan of a spouse which began on the same date as the coverage under one or the plans of both parents, the order of the benefits will be determined through the application of the birthday rule in paragraph (a), the parent(s) of the minor dependent(s) and the dependent spouse.

3) Active Employee or Retired or Former Employee

a) The plan that covers a person as an active employee, that is an employee who is not a former employee or retired, or as a dependent of an active employee will be the primary plan. The plan that covers a person as a retired or former employee, or dependent of a retired employee or a former employee is the secondary plan.

b) If the other plan does not have this rule, and as a result, the plans are not in agreement in the order in which benefits are payable, this rule will be ignored.

c) This rule shall not apply if the rule in Paragraph (1) can determine the order of the benefits.

4) COBRA or Extensions of Coverage Under State Law

a) If a person who has an extended coverage under the COBRA Law or an extended coverage under other similar federal or state law also has a coverage under another plan, the plan that covers such person as an employee, member, subscriber or retired, or that covers such person as a dependent of an employee, member, subscriber or retired, will be the primary plan, and the plan that covers that person under the COBRA Law or under an extension of coverage under other similar federal or state law will be the secondary plan.

b) If the other plan does not have this rule, and the plans do not agree in the order in which the benefits must be paid, this rule will be ignored.

c) This rule shall not apply if the rule in paragraph (1) can determine the order of the benefits.

5) Longer or Shorter Coverage Time

a) If none of the previous rules determines the order of the benefits, the plan that has covered the person insured for the longest period of time will be the primary plan and the plan that has covered the person for the shortest period of time will be the secondary plan.

b) To determine the period of time that a person has been covered under a plan, two successive plans will be treated as one only if the person was eligible to participate of the second plan within a period of twenty-four (24) hours after the termination of the first plan.

c) The beginning of a new plan does not include:

i. A change in the amount or scope of the benefits of the plan;
ii. A change in the entity that pays, provides or administers the benefits of the plan; or
iii. A change in the type of plan, as for example, from a single employer plan to a multiple employers' plan.

d) The period of time that a person has been covered under a plan is measured from the date the coverage of that person began under this plan. If we could not determine such date in the case of a group plan, the date in which the person became a member of the group for the first time will be used to determine the period of time in which the person has been covered under the group plan.

6) If none of the previous rules determines the order of the benefits, those expenses will be shared by the plans in equal parts.

If you are covered by more than one medical plan, you must submit all your claims to each one of your plans.

COVERAGE OF SERVICES BY LOCAL OR FEDERAL LAW

This policy provides all the coverages offered in it to any member, including those with diagnosis of HIV or AIDS, with physical or mental disability. In addition, it does not limit the coverage or denies a claim based on the situation of victim of abuse of the member.

The preventive screening services, according to the preschool age of the minor, required by Law 296 of September 1, 2000 and in conformity with the Normative Letter N-AV-7-8-2001 of July 6, 2001 are covered by this policy. These services include the general physical examination, vision and hearing screening, clinical laboratory tests (including the tuberculin test), psychological tests and assessments of psychosocial screening, asthma and epilepsy screening, according to the standards in force established by the Department of Health, Medicaid Program, Program of Mothers, Children and Adolescents and the American Academy of Pediatrics.

PREVENTIVE SERVICES COVERAGE

This policy covers the preventive services required by the federal laws Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA) and the Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152 (HCERA) and as established by the United States Preventive Services Task Force (USPSTF). The preventive care services that are detailed below, are included in the basic coverage and have $0 copayment or 0% coinsurance provided they are offered through participating physicians and providers in Puerto Rico. In addition, you can access this list, as well as additional information on these services, through the following link on the internet: https://www.healthcare.gov/coverage/preventive-care-benefits/.

PREVENTIVE SERVICES FOR MINORS

Preventive medicine services for minors normally include in the visit: history, measures, sensory screening, development / behavior evaluation, physical examination, anticipatory guides (such as nutritional counseling) and dental referrals, among others. Also, the minor has the following services available according to the age and other guidelines established as indicated below:

Preventive Service	**Indication**
Alcohol and drugs use	Evaluation to identify the use of alcohol and drugs.
Autism Screening	For minors between 12 and 36 months of age.
Behavioral health evaluation	Minors: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years.
Blood pressure screening	Minors: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years.
Cervical displacement	Screening for sexually active minors.
Congenital hypothyroidism	Screening for newborns.
Depression screening in adolescents	Screening for depression disorders in adolescents of 12-18 years to establish a system that can diagnose properly the necessary treatment, including psychotherapies and follow-up visits.
Development screening	Screening for children under 3 years of age and monitoring during all childhood.
Dyslipidemia	Screening for minors at risk of lipids disorders. Ages: 1-4 years, 5-10 years, 11-14 years, 15-17 years.
Prevention of dental cavities: Oral fluoride supplements	Oral Fluoride Supplements - Preschool from six (6) months to five (5) years of age.
Gonorrhea	Preventive medication for the eyes of the newborn.
Hearing screening	Universal Neonatal Hearing Screening.
Screening of growth in height, weight, and body mass index	Screening for the following ages: 0-11 months, 1-4 years, 5 -10 years, 11 - 14 years, 15 - 17 years.
Hematocrits or hemoglobin	Screening for minors.
Sickle cells disease	Screening for newborns.
Human Immunodeficiency Virus (HIV) screening test	Screening for high risk adolescents.
Iron supplements	For infants ages 6-12 months at the risk of anemia.
Lead screening	Screening for minors from 1 to 5 years of age with a high concentration of lead in the blood, regardless to whether or not they are high risk, and screening to members during their pregnancy.
Medical history	For any minor during development: Ages 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years.
Obesity	Obesity screening for children from 6 years onwards and comprehensive counseling, intensive interventions of behavior to promote improvement in the weight of the minor.

Preventive Service	Indication
Oral health	Risk assessment for newborns up to 10 years of age.
Phenylketonuria (PKU)	Screening in newborns for genetic disorders.
Sexually transmitted disease	Prevention counseling and screening for adolescents at risk.
Tuberculin	Tuberculin test for minors at risk for tuberculosis from 0 to 17 years of age.
Vision	Screening of vision at least one (1) time between 3 and 5 years of age to detect amblyopia and its risks.
Skin cancer	Counseling to minors, adolescents and young adults between 10 to 24 years of age who have clear skin to minimize their exposure to ultraviolet radiation and reduce the risk of skin cancer.
Behavior screening	For minors of all ages.
Tobacco use	Interventions, including education and counseling, for minors and adolescents to cease the use of tobacco.

PREVENTIVE SERVICES FOR ADULTS

Preventive Service	Indication
Screening of abdominal aortic aneurysm (AAA)	One (1) service for ultrasonography for the screening of the AAA in members from 65 to 75 years of age who are smokers or who have been smoking at some point.
Alcohol abuse	Screening and counseling on alcohol abuse.
Counseling and supply of aspirin to prevent the risk of cardiovascular diseases and colorectal cancer.	For adults between 50 to 59 years of age as primary prevention of cardiovascular diseases and colorectal cancer.
Hypertension screening (HBP)	High blood pressure screening for adults 18 years of age and above.
Cholesterol screening	Screening of cholesterol or lipids disorder for men between 20 to 35 years of age, if they are at high risk of coronary cardiovascular disease; men 35 years of age or older; women 20 to 45 years and 45 years of age or older, if they are at high risk of coronary cardiovascular disease.
Colorectal cancer screening	Occult blood test for colorectal cancer screening; sigmoidoscopy or colonoscopy in adults starting at the age of 50 years up to the age of 75.
Depression Screening	Evaluation for depression screening. It applies to adults who think that are depressed, including members during their pregnancy or post-partum. The screening must implement adequate systems of diagnosis, effective treatment and appropriate follow-up visits.

Preventive Service	Indication
Diabetes screening	Screening for abnormal blood sugar levels as part of the evaluation of cardiovascular risk in adults between the ages of 40 to 70 years with overweight or obesity, including intensive behavioral counseling to promote a healthy diet and physical activity.
Diet	Counseling for adults at risk for chronic diseases.
Human Immunodeficiency Virus (HIV) screening test	Screening for Human Immunodeficiency Virus (HIV) for adults up to 65 years of age and older that are in high risk.
Obesity	Counseling and screening for all adults. Physicians may provide or refer patients to intensive behavioral interventions of multiple components, to those patients who have a Body Mass Index (BMI), of 30 kg/m2 or more.
Sexually transmitted diseases	High-intensity behavioral counseling to prevent sexually transmitted diseases for sexually active adolescents and adults with a high risk to get associated diseases.
Tobacco use	Screening for all adults and interventions to stop the use of tobacco. For those that use the products to cease the use of tobacco, this plan covers the dispensing of medications to cease smoking approved by the Food and Drugs Administration (FDA) for ninety (90) consecutive days in an attempt and up to two (2) attempts per year.
Syphilis	Screening for syphilis in adults at high risk.
Bacteriuria (or infection in the urinary tract)	Screening for members during their pregnancy who show symptoms of bacteria in urine culture, between 12-16 weeks of pregnancy, or at the first prenatal visit, if it is after that term of pregnancy.
Hepatitis B Virus	Screening for adults at high risk of infection.
Lung cancer	Annual screening for lung cancer through computerized tomography for adults between the ages of 55 to 80 years with a smoking history of 30 years or more, who currently smokes or who has stopped smoking during the last 15 years.
Hepatitis C Virus	Screening for adults at high risk of infection of (HVC). Recommended for adults born between 1945 and 1965.
Fall prevention and recommendation of the use of vitamin D	Screening for adults for exercises and physical therapy to prevent falls in adults 65 years of age and older with risk of suffering falls. The use of vitamin D is recommended as a supplement to prevent the risk of falls.

Preventive Service	Indication
Healthy diet and physical activity and prevention of cardiovascular disease	Offering and referral of adults with overweight and obesity for intensive behavioral counseling to promote a healthy diet and physical activity as prevention of cardiovascular diseases.

PREVENTIVE SERVICES FOR ADULTS, INCLUDING PREGNANCIES

Preventive Service	Indication
Anemia	Routine screening of iron deficiency to members showing symptoms during pregnancy.
BRCA	Screening and counseling on genetic tests through tools that identify family history of breast cancer, ovarian cancer, cancer in the tubes, or peritoneal cancer. After being identified as high risk to a genetic mutation (BRCA1 and BRCA2), the provider will determine if the member merits to do a BRCA test.
Preventive medications for breast cancer	Clinical guidance to patients at high risk of developing breast cancer, allowing them to decide with their doctor if medication therapy is appropriate to reduce the risk of developing the disease. The physician may prescribe medications to reduce the risk of developing breast cancer, as tamoxifen or raloxifene, for patients that are found in high risk of developing the disease and that have a low risk of adverse reactions to medications.
Breast cancer screening mammography	Every one (1) or two (2) years for members over the age of 40, biannual for members between 50 and 75 years of age.
Discussion of preventive medication for breast cancer	Counseling for high-risk members.
Breastfeeding	Support and counseling through a provider trained in nursing (Pediatrician, Obstetrician/Gynecologist, Family Doctor) during pregnancy and/or the postpartum period. The breastfeeding equipment is covered with medical order after the third trimester of pregnancy and until the first year after the delivery. The additional supplies for a breastfeeding machine are covered and the equipment is available through contracted providers.
Cervical cancer screening	Screening for members who are sexually active. Members between 21 and 65 years of age must do the Papanicolaou test every three (3) years or for members between 30 to 65 years of age who want to do the test less frequently in combination with a Human Papilloma Virus (HPV) test every five (5) years.

Preventive Service	Indication
Chlamydia infection screening	Screening for members 24 years of age or less, or members 25 years of age or more that are high risk and members during their pregnancy.
Contraceptive methods approved by the FDA	Includes hormonal methods, of barrier and implanted devices, as well as the insertion and removal of intrauterine appliances. The Plan B Medication (known as the morning after pill) will be covered through contracted pharmacies. It requires a prescription.
Preventive visits that include contraceptive, prenatal and postnatal care	Covered.
Screening and counseling about domestic and interpersonal violence	Through the mental health coverage.
Folic acid supplements	Members who are planning or are capable of becoming pregnant.
Gestational diabetes screening tests	For members during their pregnancy between 24 and 28 weeks of gestation and in the first prenatal visit for members identified with high risk of diabetes.
Gonorrhea	Gonorrhea infection screening for sexually active member, including members during their pregnancy if they contain risk factors to infection (for example, whether they are young or if they contain other individual or community risk factors).
Hepatitis B Virus	Screening for members during their pregnancy.
Counseling and screening test of Human Immunodeficiency Virus (HIV)	Covered for all sexually active members. According to the administrative order No. 307 of August 14, 2013 of the Health Department of Puerto Rico, the test will be performed to members during their pregnancy as follows: a. First HIV test during the first trimester of pregnancy or in the first prenatal visit. b. Second test during the third trimester of pregnancy (between 28 and 34 weeks of pregnancy).
Test for high risk to Human Papilloma Virus (DNA Test)	It applies to members with normal cytology results. This screening test must be performed from 30 years of age, with a frequency of every three (3) years.
Osteoporosis	Screening for osteoporosis in members 65 years of age or older and in younger members whose risk of fractures is equal or greater than the risk of a member from the white race 65 years old that does not have additional risks.

Preventive Service	Indication
Classification of blood group - factor Rh (D)	Screening of blood type Rh (D) and of antibodies for all members during their pregnancy during the first prenatal consultation. Also, the USPSTF recommends to repeat the antibodies test to members during their pregnancy with tests RH(D) negative not sensitivity between weeks 24 to 28 of pregnancy, unless the biological father is known to be Rh (D) negative.
Use of tobacco (members during their pregnancy)	Screening and interventions for members who are tobacco users and extended interventions to members during pregnancy who use tobacco.
Sexually transmitted diseases	Annual counseling for sexually active members.
Syphilis	Screening for all members during their pregnancy or other high risk member.
Preventive visits for members	Annual preventive visit to obtain recommended preventive services and additional visits if necessary to obtain these services, depending on the health state and needs of the member and other risk factors.
Pre-eclampsia prevention	Use of low doses of aspirin as preventive for members during their pregnancy with 12 weeks of gestation with risk of pre-eclampsia.

VACCINE'S STANDARD COVERAGE FOR CHILDREN, ADOLESCENTS AND ADULTS

The table in this section summarizes Triple-S Salud standard vaccine's coverage. For additional information, contact our Customer Service Department or search for information in our webpage, www.ssspr.com.

A. Preventive Vaccines

The information that follows includes the vaccines considered as Preventive, as stated by the Federal Health Reform, which are covered with $0 copayment.

Federal Health Reform – Standard Preventive Vaccines without copayment
• **Hib-HepB** (90748) • **ROTA** (Rotavirus Vaccine)(90680) • **ROTA** (Rotavirus Vaccine, human - Rotarix) (90681) • **IPV*** (Inactivated Poliovirus Vaccine – injectable (90713) • **Hib*** (Haemophilus Influenza B Vaccine) (90647, 90648) • **Meningococcal conjugate** (90644)- Up to 18 months of age • **Menomune** (Meningococcal Polysaccharide Vaccine) (90733)- second dosage between 16 years of age and 18 years of age • **MCV** (Meningococcal Conjugat Vacine- Menactra) (90734)- from 9 months of age • **PPV** (Pneumococcal Polysaccharide Vaccine) (90732) • **FLU** (Influenza Virus Vaccine) (90660) (for intranasal use) • **PCV** (Pneumococcal Conjugate Vaccine - Prevnar 13) (90670) • **DTaP** (Diphtheria, Tetanus Toxoid and Acellular Pertussis Vaccine) (90700) • **DT** (Diphtheria, Tetanus Toxoid) (90702) • **HPV*** (Human Papilloma Virus) (Gardasil-90649, Cervarix-90650; 9vHPV-90651) • **Tdap*** (Tetanus, Diphtheria and Acellular Pertussis) (90715) • **Zoster** (Zostavax) (90736) • **FLU** (Influenza Virus Vaccine) (90654) (90655, 90657, 90685) (90656, 90658, 90686, 90688) (90662) (90673) • **MMR** (Measles, Mumps and Rubella Vaccine) (90707) • **VAR** (Varicella Virus Vaccine) (90716) - **HEP A** (Hepatitis A Vaccine): (90633, 90634) (90632) • **Td** (Tetanus and Diphtheria Toxoid Adsorbed) (90714) - **HEP B** (Hepatitis B Vaccine): (90740) (90743) (90744) (90746) (90747) - HEP-A + HEP-B (90636) • **Meningococcal B** (90620, 90621)

Vaccines with $0.00 copayment
• **Pentacel*** (90698) • **DtaP-IPV-HEP B** • **Kinrix*** (90696)
Vaccines with 20% coinsurance
• **Palivizumab*** (**Synagis**) (90378)

*** Vaccine is covered until the individual reaches the age indicated, according to the Vaccine Schedule established by the U.S. Preventive Services Task Force (USPSTF) and the Department of Health, including catch-up vaccines.**

Note: The codes of the vaccines included are shown as published by the CPT Manual, (Current Procedural Terminology Manual), in its last revision. Any subsequent update may change the code included. For an updated version, contact our Customer Service Department.

For more information of the preventive services covered, visit the following link on the Internet: http://www.healthcare.gov/center/regulations/prevention.html.

This policy also covers annual preventive visit, preventive screening tests and vaccines established by the Centers for Medicare and Medicaid Services (CMS), as provided for in Law 218 of August 30, 2012 and as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the Advisory Committee on Immunization Practices of the Health Department of Puerto Rico. These include preventive services and vaccines required as per the Benefits Table, as well as the following tests or services:

- Vaccine against the influenza, without age limit
- Vaccine against Hepatitis B, without age limit

Other Benefits required by Law

This policy complies with the requirements of Law No. 239 of September 13, 2012 so that covered services as detailed in this policy can be offered through psychology professionals qualified by education at the master's or doctorate degree level, trainings and experience to provide health services, duly licensed by the Puerto Rico Psychologists Board of Examiners.

In compliance with the Law for the Welfare, Integration and Development of Persons with Autism (known as BIDA), this policy covers all services directed at the diagnosis and treatment of people with disorders within the Continuum of Autism such as: genetics, neurology, immunology, gastroenterology and nutrition, physical, speech and language, occupational, and psychological therapies that will include medical visits and medically referred tests. These services will be offered without any limit, to all the people that have been diagnosed any of the conditions within the Continuum of Autism, subject to the copayments or coinsurance as established in the Section Ambulatory Medical-Surgical and Diagnostic Services.

In accordance with the requirements of Law No. 107 of 2012, this policy establishes equality of coverage for the treatment of chemotherapy against cancer in its various administration methods such as intravenously, oral, injectable or intrathecal; as per the medical order from the specialist physician or oncologist.

In compliance with Law No. 275 of September 27, 2012, Triple-S Salud will not reject or deny any treatment that is agreed upon and/or within the terms and conditions of the health agreement signed between the parties to any patient diagnosed with cancer, when a medical recommendation mediates to those purposes. In addition, it covers all preventive services and benefits referred to under the federal law ACA for the early detection of breast cancer and also studies and breast cancer monitoring tests, such as visits to specialists, clinical exams of breasts, mammography, digital mammography, magnetic resonance mammography, and sonomammography, and treatments such as, but not limited to, mastectomies, reconstructive surgery after mastectomy for the reconstruction of the extracted breast , the reconstruction of the other breast for achieve a symmetrical appearance, the breast prosthesis, treatment for physical complications during all the stages of the mastectomy, including the lymphedema (inflammation that sometimes occurs after the breast cancer treatment), as well as any post-mastectomy reconstructive surgery necessary for the physical and emotional recovery of the patient.

You can request the following additional information to understand your plan better and know of the company

- The cost of a health service, treatment or specific medication
- Policies about coverage, treatment or specific medication

- The reasons why a medication was not approved in the formulary
- Results of satisfaction surveys conducted by Triple-S Salud
- The coverage of a specific benefit and an explanation of how we determine what is going to be covered
- A report of how much you have accumulated in your maximum disbursements of the coverage
- A written description of how we pay our network providers, including descriptions and justifications for the compensation of the provider
- Programs, including incentives or sanctions to providers intending to control any referral to another specialist or provider
- Financial Information of the company
- Copy of the adverse determinations of benefits and any clinical guide used for this determination
- Status of our accreditations

How does your Coverage work?

This plan will help the member to pay for some of his costs when he is sick or injured. It will also pay for certain care to help him to remain in optimal health conditions and detect any condition with the preventive services.

In addition to the monthly payment that you make for your plan, called "premium", the member pays part of the costs when the member receives the care the plan covers. There are different types of costs that members have to pay out of their own pocket:

COPAYMENT: The predetermined fixed amount that the member has to pay at the time of receiving covered services, to the participating physician or provider or any other provider as his contribution to the cost of the services received, as established in the policy and as reported to the participating physician, pharmacy or provider. This amount is not refundable by Triple-S Salud.

COINSURANCE: The percent of the fee that the member has to pay at the time of receiving covered services, to the participating physician or provider or any other provider as his contribution to the cost of the services received, as established in this policy and as reported to the participating physician, pharmacy or provider. This amount is not refundable by Triple-S Salud.

MAXIMUM OUT OF POCKET: It is the maximum amount established that the person must pay during the policy year. Under our plan, there is a maximum of disbursements that the members pay according to their type of contract for covered essential medical-hospital services. The maximum amount of disbursement is of $6,350 in an individual contract and $12,700 in a couple or family contract. This is the maximum amount that members pay during the policy year for covered essential medical-hospital services under the policy when visiting providers within the network, including the purchase of medications and payments for essential dental services, as described in this policy. Once the member reaches the amount that applies to him according to his type of contract, he will not have to make additional disbursements for the rest of the policy year. The services rendered by non-participating providers in and outside Puerto Rico, payments made by the member for services not covered under this policy, payments for dental services, alternative therapy services (Triple-S Natural), and the monthly premium paid to Triple-S Salud for the plan, are not considered eligible expenses for the accumulation of the maximum out of pocket.

The member will be responsible to pay directly to the participating provider the copayment or coinsurance stated in the table of benefits.

AMBULATORY MEDICAL-SURGICAL AND DIAGNOSTIC SERVICES IN AMBULATORY FORM

- If the person is not admitted in the hospital, he/she will have the right to receive the following services, among others:

Benefits Description	You Pay
Treatment and Diagnostic Services	
Medical professional services: • Visits to physicians/surgeons office, without limits on the number of visits	$8.00 copayment for visit to a general practitioner $12.00 copayment for visit to a specialist $18.00 copayment for visit to a sub-specialist
• Visits to audiologists	$8.00 copayment per visit
• Visits to optometrists	$8.00 copayment per visit
• Visits to podiatrists	$8.00 copayment per visit
• Visits to clinical psychologists	$12.00 copayment per visit
• Visits to chiropractors	$7.00 copayment per visit
• In-home medical services by physicians who render this service.	$15.00 copayment per visit
• Intra-articular injections, up to two (2) daily injections up to a maximum of twelve (12) injections per policy year, per member	Nothing
• Hospital emergency room services, including supplies and medications included in the suture tray contracted with Triple-S Salud. It also covers medications and supplies in addition to those included in the suture tray, provided in the emergency room because of accidents or illnesses. If the insured member calls Teleconsulta and receives the recommendation to go to an emergency room with a registration number; a lower copayment/coinsurance may apply for the use of said facilities. If a nonparticipating provider cannot process the number on his system for the exemption or reduction of the lower copayment/coinsurance, the member will pay it and will request reimbursement to Triple-S Salud for the amount that he would have been exempted or reduced. Psychiatric emergencies will also be covered as well as the transportation between health services providing institutions including ambulances certified by the Public Service Commission and the Department of Health in conformance with what is established in the last paragraph of Article 4.20(b) of Law No. 183 of August 6, 2008 and as indicated in the Ambulance Benefit section that appear under the section Services Provided by a Hospital or Another Facility and Ambulance Services. For diagnostic tests performed in the emergency room other than laboratory tests and X-rays, the coinsurances and limits that correspond to the ambulatory services will apply as stated in the policy.	$50.00 copayment for illness Nothing for accident Nothing, if recommended by Teleconsulta
• Cryosurgery of the uterus limited to one (1) procedure per policy year, per member • Services for tuberculosis conditions • Sterilization services	Nothing

Laboratories, X-Rays and Other Diagnostic Tests	
Tests such as: • Clinical Laboratory	30% coinsurance
Tests such as: • X-Rays • Nuclear medicine tests • Single Photon Emission Computerized Tomography (SPECT) • Sonograms • Angiography by magnetic resonance study (MRA) • Tympanometry, up to one (1) per policy year, per insured member • Computerized Tomography, covered up to one (1) per anatomic region, per policy year, per insured member • Magnetic Resonance Studies (MRI), covered up to one (1) per anatomic region, per policy year, per insured member • Pet Scan and Pet CT, up to one per policy year, subject to Precertification, except for conditions related to lymphomas, including Hodgkin's disease, for which the plan will cover up to two (2) per policy year, subject to Precertification. • Electromyograms, up to two (2) per anatomic region, per policy year, per insured member • Nerve Conduction Velocity Study, up to two (2) tests of each type, per policy year, per insured member • Electroencephalograms • Non-invasive cardiovascular tests • Vascular non-invasive tests • Electrocardiograms • Neurological tests and procedures • Audiological tests such as vestibular function tests and special diagnostic procedures • Polysomnography (study of sleeping disorders), up to one test of each type, per life • Bone density test for insured members under age 65 or when it is not provided as a preventive service as provided by federal law, but as follow-up test to a diagnosis or treatment of a condition. • Pelvic exams and all types of vaginal cytological tests that may be required by a physician to detect, diagnose, and treat early stages of anomalies that may result in cervical cancer. • Mammographies, digital mammographies or sonomammographies when not rendered as preventive tests as provided by federal law, but as follow-up test to a diagnosis or treatment of a condition • Other diagnostic tests	25% coinsurance
• Gastrointestinal endoscopies	40% coinsurance

Vision Care	
• Ophthalmologic diagnostic tests • Refraction test, one (1) test per insured member, per policy year, as long as the test is performed by an ophthalmologist or an optometrist.	25% coinsurance
Maternity Services (applies to the primary member, spouse and dependents) without waiting periods	
• Prenatal and postnatal preventive visits and services as defined by Health Resources and Services Administration (HRSA)	$12.00 copayment for the visit to the specialist
• Obstetrics services • Well baby care preventive services according to the ages and coverage recommended by the United States Preventive Services Task Force (USPSTF)	Nothing
• Sonograms, according to the clinical protocol	25% coinsurance
• Biophysical Profile, up to one (1) per pregnancy, per member with right to maternity	50% coinsurance
Surgeries	
• Surgeries in ambulatory form at the physician's office	Nothing
Allergy care	
• Allergy tests, up to a maximum of fifty (50) tests per policy year, per member	Nothing
Treatment Therapy	
• Radiotherapy	Nothing
• Chemotherapy in all its administration methods (intravenous, oral, injectable or intrathecal); according to the medical order of the specialist physician or oncologist. Oral chemotherapy is covered under the pharmacy benefit.	10% coinsurance
• Cobalt • Dialysis and Hemodialysis: Services related to any type of dialysis or hemodialysis, as well as any complications and their corresponding hospital or medical-surgical services, will be covered for the first ninety (90) days from: a. the date in which the member became eligible for this policy for the first time; or b. the date in which he/she received the first dialysis or hemodialysis. This will apply when subsequent dialysis or hemodialysis are related to the same clinical condition.	Nothing
Respiratory Therapy (administered at the doctor's office)	
• Respiratory therapy (provided by physician specialized in allergies, pediatric allergies, anesthesia, pneumology and pediatric pneumology, and laboratories located within a hospital facility), up	$5.00 copayment per therapy

to two (2) daily sessions for a maximum of twenty (20) sessions per policy year, per member	
Chiropractor services and Physical Therapy	
• Physical therapies and/or manipulations provided by chiropractors are covered up to a maximum of twenty (20) physical therapies or manipulations, as a set, per policy year, per member. In these cases, supervision does not require the direct intervention (face to face) of the physician, but needs to be available in the location to evaluate and recommend a change in the treatment plan.	$7.00 copayment per visit $7.00 copayment per therapy or manipulation If the member receives services from a non-participating chiropractor, they will be reimbursed at 100% from Triple-S Salud established fees, after deducting the applicable copayment. Besides, services may be covered through Assignment of Benefits.
Durable Medical Equipment (DME)	
Rent or purchase, subject to a Precertification: • Maximum benefit of $5,000 per policy year. • Rent or purchase of oxygen and necessary equipment for its administration. • Rent or purchase, according to the criteria established by Triple-S Salud, of wheel chair or hospital type bed. • Rent or purchase, according to the criteria established by Triple-S Salud, respirators, ventilators, and other equipment needed in case of respiratory paralysis. • Glucometer, one every year Services provided by non-participating physicians in Puerto Rico will be paid by indemnization based on the fees established by Triple-S Salud, after the corresponding coinsurance for the rendered service is deducted.	25% coinsurance
The following services are covered for children under 21 years of age diagnosed with Diabetes Mellitus Type 1, as required by law 177 of August 13, 2016: • Lancets, up to 150 for 30 days • Test Strips, up to 150 for 30 days • Insulin infusion pump and supplies for members under 21 years of age diagnosed with Diabetes Mellitus Type 1, as required by Law 177 of August 13, 2016. Requires precertification.	20% coinsurance; nothing for the supplies for the insulin infusion pump
Mechanical Ventilator	
• Coverage will include the medical necessary services, tests and equipment for members under age 21 and even after age 21 require the use of the technological equipment to keep the patient alive; a minimum of one (1) eight-hour daily shift per patient, of services by skilled nurses with knowledge on respiratory therapy or respiratory therapists with knowledge on nursing; the supplies needed to handle the equipment; physical and occupational	Nothing

therapies needed for the motor development of these patients, as well as the prescription drugs, which must be dispensed by a participating pharmacy, freely chosen by the member and authorized under the laws of Puerto Rico (under the pharmacy benefit). Coverage provides for each member to have access to the appropriate laboratory tests and immunization according to the age, and physical condition of the member. • These services will be covered subject to member or his/her representative submitting evidence of medical justification and the registration of the member in the registry the Department of Health has created to this purpose. It also includes the supplies for the handling of technological equipment of the Mechanical Ventilator. • The mechanical ventilator services and services by skilled nurses with knowledge of respiratory therapy or respiratory therapists with knowledge on nursing, the supplies necessary for handling the technological equipment, and physical and occupational therapies will be covered at 100%. For the copayments and coinsurances for medical services, treatments, diagnostic tests, and prescription drugs, refer to the table of benefits of this policy.	
Home Health Care	
Triple-S Salud will cover these services if they begin within 14 days from the date the member was released from the hospital after a hospitalization of at least three (3) days and if they are rendered for the same condition or for any situation related to the condition for which the member was hospitalized. It covers the following services and supplies provided at the home of the Patient by a Home Health Care Agency certified by the Health Department of Puerto Rico. **Requires precertification.** • **Nursing services** - partial or intermittent services provided or under the supervision of a registered nurse. • **Home Health Auxiliary Services** – partial or intermittent services rendered primarily for the patient care. • **Physical, occupational and speech therapies (habilitative and rehabilitative)** – a maximum of 40 visits per insured member, per policy year. • A visit by an employee of the home health care agency or four (4) hours of services by an aide will be considered as a home visit. • Services provided by non-participating facilities in Puerto Rico or non-participating of the Blue Cross Blue Shield Association, will be paid by compensation based on the established fees, after deducting the corresponding coinsurance for the provided service. **Note:** These services must be supervised by a licensed physician and **their medical necessity must be certified in writing.**	25% coinsurance

Nutrition Services	
• **NUTRITION SERVICES TREATMENT OF MORBID OBESITY, RENAL CONDITIONS AND DIABETES**: Triple-S Salud will pay for nutrition services rendered in Puerto Rico by physicians specialized in nutrition or metabolic illnesses. Visits to these specialists, duly certified by the Commonwealth's governmental entity designated for this purpose, will be covered as long as they are medically necessary and are related only with the treatment of morbid obesity, renal conditions and diabetes. Visits will be limited to a maximum of four (4) visits per policy year. Triple-S Salud will reimburse up to a maximum of $20.00 per visit. Renal services will be covered for the first 90 days from the date in which the member became eligible for this policy for the first time or the date in which he/she received the first dialysis or hemodialysis. This will applies when subsequent dialysis or hemodialysis are related to the same clinical condition.	Triple-S Salud will reimburse up to a maximum of **TWENTY DOLLARS ($20.00)** for each visit.
Triple-S Natural	
• The program is available only through the Program's participating facilities. For a list of the participating facilities, refer to the Provider and Participant Directory. The plan covers up to six (6) visits per policy year, per insured member.	$15.00 copayment per visit
Other services for the treatment of disorders within the continuum of Autism	
This policy covers the services targeted for the diagnosis and treatment of persons with disorders within the Continuum of Autism without limits such as: • Neurological tests • Immunology • Genetic testing, subject to precertification • Laboratory tests for autism • Services of Gastroenterology • Nutrition services • Physical therapy • Occupational therapy and speech • Visits to a psychiatrist, psychologist, with master's or doctoral degree and valid license issued by the Board of Examiners of Psychologists of Puerto Rico) or social worker (by reimbursement). • Psychological tests and evaluations	• Neurological tests - 25% coinsurance • Immunology - 25% coinsurance • Genetic testing - 25% coinsurance • Laboratory tests for autism - 25% coinsurance • Services of gastroenterology - 40% coinsurance • Services of nutrition - $0.00 copayment • Physical therapy - $7.00 copayment • Occupational therapy and speech therapy- $7.00 copayment • Visits to a psychiatrist, psychologist, with master's or doctoral degrees and current license issued by the Board of Examiners of Psychologists of Puerto Rico) or social worker (by reimbursement) - $12.00 copayment. • Psychological tests and evaluations - $10.00 copayment

Hospice	
Services rendered through a hospice for members that have been diagnosed with a life expectancy of six (6) or less months as a result of a terminal health condition. **Note:** These services **require a precertification** from Triple-S Salud and must be evaluated by their Individual Case Management Program for coordination through the network participating providers.	
Preventive Service Centers	
Evaluation ✓ Medical history ✓ Physical exam ✓ Screening for depression ✓ Counseling on: Alcoholism, Tobacco, Risky behaviors, Sexuality, Cancer, Domestic violence, Prevention of falls, Diet and Nutrition **Preventive Screening Tests** ✓ CBC ✓ Cholesterol ✓ PAP (cervical cancer) ✓ Chlamydia ✓ Gonorrhea ✓ Syphilis ✓ HIV ✓ Glycosylated Hemoglobin ✓ Visual Examination According to age and gender, and the guidelines of the United States Preventive Services Task Force (USPSTF). For a detailed list of the services with $0 copayment, refer to sub-section on Services Covered by Federal or Local Law in the benefit certificate. **Referrals** ✓ Screening mammography ✓ Vaccines ✓ Bone density scan ✓ Colonoscopy ✓ Sigmoidoscopy ✓ Others Note: For services or tests not rendered as preventive tests as provided by federal law, but as follow-up to a diagnostic or treatment of a condition, the copayments or coinsurances that correspond to your coverage will apply. Some Preventive Centers may refer you to a preferred network provider in cases in which any of the tests needed to complete your screening is not available at their facilities.	$0.00

MEDICAL-SURGICAL SERVICES DURING PERIODS OF HOSPITALIZATION

- During hospitalization periods the insured member is entitled to receive the following medical-surgical services, among others:

Benefits Description	You Pay
Medical Surgical Services	
During hospitalization periods the insured member is entitled to receive the following medical-surgical services, among others: • Surgeries, including orthognathic surgery • Skin, Bone ,and Corneal Transplants • Mastectomy, reconstructive surgery after mastectomy for the reconstruction of the breast removed, surgery and the reconstruction of the other breast to achieve an asymmetric appearance, breast prosthesis necessary before or during reconstruction, treatment for physical complications during all the stages of the mastectomy, including lymphedema (an inflammation that sometimes occurs after breast cancer), as well as any other reconstructive surgery after mastectomy for the physical and emotional recovery of the insured member. • Rhinoplasty services	Nothing
• Bariatric Surgery: This policy only covers gastric bypass surgery for the treatment of morbid obesity, to a maximum of one lifetime surgery, so long as the services are available in Puerto Rico. Surgeries for the removal of excess skin are covered if the physician certifies that it is necessary to remove the excess of skin because it affects the functioning of any part of the body. These surgical procedures **require Triple-S Salud's precertification**.	
• Diagnostic services • Treatments • Administration of anesthesia • Specialists consultation • Gastrointestinal endoscopies • Sterilization services • Hearing evaluations, including Neonatal Hearing Screening Test • Chemotherapy in all its modalities of administration (intravenous, oral, injectable or intrathecal) and radiotherapy	Nothing
• Pet Scan and Pet CT, up to one (1) per policy year, per insured member, except for conditions related to lymphomas, including Hodgkin's disease, for which the plan will cover up to two (2) per policy year, per insured member, subject to precertification. • Electromyograms, up to two (2) per anatomic region, per policy year, per insured member • Nerve Conduction Velocity Study, up to two (2) test of each type, per policy year, per insured member	Nothing
• Invasive cardiovascular tests	25% coinsurance

SERVICES PROVIDED BY A HOSPITAL OR OTHER FACILITY, AND AMBULANCE SERVICES

- Triple-S Salud agrees to pay for services contracted with the corresponding hospital during the hospitalization of the insured member while the insurance is in effect, so long as the attending physician orders in writing said hospitalization and it is medically necessary.

Benefits Description	You Pay
Hospitalizations	
• Semi-private or isolation room up to a maximum of three hundred and sixty-five (365) days for regular hospitalizations.	$75.00 copayment for regular admission
• Meals and special diets • Use of telemetric services • Use of Recovery room • Use of *Step Down Unit* • Use of Intensive Care units, Coronary Care, Pediatric Intensive Care, and Neonatal Intensive Care • General nursing services • Administration of anesthesia by non-medical personnel • Clinical laboratory services • Medications, biological products, healing materials, products related to hyper alimentation and anesthesia materials • Production of electrocardiograms • Production of radiological studies • Physical therapy and rehabilitation services • Use of physicians in training, interns and residents of the hospital authorized to render medical services to patients. • Respiratory therapy services • Use of the Emergency room when the member is admitted to the hospital • Use of other facilities, services, equipment and materials usually provided by the hospital and ordered by the physician in charge which have not been expressly excluded from the contract with the hospital	Nothing, these services are included in the payment of the hospitalization copayment

• Services related to any type of dialysis or hemodialysis, as well as any complications and their corresponding hospital or medical-surgical services, will be covered for the first ninety (90) days from: a. the date in which the member became eligible for this policy for the first time; or b. the date in which he/she receives the first dialysis or hemodialysis. This will apply when subsequent dialysis or hemodialysis are related to the same clinical condition. • Chemotherapy in all its modalities of administration (intravenous, oral, injectable or intrathecal) and radiotherapy • Blood for transfusions	Nothing, these services are included in the payment of the hospitalization copayment.
• Lithotripsy procedure (ESWL); precertification required	$500.00 copayment
• Ambulatory surgery	$75.00 copayment
Maternity Hospital Care – (for the insured employee, spouse and direct dependents)	
• Semiprivate or isolation room, assistance and physical care for the newborn, education on the care of the newborn for both parents, assistance and training on breastfeeding, orientation on in-home support and the performance of any treatment or medical test for the newborn or the mother. **Note:** To look up hospitals in your area, visit our webpage at www.ssspr.com, or refer to Triple-S Salud Provider and Participant Directory. If you need additional information, contact Customer Service.	$75.00 copayment for birth hospitalization
• Obstetrics services • Use of maternity ward • Production of Fetal Monitoring • Use of Well-Baby Nursery	Nothing
Skilled Nursing Facilities (SNF)	
The plan will covered these services if they begin within fourteen (14) days from the date the insured member is discharged from a hospital, after a hospitalization of at least three (3) days and if they are rendered for the same condition or in relation to the condition for which the person was hospitalized. **Requires precertification.** • They are covered up to a maximum of one hundred twenty (120) days per policy year, per insured member. **Note**: These services must be supervised full-time by a licensed physician or a registered nurse **and their medical necessity must be certified in writing.**	Nothing

Ambulance	
• Air ambulance services in Puerto Rico, subject to medical necessity	Nothing
• Ground ambulance services are covered based on the corresponding fees determined by Triple-S Salud and according to the distance traveled. According to Law No. 383 of September 6, 2000, when the service is obtained through 911 System in cases of emergency, Triple-S Salud will pay directly to the provider. The service will be covered only if all of the following requirements are met: a) the patient was transported by an ambulance service as defined in this policy; b) the patient had an illness or injury for which other means of transportation were contraindicated; c) the patient forwards the claim to Triple-S Salud with a medical certification on the emergency that includes the diagnostic; d) the invoice for this service must indicate the place where the member was picked up and where the person was taken. This benefit is covered if the patient was transported: a) from his/her residence or from the place of the emergency to the hospital or skilled nursing facility; b) between hospitals or from a hospital to a skilled nursing facility – in cases where the institution that transfers or authorizes the discharge is not the appropriate facility for the covered service; c) from the hospital to the member’s home, if the condition of discharged patient requires it. d) Between health services providing facilities, in case of psychiatric emergencies provided by ambulances certified by the Public Service Commission and the Department of Health.	Nothing for an emergency In cases that are not emergency, this benefit is covered by reimbursement. The member pays the total cost and Triple-S Salud will reimburse you up to a maximum of **$80.00** per case.

MENTAL HEALTH AND SUBSTANCE ABUSE

This policy covers mental health and controlled substance abuse services as provided under state and federal laws, State Law 183 of August 6, 2008, and the Federal Law Mental Health Parity and Addiction Equity Act of 2008 which promotes equity in the care of mental health diseases and substance abuse. This policy does not have greater restrictions in limits with medical-surgical benefits, such as limits of days or visits, for benefits/substance abuse mental health that are applied to medical-surgical benefits, copayments have no greater restrictions to the medical-surgical benefits.

Benefits Description	You Pay
Mental General Conditions	
Treatment services for the mental health care: Hospitalizations for mental conditions, including partial hospitalizations, will be covered according to the justified medical necessity. • Regular admissions • Partial admissions **Note:** Medical-surgical services during hospitalization periods for mental conditions are covered according to the justified medical necessity.	$75.00 copayment for regular admissions $50.00 copayment for partial admissions
• Electroshock therapy for mental conditions, covered according to the justified medical necessity and to the standard of the American Psychiatric Association (APA).	Nothing
• Special nursing services during hospitalizations for mental conditions are covered if ordered by a psychiatrist, for up to seventy two (72) consecutive hours for each hospitalization.	Triple-S Salud reimburses for each period of eight (8) consecutive hours of services rendered by a graduate nurse up to **FIFTEEN DOLLARS ($15.00)** and up to **TEN DOLLARS ($10.00)** if services are rendered by a licensed practical nurse.
• Patient's visits to the office of the psychiatrist or psychologist (with an MA or PhD and a valid license issued by the Puerto Rico Board of Psychologist Examiners)	$12.00 copayment per visit
• Visits of immediate family members (collaterals), including marital counseling, provided by a psychiatrist or psychologist (with a master's or doctorate degree and a valid license issued by the Puerto Rico Board of Psychologist Examiners)	$12.00 copayment per visit
• Visits for group therapy (of patients), according to the justified medical necessity	$5.00 copayment per therapy

Others Psychological Evaluations	
• **Psychological evaluation**	$10.00 copayment
• **Psychological test:** The psychological tests required by the Law Num. 296 of September 1, 2000, known as the Law of Conservation of the Children and Adolescents' Health.	$10.00 copayment
Substances Abuse (drug addiction and alcoholism)	
• Regular admissions • Partial admissions **Note:** Medical-surgical services during hospitalization periods for drug addiction and alcoholism are covered according to the justified medical necessity.	$75.00 copayment for regular admissions $50.00 copayment for partial admissions
• Patient's visits to the office of the psychiatrist or psychologist (with an MA or PhD and a valid license issued by the Puerto Rico Board of Psychologist Examiners)	$12.00 copayment per visit
• Visits of immediate family members (collaterals), including marital counseling, provided by a psychiatrist or psychologist (with a master's or doctorate degree and a valid license issued by the Puerto Rico Board of Psychologist Examiners)	$12.00 copayment per visit
• Visits for group therapy (of patients)	$5.00 copayment per therapy
Residential Treatment	
• Covers residential treatment for drug abuse and alcoholism as long as there is a medical justification and the service is available in Puerto Rico. Requires precertification.	Nothing

MAJOR MEDICAL COVERAGE

Benefits Description

Benefits

The Major Medical coverage is issued in consideration to the payment of the premiums by the employer, in advanced, and is subject to the terms and conditions of the policy for hospitalization, medical-surgical, and ambulatory services of Triple-S Salud that are not in conflict with the benefits and conditions of this coverage.

The Major Medical coverage provides benefits for services as specified in Subsection B of Covered Medical Expenses and services provided outside Puerto Rico if they meet the conditions laid down in this coverage for the same.

Medical expenses covered under the major medical insurance will be paid directly to the member or through Assignment of Benefits, according to Triple-S Salud established fees and to the amounts applicable to the member and each one of his/her eligible dependents.

In order to get reimbursement for covered medical expenses, the person must be insured under the basic policy for hospitalization, medical-surgical, and ambulatory services under the corresponding or analogous coverage to that of the requested service under this coverage. These benefits are subject to the terms and conditions specifically established for said benefits, and are only offered to those members that live permanently in the service area.

The expenses for services received in or outside the hospital, in any part of the world, will be paid while they are related to a disease, accident, pregnancy, childbirth or medical condition as follows:

- If the service is provided in Puerto Rico, the reimbursement will be made on the basis of the scale of medical benefits established by Triple-S Salud for such purposes;
- If the service is provided outside of Puerto Rico, it will be paid on the basis of the rates established by the plans of the Blue Cross and Blue Shield Association (BCBSA), to use the BCBSA participating providers, except otherwise specified in this policy.
- Services provided through non- participating providers outside Puerto Rico will not be covered, except in cases of emergency.
    - the percentage of the rate for non-participating providers established by the local site plan Blue Cross Blue Shield Association
    - or the greater of the following three amounts (adjusted to the shared costs of the network of participating providers): negotiated rate with participating providers, the amount of the usual, customary and reasonable (UCR) or the amount that Medicare would pay.

In both cases, the insured member will be responsible for paying the deductible and/or coinsurance established on this coverage.

All services rendered outside Puerto Rico will be paid only through this coverage, subject to a Triple-S Salud precertification, except in cases of emergency or if otherwise stated in the Limitations section. In those cases in which services are rendered without a precertification or are not emergency, these services will be paid directly to the member based on Triple-S Salud established fees for participating providers or through Assignment of Benefits.

The incurred expenses for covered services resulting from a medical emergency while the affected member is outside Puerto Rico, will not require a precertification, but will be subject to the corroboration by Triple-S Salud of its reasoning and medical necessity.

Services that require precertification in the Basic Coverage keep this requirement in the Major Medical coverage.

Reimbursement for services provided in Puerto Rico shall be carried out on the basis of the scale of medical benefits established by Triple-S Salud for such purposes.

The insured member may request assignment of benefits for such services. By accepting the assignment of benefits, the hospital or facility is not a participant in the Blue Cross and Blue Shield Association will bill you directly to Triple-S Salud for services provided to the insured member.

Coinsurance:

a. Each insured member shall be liable of 20% of the covered medical expenses.

b. Each insured family will be responsible of 20% of the covered medical expenses.

Each person or family insured will be responsible for the difference between the expense incurred and the fees established by Triple-S Salud for the reimbursement of the covered medical expenses.

The amounts applicable for the coinsurance of the covered medical expenses will be determined based on the established fees for the covered medical expenses.

A. REIMBURSEMENT: The covered expenses incurred for medical services will be reimbursed according to the following conditions:

1. 80% of the covered medical expenses incurred during a policy year, by the member or his/her dependent while insured subject to the limitations established in this coverage.

B. COVERED MEDICAL EXPENSES: We will cover the medical expenses necessary for the treatment of injuries or diseases suffered by the insured member and by recommendation and approval of the physician in charge of the case when these are rendered outside of Puerto Rico, or in Puerto Rico when extends the benefits of the basic if they were limited or excluded. This Major Medical Expenses coverage will not cover the services that exceed the limitations of the Basic Coverage, except in those services expressly indicated in this section.

1. **Anesthesia and its administration**

2. **Durable medical equipment (only for services outside Puerto Rico and a Triple-S Salud's precertification is required):**

   a. Rent or purchase of oxygen and necessary equipment for its administration.

   b. Rent or purchase, according to the criteria established by Triple-S Salud, of a wheel chair or adjustable bed.

   c. Rent or purchase, according to the criteria established by Triple-S Salud, of an iron lung or other equipment for respiratory paralysis.

3. **Medical materials or supplies:**
   a. Covered drugs prescribed by a physician-surgeon during hospitalization periods
   b. Surgical supplies such as bandages and gauze

4. **Ground ambulance services** - To and from any medical institution. These services are covered if they are rendered by a vehicle duly authorized for such purposes.

5. **Ambulatory Services for mental conditions, drug addiction and alcoholism**

6. **Services in Ambulatory Surgical Centers**

7. **Nursing care** - Certified as medically necessary and provided by a person who is duly certified for such purposes, who is not a member of the member's immediate family or does not reside in the member home.

8. **Hospital Services**: Semi-private room and meals, plus other service and supplies for regular hospitalizations, mental conditions, drugs and alcoholism.

9. **X-ray and laboratory services** - For diagnostic and treatment purpose.

10. Physicians services

11. **Physical Therapy and Rehabilitation Services (These benefits will be covered when are rendered out of Puerto Rico only):** Of the modality of treatment and duration prescribed by the physician in charge of the case and under the supervision of a surgeon specialist in physiatrist. In this case the supervision does not require direct intervention (face to face) of the physician but his/her availability is required, in place so that, if necessary, can evaluate or recommend a change in the treatment plan.

12. **Other services**: The following services will be covered provided that they are considered medically necessary. Those services that are not considered necessary, are not in accordance with the generally accepted principles of medical practice, are experimental or investigative or are provided in excess of those that are generally required for the diagnostic, prevention or treatment of an illness, injury, malfunction of the organic system, or the condition of pregnancy are excluded.

    a. Hearing aids, as established in the Limitations section.
    b. Prosthetic devices or implants to replace body organs or parts or to aid in their functioning, such as prosthesis, pacemakers and valves, etc.; replacement is excluded.
    c. Surgical assistance
    d. Mammoplasties, subject to Triple-S Salud precertification
    e. Sports medicine, as established in the Limitations section.
    f. Cardiac rehabilitation: These services will be covered if rendered by a physiatrist specialized in exercise physiology and rehabilitation techniques. The purpose is to minimize physical and psychological disabilities, resulting from cardiovascular illness. These services will be reimbursed according the reasonable charges of the area were services are rendered and the medical necessity dispositions established by Triple-S Salud.
    g. Intravenous or inhaled anesthetics applied at the dentist's or dental surgeon's office.
    h. Pre and postnatal services
    i. Tuboplasties
    j. Vasovasostomies

k. Positron Emission Tomography (PET CT and PET Scan), as established in the section of Limitations.
l. Computerized tomography, as established in the Limitations section.

Major Medical Limitations

1. Sports medicine is covered up to a maximum benefit of twenty (20) therapies per insured member, per policy year.

2. Computerized tomography and magnetic resonance (MRI) studies are covered up to a maximum of two (2) studies, of each one, per policy year, per insured member.

3. Positron Emission Tomography (PET CT and PET Scan) tests are covered at the contracted facilities by Triple-S Salud only, up to a maximum of one (1) per policy year, per insured member. Requires precertification.

4. Hearing aids are limited up to a maximum of **Two Hundred and Fifty Dollars ($250.00)** per policy year, per member.

ORGAN AND TISSUES TRANSPLANT COVERAGE

The benefits provided by this policy are subject to the terms and conditions specifically established for these. They are only offered to those insured members who permanently reside in the Service Area.

Triple-S Salud is responsible for the payment of services provided to an insured member subject to the provisions of this policy and to the following conditions:

1. The covered benefits are for every policy year and for each person insured; except where provided otherwise. The benefits not used in a policy year, will not accumulate to the next policy year.

2. Triple-S Salud does not commit to designate the physician, hospital or laboratory of the Transplant Network to provide its services to the insured members.

3. Triple-S Salud or its authorized representative can require a second medical opinion, by physicians designated by it, when it deems necessary.

4. The member, physician, hospital and facility of the Transplant Network will be oriented on the pre-certification procedure. In cases in which Triple-S Salud requires pre-certification or authorization before rendering the services, Triple-S Salud will not be liable for the payment of such services if they have been provided or received without this pre-certification or previous authorization by Triple-S Salud or its authorized representative.

These services will be covered by reimburement or assignment of benefits only through facilities established in the Transplant Network in and outside Puerto Rico. They will be covered at 100% of the fees negotiated with the facilities, without being subject to coinsurance or deductibles.

Once the services are pre-certified, the person insured may request Assignment of Benefits. By accepting the Assignment of Benefits, the physician, hospital or facility will accept to bill Triple-S Salud directly for the covered services to the insured member.

Benefits

Maximum Benefit	Nothing
Member pay	$0.00
Covered organs transplant	Heart, heart-lung, lung (unilateral or bilateral), liver, pancreas-kidney, kidney.
Medical Expenses Coverage	Recipient: It covers expenses directly related to the procedure; it includes evaluation, care prior to the surgery, transplant, care after surgery and immunosuppressive drugs. Organs (procurement): It covers expenses and services provided or related to obtaining, preservation and transportation of organs to be used in the covered transplant. Transportation, meals and accommodation - the maximum limit of covered expenses to be reimbursed to the insured member for transportation, meals and accommodation is $10,000 for each type of transplant. • Transportation - from and to the place of the surgery for the patient and a companion. If the patient is less than nineteen (19) years of age, he/she will be allowed the transportation

	for two accompanying persons (parents or persons having legal custody of the patient). • Meals and accommodation - this plan will reimburse up to a maximum of $150.00 daily per person or $200.00 daily for two people (parents or people who have legal custody of the patient who is less than nineteen (19) years old). **Re-transplant** **Immunosuppressive Drugs:** Immunosuppressive drugs covers duly approved by the Food and Drug Administration (FDA) and medications used in immunosuppressive therapies. The benefit will be covered up to the maximum benefit. **Pre-transplant expenses**: This policy covers medical expenses related to the evaluation and preparation of an insured member eligible to receive an organ transplant or bone marrow for a period of thirty (30) days prior to the procedure of transplantation of organs or bone marrow, in accordance with the established medical policy by Triple-S Salud. In addition, Triple-S Salud will cover a pre-transplant evaluation to determine if the patient is eligible candidate for transplantation regardless of the date on which the same. This evaluation shall be governed by the protocol approved by Triple-S Salud.
Bone Marrow Transplant	It covers the allogeneic, autologous, syngeneic and hematopoietic stem cell transplants provided they are indicated in the following conditions and diseases: breast cancer, non-malignant hematological disorders such as aplastic anemia, lymphocytic acute leukemia, non- lymphocytic acute leukemia, acute myelogenous leukemia, acute and chronic myelogenous leukemia in remission, infantile malignant osteopetrosis, Wiskott-Aldrich Syndrome, Hodgkin's disease, lymphomas that are not Hodgkin type, severe combined neuroblastomas in advanced stages and immunodeficiency. The expenses covered for these transplants are as follows: 1) Recipient - It covers expenses directly related to the procedure; it includes evaluation, care prior to the surgery, transplant, care after surgery and immunosuppressive drugs. 2) Donation and storage of bone marrow - expenses and services rendered or related to obtaining, conservation and transportation of the tissues to be used in the covered transplant. 3) Treatments of chemotherapy or of radiation before performing the transplant. 4) Ambulatory care related directly to the care after the transplant. 5) Transportation, meals and accommodation - the maximum limit of covered expenses to be reimbursed to the insured member for transportation, meals and accommodation is $10,000 for each type of transplant.

	a) Transportation - from and to the place of the surgery for the patient and a companion. If the patient is less than nineteen (19) years of age, he/she will be allowed the transportation for two accompanying persons (parents or person having legal custody of the patient). b) Meals and accommodation - this plan will reimburse up to a maximum of $150.00 daily per person or $200.00 daily for two people (parents or people who have legal custody of the patient who is less than nineteen (19) years old). 6) Re-transplant
Precertifications	Pre-certifications procedure for cases of Organ and Tissue Transplants: a. The referral for the transplant services will be done by telephone, facsimile or in person in the facility designated by Triple-S Salud for the coordination of services. b. Your eligibility, coverage and waiting period will be verified. c. Once the coverage is confirmed, we will verify the specialty of the physician that refers and the limitations or contraindications for the different types of transplants. d. The Triple-S Salud specialist in transplant cases or the authorized representative will offer you an initial orientation on the benefits of the transplant coverage and alternatives. A precertification will be issued for the referral to one of the facilities in the Transplant Network. e. The Triple-S Salud specialist in transplant cases or the authorized representative will coordinate with the institution selected by the member and by the physician, the referral to receive transplant services if the selected institution is participant of the established Transplant Network. f. The Transplant Program of the selected institution will coordinate a clinical evaluation of the candidate to transplant, per their criteria of selection of patients and will keep direct communication with the specialist in transplant cases appointed by Triple-S Salud. g. The member will request to Triple-S Salud or its authorized representative a pre-certification for every stage of the transplant: pre-transplant, transplant, post-transplant and re-transplant. The claims of the transplant services rendered by the selected institution, will be coordinated between this and Triple-S Salud, Inc.

PRESCRIPTION DRUG BENEFIT (F-26)

- The pharmacy coverage will be subject to the terms and conditions of the hospitalization, medical surgical and ambulatory services that are not in conflict with the benefits and conditions, described in this section. In this case, the provisions of the prescription drug coverage shall prevail.

- This benefit is ruled by the guidelines of the Food and Drug Administration (FDA). These include dosage, drug equivalency, and therapeutic classification, among others. It is required to show the Triple-S Salud ID card at any participating pharmacy when requesting the benefits, so they are covered by this coverage. The participating pharmacy will dispense, upon showing the member's ID card and a prescription, the covered prescription drugs included in the Prescription Drug List or Formulary, that are specified in the prescription. It will not charge or collect from the member any amount in excess of the amount set forth in the You Pay column.

- When receiving the prescription drugs, the insured member will have to sign for the services received and show a second photo ID.

- If your physician ordered a prescription drug that is not covered by your prescription drug benefit, the physician can write a new prescription ordering a prescription drug that is covered. Or, he can request an exception in accordance with the section Process for Exceptions to the Prescription Drug List or Formulary in this policy. This applies when the therapeutic classification (category) is covered and there are other treatment options.

- This plan will provide for the dispensing of covered prescription drugs, regardless of the ailment, illness, injury, condition, or disease for which they are prescribed, so long as the prescription drug has the approval from the FDA for at least one indication and the drug is recognized for the treatment of ailment, illness, injury, condition, or disease that is treated in one of the standard reference compendia or generally accepted peer-reviewed medical literature. However, this plan is not required to cover a prescription drug when the FDA has determined that its use is contraindicated for the treatment of the indication for which it is prescribed. In addition, it will include medically necessary services associated to the administration of the prescription drug.

- A pharmacy is not required to dispense a prescription ordered if for any reason, and according to their professional judgment, should not be dispensed. This does not apply to decisions made by the pharmacies regarding the fee applied by Triple-S Salud.

- Prescriptions issued by physicians where the indications for use or the amount of the prescription drug to be dispensed are not specified, the pharmacy will only dispense a supply for forty–eight (48) hours. For example, when a physician writes in his/her instructions "use when necessary (PRN, for its acronym in Latin)."

- Prescription drugs refills may not be dispensed before the person has used up 75% of the supply from the date of last dispensing or after six (6) months from the original date of the prescription, unless otherwise provided by the law that controls the dispensing of controlled substances.

- The people insured under an individual plan, supplementary cover to the Medicare Program (also known as Medigap) or a Medicare Advantage plan, you will not be eligible for the benefits offered on this pharmacy coverage.

BENEFITS

This pharmacy coverage has the following characteristics:

- This policy covers generic or brand-name medications which label contains the legend «Caution: Federal law prohibits dispensing without prescription» and insulin Also, some Over-the Counter (OTC) are covered, as established in the Limitations section. Some maintenance medications may be acquired through Mail Order or the Drugs Dispensed by means of the 90 day Supply programs at Pharmacies.

- The dispensing of generic drugs will be the first option, except when the generic drug is not available in market.

- The dispensing of generic drugs will be the first option, except when the generic drug is not available in market. If the member elects, or his physician prescribes, a brand-name drug when there is a generic available in market, the member will pay the brand-name copayment and the difference in cost between the brand-name drug and the generic drug.

- The amount of prescription drugs dispensed according to an original prescription will be limited to a supply for fifteen (15) days for acute prescription drugs, and thirty (30) days for diabetes, including insulin, prescription drugs for the thyroid and their derivatives, nitroglycerin, diuretics, digital preparations, hypotensive drugs, blockers, anticoagulants, anticonvulsants, antiarthritics, vasodilators, prescription drugs for asthma, cholesterol, Parkinson and tranquilizers included in the benzodiazepines family.

- The amount of maintenance prescription drugs will be provided up to a maximum of 180 days according to the dispensing of the original prescription, and up to five (5) refills all of them with supplies for 30 days. The prescription must state in writing that the physician authorizes the refills.

- Ninety (90)-day supplies apply for some maintenance drugs such as prescription drugs for cardiac conditions, thyroid and diabetes, among others, dispensed through the Prescription Drug Mail Order Program or the Ninety-day Prescription Drugs Dispensing Program through Retail Pharmacies. This does not apply to Specialty Products.

- This prescription drug benefit uses a prescription Drug List or Formulary, which the Pharmacy and Therapeutics Committee approves for this coverage. Our Pharmacy and Therapeutics Committee is composed of physicians, clinical pharmacists and other health professionals that meet periodically to evaluate and choose those prescription drugs to be included in the List or Formulary, following a strict clinical evaluation process. The Pharmacy and Therapeutic Committee evaluates the Prescription Drug List or Formulary and approves changes such as:

  a) To include new medications
  b) Change medications from a tier with a higher copayment/coinsurance to a tier with a lower copayment/coinsurance
  c) Changes for safety reasons, if the manufacturer cannot supply it or has withdrawn it from market.

  The Prescription Drug List or Formulary details the prescription drugs covered. Because of the dynamic nature of the process, the Pharmacy and Therapeutics Committee evaluates the Prescription Drug List or Formulary and approves changes where new medications are included, which are evaluated for a term not exceeding 90 days after their approval by the FDA, medications are changed from a higher copayment/coinsurance tier to a lower copayment/coinsurance tier or for safety reasons if the manufacturer of the prescription drug cannot supply it or has withdrawn it from market. This Prescription Drug List or Formulary is printed once a year.

We will notify changes to all insured members and participating pharmacies no later than the effective date of the change. In the case of inclusion of new prescription drugs in the Drug List or Formulary, we will notify thirty (30) days prior to the effective date of the inclusion.

- Preventive services are covered as required by federal laws Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA) and Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152 (HCERA) and as established by the United States Preventive Services Task Force (USPSTF). The insured member will not pay for prescription drugs required by federal laws, including contraceptives approved by the FDA with a prescription from the physician, as well as folic acid for insured members during pregnancy, tamoxifen and raloxifene for insured members at high risk of breast cancer and low risk of side effects from these drugs, aspirin to prevent cardiovascular diseases and iron supplements to prevent anemia in children from six to 12 months of age, as established in the You Pay column.

- Some prescription drugs are subject to management procedures. As part of the information provided on this policy, Triple-S Salud will provide its members with the Prescription Drug List or Formulary, which offers detailed information on which are the prescription drugs that are subject to the management procedures. The following reference guidelines establish the different types of management procedures that may apply:

  a. **Step Therapy Program (ST):** In some cases, we require that the member first try a medication as therapy for his/her condition before we cover another medication for his/her condition. This program requires the use of over-the counter drugs (OTC) or generic drugs as a therapy before we cover another drug for some medical conditions. In this way, you can achieve accessibility to drugs of proven effectiveness and safety at lower copayments or even $0 copayment in first step prescription drugs, helping you to achieve better compliance with drug therapy.

     The classification that requires an OTC drug as first step includes proton pump inhibitors (PPI), non-drowsy antihistamine and ocular allergy agents. The classifications that require a generic drug as first step include statins for cholesterol, prescription drugs for asthma, anti-inflammatory analgesics, attention deficit hyperactivity disorder (ADHD), diabetes, oral biophosphonates for osteoporosis and nasal corticosteroids for allergies. These drugs are also included in Triple-S Salud Prescription Drugs List or Formulary.

     This program will apply to members that use the prescription drug for the first time or if a period of over 6 months has passed, from the time the member used any of the drugs. The purpose of the program is to establish when the second step drugs will be used and not to intervene with the treatment recommendation of the physician that treats the member. The member will be free to discuss with his/her physician, all the treatment options available for his/her health conditions and to make informed decisions regarding his/her treatment.

     For first step drugs, the prescription will be processed and approved. In case of second step drugs, if the member has used the first step drugs in the last six (6) months they will be processed and approved. If the member has not used first step medications, the pharmacy will inform him/her that he/she must use first step drugs. The physician, after evaluating the member's case, must write a prescription with the first step drug or request a preauthorization from Triple-S Salud for a second step drug, including a medical justification for its approval.

     If a member with or without prior coverage under another Health Plan enrolls in Triple-S Salud and was using a second step prescription drug, the insured member must provide evidence that he/she was using the second step prescription drug. The pharmacy or the insured member must send to Triple-S Salud, as soon as possible, a copy of one of the following documents: pharmacy claim history or a utilization report of the previous Health Plan (explanation of benefits; EOB).

b. Prescription **Drugs that require preauthorization (PA):** Certain prescription drugs need a preauthorization to be obtained by the patient. They are identified in the Prescription Drug List or Formulary with PA (requires preauthorization), in which case, the pharmacy processes the preauthorization before dispensing the prescription drugs to the patient. The pharmacy will also contact us to obtain authorization for changes in doses and when charges exceed $500 per prescription dispensed, to avoid billing errors.

   Prescription drugs that require preauthorization are usually those that present side effects, are candidates to inappropriate use or have a high price.

   Those prescription drugs that have been identified as requiring a preauthorization must satisfy the clinical criteria established as determined by the Committee of Pharmacy and Therapeutics. These clinical criteria have been developed according to current medical literature.

c. **Quantity Limits (QL)**: Certain prescription drugs have a limit to the amount to be dispensed. These amounts are established according to what the manufacturer has suggested, such as an amount not related to side effects and which is effective for the treatment of a condition.

d. **Medical Specialty Limits (SL)**: Some prescription drugs have a specialty limit, depending on the specialist that is treating the condition. For example, for a liver condition a gastroenterologist or infectologist must prescribe Ribavirin. These specialty limits are established according to current medical literature.

e. **Age Limits (AL):** Some prescription drugs have an age limit. For example, prescription drug Ritalin (methylphenidate) is dispensed to members until they attain age 18.

- **Services rendered by participating pharmacies:** The participating pharmacy will provide, upon presentation of the Triple-S Health member card and a prescription, the covered drugs specified by that prescription; and shall not charge or charge any amount to the member that results in an excess of the copayment or coinsurance.

- **Services rendered by non-participating pharmacies in the United States of America:** If the medications are supplied by a non-participating pharmacy in the United States of America, the insured member shall have the right to receive a reimbursement for the incurred expenses, as established in the Limitations section of this coverage, less any applicable deductible or coinsurance, as established in the You Pay section. The medications are covered only when provided by pharmacies located in the United States of America or its possessions, except Puerto Rico.

Benefits Description	You Pay
Coverage Type	
This pharmacy coverage has the following principal characteristics: • Dispatch of medications with a List of Medications	$5.00 for generic drugs $10.00 for preferred brand-name drugs $15.00 for brand-name drugs 25% or $15.00, whichever is higher, for non- preferred drugs out of the Non-Preferred Drug List 10% coinsurance for chemotherapy drugs $0.00 for Over the Counter (OTC) medications, medications required by federal laws, including oral contraceptives and contraceptives approved by the FDA, with a prescription from the physician.
90-Days Dispensing Program	**You Pay**
Copayments or coinsurances for supply for ninety (90) consecutive days for medications supplied through the Mail-Order Pharmacy Program or the 90-Day Drug-Dispensing Program in pharmacies. **Note:** This program is limited to some maintenance drugs. The exclusions and limitations mentioned in this coverage will apply to this program.	$10.00 for generic drugs $20.00 for preferred brand-name drugs $30.00 for brand-name drugs 25% or $45.00, whichever is higher, for non-preferred drugs out of the Non-Preferred Drug List

LIMITATIONS

1. The member receiving services rendered by non-participating pharmacies in the United States of America and its possessions, except Puerto Rico, as established in the Exclusions section, shall have the right to receive reimbursement for medications covered in an amount not exceeding seventy five per cent (75%) of the fee established by Triple-S Salud.

2. Medications with a thirty (30) day supply are limited to: products for diabetes, including insulin, thyroid medications and its derivatives, nitroglycerin, diuretics, digital preparations, medicines for hypertension, blockers, antiarthritic, anticonvulsive, anticoagulant, hemorheologic, sex hormones, vasodilator, oral medications for cancer, ulcers, medications for asthma, cholesterol medications, medications for Parkinson® and glaucoma, among others. Medications for ulcers are limited to Tagamet®, Zantac®, Pepcid®, Axid®, and Carafate®.

3. Tranquilizers defined as benzodiazepines (i.e. Valium®, Xanax®, Tranxene®, and Halcion®) will be covered only when prescribed by psychiatrists.

4. Psychotherapeutic drugs will be covered with a thirty (30) day supply with refill if psychiatrists or neurologists prescribe them. If prescribed by other specialties, the supply will cover fifteen (15) days without refills.

5. The drugs shipped through the dispatch of medicines by mail (mail order) or dispensation of drugs to 90 days in contracted pharmacies in Puerto Rico will be limited to certain maintenance medications. Applies to the following conditions: Hypertension, Diabetes (insulin and oral tablets), thyroid, Cholesterol, epilepsy (seizures), Estrogen, Alzheimer's (do not apply the patches), Parkinson's disease, Osteoporosis, Prostate, among others. Does not apply to specialty products.

6. The specialized products will be dispensed through the Exclusive Specialized Pharmacy Network (ESPN).

7. Over the Counter (*OTC*) drugs covered include: *Prilosec® OTC*, *Claritin®*, *Zyrtec®* OTC, Z*aditor® OTC* and its generic version, as well as any other drug Triple-S Salud decides to include. Some doses of aspirin are covered for member of eighteen years and older, and contraceptives approved by the FDA. The same are included in the List of Medications. To obtain the drug through his/her pharmacy coverage it is required that your physician writes a prescription, indicating the choice of the OTC drug and the OTC contraceptives. The rest of the OTC drugs remain excluded.

DENTAL COVERAGE (DA-20)

DENTAL BENEFITS

Basic Services

Triple-S Salud Dental Coverage is designed to provide the services that are necessary to maintain excellent oral health.

This coverage is issued in consideration of the payment by the employer of the premiums in advance and is subject to the terms and conditions of the basic cover that are not in conflict with the benefits and conditions of this coverage.

In compliance with Law 352 of December 22nd, 1999, this policy covers the general anesthesia and hospitalization services required for certain cases of dental procedures covered for infants, children, adolescents or persons with physical or mental impairments, according to the criteria established in this law. Copayments and coinsurance apply according to your coverage. Requires precertification.

Covered Services:	You Pay
A. Diagnostic and Preventive Services 1. Initial comprehensive evaluation by a general dentist or specialist 2. Routine periodic evaluations 3. Emergency evaluation 4. Periapical, bitewing, and oclusal x-rays 5. Panoramic or fullmouth x-rays (complete series of x-rays) 6. Pulp vitality tests 7. Dental prophylaxis (cleaning) 8. Topical application of fluoride varnish for children under 5 years of age 9. Topical fluoride treatment for children under nineteen (19) years of age. 10. Topical fluoride treatment for adults only with special conditions 11. Fixed space maintainers (unilateral, bilateral) 12. Fissure sealants in posterior permanent teeth for children under 14 years of age	Nothing, except for: 20% coinsurance • Fixed space maintainers
B. Restorative, Surgical and Other Services 1. Amalgam restorations 2. Composite resin restorations on anterior and posterior teeth 3. Stainless steel crowns on deciduous teeth 4. Provisional crown 5. Post and core construction 6. Crown repairs 7. Endodontic services in anterior, premolar, and molar teeth 8. Endodontic retreatment in anterior, premolar and molar teeth 9. Apicectomies on anterior, premolar, and molar teeth 10. Pulpar debridement	Nothing, except for: 30% coinsurance • Composite resin restorations on posterior teeth; • Surgical extractions; • Surgical repositioning of impacted teeth 50% coinsurance • Rebase

11. Complete or partial denture repair 12. Re-cement or re-bond crown 13. Complete and partial denture rebase and reline 14. Repair of fixed bridgework 15. Oral surgery and extractions (pre and post-operative care) 16. Surgical repositioning of impacted teeth 17. Alveoloplasty 18. Occlusal adjustment 19. Hospital visit	• Reline • Alveoloplasty

BASIC SERVICES LIMITATIONS:

1. The initial comprehensive examination is limited to one (1) every three (3) years
2. The routine periodic evaluation, the, emergency examination, and dental prophylaxis are all limited to two (2) services, per member, per policy year. These should be done at an interval of no less than six (6) months from the last date of service.
3. The full mouth or the panoramic x-rays are limited to no more than one (1) full set of x-rays or a panoramic film every three (3) years, per member and no more than one (1) pair of bitewing x-rays every policy year, per member.
4. The treatment of fluoride varnish is limited to two (2) per policy year to an interval of not less than six (6) months, until the day the member reaches five (5) years of age.
5. The topical fluoride treatment is limited two (2) per policy year at an interval not less than six (6) months, until the day that the member turns nineteen (19) years of age
6. Amalgam and of composite resin restorations are limited to one (1) every two (2) years per tooth per surface.
7. The fissure sealants are limited to one (1) per lifetime; only on permanent and unfilled posterior teeth.

Prosthesis Services	
BENEFITS The dentist will be required to submit to Triple-S Salud a Precertification of benefits for the recommended treatment plan before rendering these services to the member (Benefit Precertification) 1. Crown – predominantly base and noble metal 2. Crown – with high noble metal 3. Crowns over implants – high noble metal, according to the rules and established limitations 4. Complete Denture (complete set) 5. Partial Denture (removable bridges) 6. Fixed bridges – predominantly base and noble metal 7. Fixed bridges – with high noble metal 8. Maryland Bridge	50% coinsurance 57% coinsurance for: • Crowns and crowns with high noble retainers

LIMITATIONS TO PROSTHETIC SERVICES

1. These services are subject to the Precertification of Triple-S Salud.
2. Crowns, fixed bridges and removable dentures done under policy validation are covered for full replacement only after five (5) years from the date that the original bridge or denture was made.

Periodontal Services	
COVERED SERVICES 1. Periodontal examination 2. Gingivectomy and gingivoplasty 3. Bone surgery related to periodontal infections 4. Mucogingival surgery 5. Soft tissue and bone grafts; and membranes for tissue regeneration 6. Provisional splinting – extracoronal 7. Scaling and root planing 8. Periodontal maintenance 9. Full mouth debridement. The costs for periodontal service are covered based on the fees designated for such purposes, until the limit established is reached.	Nothing Maximum benefit of $1,000, per policy year, per member
Orthodontic Services	
COVERED SERVICES 1. Diagnostic services, including x-rays and study models 2. Active treatment, including necessary devices 3. Retention treatment posterior to active treatment	Nothing Reimbursement or Benefit Assignment

LIMITATIONS TO ORTHODONTIC SERVICES

1. Benefits will be available to the eligible employee and his/her direct dependents.
2. Orthodontic services are covered with no age limit.

REIMBURSEMENT

Orthodontic services are reimbursed based on the submitted charge based on direct compensation to the member and subject to the following conditions:

1. Orthodontic services are reimbursed at a 100% of the submitted charge until the maximum benefit is reached.
2. Maximum benefit - The insured member is entitled to receive orthodontic services covered, until the maximum lifetime benefit of $1,000.00 is reached.

PRECERTIFICATION

The prosthesis, periodontal and endodontic retreatment services will be subject to Triple-S Salud Precertification for the treatment plan recommended by the dentist. If services are rendered without the Precertification, they will not be covered by Triple-S Salud.

When the member, uses the services of participating dentists, they will be responsible for requesting a Precertification from Triple-S Salud before the covered services are rendered. Nevertheless, in the case that the member receives the services by a non-participating dentist outside Puerto Rico, you will pay for the services and request reimbursement from Triple-S Salud. For the evaluation of the reimbursement request, it is required a detailed receipt which includes the service codes for the received services and X-rays.

INDEMNITY FOR THE MEMBER

If the service is rendered outside of Puerto Rico by a non-participating dentist, Triple-S Salud will pay the member the lesser amount between 100% of the expense incurred and 100% of the fee that would have been paid to a participating dentist for the same service according to Triple-S Salud' established fees, after deducting any copayments or coinsurance, if applicable.

The limits established under this policy will apply to any service rendered by a dentist outside of Puerto Rico to a member, as if the services had been rendered in Puerto Rico.

INDIVIDUAL ELIGIBILITY

In this coverage, the eligibility ceases when the member turns 65 year-old. The employees not retired and their spouses insured in the group policy, older than 65 years, can be insured by the Dental Coverage benefit.

EXCLUSIONS TO THE BASIC COVERAGE

This policy does not cover the following expenses or services:

1. Services rendered while the person's insurance is not in effect.

2. Services that may be received in accordance with laws for Compensation for Accidents on the Job, employer's liability, private plans for compensation for accidents on the job, automobile accidents (ACAA), and services available through state or federal legislation which the member is not legally required to pay. Such services will also be excluded when they are denied by the concerned government agencies because of noncompliance or violation of requirements or provisions of above indicated laws, even when the noncompliance or violation does not constitute a crime.

3. Services for treatment arising from the insured member committing a crime or violating the laws of the Commonwealth of Puerto Rico or any other country, except those injuries resulting from an act of domestic violence or medical condition.

4. Services received without charge or defrayed through donations.

5. Expenses or services for personal comfort such as telephone, television or custodial services, rest home, convalescent home, or home care, except post-hospital services provided through a Home Healthcare Agency.

6. Services rendered by health professionals, who are not doctors in medicine or odontology, except audiologists, optometrists, podiatrists, psychologists, social workers (for autism only), chiropractors, and others specified in the policy.

7. Expenses for physical examinations required by the employer of the insured employee.

8. Reimbursement of expenses covering payments made by a member to any physician or participating provider despite not being required to do so by this contract.

9. Expenses for services rendered by non-participating physicians, hospitals, laboratories, and other providers in Puerto Rico, except in case of emergency, which will be covered as required by law and as provided in this policy.

10. Expenses for services received without a precertification from Triple-S Salud, except in case of emergency, as provided in the policy.

11. Services that are not medically necessary, services considered experimental or investigational, as defined by the Food and Drug Administration (FDA), Department of Human and Health Services (DHHS), the Commonwealth's Department of Health, or the Technology Evaluation Center (TEC) of the Blue Cross and Blue Shield Association for specific indications and methods ordered.

12. Expenses or services for new medical procedures or new medications that are not considered to be experimental or investigative, until Triple-S Salud determines their inclusion in the coverage offered under this policy. Neither are covered expenses for research clinical studies or treatments (i.e., clinical trials), devices, experimental or investigative medications administered to be used as part of these studies, services or products provided to obtain data and analysis, and not for the direct management of the patient, and items or services without cost to the member commonly offered by the sponsor of the research. This applies even if the member has signed up for the study to treat an illness that threatens his life, for which there is no effective treatment and obtains the approval of his physician for his participation in the study, because it offers a potential benefit to the patient. In these cases, Triple-S Salud will cover routine medical expenses of the patient according to the terms and conditions established in this policy. Routine medical expenses are those medically necessary expenses required for the study (clinical trials) and which are normally available to members under this

plan whether or not participating in a clinical trial, as well as services to diagnose and treat complications resulting from the study, according to the established coverage in this policy.

13. Expenses for cosmetic surgery or to correct physical defects: mammoplasties or reconstruction of the breasts to reduce or increase their size, except mammoplasty and reconstruction after a mastectomy for breast cancer; septoplasty, rhinoseptoplasty, blepharoplasty; surgery and medical treatment whose purpose is to control obesity, except treatment for morbid obesity and metabolic syndrome including bariatric surgery, as defined by Law 212 of August 9, 2008 in Puerto Rico and defined in the Definitions section of this policy; or liposuction, abdominoplasty and abdominal rhytidectomy and sclerotic solution injections for varicose veins of the legs. In addition, hospital, medical/surgical services and complications associated to these treatments and procedures are excluded regardless if there is or not a medical justification for the procedure.

14. Expenses for orthopedic or orthotic devices, prosthesis or implants (except breast prosthesis after a mastectomy) and other artificial devices. Hospital and medical-surgical expenses necessary for the implantation of these devices will be covered.

15. Expenses for contraceptive methods for the insured member; except those indicated as covered in this policy.

16. Services for infertility treatment, conception by artificial means (e.g., in vitro fertilization, intracytoplasmic sperm injection, embryo transfer, donor fertilization) and surgical procedures to restore the ability to procreate. Hospital, medical and surgical services, treatment for any complications that may arise and drugs and hormones used for this purpose are also excluded. Labs ordered for the treatment of infertility will be covered, as long as they are a covered service under this policy.

17. Expenses for scalenotomy services - division of the scalene anticus muscle without resection of the cervical rib.

18. Expenses for alternative medicine treatments, except those specified as covered in the Triple-S Natural Program and that are rendered by participating providers of this Program.

19. Expenses for sports medicine, psychoanalysis and cardiac rehabilitation.

20. Intravenous or inhaled analgesia services provided in the office of the oral surgeon or dentist.

21. Services necessary for the treatment of the temporomandibular articulation syndrome (articulation of the jawbone), whether it is through the application of prosthetic devices or any other method.

22. Expenses for the excision of granulomas or radicular cysts (periapical) originated by infection of the tooth pulp; services necessary to correct the vertical dimension or occlusion, removal of exocytosis (mandibular or maxillary torus, etc.).

23. Expenses related to materials for orthognathic surgery (Mandibular and maxillary osteotomy [Le Fort]).

24. Expenses for allergy immunotherapy.

25. Services rendered for an induced abortion.

26. Expenses in excess of the first 30 days for newborns of the direct dependent of the insured employee after birth.

27. Services rendered at Ambulatory Surgery Centers for procedures that can be performed in the surgeon's office.

28. Expenses resulting from organ or tissue transplants (example heart, heart-lung, kidney, liver, pancreas, bone marrow). Hospitalizations, complications, chemotherapies and immunosuppressant drugs related to the transplant are also excluded. Only the organ and tissue transplants specifically included in this policy will be covered.

29. Hospitalizations due to services or procedures that may be performed on an outpatient basis.

30. Expenses related with the administration of the employer drug detection program, such as: coordination, sample taking and administration of detection tests even when they are provided by a participating provider, coordination of services to the employee that must be made by the employer or the entity responsible to manage the program, among others. In addition, expenses for care, supplies, treatment and/or services that the member obtains from the employer without cost and the services provided by the Employee Assistance Program of the employer as part of the employer drug detection program are excluded.

31. Expenses brought about by war, civil disobedience or international armed conflict, except in those cases where the services received are related to an injury suffered while the member was active in the army (service connected), in whose case Triple-S Salud will recover from the Veterans Administration.

32. Laboratory tests that are not coded in the Laboratory Manual, as well as those considered experimental or investigational will not be considered for payment by Triple-S Salud.

33. Expenses for heavy metals, doping, HLA Typing and paternity labs tests.

34. Immunizations for traveling purposes or against occupational hazards and risks.

35. Expenses for services rendered by sea ambulance.

36. Services rendered by Residential Treatment facilities outside Puerto Rico, regardless if there is or not a medical justification for the treatment.

37. Surgery to remove excess skin after a bariatric surgery or gastric bypass surgery will not be covered, unless the treating physician certifies that is necessary to remove the excess skin because it affects the functioning of a body part. Precertification required.

38. Expenses for the removal of skin tags, ptosis repair, injection in tendons/ trigger points.

39. Expenses for occupational therapy and speech therapy, except those offered under the post-hospital services and BIDA law.

40. Services of surgical assistance, regardless of whether or not there is no medical justification for the same.

41. Expenses for dental services. In addition, hospital services are excluded, medical-surgical procedures and complications associated with these.

42. *Doppler Color Flow*.

43. Expenses for services provided to optional dependents, be it understood immediate family members, who are not eligible as dependents, except as defined by law as set out in the definition of optional dependent.

44. Expenses for medical services in interpretation of fetal monitoring.

45. Preventive services rendered by providers outside of Puerto Rico.

EXCLUSIONS FOR THE MAJOR MEDICAL EXPENSES COVERAGE

Exclusions of the Basic Coverage of hospitalization, medical/surgical and ambulatory services apply to this coverage, except those services specifically listed as covered services.

This coverage excludes the following expenses:

1. Caused by war or armed international conflict.

2. Services in excess of the limits set forth in the Basic Coverage, except those services expressly indicated in the Limitation section of the Major Medical Expenses coverage.

3. Expenses for services not included in the Basic Coverage, except those indicated in this policy.

4. Dental services for the care and treatment of the teeth and gums.

5. Eyeglasses, orthopedic and orthotic devices, except those that are required because of an accidental injury.

6. Services while admitted in an institution that is primarily a school or other institution for training, a resting place, a home for senior citizens or a private sanatorium.

7. Services of a social worker including a psychologist or psychiatric social worker; except in cases of autism.

8. Services provided by an air ambulance, which are covered in the Basic Coverage.

   The services provided by a marine ambulance are also excluded.

9. Services related to any type of dialysis or hemodialysis, and complications related to them, and their respective hospital or medical/surgical services, regardless of the health condition that made them necessary.

10. Expenses for copayments or coinsurances applicable to the basic policy of hospitalization, medical-surgical and ambulatory services and their riders.

11. Expenses for post-hospital services received in a Skilled Nursing Care Facility or in a Home Health Care Agency.

12. Expenses for immunizations, radioactive treatment and tympanometry.

13. Services provided by non-participating professionals and facilities in Puerto Rico, except in cases of emergency or when the specialty is not available in the network of participating providers of Triple-S Salud.

14. Expenses for services provided to optional dependents, regardless of whether they are subscribed to the Basic Coverage of hospitalization, medical-surgical and outpatient services.

15. Services provided by non-participating professionals and facilities outside of Puerto Rico, except in cases of emergency.

ORGAN AND TRANSPLANT EXCLUSIONS

This policy does not cover the following expenses or services:

1. Expenses caused by war or international armed conflict.

2. Services provided while the insurance of the person is not in force.

3. Services available under state or federal law, for which the insured member is not legally bound to pay. These services will also be excluded when they are denied by the appropriate government agencies, due to the breach or violation of the requirements or provisions of the above-mentioned laws, even if such breach or violation does not constitute a crime.

4. Services for treatments resulting from the commission of a crime or a breach of the laws of the Commonwealth of Puerto Rico, or any other country, by the covered person, except in those injuries resulting from an act of domestic violence or medical condition.

5. Services that are received free of charge or paid through donations.

6. Expenses or services of personal comfort such as telephone, television, services of custodial care, rest house, convalescence home or home care.

7. Reimbursement of expenses incurred for payments that an insured member makes to any physician or provider for services not covered under this policy.

8. Services that not are medically necessary, services considered experimental or investigative, as defined by the Food and Drug Administration (FDA), Department of Human and Health Services (DHHS), the Department of Health, or are not in accordance with the medical policy established by the Technology Evaluation & Coverage Manual (TEC) of the Blue Cross and Blue Shield Association for the specific indications and methods that are ordered.

9. Expenses or services for new medical procedures, not considered experimental or investigative services, until Triple-S Salud determines their inclusion in the coverage offered under this policy. Once included in the coverage, Triple-S Salud will pay for such services a quantity not greater than the average amount that it would have paid if said service was provided through conventional methods, until a fee is established for these procedures.

10. Expenses and services associated with organ and tissue transplants provided or received without a precertification from Triple-S Salud or its authorized representative.

11. Expenses for services of special nurses and expenses for home visits.

12. Services provided by air or sea ambulance.

13. Expenses for services provided to optional dependents, regardless of whether they are subscribed to the Basic Coverage of hospitalization, medical-surgical and outpatient services.

14. Expenses for services provided by facilities and/or providers that are not part of the established Organ Transplant Network.

PRESCRIPTION DRUG BENEFIT EXCLUSIONS

The exclusions of the policy of inpatient hospital services, outpatient medical-surgical and apply to this cover, except those services which are specifically mentioned as covered services. Triple-S Salud will not be responsible for the expenses corresponding to the following benefits:

1. Prescription drugs that do not have the legend: «*Caution: Federal law prohibits dispensing without prescription*» (*Over-the-Counter* [*OTC*]), except those included in Triple-S Salud OTC Program and some doses of aspirin for members over 18 years of age.

2. Expenses for artificial supplies (hypodermic needles, syringes, lancets, strips, glucometers to measure glucose in blood and urine) and similar supplies, even when they are used for therapeutic purposes.

3. The following prescription drugs are excluded from the pharmacy coverage, regardless if they have the federal legend: «*Caution: Federal law prohibits dispensing without prescription*»:

   a. Medications for cosmetic purposes or any other product with the same purpose (*hydroquinone*, *minozidil solution*, *efformitine*, *finasteride*, *monobenzone*, *dihydroxyacetone* and *bimatropost*).

   b. Fluoride products for dental use (except for children between ages from six months to 6 years of age) and dermatological medications such as pediculosis and scabicides (*lindane*, *permetrine*, *crotamiton*, *malathion* and *ivermectin*), products to treat dandruff including shampoo (*phyrithione zinc 1%*), lotions and soaps, alopetia treatment (baldness) such as R*ogaine® (minoxidil topical soln)* and painkillers (*Nubain®* and *Stadol®*).

   c. Products to control obesity and other drugs used in this treatment (*benzphetamine*, *diethylpropion*, *phendimetrazine*, *phentermine* and *mazindol*).

   d. Dietetic products (*Foltx®, Metanx®, Limbrel®* and *Folbalin Plus®*).

   e. Drugs for infertility (*follitropin, clomiphene, menotropins* and *urofollitropin*), fertility or erectile dysfunction (*tadalafil, alprostadil, vardefanil, sildefanil* and yohimbine) or implants (*levonorgestrel implant, goserelin, sodium hyaluronate, hyaluronan and hylan*).

   f. Drugs used in diagnostic tests (*thyrotropin*, *dipyridamole IV 5mg/ml, gonadorelin HCl, cosyntropin* and *glucagon*) and prescription drugs for immunization*(hepatitis A & B, influenza, encephalitis, measles, mumps, poliovirus, papillomavirus, rabies, rotavirus, rubella, varicella, yellow fever, zoster, cholera, haemophilus b, lyme disease, meningococcal, plague, pneumococcal, typhoid, tetanus toxoid, diphtheria, immune globulin, respiratory syncytial virus, palivizumab, pagademase bovine, staphage lyphates* ***and their combinations****, allergy tests)*

   g. Oral nutritional supplements, except some doses of folic acid for the insured member and some presentations of iron supplements for children between 6 and 12 months of age in accordance with the regulation G*roup Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act.*

   h. Oral vitamins (alone or combined with other vitamins, minerals and

folic acid) and injectable (niacin, ascorbic acid, thiamine, riboflavin, vitamin E, pyridoxine dihidrotaquisterol, multivitamins with minerals, multivitamins with iron, multivitamins with calcium, B vitamin complex-biotin-D- folic acid, B-complex with vitamin C – folic acid and flavonoids).

i. Medications classified as treatment for alternative medicine (valerian root, European mistletoe, glucosamine-condointrine – PABA-vit E and alphalipoic acid).

4. Products considered experimental or investigative for the treatment of certain conditions, for which the Food and Drug Administration has not authorized their use. Expenses related to investigative clinical treatment studies (i.e., clinical trials), devices, experimental or investigative medications administered to be used as part of these studies, services or products provided to obtain data and analysis, and not for the direct management of the patient, and items or services without cost to the member which the sponsor of the research commonly offers are not covered. This applies even when the member has registered in the study to treat a disease that threatens his life, for which there is not an effective treatment and obtains the approval of the physician for his participation in the study because, this offers a potential benefit to the patient. In these cases, Triple-S Salud will cover the routine medical expenses of the patient according to the terms and conditions established in this policy. Routine medical expenses are those medically necessary expenses required for the study (clinical trials) and which are normally available to members under this plan whether or not they are participating in a clinical trial, as well as services to diagnose and treat complications resulting from the study, according to the coverage established in this policy.

5. Services rendered by non-participating pharmacies in Puerto Rico.

6. Services rendered by pharmacies outside Puerto Rico and the United States.

7. Refills ordered by a dentist or podiatrist.

8. Expenses for injectable antineoplastic agents.

9. Triple-S Salud reserves the right to choose those prescription drugs to be included in its Prescription Drug Coverage. Any expense for new prescription drugs will not be covered until said prescription drug is evaluated in a term not greater than 90 days after the FDA approval and recommended for inclusion by Triple-S Salud Pharmacy and Therapeutics Committee. In addition, any new prescription drug of an excluded therapeutic classification (categories) will also be considered an exclusion.

10. These will also be excluded: Trypan Blue solution (azoic dye which is used in histological staining allowing to differentiate between living cells and dead cells), intravenous lacosamide Vimpat® (medication to treat seizures), intracranial implants of carmustine (used to treat malignant glioma or glioblastoma multiforme, a type of brain tumor, its injectable version is covered under the basic coverage), viaspan (cold solution of storage for the conservation of organs before a transplant), sodium tetradecyl sulfate (improves the appearance of varicose veins), polidocanol (treatment of varicose veins), sodium murruato (treatment of hemangiomas), intrapleural talc (prevents malignant pleural effusion (fluid accumulation in the chest cavity of people with cancer or other serious illnesses) in people who already have this condition), solution for peritoneal dialysis (correction of the imbalance of electrolytes, fluid overload and elimination of metabolites in patients with severe renal insufficiency) and homeopathic products in all its presentations (natural products used to treat different conditions on an individual basis).

11. Prescription drugs for organ and tissue transplants (*cyclosporine modified*, *tacrolimus, sirolimus, cyclosporine, mycophenolate sodium, everolimus, azathropin, belatacept* and *basiliximab*).

12. Blood and its components (hetastarch6%/nacl IV, rehomacrodex IV, human albumin and fractions of plasma proteins).

13. Contraceptive methods as well as the services and any complications related to them, except those required for women by the federal law.

14. Acne medications (isotretinoin, tretinoin and its combinations).

15. Growth hormones *(somatropin, somatrem)*
.
16. Nutrients *(Dextrose, Lyposyn, Fructose, Alanicem, L-Carnitine, Trytophan).*

17. Anaphylaxis drugs *(epinephrine device).*

DENTAL COVERAGE EXCLUSIONS

The exclusions mentioned in the basic coverage related to hospitalization, medical-surgical and ambulatory services apply to this cover, except those services that are specifically mentioned as covered benefits.

Triple-S Salud will not pay for the following expenses or services, except if on the contrary are further stated:

1. All services not included as covered services in the coverage description.
2. Services for Full Mouth Reconstruction.
3. Endodontic treatment of primary (deciduous) teeth.
4. Basic, prosthesis, and periodontal dental services rendered by non-participating dental-surgeons in Puerto Rico.
5. All dental services that are rendered for beautification purposes.
6. Temporomandibular (TMJ) syndrome treatment.
7. Expenses for device replacements or repairs provided under orthodontic services.
8. The treatment of fluoride varnish is mutually exclusive of the topical fluoride treatment, (it is one or the other), not both.

PROCEDURE FOR OBTAINING REIMBURSEMENT

1. Claims for reimbursement must be sent to:

   a. Through our Internet portal www.ssspr.com. In the section of members on the left hand you will find the steps to submit a refund online. The tool also provides an educational brochure to guide you in this process.

   b. Through electronic mail (email). For medical services, you must send it to the following address: reembolso@ssspr.com. For dental services, you must send the document to: reemdental@ssspr.com.

   c. By mail: Triple-S Salud, Inc. PO Box 363628, San Juan, PR 00936-3628

   d. Must include the following:

      - Full name and contract number of the member who received the service
      - Date of service
      - Diagnosis code (ICD-10)
      - CPT code
      - National Provider Identifier (NPI)
      - Stamp or letterhead with provider's name, address, and specialty
      - Amount and description of services received
      - Amount paid
      - Provider or participant signature and license
      - Reason for requesting reimbursement
      - In the case of ambulance services, you must include information about the distance traveled, as well as evidence of medical necessity.
      - For services that require a precertification, include a copy of the precertification.

   To request reimbursement for prescription drugs you must include:

      - Original receipt from the pharmacy
      - Name and contract number of the member that received the services
      - Name of the medicine
      - Daily dose
      - Number of the prescription
      - Amount dispensed
      - National Drug Code (NDC)
      - National Provider Identifier (NPI) of the pharmacy and the prescribing physician
      - If you paid a participating pharmacy, indicate the reason
      - Indicate cost per drug

   To request reimbursement for dental services you must include:

      - Service code, tooth number and surface number.
      - Amount paid for each service.
      - If the member pays more than one visit in one receipt, he/she must send the exact dates (**MONTH**, **DAY**, and **YEAR**) of the services for which he/she paid.
      - In case of orthodontic services, if he/she has the orthodontics coverage must include the detail of the first visit, down payment, monthly payments, total cost and duration of active treatment.
      - If the person has dental prosthesis and periodontal services coverage, must include X-rays.

   To request reimbursement through Coordination of Benefits add:

      - Contract number of the other plan
      - If the reimbursement is for amounts left unpaid by your other plan, you must include the Explanation of Benefits of the other plan.

2. You must send Triple-S Salud written notice of the claim within 20 days from the date the service was received or as soon as it is reasonably possible for the insured member or the employer, as long as it does not

exceed a one-year term from the date the service was rendered.

3. Triple-S Salud has up to 15 days to send an acknowledgement of receipt after it receives the claim. Notifications sent to any of the persons the member designated to receive claims on his behalf will be considered a notification provided to the member, as long as the authorization is in effect and has not been revoked. If the person is not authorized and receives a notification on behalf of the member, he must inform it to the claimant within 7 days and must indicate the name and address of the person who must receive the notice.

4. Triple-S Salud will conduct the investigation, make the adjustment and solve any claim within the shortest period within 90 days after it received the request. If Triple-S Salud cannot solve the situation within the timeframe previously stated, it will keep in its records the documents evidencing a fair cause to exceed this term. The Insurance Commissioner has the authority to request the immediate solution of any claim, if he understands that the process is being unduly and unreasonably delayed.

PRECERTIFICATIONS

The precertification process guarantees that you and your family will receive the adequate level of care for your health condition. The purpose of the precertification is to set forth coordinated care measures to ensure that hospital and ambulatory services are rendered in an adequate location, when needed and by the adequate professional. It also helps to verify the member's eligibility for the service requested.

The physician, hospital and facility are oriented on those services that must be preauthorized. The precertification may be for hospital or ambulatory services.

Precertification requests for studies and procedures will be requested by the attending physician, the clinical staff he/she designates or the facility where you will receive the service, by calling to Triple-S Salud Precertification's Department; the call center that handles these cases Monday to Friday from 7:00am to 6:00pm. Providers may also request a precertification for some studies and procedures through our website at www.ssspr.com, available 24 hours a day, 7 days a week.

The services for which you or your physician must request a precertification to Triple-S Salud are:

- Bariatric surgery and surgery post-bariatric surgery (torso and abdomen)
- Lithotripsy
- PET CT Scan or PET Scan
- Reconstructive surgeries and procedures that can be performed ambulatory and for a medical reason need another level of care (change in care level)
- Respiratory syncytial virus immunoprophylaxis
- Genetic tests
- Durable medical equipment
- Skilled nursing facility
- Home healthcare services
- Hospice
- Non-emergency services in the United States
- General anesthesia and hospitalization services for dental procedures for minors and people with physical or mental disabilities that require them.
- Insulin infusion pump and supplies for members under the age of 21 diagnosed with Diabetes Mellitus Type 1.

For precertifications or if you need a medical service and have questions on whether or not you should request a precertification, or if you need additional information, contact our Customer Service Department at (787) 774-6060.

You may submit the required information by fax or mail.

Main Office: (787) 749-0265

Mail:
Triple-S Salud, Inc.
Precertifications Department
PO Box 363628
San Juan, PR 00936-3628

PROCEDURE FOR PROCESSING PRECERTIFICATIONS

Upon receipt of the request for the precertification, Triple-S Salud will evaluate the request and will notify its determination to you in a period not longer than 15 days after its receipt.

If the request is incomplete and does not meet the minimum requirements for evaluation, Triple-S Salud will notify you in writing or verbally in a period not to exceed five (5) days and will confirm the information that you must submit to complete the evaluation process. If you request that the confirmation is in writing, Triple-S Salud will send you the notice within the prescribed period. In these cases, you will have up to 45 days to provide the information requested from the date of the notification.

Triple-S Salud may need fifteen (15) additional days to the initial term to make a decision on your request for precertification. In these cases, Triple-S Salud will notify you no later than fifteen (15) days of having received your request of precertification and will include the reasons to extend that term.

PRECERTIFICATIONS IN URGENT CASES

You may need Triple-S Salud to consider your precertification request urgently. This may be due to a health condition which, according to the opinion of the treating physician, may jeopardize your life, health or ability to regain maximum functions or because waiting for the standard precertification process would subject you to severe pain that could not be adequately managed without the treatment for which the precertification is requested. In this case, the treating physician must certify the urgency of the precertification. Once indicated by the physician, Triple-S Salud will work the request urgently. The request in these cases may be initiated in writing or orally. Triple-S Salud must notify you their decision, either orally or in writing, unless you request it must be in writing, within 24 hours from the receipt of your request. If Triple-S Salud needs additional information to issue their determination, they must notify you orally or in writing, unless you request it must be in writing, within 24 hours from the receipt of your request. You or your representative will have no less than 48 hours from the notification to submit any additional information requested. Once Triple-S Salud receives the additional information, they must give you an answer within 48 hours from the earlier between the date of receipt of the additional information and the expiration date of the term allowed to receive it. If Triple-S Salud does not receive the additional information within the term required, they may deny the certification of the benefit requested.

The notification on the adverse determination will include the following:

- Date of service, provider, amount of the claim, diagnostic and treatment codes, as well as their meanings, if applicable.
- Specific reasons for the adverse determination, including the denial code and its meaning, as well as a description of the standards, if any, used for the determination;
- Reference to the specific plan provisions on which the determination is based;
- Description of all the materials or additional information needed to complete the request, including an explanation on why it is necessary;
- Description of the plan's internal grievance procedures and expedite review procedures, including the timeframes that apply to said procedures;
- If to make the adverse determination, they considered a rule, guideline, internal protocol or other similar criteria, the plan will provide a copy to the insured member; free of charge
- If the adverse determination considered the judgment of medical necessity, in the experimental or investigational nature of the procedure or a similar exclusion or limit, they will include an explanation of the scientific or clinical reasoning considered for the determination when applying the terms of the health plan to the circumstances of the insured member.

You have the right to contact the Office of the Insurance Commissioner or the Health Ombudsman to request help at any moment and have the right to file a lawsuit in a competent court when you exhaust Triple-S Salud internal grievance procedures. The Office of the Insurance Commissioner is located at GAM Tower, Urb. Caparra Hills Industrial Park, 2 Tabonuco Street Suite 400, Guaynabo, PR, and you can contact them at (787) 304-8686. The Office of the Patients Ombudsman is located at Mercantil Plaza, 1501 Ponce de León Ave., Hato Rey, PR and you can contact them at (787) 977-0909 (Metro Area) or the toll-free number 1-800-981-0031.

EXPEDITE (FAST) APPEALS OF PRECERTIFICATIONS DENIED ON URGENT CASES

If you do not agree with the initial determination in case of urgent precertifications you can request an expedite appeal. You or your representative must present the arguments on why you understand that your precertification must be granted under the terms of your policy and submit the documentary evidence Triple-S Salud requests or the one on which you base your arguments. Triple-S Salud must answer your appeal orally, in writing, or electronically within 48 hours from the receipt of your request. If they contact you orally, they must send the written notification no later than three days after they gave you the oral notification.

PREAUTHORIZATIONS FOR PRESCRIPTION DRUGS

Certain prescription drugs need a preauthorization for the patient to obtain them. Prescription drugs that require a preauthorization are usually those that may have adverse side effects, are candidates to inappropriate use or relate to high costs.

The physicians and the pharmacies are oriented on the prescription drugs that must be preauthorized. In addition, prescription drugs that require a preauthorization are identified in the Prescription Drug List or Formulary with acronym PA on the column to the right of the prescription drug, in which case the pharmacy obtains the preauthorization before dispensing the drug.

For a preauthorization or if when needing a prescription drug, the member is not sure whether he/she must obtain or not a preauthorization, or if he/she needs additional information, the member must contact the Customer Service Department at (787) 774-6060.

Procedure for the processing of Preauthorizations

Triple-S Salud has a period of 72 hours (3 days) from the receipt of the prescription drug preauthorization request for the following:

a. Notify its determination or,

b. Request documentation to the physician, the member, or the pharmacy, if it has not received the documentation required.

If the documentation requested for the evaluation of the prescription drug is not received within 72 hours, Triple-S Salud will send a notice to the member requesting the additional information needed within a term that does not exceed 45 days. The member must send the information by fax, identifying it with his/her contract number.

If Triple-S Salud does not make a determination regarding the preauthorization request or notifies the member during the established term (72 hours; 36 for controlled prescription drugs) the member will have the right to receive a thirty (30)-day supply of the prescription drug object of the precertification request, as requested or prescribed, or in the case of step therapy, for the terms provided by the coverage.

Triple-S Salud will make a determination regarding the preauthorization request before the person finishes the prescription drug dispensed. If the determination is not made and the notice is not sent within this period, coverage will be maintained continuously and within the same terms. This, as long as the prescription drug is being prescribed, it is considered a safe treatment, and until the person has exhausted the applicable limits for the benefits.

PROCESS FOR EXCEPTIONS TO THE PRESCRIPTION DRUG LIST OR FORMULARY

The member can request Triple-S Salud to make an exception to the coverage rules as long as the prescription drug is not exclusion. An exception is when the member requests us to cover a prescription drug that is not included in the Formulary or Prescription Drug List of his coverage. There are prescription drugs that are classified as categorical exclusions. This means that the plan has established a specific provision for not covering a prescription drug identifying it by its scientific or commercial name.

Types of exceptions

There are several types of exceptions the insured member can request:

- The member can request us to cover his medicine even when it is not in our Formulary or Prescription Drug List.
- The member can request us to cover a medicine that has been or will be removed from the Formulary or Prescription Drug List.
- The member can request us a management exception, which implies that the drug prescribed will not be covered until the member complies with the step therapy requirement or if it has a limit to the amount to be dispensed.
- The member can request us a duplicate therapy exception if there is a change in dose or the physician has prescribed another drug from the same therapeutic category.
- Another exception the plan can grant is for medicines whose use does not have the approval of the Food and Drugs Administration (FDA). These prescription drugs are not usually covered, except in those health conditions in which its efficiency has been proved based on scientific or medical evidence for that other use, according to reference books that include the medical categories for their approval or denial.

How to make the request

The member, his/her authorized representative, or the prescribing physician can request the exception request as follows:

1. Through telephone calls at (787) 749-4949 – the person will be given instructions on the process to follow to request an exception.
2. By fax at (787) 774-4832 of the Pharmacy Department – must send all the documents for us to evaluate the request and must include the contract number.
3. By mail, to the following address: Triple-S Salud, PO Box 363628, San Juan, PR 00936-3628.

Information required for the approval of your exception request

To process your exception request, your physician must provide the following information:

- Name of the patient
- Contract number
- Primary diagnostic
- Reason for which the member cannot use any of the prescription drugs:
  - In the formulary that is a clinically acceptable option to treat the illness or the medical condition;
  - The first step prescription drugs in step therapy
- Reason for which a greater dose is required or why the physician prescribes another prescription drug of the same therapeutic category.

How Triple-S Salud processes a prescription drug exception

I. The mechanism to request a medical exception will be available in the following cases:

   a. Prescription drugs not covered by the formulary
   b. Discontinuation of coverage for reasons other than safety or manufacturer recall
   c. Exception to the step therapy or dose limitation procedures

II. Triple-S Salud Department of Pharmacy has established that only the insured

member or his personal representative can make the exception request in writing using Form CSS-AS-04-002, for the following reasons:

a. There is not a prescription drug listed on the formulary that is a clinically acceptable alternative to treat the member's disease or medical condition.

b. The prescription drug alternative listed on the formulary or that is required according to step therapy:

   1) Has been ineffective in the treatment of the member's disease or medical condition or based on clinical and medical evidence and scientific evidence and the known relevant physical and mental characteristics of the insured member and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

   2) Has caused, or based on sound clinical evidence and medical and scientific evidence is likely to cause and adverse reaction or other harm to the insured member.

   3) The member was already on a higher level of the step therapy of another health plan, for which it would be unreasonable to require the person to begin in a lower level of step therapy.

c. The number of doses that is available under a dose restriction for the prescription drug has been ineffective in the treatment of the member's disease or medical condition or, based on clinical and medical evidence and scientific evidence and the known relevant physical or mental characteristics of the member and known characteristics of the drug regimen, is likely to be ineffective or adversely affects the drug's effectiveness or patient compliance.

The exception request form is available for free at www.ssspr.com in Insured Forms and on the Prescription Drug Lists or Formularies.

III. The written request for a medical exception must include the following information:

a. Name, group number, contract number

b. Patient history

c. The primary diagnosis related to the prescription drug that is the subject of the medical exception request.

d. The reason:

   1) Why the prescription drug on the formulary is not acceptable for the individual patient;

   2) If the medical exception request involves a step therapy requirement, why prescription drug required to be used is not acceptable for the individual patient.

   3) If the medical exception request involves a dose restriction, why the available doses for the prescription drug is not acceptable for the individual patient.

IV. The medical exception request is reviewed by the appropriate health care professionals, depending on the health condition for which the exception is requested, who are experienced in prescription drug management.

V. The health professional evaluating the request will use documented clinical review criteria that:

a. Are based on sound clinical evidence and medical and scientific evidence.

b. Appropriate practice guidelines

c. The benefits and exclusions of the policy

VI. Triple-S Salud Pharmacy Department will issue its determination within 72 hours, or 36 hours in case of controlled drugs, after the later of the date of receipt

of the request or the date of receipt of the medical certification together with all the documents necessary for the evaluation of the request.

VII. If Triple-S Salud's Pharmacy Department fails to make a determination on the request within the time frame mentioned above, it will honor the insured member's right to a supply for up to 30 days of the prescription drug.

VIII. If Triple-S Salud's Pharmacy Department fails to make a determination before the 30-day period expires, it shall maintain coverage on an ongoing basis, as long as the prescription drug continues to be prescribed for the same condition and is considered safe.

IX. If Triple-S Salud's Pharmacy Department approves the medical exception, it will provide coverage for the prescription drug and will not require the member to request approval for a refill or a new prescription to continue using the same prescription drug, so long as the prescription drug is prescribed to treat the same disease or medical condition and the prescription drug continues to be safe.

X. Triple-S Salud's Pharmacy Department shall not establish a copayment or coinsurance tier that is applicable only to prescription drugs approved for coverage by medical exception.

XI. Any denial of a medical exception will be notified to:

1) The member or, if applicable, to the personal representative in writing or electronically if the member has agreed to receive information in this manner.
2) The prescribing physician electronically or, upon request, in writing.

XII. In the denial notice, the plan will inform the member of his right to file a grievance as established in this policy.

XIII. The denial shall set forth:

a. The specific reasons for the denial
b. A reference to the evidence or documentation, including the clinical review criteria and the practice guidelines considered in reaching the decision to deny the request.
c. Instructions for requesting a written statement of the clinical and medical or scientific justification for the denial
d. A description of the process for filing a grievance to appeal the denial, including the time limits.

XIV. Triple-S Salud's Pharmacy Department will keep written and electronic records documenting the medical exception request process.

Process for notifying the coverage determination

The process for notifying denials that do not meet the criteria set forth for non-formulary coverage, preauthorization, step-therapy, quantity limits, duplicate therapy, use not approved by the FDA, includes:

- The specific reasons for the denial;
- A reference to the evidence or documentation, including the clinical review criteria and the practice guidelines as well as clinical and medical evidence and scientific evidence considered in reaching the decision to deny the request;
- Instructions for requesting a written statement of the clinical and medical or scientific justification for the denial; and
- A description of the process and procedures for filing a grievance to appeal the denial.

The denial shall be issued in a manner to be understood by the member or, if applicable, by the person's personal representative. If they deny the exception request, the insured member or the prescribing physician can appeal our determination pursuant to the process on Appeals to Adverse Benefit Determinations.

APPEALS TO ADVERSE BENEFIT DETERMINATIONS

Adverse determination means:

- A determination made by a health carrier or utilization review organization where a benefit is denied, reduced or terminated, or the payment is not provided, in whole or in part, for upon application of utilization review techniques and based upon the information provided, the benefit claimed, according to the health carrier, does not meet the requirements of medical necessity and appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational;

- The denial, reduction, termination or absence of payment of a benefit, either partially or in its entirely, by the insurer, or an organization of utilization review, based on the determination of the eligibility of the member to participate in the medical plan; or

- The determination resulting from a prospective review or retrospective review that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit.

- Rescission of Coverage

The member may request a review of the determination as explained below.

RIGHT TO APPEAL AN ADVERSE DETERMINATION

If you disagree with Triple-S Salud's adverse determination related to a request for reimbursement, a request for precertification or any other adverse benefits determination described in this policy, you may appeal Triple-S Salud's determination:

APPEALS PROCEDURE

1. First level of appeal

You or your authorized representative (please refer to the requirements that appear at the end of this Section in Right to Appoint a Representative), must file grievance, in writing, within 180 days after the date you received the first notice on the adverse determination to be evaluated regardless if you included with your appeal all the information needed to make the determination. When filing your appeal, you may request assistance from the Office of the Insurance Commissioner, the Patient's Ombudsman or a lawyer of your preference (at your expense). For your appeal to be considered, it must include the following, when applicable:

- Name and contract number of the plan member that received the services being appealed
- Date of service
- Number of services and description of the services received
- Original receipt for any amount paid by the appellant
- Invoices from the provider
- Name and address of the provider
- Evidence of the precertification granted and/or the medical need certification, if any of these was required in order to receive the service
- Forms CMS-1500 or UB-92, duly completed by the provider
- A written statement explaining why you believe Triple-S Salud was mistaken in its decision on your reimbursement, precertification or benefit claim pursuant to the provisions of this policy

You must also submit any other written evidence or information regarding your appeal. You must send your request for appeal to Triple-S Salud, Inc. Customer Service Division, PO BOX 363628, San Juan, PR 00936-3628. In this level of appeal, Triple-S Salud will evaluate your grievance. For information on your request, call the contact numbers of our Department.

Triple-S Salud will acknowledge receipt of the grievance to the insured member no later than three (3) working days from the date it was received, and will confirm the representative designated to coordinate the review on the first

level, including the person's contact information. They will also inform you your rights on filing the grievance.

If the grievance results from a utilization review adverse determination, Triple-S Salud will designate one or more clinical peers of the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peers shall not have been involved in the initial adverse determination. They will also ensure that the clinical peers to perform the review have the appropriate expertise to evaluate the appeal.

The reviewer(s) will take into consideration all comments, documents and records, and other information regarding the review request submitted, regardless if the information was submitted or considered in making the initial adverse determination.

Besides submitting written comments, documents, files and other materials relating to the grievance object of the review, you have the right to receive, upon request and free of charge, access to, and copies of all the documents and records relevant to the grievance. This includes any information relevant to the filing of the grievance that:

- Was relied upon in making the benefit determination;
- Was submitted, considered or generated in the course of making the adverse determination, without regard to whether the document, record or other information was relied upon in making the determination;
- Demonstrates that, in making the determination, Triple-S Salud consistently applied, the same administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons or members; or
- Constitutes a statement of policy or guidance with respect to the health benefit plan concerning the denied health care service or treatment for the member's diagnosis, without regard to whether they were relied upon in making the initial adverse determination.

Triple-S Salud will notify its decision, in writing, to the insured member or to his/her personal representative, according to the established terms and given the person's medical condition:

- Grievances in which the member requests a review of a first level adverse determination involving a prospective review, within a reasonable period of time, that is appropriate given the medical condition of the member, but no later than fifteen (15) calendar days after the date the plan received the grievance.
- Grievances in which the insured member requests a review of a first level adverse determination involving a retrospective review, within a reasonable period of time, but no later than thirty (30) calendar days after the date the plan received the grievance.

Said determination will include:

- The titles and qualifying credentials of the reviewers that participated in the evaluation of the grievance;
- A statement of the reviewers' understanding of the grievance;
- The reviewers' determination with the medical justification and the contract basis for the insured member or his personal representative to respond further to the evaluation;
- The evidence or documentation used as the basis for the determination;
- In case of an adverse determination:
    - The specific reason for the adverse determination;
    - Reference to the specific health plan provisions on which the determination is based;
    - A statement that the insured member is entitled to receive free of charge access to and copies of the documents, records and any other relevant information used in the evaluation of the grievance, including any rule, guideline, internal protocol or any other similar criterion the plan relied upon to make the determination.
    - If the adverse determination is based on a medical necessity or experimental or investigational

treatment or a similar exclusion or limit, a written explanation of the scientific or clinical judgment used for making the determination, or a statement saying that an explanation will be provided to the member, or, if applicable, to his personal representative, free of charge upon request.

- If applicable, it must also include the instructions to request a copy of the rule, guideline, internal protocol or any other similar criterion relied upon when making the determination; an explanation of the scientific or clinical reasoning followed when making the determination; and the description of the process to obtain an additional voluntary review, as well as the terms for this review, in case the insured member is interested in requesting it. Likewise, it must include a description for obtaining an independent external review, if the insured member decides not to request another voluntary review and the member's right to bring a civil action in a court of competent jurisdiction.

- If applicable, it must also include a statement indicating other available options for voluntary resolutions to controversies, such as mediation and arbitration, and the right to contact the Office of the Insurance Commissioner or the Ombudsman Office for orientation and assistance, as well as the information on the contact numbers to call in these cases.

If your case is considered Urgent, Triple-S Salud will notify its decision no later than 48 hours, from the receipt of the complete request for appeal. An urgent appeal is an appeal request for services or medical treatment for which waiting for standard process to answer an appeal: a) may jeopardize the life of the plan member or the ability of a vital organ of his body to function at its maximum capacity, or b) on physician's opinion, the member will be submitted to severe pain that cannot be adequately managed without the medical care or treatment object of the appeal.

In case of appeals to precertifications, as well as prospective reviews, Triple-S Salud must inform their decision within 15 days from the receipt of your appeal request. In other cases, including retrospective reviews, Triple-S Salud must give an answer within 30 days from the receipt of the appeal request. The time to answer your grievance will be counted from Triple-S Salud receipt of the appeal request, without regard to whether you submit all the documentation necessary to make the determination. If the request for appeal does not include all the information necessary to make the determination, Triple-S Salud will notify the insured member or his personal representative the reasons why it cannot process the grievance and will indicate the documents or additional information the member must submit. If additional information is required, the member must provide the additional information within 45 days from the date of receipt of the notice. If the member fails to submit the information requested within this period, Triple-S Salud will make its decision based on the documents and information already submitted. Triple-S Salud may also notify you that your appeal is being evaluated, but it needs an extension. In this case, Triple-S Salud will have 15 additional days to notify their decision. Once Triple-S Salud notifies the member its decision, the member has the right to request Triple-S Salud to disclose the names and positions of the officers or experts that participated in the evaluation of the appeal, as well as an explanation of the criteria on which they based their decision.

The insured member has the right to contact the Office of the Insurance Commissioner or the Office of the Advocate for Patients to request their help. The information to contact these offices appears at the end of this Section, under subsection, Right to be Assisted.

2. Second level of appeal

If you do not agree with Triple-S Salud's decision on your first appeal, you have the right to file a second appeal within 60 days from the date Triple-S Salud notified its determination on your first appeal.

With this second request for appeal, you must include a copy of all the documents related to your first appeal and a statement to support your view on why you believe Triple-S Salud was mistaken in its determination on your first appeal. You may also include any additional evidence to support your allegations.

Your second appeal will be evaluated by reviewers that did not intervene in the

determination on the first appeal and are not subordinates of the persons who made the determination on your first appeal. Triple-S Salud previous decisions will not be considered in the review of your request for a second appeal. You have the right to request Triple-S Salud to disclose the names and positions of the officers or experts that evaluated your second appeal, as well as an explanation of the criteria on which they based their decision.

In case of urgent appeals (as defined earlier), Triple-S Salud must provide their determination to your appeal within 48 hours. In cases of precertification appeals, Triple-S Salud must respond to your second appeal within 15 days from the date it received your appeal. In other cases, Triple-S Salud must respond within 30 days from the date it received your appeal.

You have the right to contact the Office of the Insurance Commissioner or the Office of the Health Ombudsman to request their help. The information to contact these offices appears at the end of this Section, under subsection, Right to be Assisted.

3. Voluntary Review Level

If you are not satisfied with Triple-S Salud's determination on the First Level of Internal Appeal, you may request in writing a voluntary review of your case. At the voluntary level, you may provide additional information on your case that was not provided in the previous level of internal review.

Upon receipt of the request for an additional voluntary review, Triple-S Salud will acknowledge receipt and will notify the insured member or his personal representative on his right to:

- Request, within the specified time the opportunity to appear in person before the review panel it designated
- Receive copies of all documents, records and other information that are not confidential or privileged related to the request for additional voluntary review, if it is requested.
- Bring your case before the review panel
- Present written comments, documents, files and other materials regarding the additional voluntary review for the consideration of the panel before or during the review meeting, if applicable.
- If it were applicable, make questions to the review panel representatives; and
- Have the help or the representation of any person, including a lawyer, chosen by the member.

Triple-S Salud will not condition the right the insured member has to a fair review and to attend the review meeting.

Once the insured member or the personal representative receives our acknowledgement of receipt on his request, he may state in writing his interest on appearing before the review panel within 15 business days from the receipt of the acknowledgment of receipt.

Triple-S Salud will appoint a review committee to evaluate your request for you or your appointed representative to appear in person or by phone before the committee to bring your appeal. Most people of the review panel will have the proper expertise and did not form part of the first level review. If your appearance to a hearing before the panel is necessary, the date will be communicated to you in writing with at least 15 calendar days in advance and if Triple-S Salud will be assisted by its legal representation, it will indicate you that you can be assisted by your own legal representation. The hearing must occur no later than 30 calendar days after receipt of the request of the voluntary level review.

If the hearing takes place, the committee will conduct its evaluation, considering all comments, documents, files and any other information related to the voluntary review request you or your authorized representative submitted, regardless if the information you submitted was presented or considered when making prior determinations. The determination on the review will be issued no later than ten (10) calendar days after the hearing. If the hearing is not performed, Triple-S Salud will issue the committee's determination in writing or electronically, if it was requested, no later than 45 days from: 1) the date in which the person or personal representative indicated that he/she would not request a hearing, or 2) the date in which the term for the person to request a hearing before a committee ends. Once you receive notice on Triple-S Salud's determination, you have the right to request Triple-S Salud to provide you the names, titles and credentials of the officers or experts that

participated in the evaluation of your appeal, as well as an explanation on the grounds for their decision, a statement of the interpretation that the review panel did and all the relevant facts, reference to the evidence or documentation that the review panel considered for the determination.

If the request for additional voluntary review is related to an adverse determination, you will receive the instructions to request a written statement of the medical justification as well as the clinical review criteria used for the determination and if applicable, a declaration with the procedures to obtain an external independent review of the adverse determination.

If within twenty (20) calendar days Triple-S Salud has not complied with the determination of the review committee, the latter has the obligation to notify the fact to the Insurance Commissioner Office.

You have the right to contact the Office of the Insurance Commissioner or the Office of the Health Ombudsman to request help. The information to contact these offices appears at the end of this section under, Right to be Assisted.

4. External Appeal Process

Triple-S Salud has chosen to benefit from the External Review Process through the Office of the Commissioner of Insurance (OCI). If after exhausting all levels of internal appeal, you are not satisfied with the final determination, you may request an external review by an Independent Review Organization (IRO), through the Insurance Commissioner, if you comply with certain requirements, as explained below. You will pay a nominal cost not greater than $25.00 for each review. Provided, that for the same member the cost cannot exceed seventy-five dollars ($75.00) per policy year. The amount paid by you will be refunded if this obtains an opinion on your favor.

The IRO is an accredited organization that conduct independent medical reviews. These reviews are conducted by an independent physician. The IRO has no connection or affiliation with Triple-S Salud. The IRO acts as a trustee of the Plan regarding the external reviews sent to the IRO.

The External Review Program provides an independent review process to evaluate appeals that only comply with the following requirements: a) your appeal is related to a retroactive cancellation of coverage,(coverage rescission); b) denial of coverage for medical care based on medical necessity, appropriateness, facility that will offer healthcare, level of care or effectiveness of a covered benefit and because of exclusions for experimental or investigational services or unproven services; c) if the plan failed to strictly comply with the procedure established under federal law, unless the violation has been:

- de *minimis*;
- non-prejudicial, attributable to good cause on matters beyond the plan's control
- in the context of an ongoing good faith exchange of information; and
- Not reflective of a practice of non-compliance

The External Review Program does not apply if the adverse benefit determination is based on an administrative determination such as:

- your eligibility;
- explicit exclusion of benefits
- defined benefit limits

Standard Independent Review Procedure

You may request an independent review of an adverse benefit determination that meet the requirements set forth in the preceding paragraphs.

All requests for external review must be filed within 120 days from the date you received the adverse determination. To request an external review, you or your authorized representative may call to request an external review to the toll-free number 787-304-8686.

You must complete the form to request the external review and the form for the Authorization of Use and Disclosure of Protected Health Information along with the final notification of adverse determination and send them by fax, mail or email to the Office of the Commissioner of Insurance as follows:

- **By Fax:** 787-273-6082
- **Regular Mail:**
  Office of the Insurance Commissioner
  Investigations Division
  B5 Tabonuco Street, Suite 216

PMB 356 Guaynabo, PR 00968-3029

- **By electronic mail: salud@ocs.pr.gov**

Remember, the information you provide in the application form will be used to request Triple-S Salud relevant documents, so that the independent review examiner can complete his evaluation. You also may submit information and documents to support your application such as our denial letter, evidence of benefits (EOB) and letters from your doctors, among others.

The independent review organization may also ask us to provide the information we used to make our adverse benefit determination. **If you have any questions during the external review process, you may call 787-304-8686.**

Preliminary Evaluation

When the external reviewer receives the request for external review, the reviewer will ask Triple-S Salud for the following documents, which it took into consideration in making the adverse benefit determination, including:

- Certificate of coverage or benefits
- Copy of the Final Adverse Benefit Determination;
- Summary of the claim;
- An explanation of the plan or who issued the Adverse Benefit Determination;
- All documents and information taken into account when making the adverse benefit determination or the final adverse benefit determination taken internally, including any additional information provided to the plan or issuer of the determination or that was taken into account during the external appeals process.

Triple-S Salud must provide the reviewer the information indicated in the previous paragraph within five (5) business days. The reviewer will evaluate the information received from Triple-S Salud and may request additional information if he deems it necessary for external review. If the reviewer requests additional information, Triple S Salud will provide the information within five (5) business days from the date they received the request.

The reviewer will evaluate your request for external review to determine if:

- you were covered under the plan at the time you requested the service or the service provided; The adverse determination is not related to eligibility;
- you exhausted all internal appeal processes of the Plan; and
- you provided all the necessary documents to complete the external review.

The reviewer will notify you in writing within one (1) business day from completing the review, if the adverse determination is eligible for external review and if additional information is needed. If additional information is needed, you must provide it on the later date between the last day of the 120-day deadline set for submitting the request, as described above, or 48 hours after receiving the notification.

Review process

The external reviewer will review the information provided by Triple-S Salud and will send them all documents the claimant sent directly to him, within one (1) business day. Once they receive all documents, Triple-S Salud might reconsider its original decision on the complaint. The external review may only end if Triple-S Salud decides to reverse its adverse benefit determination and provide coverage or payment. Triple-S Salud must provide written notice of its determination to the claimant and the reviewer within one working day after deciding to reverse its decision. Upon receiving this notification, the evaluator shall conclude the external review.

However, if no external review is terminated for the reason stated above, the reviewer will continue the evaluation and will notify you and Triple-S Salud of the final determination within (45) days from the date you requested the external review. The notification shall include:

- a general description on the reason for the request for external review, including enough information to identify the claim, the date the IRO received the request for external review and the date of its decision;
- reference to the evidence or documentation he considered in making his decision; the reasons for his decision, including any standard based on evidence on which the decision was based;

- a statement that the determination is binding, except to the extent that there are remedies available under federal or state laws; and
- a statement indicating that judicial review may be available;

If the decision of the Independent Review Organization reverses the adverse benefit determination, the Plan will accept the decision and provide benefits for the service or procedure, according to the terms and conditions of the Plan. However, if the decision confirms Triple-S Salud adverse benefit determination, the Plan is not required to provide the benefits for the service or procedure.

Expedited External Review

Your adverse benefit determination may be eligible for expedited external review if:

- you have received an adverse benefit determination that involves a medical condition for which, the deadline for completion of an expedited internal appeal (as described above), could jeopardize your life or health, or your ability to regain maximum function and have submitted a request for an expedite internal appeal;
- you have received an adverse benefit determination that is related to a medical condition and the deadline for completing the standard independent appeals process can jeopardize your life, health, or ability to regain maximum function of your body; or
- an adverse benefit determination that is related to an admission, availability of care, or a service or item for which you received emergency services, but have not been discharged from the facility. The examiner will follow the review process described in the preceding paragraphs and shall provide notification of the final decision within 48 hours from the date he received your request for an expedited external review. However, if the request is related to an urgent care situation and you are in the course of treatment for the condition, the final decision must be notified within 24 hours. In these cases, the examiner may provide the notice orally, but must give written notice to you and the Plan within 48 hours.

You have the right to contact the Office of the Insurance Commissioner or the Office of the Health Ombudsman to request help. The information to contact these offices is found at the end of this section under subsection, Right to be Assisted.

Voluntary External Review

Your decision on whether or not to submit a claim to this voluntary external review will have no effect on your rights under the plan and the information about the regulations that apply; the process for choosing who makes the decisions, and the circumstances, if any, that may affect impartiality of the person making the decision, such as financial or personal interests in the outcome of any past or present relationship with any of the parties participating in the review process. You do not have to pay any fee or charge as part of this voluntary external review.

If you choose not to submit a claim to voluntary external review, the Plan will not state that you failed to exhaust all administrative remedies under the Plan. If you submit a claim for voluntary external review, the Plan agrees to inform any statute of limitations that applies if you decide to pursue the case in court.

Contact the Commissioner of Insurance at 787-304-8686 for more information on the voluntary external review process.

The Commissioner of Insurance will keep the file of your case for five (5) years and it will be available for evaluation if you request it.

If your case does not meet the criteria specified in the first paragraph in this section, you have the right to request an investigation of the case to the U.S. District Court for the District of Puerto Rico under Section §502(a) of the Employee Retirement Income Security Act (ERISA) or the Office of the Insurance Commissioner of Puerto Rico.

You are required to exhaust all internal appeal procedures previously described before filing a complaint with the Office of the Insurance Commissioner.

Standard Review of Grievances not related to adverse determinations

You or your personal representative is entitled to request a standard review of a grievance not related to an adverse determination on benefits (for example, a grievance regarding the enrollment process or cancellation of the policy, services provided by our staff).

Triple-S Salud will inform you about your rights within three (3) business days from the receipt of the grievance, and will appoint one or more persons who have not participated in the initial evaluation of your grievance. It will also provide information on the representative to perform the standard review of the grievance.

Triple-S Salud will notify, in writing, its determination no later than thirty (30) calendar days from the receipt of the grievance. Once you are notified on Triple-S Salud's determination, you have the right to request Triple-S Salud that in the notification they disclose the names and titles of the officers or experts involved in the evaluation of your appeal, as well as an explanation on the basis for their decision. The notification must also include:

- The determination of the reviewers in clear terms and the contractual basis or medical justification, so you can respond to the arguments in it;
- Reference to the evidence or documentation used as basis for the determination.
- If applicable:
    - a written statement that includes the description of the process to obtain an additional voluntary review in case the insured member is interested in requesting it, as well as the procedure to follow and the corresponding deadlines.
    - a notification on the right of the insured member to contact the Office of the Insurance Commissioner or the Office of the Health Ombudsman to request orientation and help and the information to contact them in case it were necessary.

Where Triple-S Salud fails to comply with its obligations under this process of Appeals of Adverse Determinations of Benefits, the insured member may start the process of external review of the claim or exercise any of the remedies available under §502 (a) of ERISA or under the law of Puerto Rico.
You have the right to contact the Office of the Insurance Commissioner or the Office of the Health Ombudsman to request help. The information to contact these offices appears below.

RIGHT TO BE ASSISTED

You have the right to be assisted by the Office of the Insurance Commissioner or by the Health Ombudsman in the appeal processes previously described. The Office of the Insurance Commissioner is located at GAM Tower, Urb. Caparra Hills Industrial Park 2, Tabonuco Street, Suite 400, Guaynabo, PR or you may call at (787) 304-8686.

The Health Ombudsman Office is located at Mercantil Plaza, 1501 Ponce de Leon Avenue, Hato Rey, PR and you can contact them at (787) 977-0909 (Metro Area) or the toll-free number 1-800-981-0031.

RIGHT TO APPOINT A REPRESENTATIVE

You have the right to appoint a representative to act on your behalf in dealings with Triple-S Salud. The designation of a representative must meet the following criteria:

a. Name and contract number of the member
b. Name, address and telephone number of the person designated as authorized representative, as well as his or her relationship with the member.
c. The specific issue for which the representative is appointed.
d. Signature and date on which the designation is granted.
e. Expiration date of the designation.

Triple-S Salud may request the authorized representative to provide additional information to confirm the identity of the authorized representative in case he/she call or visit any of our offices.

The member is responsible of notifying Triple-S Salud, in writing, if the designation is revoked before the expiration date.

The member is entitled to the benefits to be determined, as agreed, as a result of the appeals process.

YOUR RIGHTS AND RESPONSIBILITIES AS A PATIENT

Law 194 of August 25, 2000, as amended, known as the "Patient's Bill of Rights and Responsibilities", states the rights and responsibilities of the users of the medical and hospital health care system in Puerto Rico.

Right to high quality health services

Services consistent with the generally accepted standards of medical practice.

Rights regarding the collection and disclosing of information

You have the right to receive truthful, reliable, and easy-to-understand information, in English and Spanish, about your health plan such as the:

- Covered benefits, limitations and exclusions
- premiums and copayments to pay
- Providers and Participants Directory
- access to specialists and emergency services
- process for precertifications and grievances

Right regarding the selection of plans and providers

Every individual has the right to:

- Choose health care plans and providers are appropriate and that best suit their needs without being discriminated for their socioeconomic status, payment capacity, preexisting medical conditions or medical history, regardless of their age.

- Have a plan that has a network of authorized providers that is sufficient to assure that all the services covered by the plan will be accessible and available without unreasonable delays and within reasonable geographic proximity from the plan member's residence or workplace, including emergency services available 24 hours a day, 7 days a week. Any health care plan that offers health care services in Puerto Rico must allow each patient to receive primary health care from any primary health care service participating provider the person has chosen, according to the provisions of the health care plan.

- Have a health plan that allows the insured member to receive necessary or appropriate specialized services for the maintenance of the person's health, according to the referral procedures established by the health care plan. This includes access to specialists qualified for patients with special conditions or special medical or health care needs, in order to guarantee direct and fast access to qualified providers or specialists those members and beneficiaries have chosen within the plan's network of providers. In case a special authorization under the plan is required to have access to qualified providers or specialists, the plan will guarantee an adequate number of visits to cover the health needs of said members and beneficiaries.

Patient's right to the continuity of health care service

In case of termination of the provider or of the cancellation of the health plan, the insured member must be notified of said cancellation or termination at least 30 days in advance. In cases of cancellation and subject to the payment of premiums, the plan member will have the right to continue receiving the benefits for a 90-day transition period. If the patient is hospitalized on the cancelation date and the date of discharge was scheduled before the termination date, the transition period will be extended to 90 days after the date of the discharge. In case of pregnancy, if the cancellation takes place in the second quarter, the transition period will be extended until the later between the dates the member is discharged or the newborn is discharged from the hospital. In case of patients diagnosed with a terminal condition before the plan's cancellation date and the person continues to receive services for said condition before the plan's termination date, the transition period will be extended for the rest of the patient's life.

Right regarding access to emergency services and facilities

- Free and unrestricted access to emergency services and facilities when and where the need arises without a prior authorization or waiting periods.

- If emergency services are provided by non-participating providers, the insured member will only pay the applicable copayment or coinsurance.

Right to participate in the decision-making process about your treatment

- Right to have full participation or the participation of a person you completely trust in the decisions about your medical care.

- Receive all the necessary information and the treatment options available, the costs, risks and probabilities of success of said options.

- Your health services provider must respect and abide by your decisions and preferences regarding your treatment.

- No health care plan can impose gag rules, penalties or any other type of sanctions or rules that interfere with the physician-patient communication.

- The health professional should provide the medical order for laboratory tests, X-rays or medications, for you to select the facility at which you will receive the services.

Right regarding respect and the same treatment

- Right to receive the respectful treatment from any health service provider at all times, regardless of race, color, gender, age, religion, origin, ideology, disability, medical or genetic information, social status, sexual orientation, payment capacity or form of payment.

Right to confidentiality of information and medical records

- Contact your medical service providers freely and without apprehensions.

- Trust that your medical records will be kept under strict confidentiality and will not be disclosed without your authorization, except for medical or treatment purposes or a judicial order or by specific authorization of law.

- Obtain a receipt for expenses incurred for the partial or full payment of copayments or coinsurances. The receipt must specify the date of the service, name, license number and specialty of the provider, name of the patient and the person paying for the services, detail of the services, amount paid and the signature of the authorized officer.

- Access or obtain a copy of your medical record. Your doctor must give you a copy of your medical record within a period of five business days from the date of your request. Hospitals have a maximum term of 15 business days. They can charge you a fee of $0.75 per page, but not more than $25.00 for the record. If the patient-physician relation is broken, you have the right to request the original record free of charge, even if you have a pending debt with the health services provider.

- Receive a quarterly utilization report that includes, among other things, the name of the member, type and description of the service, date and provider that rendered the service and the amount paid for the service. The insured member can access the quarterly utilization report that provides the details on paid services for his benefit or the benefit of the dependents, by registering as an insured member on Triple-S Salud website (www.ssspr.com).

Rights regarding complaints and grievances

- Every health provider or insurer will have available a procedure to resolve, quickly and fairly, any complaint presented by a plan member and will have appeal mechanisms for the reconsideration of determinations.

- Receive response to your concerns in the language of your predilection, either English or Spanish.

Your responsibility as a patient is to:

- Provide the necessary information about health plans and the payment of any account. Know the rules for the coordination of benefits.

- Inform the insurer about any instance or suspicion of fraud against the health plan. If you suspect fraud against the health plan, please contact our Customer Service Department at 787-774-6060 or through our website at www.ssspr.com.

- Inform the most complete and accurate information on your health condition, including previous diseases, medications, etc. Participate in every decision regarding your medical care. Know the risks and limits of medicine.

- Know the coverage, options and benefits and other details of the health plan.

- Comply with your health plan administrative procedures.

- Adopt a healthy lifestyle.

- Notify the physician of unexpected changes in your condition.

- Make known that you clearly understand the course of action recommended by the health professional.

- Provide a copy of your advance directives.

- Notify the physician if you anticipate problems with the prescribed treatment.

- Recognize the obligation of the provider to be efficient and equitable when providing care to other patients.

- Be considerate, so that your individual behavior does not affect others.

- Resolve any difference through the insurer's established procedures.

PRIVACY PRACTICE NOTICE

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO IT.

REVIEW IT CAREFULLY. THE PROTECTION OF YOUR FINANCIAL AND HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duties

Triple-S Salud is firm in its commitment to protect the privacy of your medical information. This notice informs you on our privacy practices and your rights regarding your medical information. We will follow the privacy practices described in this notice while it is in effect.

This notice contains some examples of the types of information we collect and describe the types of uses and disclosures we execute. The examples provided are for illustrative purposes and shall not be construed as a complete listing of such uses and disclosures.

We reserve the right to change our privacy practices and the terms of this notice. Before we make a significant change in our privacy practices, we will change this notice and send an updated notice to our active subscribers.

General Information

Our pledge is to limit to the minimum necessary the information we collect in order to administer your insurance products or benefits. As part of our administrative functions, we may collect your personal information from different sources such as:

- Information that you provide in the documents for a service;
- Information from transactions you make with us or our affiliates;
- consumer credit reporting agencies;
- healthcare providers;
- Government health programs

We do not use or disclose genetic information for underwriting purposes.

Laws and Regulations

HIPAA: The Health Insurance Portability and Accountability Act, HIPAA of 1996 was created to protect millions of workers and their families in the United States that suffer from some medical condition.

HITECH: Health Information Technology for Economic and Clinical Health, impacted significantly on the administration and electronic exchange of health information. It provides, for the states and territories of the American nation, billions of dollars in incentives for the adoption and implementation of technological infrastructure with capacity to maintain applications.

Rule of Privacy and Security: The privacy and security regulations for the protected health information is required under the 45 CFR, Sections 160 and 164.

Uses and Disclosures of Information

We may use and disclose your personal information to our business associates, who provide services on our behalf and contribute in the administration or coordination of your services. We only share the minimum necessary information and require from each of our business associates to sign a written agreement in which they provide satisfactory assurances of compliance with the security and privacy of your health information. If the business associate goes out of business, we will maintain your information secure to provide the services you need.

As part of our administrative functions, we may use or disclose your information, without your authorization, for treatment, payment and healthcare operations, and when authorized or permitted by law. For example:

Treatment: To a physician or other health care provider who provides medical services to you.

Payment: To pay your medical claims, to determine your eligibility for benefits, to coordinate your benefits with other payers, or to collect premiums, and the like.

Health Care Operations: For audits, legal services, including detection of fraud and abuse and compliance, business planning and

development, administrative and business management activities, and patient safety activities, credentialing, disease management, training of medical or pharmacy students.

Affiliated Covered Entities: These companies are subject to the same statutes that require protection for your protected health information.

Your Employer, union or other employee organization: Disclose information to your employer on whether you are enrolled or disenrolled in the health plan your employer sponsors, and summary health information (aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan) to be used for the administration of the group health plan.

Disaster relief and emergency situations: We can use or disclose your health information as permitted or required by law.

Government Sponsored Benefits Programs: We can use or disclose your health information as permitted or required by law.

Public health and safety activities: We can use or disclose your health information as permitted by law for the following purposes:

- Public health activities including the report of statistics on diseases and vital information, among others;
- Report child and/or adult abuse or domestic violence;
- Activities of regulatory agencies;
- Response to court and administrative orders;
- To the officers of the public order or national security affairs;
- To prevent an imminent threat to the public health or safety;
- For activities of scientific research
- as authorized by state worker's compensation laws; and
- as otherwise required by applicable laws and regulations

Health-Related Products and Services: We may use your medical information to inform you about health-related products, benefits and services we provide or include in our benefits plan or treatment alternatives that may be of interest to you. We will call or send you reminders of your medical appointments or the preventive services that you need according to your age or health condition.

With Your Authorization: You may give us a written authorization to disclose your medical information to anyone for any purpose. Activities such as marketing of non-health related products or services or the sale of health information must be authorized by you. In these cases your health insurance policy and your benefits will not be affected if you denied the authorization.
The authorization must be signed and dated, mention the entity authorized to provide/receive the information, a brief description of the data to be disclosed and the expiration date, which will not exceed 2 years from the date of signage, except if you signed the authorization for one of the following purposes:

- to substantiate a request for benefits under a life insurance policy, its reinstallation or modifications to such policy, in which case the authorization will be valid for thirty (30) months or until the application is denied, the earlier of the two events; or
- to substantiate or facilitate the communication of an ongoing treatment of a chronic disease or rehabilitation of an injury.

The disclosed information pursuant to your authorization may be redisclosed by the recipient of the information and may not be protected by applicable privacy laws. You may revoke the authorization in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. We will keep copies of the authorizations and revocations executed by you.

Family and Friends Involved in Your Care or Payment for Care: To a family member or friend you involve in your health care or payment for your health care, unless you request a restriction. We will disclose only the medical information that is relevant to the person's involvement.

Before we make such a disclosure, we will provide you with an opportunity to object. If you are not present or disabled or in case of emergency we will use our professional judgment to determine whether disclosing your medical information is in your best interest.

Terminated accounts: We will not share the data of persons who are no longer our customers or who do not maintain a service relationship with us, except as required or permitted by law.

Security safeguards: We have implemented physical, technical and administrative safeguards to limit access to your personal information. Our employees and business associates are trained and know their duty to protect and maintain the privacy of your medical information, and are committed to comply with the highest security and privacy standards to handle your information in a responsible manner.

Individual Rights

Access: You have the right to examine and receive a copy of your protected health information on enrollment and claims within the limits and exceptions provided by law. You must make a written request. Upon receipt of your request, we will have thirty (30) days to do any of the following activities:

- request for additional time
- provide the requested information or allow you to examine your information during working hours
- inform you that we do not have the requested information, in which case, we will orient you where to find it if we know the source
- deny the request, partially or in its entirety, because the information originates from a confidential source or was compiled in anticipation of a legal proceeding, investigations by law enforcement agencies or the anti-fraud unit or quality assurance programs or which disclosures are prohibited by law. We will notify you in writing the reasons for the denial, except in the event there's an ongoing investigation duly constituted by law or in anticipation of a legal proceeding.

The first report will be free of charge, but we may charge you reasonable, cost-based fees for subsequent reports. If you request the report in a special format, you may have to pay an additional charge.

Disclosure Accounting: You have the right to receive a list of instances after April 14, 2003, in which we disclosed your protected health information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities. The report will provide the name of the entity to which we disclosed your information, the date and purpose of the disclosure and a brief description of the data disclosed. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to your additional requests. The report only covers the last six (6) years.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information, if such disclosure may put your life at risk, as in a case of domestic violence. We are not required to agree to your request. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. Any agreement we may make to a request for restriction must be in writing signed by an authorized officer.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by alternative means or to alternative locations if your life may be at risk. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request. We will accommodate your request if it is reasonable, specifies the alternative means or location for confidential communication, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the subscriber.

Amendment: You have the right to request that we amend your medical information. Your request must be in writing, and it must explain and justify the amendment requested. Within 60 days we will execute the amendment. Is we need additional time, we will request you in writing an additional period of 30 days prior to the termination of the original period.

If we deny your request, we will provide you a written explanation. You have the right to request that we include your statement of disagreement with the determination taken by us in future disclosures of the disputed information. If we accept your request, we will make your

amendment part of your record and use reasonable efforts to inform our business associates and others who we know may have and rely on the unamended information.

Business Closure: In the event of business closure, we will communicate with you to let you know how to obtain your claims history and any other information.

Notice of security breaches in which your health information may be at risk: You are entitled to be notified by any means if the security breach is the result of not having your information secured by technologies or methodologies approved by the Department of Health and Human Services.

Electronic Notice: If you receive this notice on our website (www.ssspr.com) or by e-mail, you are entitled to receive this notice in written form.

Civil Rights for Individuals under Section 1557

Triple-S Salud, Inc. complies with federal civil rights laws and does not discriminate on grounds of race, color, nationality, age, disability or sex. Triple-S Salud, Inc. does not exclude persons nor treats them differently because of their ethnic origin, color, nationality, age, disability or sex. We offer free assistance and services to persons with disabilities to communicate effectively with us, as:

- Qualified sign language interpreters.
- Information written in other formats (large font, audio, accessible electronic formats, other formats).

We offer free linguistic services to people whose first language is not English, such as:

- Qualified interpreters
- Information written in other languages

If would like to receive any of these services, you can call (787) 774-6060 or 1-800-981-3241.

For telephone services for audio impaired (TTY/TDD) call (787) 792-1370 or free of charge 1-866-215-1999.

If you consider that we did not provide you these services or consider that we have otherwise discriminated by reasons of ethnic origin, color, nationality, age, disability or sex, you can submit a claim in person or by postal mail, fax, or electronic mail to the following office:

Compliance and Privacy Office
Telephone: (787) 277-6686
Fax: (787) 706-4004
Electronic Mail: privacidad@ssspr.com
Address: PO Box 363628, San Juan, PR 00936-3628

You can also submit a claim of civil rights before the Office of Civil Rights of the Department of Health and Human Services of the United States electronically, by postal mail or by phone:

U.S. DHHS
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Telephone: 1-800-368-1019
TDD: 1-800-537-7697
Address: 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

Questions

If you want more information about our privacy practices or have questions or concerns, please contact us. All the forms to exercise your rights are available at: www.ssspr.com.

If you are concerned that we or any of our business associates may have violated your privacy rights, or you disagree with a decision we made about access to your health information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your medical information, you may present your complaint to the address of the Compliance and Privacy Office previously mentioned.

You also may submit your complaint in writing to the Department of Health and Human Services (DHHS) to the following address:

Region II, OCR, US DHHS

Telephone: (212) 264-3313
Fax: (212) 264-3039
TDD: (212) 264-2355
Address: Jacob Javits Federal Building, 26 Federal Plaza – Ste 3312, New York, NY, 10278

We will not take any kind of retaliation if you decide to file a complaint with us or with the DHHS.

Si interesa una copia de este aviso en español, visite nuestra página:

http://www.ssspr.com/SSSPortal/GeneralInfo/politica-privacidad.html.

GENERAL PROVISIONS

1. **BENEFIT CERTIFICATES:** Triple-S Salud will issue to the policyholder a policy/certificate of benefits. In addition, Triple-S Salud will provide a list of Triple-S Salud participating physicians and providers, as well as the Summary of Benefits Coverage (SBC)**.**

2. **BLUECARD PROGRAM AND OUT OF AREA SERVICES:** Triple-S Salud Inc. (hereinafter Triple-S Salud) is an independent licensee of the Blue Cross and Blue Shield Association. This allows us to relate with other Blue Cross and/or Blue Shield licensees referred to generally as Inter-Plan Programs. Whenever members access healthcare services outside the geographic area, the claims for those services may be processed through one of these Inter-Plan Programs, including the Blue Card Program, and presented to us for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. Inter-Plan Programs available to members are described below.

   Typically, when members obtain care outside the geographic area Triple-S Salud serves, they obtain care from healthcare providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (Known as Host Blue). In some instances, members may obtain care from non-participating healthcare providers or providers that do not have a contractual agreement. Payment practices in both instances are described below.

   Under the BlueCard Program, when member access covered healthcare services within the geographic area served by a Host Blue, Triple-S Salud is responsible to you for fulfilling our contractual obligations, while the Host Blue will be responsible for providing such services as contracting and handling interactions with network participating providers.

   Liability calculation method per claim

   When claims are processed through the BlueCard Program, the member's liability on claims for covered healthcare services will be based on the lower of the billed covered charges or the negotiated price made available to Triple-S Salud by the Host Blue.

   The calculation of the member's liability on claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated priced made available to Triple-S Salud by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating health care provider an inclusive allowance (e.g., per case or per day amount) for specific health care services.

   Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The method may be one of the following:

   (i) Negotiated fee- A fixed amount that means a negotiated payment without any other increases or decreases.

   (ii) Estimated fee. – It considers certain payments negotiated with the provider and other claim-and-non-claim related transactions.

   (iii) Average fee - it is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with its healthcare providers, or a similar classification of its providers, or with an individual provider, and other claim-and-non-claim related transactions.

   Transactions for cases (ii) and (iii) may include, but are not limited to, recovery of amounts for fraud and abuse, reimbursements to providers not applied to specific claims, prospective adjustments and payments for performance or incentives.

   Host Blues using either an estimated price or an average price may prospectively adjust past prices on claims processed through the BlueCard Program if the payments were underestimated or overestimated. However, the amount paid by the member and the group is a final price. The BlueCard Program requires that the price submitted by a Host Blue is a final price, irrespective of any future adjustments based on the use of estimated or average pricing.

If the Host Blue uses either an estimated price or an average price on a claim, it may also hold some portion of the amount that the group pays in a variance account, pending settlement with its participating healthcare providers. Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from the group. Such payable or receivable would be eventually exhausted by healthcare provider settlements and/or through prospective adjustment to the negotiated prices. Some Host Blues may retain interest earned, if any, on funds held in variance accounts.

Notwithstanding, some states require Host Blues to use a specific formula to calculate the coinsurance or copayment for covered healthcare services that does not reflect the entire savings realized or expected to be realized on a particular claim to add a surcharge. In these cases, Triple-S Salud will calculate the coinsurance or copayment amount in accordance with the state's applicable laws.

Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds and unsolicited refunds. In some cases the Host Blue will engage a third party to assist in the identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with the applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

Non-participating providers outside the service area

When covered healthcare services are provided by a non-participating provider outside our service area, the amount the member pays for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment Triple-S Salud will make for the covered services, as set forth in this paragraph.

In some exception cases, we may pay claims from non-participating healthcare providers outside our service area based on the provider's billed charge, such as in situations when the member did not have reasonable access to a participating provider. In other exceptions cases, we may pay such claims based on the payment Triple-S Salud would make if it were paying a non-participating provider inside its service area, as described elsewhere in this agreement, where the Host Blue's corresponding payment would be more than Triple-S Salud in-service area non-participating provider payment, it may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the member may be responsible for the difference between the amount that the non-participating provider bills and the payment Triple-S Salud will make for the covered services, as set forth in this paragraph.

3. **CIVIL ACTIONS:** No civil action shall be taken to claim any rights of the person insured under this policy before sixty (60) days have elapsed after written proof of the service has been submitted, according to the requirements of this policy. No action shall be taken after three (3) years have elapsed from the date in which it was required that written proof of the service had to be submitted.

4. **CIVIL RIGHTS FOR INDIVIDUALS UNDER SECTION 1557:** Triple-S Salud, Inc. complies with federal civil rights laws and does not discriminate on grounds of race, color, nationality, age, disability or sex.

   Triple-S Salud, Inc. does not exclude persons nor treats them differently because of their ethnic origin, color, nationality, age, disability or sex.

   We offer assistance and free services to people with disabilities so they communicate effectively with us. We also offer free

language services to people whose first language is not English.

For more information, please refer to our website: https://www.ssspr.com/en/privacy-policy or call the following numbers: (787) 774-6060 or free of charge to 1-800-981-3241, for telephone services for audio impaired (TTY/TDD) at (787) 792-1370 or free of charge to 1-866-215-1999.

5. **CLAIM PAYMENTS:** As a rule, the benefits provided under this policy will be paid to the participating professional or provider, except in case of emergency, when payments will be made as provided by law. If the member received the services from a non-participating facility or provider during an emergency, services will be paid directly to the provider.

   In case an insured member receives healthcare after an emergency or post stabilization services that would be covered under the health plan, except for the fact that they were rendered by a non-participating provider, Triple-S Salud will reimburse the insured member based on the lesser amount between the expense incurred and the fee it would have paid to a participating provider, after deducting the applicable copayment or coinsurance set in the policy, so long as there is a valid medical reason for not transferring the patient to a participating provider. This policy also has benefits that are paid to the member by indemnification or reimbursement, even if the provider is a participating provider.

   For Triple-S Salud to be able to indemnify or issue a reimbursement to the member in these cases, the insured member must give Triple-S Salud notice of the claim in writing within 20 days from the date of service, or if after said term, as soon as reasonably possible, but in any case no later than one (1) year from the date of service.

6. **COBRA (CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT); APPLIES TO EMPLOYERS WITH 20 OR MORE EMPLOYEES:** Provides, in some instances, extended coverage to covered employees and eligible direct dependents when coverage under the group medical plan ends for reasons set forth in this legislation (qualified events). The insured employee must confirm with the employer if he/she is eligible for the coverage. The employer, not Triple-S Salud, will be the COBRA administrator.

   In case of employment termination, by discharge (provided it is not due to gross misconduct), resignation or reduction of hours, the COBRA Law establishes that the plan member in the group medical plan has the right to an extended coverage for 18 months. This coverage may also be available for his/her direct dependents. If the plan member under COBRA is disabled within 60 days of enrollment in coverage and his/her disability is certified by the Social Security Administration, after the qualified event, then the plan member under COBRA shall have the right to an 11-month extension under COBRA. Finally, in the case of a divorce or death of the employee, then the spouse and the children shall have the right to a 36-month period of extended coverage. The direct dependent (child) shall have a period of 36 months if he/she loses eligibility under the plan. If the employee receives Medicare benefits, his/her spouse and dependents shall have the right to 36 months of extended coverage. The extended coverage under COBRA can terminated for the following reasons:

   a. End of COBRA period;
   b. Lack of payment;
   c. Employer terminates the group health plan;
   d. Member enrolls in Medicare;
   e. Member enrolls in another health plan that does not have a waiting period;
   f. Member commits a fault that according to the plan is just cause for cancelling his/her plan (example: submitting fraudulent claims).

   Transition cases will be included as COBRA cases for group experience purposes.

7. **CONFIDENTIALITY**: Triple-S Salud will keep the confidentiality of the insured member's medical and claims in accordance with the policies and procedures set forth in the Privacy Practice Notice included in this policy.

8. **CONVERSION CLAUSE:**

   a. If coverage under this policy ends because the employee is terminated from employment or no longer belongs to an

employee class or classes eligible for coverage under the policy, the person is entitled to have Triple-S Salud issue an individual basic coverage, with no risk evaluation, within the different levels of metallic coverages approved for newly insured members requesting an individual health plan and accepting to pay the premiums of said individual health plan. The written application for enrollment in an individual plan will be submitted and the premiums paid to Triple-S Salud no later than thirty (30) days from the termination, provided that:

1) If the insured member had a previous qualifying coverage with benefits that do not compare or do not surpass those offered in the coverage of the individual silver health plan, Triple-S Salud will offer an individual basic bronze plan to a person, who is converting his plan between coverage periods, until the next enrollment period. During the enrollment period the member may choose the individual basic health plan he prefers.

2) The individual policy premium will be in accordance with the rates in effect at Triple-S Salud, applicable to the form and the benefits of the individual policy chosen by the member. The Health Condition of the member will not be considered for risk classification.

3) The individual health plan should also cover the insured employee's spouse or direct dependents if they were covered on the termination date of the group health plan. At Triple-S Salud's option, a separate individual policy may be issued to cover the spouse or direct dependents enrolled.

4) The individual policy will be effective upon termination of coverage under the group policy.

5) Triple-S Salud will not be required to issue an individual policy to a person who:
   a. Does not request the basic individual health plan within thirty days of the qualifying event or no later than thirty (30) days after losing eligibility for his existing qualifying coverage.

   b. Is covered or is eligible for coverage under another health benefit arrangement, whether public or private, including Medicare supplementary policies or the Medicare Program, established in conformance with Title XVIII of the Social Security Act, as amended, or any other federal or state law, except in the case of a person that is eligible for Medicare for a reason other than age.

   c. Is covered or is eligible for coverage under a health plan that provides healthcare coverage offered by the employer of the recently covered person.

   d. Is covered or is eligible for coverage under a health plan that provides healthcare coverage under which the spouse, custodial parent or guardian is eligible to be enrolled, except if said health plan is the Puerto Rico Government Health Insurance Plan (GHIP) or any other government health plan that is administered by the Health Insurance Administration.

   e. For the period in which he is covered in accordance with the previous individual health plan and that ends after the effective date of the new coverage.

   f. Is covered or is eligible for an extended group health plan according to Section 4980 b of the Federal Internal Revenue Code, sections 601 to 608 of the Employee Retirement Income Security Act (ERISA) of 1974, as amended, Sections 2201 to 2208 of the Public Health Service Act (PHSA), as amended or any other extended group health plan required by law.

b. Subject to the conditions and limitations under clause (a) of this section, the privilege of conversion will be granted to:

1) the spouse or direct dependents of the member, whose coverage under the group policy ceases because of the death of said person;

2) the spouse or direct dependents of the person whose coverage ceases because he does not qualify as a dependent under the group policy even when the insured member continues to be covered under the group policy;

c. If a person insured under the group policy loses coverage under the individual policy described in clause (a) of this section, during the period he would have qualified for the issuance of said individual policy, but before the individual policy goes into effect, the benefits for which he/she would be eligible under the Individual policy will be payable as claim against the group policy even if the individual policy has not been requested or payment of the first premium has not been made.

d. If an individual insured under this group policy acquires the right to obtain an individual policy under the terms of the group policy, subject to applying and paying the first premium within the period specified in the policy, and if this individual is not notified of the existence of this right at least fifteen (15) days before the date of expiration of this period, the individual will have an additional period during which he/she may exercise the right, but none of this implies continuation of a policy beyond the period provided in the policy.
The additional period will expire fifteen (15) days after the individual has been notified, but in no case will this period be extended more than sixty (60) days after the expiration date provided in the policy. A written notice delivered to the individual or mailed by the policyholder to the last known address of the individual, will be considered notice for the purpose of this paragraph. If an additional period is granted to exercise the right to conversion, as provided here, and if the written application for said individual policy, accompanied by the first premium, is submitted during the additional period, the individual policy will go into effect upon termination of insurance under the group policy.

9. **EXEMPTION OF MEMBER'S LIABILITY:** The insured member is not liable to pay for those services for which the participating provider failed to comply with eligibility procedures, payment policies, or the service protocols established by Triple-S Salud.

10. **GRACE PERIOD:** A grace period of 31 calendar days will be granted for the payment of each premium due after the first premium. During this grace period the policy will remain in force.

11. **IDENTIFICATION:** Triple-S Salud will issue a card to each member, which they are required to show to any Triple-S Salud participating provider from whom services are requested, for the services to be covered under the policy. In addition, the member should present a second photo ID card.

12. **INDEPENDENT LICENSEE OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION:** The member and its dependents, through this means expressly acknowledges and know that this policy constitutes an agreement solely between the member and Triple-S Salud, which is an independent corporation that operates under a license of the Blue Cross and Blue Shield Association, an independent association of Blue Cross and Blue Shield Plans, allowing Triple-S Salud to use the service mark Blue Cross and Blue Shield in Puerto Rico and Virgin Islands, and Triple-S Salud does not have a contract as agent of the Association.

    Moreover, the member and its dependents agree that it has not entered into this policy based upon representations from any carrier other than Triple-S Salud and that no person, entity or organization other than Triple-S Salud may be responsible for any obligation of Triple-S Salud, towards the member that may arise from this policy.

    What was previously stated will not create any additional obligation on the part of Triple-S Salud, unless these obligations arise from the provisions of this agreement.

13. **INDIVIDUAL CANCELLATION:** Triple-S Salud may cancel the insurance of any insured member who commits fraud or makes false misrepresentations of material facts or has submitted or made someone submit a false claim or any evidence to support it, for the payment of a claim pursuant to any of Triple-S Salud's policies, regardless of the date in which the action was committed or the date and the manner in which it was discovered or when the insured member presents patterns of fraud in the use of the benefits provided by this policy. The member will be notified of the cancellation through a notice delivered to him or mailed to the last known address in Triple-S Salud's records, indicating when the cancellation will be effective, which will not be less than thirty (30) days after the date on notice.

    Triple-S Salud will issue a certification of coverage to the insured employee, as required by HIPAA. If the insured member does not receive said certification of coverage, he/she may obtain it by calling our Customer Services Department at 787-774-6060.

14. **INDIVIDUAL TERMINATION:** It is the insured employee's responsibility, to return the insurance identification cards to Triple-S Salud if he ceases employment or retires. Triple-S Salud will not cover services received after termination of coverage. The employee will be liable for the payment of these services.

15. **MANDATORY COVERAGES:** This policy is subject to federal and local laws and regulations that may require, during the effectiveness of the policy, that coverage is provided for additional hospital and medical-surgical services that were not a part of the covered services when this policy was effective. These mandatory coverages that take effect after the policy was issued may have an impact in costs and premiums.

16. **MODEL FOR CLAIMS:** When Triple-S Salud receives a claim notice, it will provide the claimant the forms it usually provides for the submission of proofs of loss. If the forms are not provided within 15 days from the receipt of the notice, it will be considered that the claimant met the policy requirements regarding proofs of loss if the person submits written proofs of what happened and the nature and extent of the loss object of the claim, within the time frame established in this policy for submitting the proofs of loss.

17. **NOTICE OF CLAIM:** Written notice of claim should be given to Triple-S Salud, by the member or the employer within twenty (20) days after a service was received or, as soon as reasonably possible, but within a period that does not exceed a year from the date the service was provided. A written notice given by the member on his behalf to Triple-S Salud at its main office in San Juan, Puerto Rico or at any of its Service Centers around the island, or to any Triple-S Salud authorized representative, with enough information, so that it may be identified, will be considered notice given to Triple-S Salud.

18. **PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES:** Triple-S Salud will require its members, or in case of disabled persons or minors, to the parents, guardians or trustees of these persons, to read and familiarize with the Patient's Bill of Rights and Responsibilities or an appropriate and reasonable summary of the document, as prepared and authorized by the Department of Health. The summary of this Bill is found in this policy.

19. **PERSONAL RIGHTS:** The member may not yield, transfer, or waive in favor of a third party any of the rights and benefits that he/she may claim by virtue of this policy. It is provided that Triple-S Salud reserves the right to recover all expenses incurred in case the member, with expressed or implicit consent, allows non-members to use the card issued by Triple-S Salud in his/her favor. It is also provided that recovery of such expenses will not prevent Triple-S Salud from terminating the insurance contract when illegal use of the card is discovered, or from filing a civil action for the prosecution of the member or the person making unlawful use of the card.

20. **PHYSICAL EXAMINATIONS:** Triple-S Salud will have the right and the opportunity to examine, at its own expense, the member when, and as frequently as it deems necessary, for audit purposes or fraud investigations.

21. **PREMIUM PAYMENTS:** Both the employer and the employee will be jointly liable for the payment of the premium covering the policy; provided that such liability will cover all the premiums outstanding to the termination date of the policy, in accordance with the TERMINATION clause.

    Triple-S Salud is entitled to collect from the insured employee the premium due or, the costs incurred in the payment of claims for services rendered to the member after the cancellation of the person's health plan. Triple-S Salud may use collection agency services to request the payment of any outstanding debt with the plan. It is provided that the debtor is required to pay the costs, expenses and attorney fees, as well as any other additional amount or expense in which Triple-S Salud incurs to collect the debt, except if otherwise provided by court.

    Triple-S Salud reserves the right to provide detailed information regarding lack of payment by an employer or member to any agency, institution, or organism engaged in credit inquiries.

22. **QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO):** This provision is a requirement of ERISA (Employee Retirement Income Security Act) for group health plans that extend health coverage to the children of employees that are divorced, legally separated, or have never gotten married when required by the State. This provision states that the plan can be required to provide health coverage for a child that is a dependent of the employee. The State or Court may request a group covered by ERISA to extend coverage to a dependent child of an employee using a child support order for health coverage.

23. **RECOVERY OF PAYMENTS MADE IN EXCESS OR BY MISTAKE:** If Triple-S Salud issues a payment for a claim to the member and said payment was issued by mistake and for an amount higher than the amount claimed by the member, Triple-S Salud can recover from the member the amount paid in excess.
24. **REINSTATEMENT:** If payment of any renewal premium is not made within the time granted to the group for its payment, subsequent acceptance of a premium, by the insurer or any duly authorized agent of the insurer to accept such premium, without requiring an application for reinstatement will reinstate the policy. However, if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium paid, the policy will be reinstated upon approval of said application by the insurer or, in the absence of such approval, on the forty-fifth day after the date of said conditional receipt, unless the insurer has notified the member in writing that said application has not been approved. The reinstated policy will only cover losses resulting from any accidental injury that may occur after the date of reinstatement and losses due to any illness that may begin more than ten days after such date.

    In any other respect, the group and the insurer will have the same rights under the policy they had before due date of the unpaid premium, subject to any provisions endorsed or attached to this document regarding reinstatement. Any premium accepted in relation to a reinstatement shall be applied to a period for which no premium was previously paid and that do not exceed more than sixty (60) days prior to the date of reinstatement.

25. **RIGHT TO GUARANTEED RENEWAL OF THE PLAN**: The employer has the right to request the guaranteed renewal of the health insurance plan of all eligible employees and their dependents, except in the following cases:

    a. Failure to pay premiums, considering the grace period;

    b. When the employer, the eligible employee or any of the eligible dependents performed an act that constitute fraud. In this case, Triple-S Salud may opt not to renew the health plan to the employer, the eligible employee, or the insured member for a period of one year from the date of coverage termination;

    c. When the employer, the eligible employee or the insured member has made an intentional false misrepresentation of important material facts under the terms of the health plan.

In this case, Triple-S Salud may opt not to renew the health plan to the employer, the eligible employee or the insured member for a period of one year from the date coverage termination.

d. Failure to meet the minimum participation requirements set forth by Triple-S Salud;

e. Failure to meet employer contribution requirements;

f. In case Triple-S Salud decides to discontinue offering all market plans in Puerto Rico: In this case, Triple-S Salud must provide written notice to the Office of the Insurance Commissioner of Puerto Rico, plan sponsors and plan members at least 180 days before the health plan renewal date.

g. When the Insurance Commissioner determines that continuance of the health plan does not respond to the best interests of the policyholders or will affect the insurer's ability to meet its contractual obligations.

h. In case of health plans made available to the small group market through a preferred network, when no employee insured of the employer live, reside or work in the service area of the insurer.

26. **RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT:** Any person insured under a group health plan for more than eighteen (18) months is entitled to enroll in an individual policy without waiting periods or exclusions for preexisting conditions.

    To benefit from this right, the request for enrollment in the plan should be made within a period of time that does not exceed sixty-three days from the date the member lost coverage under the previous group plan, or lost the employer's contributions, and the termination of the plan must be for one of the following reasons:

    - Loss of eligibility (for resignation or termination of employment)
    - Loss of employer contributions, or
    - Termination of coverage under COBRA

27. **RIGHTS UNDER LAW NO. 248 OF AUGUST 15, 1999 TO ENSURE ADEQUATE CARE FOR MOTHERS AND THEIR NEWBORNS DURING THE POSTPARTUM PROTECTION:** The aforementioned federal law establish the following:

    a. Mother and newborn hospital length of stay in connection to childbirth will not be limited to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section.

    b. Nevertheless, insurers and group plans may cover shorter stays, if the physician, after consulting the mother, orders the discharge from the hospital of the mother or the newborn before reaching the aforementioned terms.

    c. If the mother and newborn are discharged earlier than the period specified in paragraph (a) of this section, but in accordance with clause (b), coverage will provide for one follow-up visit within the next forty and eight (48) hours. The services will include, but will not be limited to, assistance and physical care of the newborn, education on care of the newborn for both parents, training on breast-feeding, orientation on home support for the mother, treatment and medical tests for the newborn and the mother.

    d. Neither insurers nor group plans will design benefits or include deductibles or coinsurances that imply unfavorable treatment in any portion of the hospitalization.

28. **TIME LIMIT ON CERTAIN DEFENSES:**

    a. After two (2) years from the date of this policy, any false statement (except a fraudulent statement) made by any person insured under the policy may be used to cancel the insurance on your person or deny a claim for services that begin after the expiry of the period of two (2) years.

    b. Any claims for services that begin after two (2) years from the date of issue of this policy, will be reduced or refused on the grounds that, prior to the effective date of the cover of this

policy, there was a physical illness or injury is not excluded from the cover by name or specific description, effective on the date of service.

29. **TERMINATION:** Triple-S Salud reserves the right to terminate this policy on the due date for lack of payment of any due premium, after the grace period, through written notice to the insured employee no less than thirty (30) days in advance.

    In addition, Triple-S Salud reserves the right to terminate this policy for lack of payment of any premium through written notice to the employer no less than thirty days in advance. If the employer decides to cancel this policy to obtain the plan through another insurer, the employer can cancel this policy by sending written notice to Triple-S Salud at least thirty (30) days prior to the cancellation of the policy. However, if the employer decides not to continue the health plan as part of the fringe benefits, the employer must give written notice Triple-S Salud no less than forty five (45) days prior to the effective date of the cancellation, which will be effective on the last day of the month following the date of receipt of the notice. Termination will not affect any claim for services rendered before the termination date.

    In case the organization offering a healthcare plan ceases to exist or in case of termination or cancellation of a provider, Triple-S Salud will notify this termination or cancellation 30 calendar days prior to the date of termination or cancellation.

    Subject to the payment of any premium, in case of termination of a provider or the policy, the insured employee can continue receiving the services of said provider during a ninety (90)-day transition period from the date of termination of the policy or the provider contract.

    The transition period, under the circumstances described below, will take place in the following manner:

    a. If the plan member is hospitalized at the time of termination of the policy and the date of discharge was programmed prior to such termination, the transition period will be extended from the termination date of the policy up to ninety (90) days after the plan member has been discharged from the hospital.

    b. In the case of a plan member who is in the second trimester of pregnancy on the termination date of the policy and the provider has been providing pregnancy medical treatment prior to the termination date of the policy, the transition period for pregnancy medical services will be extended until the date the plan member is discharged from the hospital due to childbirth or the newborn's date of discharge, whichever date comes last.

    c. In the case of a patient diagnosed with a terminal condition by a Triple-S Salud participating physician prior to the termination date of the policy and the person was receiving services for that condition before the termination date of the plan, the transition period will be extended for the remaining life of the patient.

    The transition care period is subject to the payment of the corresponding premium and may be denied or terminated if the plan member and/or provider incurs in fraud against the insurance. The member can choose to enroll in a direct payment policy or choose the transition period for the plan termination. Once the termination transition period ends, the provisions set forth in the Conversion clause will apply.

30. **THIRD PARTY ACTIONS:** If by fault or negligence of a third party the insured member suffers an illness or an injury covered under the policy, Triple-S Salud is entitled to subrogate in the rights of the member in order to claim and receive from that third party a compensation equivalent to the expenses incurred in treating the member as a result of such negligent action.

    The member acknowledges Triple-S Salud's right of subrogation and will be responsible for notifying Triple-S Salud of all actions initiated against the third party; provided that if the member acts otherwise, the member will be liable for paying such expenses to Triple-S Salud.

31. **TOTAL COVERED SERVICE PAYMENT IF THERE IS NOT A PROVIDER:** In cases where a member needs a medically necessary service covered by the plan for which there is no contracted provider and it is not provided in your coverage that the service will be provided by reimbursement to the member, Triple-S Salud will coordinate and establish a special agreement with a non-participating provider for the provision of such services to the member.

    This will be subject to the terms and conditions of the policy of the member and the payment to the provider based on the fee established by Triple-S Salud for the services to be rendered.

32. **TRANSFER OF COVERAGE:** If the member moves to the service area of another plan affiliated to the Blue Cross and Blue Shield Association and if the member requests it, Triple-S Salud will process the transfer to the plan that services the area of the member's new address.

    The new plan should at least offer the member its group conversion policy. This is a type of policy usually offered to insured members who leave a group and request coverage as individuals. The conversion policy offers coverage without requiring a medical examination or health certificate.

    If the member accepts the conversion policy, the new plan will credit the time the person was insured under Triple-S Salud against any waiting period. Any physical or mental condition covered by Triple-S Salud will be covered by the new plan without a waiting period if the new plan offers the same feature to other persons who have the same type of coverage.

    The fees and benefits available in the new plan may vary significantly from those offered by Triple-S Salud.
    The new plan may offer the member other types of coverage that are outside the Transfer Plan. These policies may require a medical examination or health certificate to exclude coverage for preexisting conditions or they may choose not to apply the time the person was insured under Triple-S Salud to the waiting periods.

    The member may acquire additional information about the Transfer Program by contacting our Customer Service Department.

33. **TRIPLE-S SALUD'S RIGHT TO AUDIT:** When subscribing to this policy, insured members accept, acknowledge and understand that Triple-S Salud, as payer of the health services incurred, has the authority to access their medical information to audit all or any health service claims that Triple-S Salud has paid.

34. **UNIQUE CONTRACT-CHANGES:** This policy, riders, and attached documents, if any, constitute the entire text of the insurance contract. No change to this policy will be valid until approved by the executive officer designated by the Board of Directors of Triple-S Salud and the Office of the Commissioner of Insurance of Puerto Rico before its use, and unless said approval is endorsed in the present document, or is attached to it. No agent has authority to change this policy or waive any of its provisions.

35. **WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA):** This policy provides coverage to the insured member for reconstructive surgery following a mastectomy, as well as the reconstruction of the other breast to maintain a symmetrical appearance, prostheses and any physical complications that may arise during all the stages of a mastectomy. These benefits will be provided based upon a consultation between the insured member and her physician, and are subject to the copayments and coinsurances set forth in her policy.

BASIC COVERAGE

1. **9-1-1 SYSTEM:** An answering system to public safety emergency calls, through the 9-1-1 number, created by virtue of law 144 of December 22, 1994, as amended, known as Act for the Speedy Attention of Public Safety Emergency Calls or 911 Calls Act**.**

2. **ACTIVE EMPLOYEE:** Means an employee that renders services to an employer and in exchange he receives a paycheck, salary, wage, commission, bonus or any other compensation, or which is on paid leave such as vacations, sick leave or military training leave, among others, regardless if they carry out his functions at the employer's facilities or outside them, if this employee is permanent, full-time or part time. An active employee is also an employee that is temporary absent from his work because of a personal or family health condition. An employee will become an inactive when he resigns, abandons his job, is on a leave of absence without pay (unless in those exceptional circumstances provided by law such as those provided by the State Insurance Fund and the Family Medical Leave Act) is terminated from employment, retires, dies or his position is declared vacant by the employer. This term includes temporary employees, owners or officers.

3. **AFFORDABLE COVERAGE:** Means a coverage whose total premium or the contributions to the total premium made by an employee/insured member does not exceed 9.5% of his family income.

4. **AMBULANCE SERVICES:** Transportation services received in a vehicle duly authorized by the Public Service Commission and the Department of Health of Puerto Rico to render such services.

5. **AMBULATORY SERVICES:** Services covered under this policy, received by the member while the person is not admitted as a patient in a hospital.

6. **AMBULATORY SURGERY CENTER:** A specialized institution:

   a. Regulated by law, holds a license from the regulatory agency responsible for granting such permits under the laws and regulations of the jurisdiction of its location; or

   b. Where is not regulated by law, complies with the following requirements:

      1) Is established, equipped, and operated according to the laws and regulations in effect within the jurisdiction in which it is located, for the primary purpose of providing surgical services.

      2) Operates under the supervision of a medical doctor (M.D.) licensed to practice his/her profession, who provides full-time supervision and allows surgical procedures only to be performed by a qualified doctor, who at the moment of practicing such procedures, has a similar practice in at least one hospital in the area.

      3) Requires in all cases, except those requiring local anesthesia, that a licensed anesthesiologist administer the anesthesia and is present during the complete surgical procedure.

      4) Provides at least two (2) operating rooms and at least one post anesthesia recovery room; fully equipped to perform X-rays and laboratory diagnostic tests; with trained personnel and the necessary instruments to face any foreseeable emergencies including, but not limiting to, a defibrillator, a tracheotomy kit and blood bank or any other necessary supplies.

      5) Provide full-time service of one or more registered nurses (R.N.) for the care of patients in

the operating rooms and post-anesthesia recovery rooms.

6) Has subscribed a contract with at least one hospital in the area for the immediate hospitalization of patients who develop complications or requires post-surgery hospitalization.

7) Maintains an appropriate medical record for each patient, including an admission diagnosis with a report on pre-surgery examinations, a clinical history and laboratory examinations and/or X-rays, an operation report and a report on the release of the patient, except for those who have undergone a local anesthesia procedure.

7. **ASSIGNMENT OF BENEFITS:** Process through which non-participating physicians, hospitals and facilities accept to provide the necessary services to the member, billing directly to Triple-S Salud for said services based on the rates for participating providers.

8. **BARIATRIC SURGERY:** Surgical procedure to control obesity, which can be done using four different techniques: surgical bypass, adjustable gastric band, sleeve gastrostomy or intragastric balloon. Triple-S Salud will only cover, as required by law, the gastric bypass, subject to precertification. The adjustable gastric band, intragastric balloon and sleeve gastrectomy are not covered.

9. **BLUECARD PROGRAM:** Program that allows the claim processing for services covered out of the Puerto Rican geographic area which will be paid based on the negotiated fees by the Blue Cross or the Blue Shield Plan area.

10. ***BLUE CROSS AND BLUE SHIELD* PLAN**: Independent insurer under contract with the Association of Plans Blue Cross/Blue Shield) acquires the license to belong to the association of independent plans and allows the use of its marks.

11. **COBRA LAW:** Public Law 99-272, Title X, Consolidated Omnibus Budget Reconciliation Act (COBRA), which requires all employers with twenty (20) or more employees that sponsor group health insurance plans to provide its employees and family members, in some situations, temporary coverage (called Continued Coverage) when coverage under the plan ends.

12. **COINSURANCE:** The percentage of established fees that the member will pay when purchasing a prescription drug or receiving a covered services from a participating physician or provider or any other provider, as his or her contribution to the cost of the services received, as set forth in the policy and notified to the participating physician or provider. This amount is not reimbursable by Triple-S Salud.

13. **COLLATERAL VISITS:** Interviews at the office of a psychiatrist or psychologist (with a master's or doctorate degree and a valid license issued by the Puerto Rico Board of Psychologist Examiners) with the immediate family of the patient insured under this policy.

14. **CONCURRENT REVIEW:** Utilization review carried out during the stay of the member in a facility or during the treatment of the member at the office of a health professional or another place where health care services are provided to members admitted or on an outpatient basis.

15. **CONTRACT HOLDER:** The person that holds an insurance contract with Triple-S Salud that entitles him/her to the benefits issued in his/her name and assumes the responsibilities established in the policy.

16. **COPAYMENT (COPAYMENT):** A fixed predetermined amount to be paid by the member when purchasing prescription drugs or when receiving services from a participating physician or any other provider, as his/her contribution to the cost of the services received, as set forth in the policy and has been notified to the participating

physician or provider. This amount is not reimbursable by Triple-S Salud.

17. **COSMETIC SURGERY:** That surgery, whose purpose is to improve the individual's appearance and not to restore function or correct deformities. A purely cosmetic surgery does not turn into reconstructive surgery for psychiatric or psychological reasons.

18. **CREDITABLE COVERAGE:** It is the health coverage the insured employee has before he/she enrolls under the group health plan, as long as the person has not have a substantial interruption in the coverage. The certificate of creditable coverage is provided:

    a) When the person is no longer covered by the health plan or obtains coverage as per a provision of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) on coverage continuation;

    b) In the case of a person covered by COBRA, according as per a provision of COBRA on coverage continuation, at the moment the person is no longer covered in conformance with said provision; and

    c) At the moment a request is made on behalf of a person, if the request is made within twenty-four (24) months from the date of the termination of coverage as described in sections (1) or (2), whichever date is later.

19. **CUSTODIAL CARE:** Refers to personal attention or assistance, provided permanently to a person, in daily life activities such as bathing, dressing, eating, getting in and out of bed, sitting in and standing up from a chair, moving from one place to another, using the bathroom, cooking and eating meals and taking medications. Custodial care does not require the continuous attention of medical staff.

20. **CUSTOMARY CHARGE:** A charge is customary when it is under the set of usual charges billed by the majority of physicians and service providers with similar training and experience within a specific field.

21. **DIRECT DEPENDENTS:** The following are considered direct dependents:

    a. The spouse, person with whom one is married, having complied with the ceremonies and formalities required by the law, of the insured member included in a Family Contract as long as the policy is in effect and the member lives permanently with that spouse under the same roof.

    b. Biologic or adopted children of the insured employee or the spouse of the member as defined in this clause 25 (a) until they attain age 26. The children or the spouses of the member's dependents will not be eligible for coverage under this plan, except those included in paragraph 25(d) below, or the children of the spouse of the policyholder's child.

    c. Minors placed in the home of the insured member to be adopted by the insured member. The insured member must evidence the placement for adoption with the documents requested by Triple-S Salud.

    d. Any minor not emancipated, such as a grandchildren or other blood relative of the main member will be considered a direct dependent, as long as the insured member holds permanent custody of said child awarded to the main member by a court of law through a final and binding judgment; said direct dependent may stay enrolled in the plan until he attains age 26. Any person of legal age that is a grandchild or blood relative of the main member and has been declared disabled by a court of law through a final and binding judgment; will also be accepted as a direct dependent if the custody of the disabled person was awarded to the main member by a court of law. If a member wishes to subscribe as direct dependent a grandchild or blood relative under this clause must show proof of its custodian character by presenting the final and binding judgment of court awarding

permanent custody or guardianship, as the case may be.

e. Foster children will also be considered direct dependents until they attain age 26. The policyholder may demonstrate the status of the foster children providing to Triple-S Salud a sworn statement where he/she specifies when the relationship with the minor began, legal custody or the certification of the income tax returns of the last two years, among other evidences. It will be understood that foster children are those minors, who, without being biologic or adopted children of the insured employee, have lived from their infancy under the same roof with the member in a parent-child relationship and that receive feeding as this term is defined by Article 142 of the Civil Code of Puerto Rico.

22. **DURABLE MEDICAL EQUIPMENT:** Equipment that can be used repeatedly. Its principal use is to serve a medical purpose, and not to serve the person or the injury. This equipment must be appropriate for use in the patient's home and its medical necessity must be certified. It does not include equipment that is used outside the home of the patient or whose function is limited only to convenience. Durable medical equipment includes, but is not limited to, hospital-type beds, wheelchairs, oxygen equipment and walkers, among others.

23. **EFFECTIVE DATE:** Means the first day of coverage or, if there is a waiting period, the first day of the waiting period, whichever comes first.

24. **ELIGIBILITY WAITING PERIOD:** Period of time which must pass before the member is entitled to receive certain benefits, under the health plan terms. The waiting period will not exceed 90 days.

25. **ELIGIBLE EMPLOYEE:** It means an employee that works full-time during the minimum hours required by the employer-regular work week of thirty (30) hours or more, or part-time-less than seventeen and a half (17.5) hours per regular work week-for a employer, in which there is a goodwill relationship between the employer and the employee, which is not established in order to purchase a health plan. In this computation employees that are absent of work because of a leave or a right recognized by law, such as benefits provided by the State Insurance Fund Corporation or the Family Leave Act of 1993. The term eligible employee" does not include temporary employees or independent contractors.

26. **ENROLLMENT PERIOD**: The period of time an eligible employee has to enroll in an employer health plan.

27. **EXPENSE INCURRED**: The amount the member pays out-of-pocket for a service received that was not billed to the plan or processed by assignment of benefits.

28. **EXPERIMENTAL OR INVESTIGATIONAL SERVICES:** Medical treatment:

    a. That is considered experimental or investigational as defined by the Technology Evaluation Center (TEC) of the Blue Cross and Blue Shield Association on specific indications and methods ordered or;

    b. That does not have the final approval of the appropriate regulatory agency (e.g., Food and Drug Administration (FDA), Department of Human and Health Services (DHHS), the Commonwealth's Department of Health) or;

    c. For which scientific evidence is insufficient, according to the scientific evidence available, or does not support conclusions on the effect of treatment or technology on the medical results obtained or;

    d. Have positive results reported that are insufficient to counterbalance, in an acceptable manner, the negative results of the treatment or;

    e. Is not more beneficial than other already known alternative treatments or;

f. Does not lead to improvement beyond the investigational phase.

29. **FAMILY CONTRACT:**

a. The insurance that provides benefits to any insured employee, his/her spouse and his/her direct dependents as defined in clause 25 of this section. The premium for family contracts will apply in these cases.

b. Should there be no eligible spouse as a direct dependent, as defined in clause 25, the insured member's contract with one (1) or more as direct dependents may, at his/her option, be considered a Family Contract or an Individual Contract with one (1) or more direct dependents, as defined in clause 25 of this section. In both alternatives, the premium will be the same.

The inclusion of dependents may only be done at the time the policy is purchased or on the policy renewal date, except for those cases indicated in the Changes in Enrollment or Special Enrollment sections of this policy, or if indicated otherwise in any other Law.

30. **FEES:** The fixed amount used by Triple-S Salud to pay its participating physicians or providers for the covered services rendered to the member when these services are not paid through another payment method.

31. **GENETIC INFORMATION:** Means information of genes, genetic products and inherited characteristics that may derive from the individual or a family. This includes information regarding the status of the carrier and information derived from laboratory tests that identify gene or specific chromosomal mutations, physical medical exams, family history and direct analysis of genetic material or chromosomes.

32. **GRIEVANCE:** A written or oral complaint, if it involves a request for urgent care, submitted by an insured member or on behalf of the insured member, in regard to:

a. The availability, rendering or quality of health care, including grievances related to adverse determinations that may result from a utilization review;

b. The payment or handling of claims or indemnification for health care services; or

c. Issues related to the contractual relationship between the covered person or member and the insurer.

33. **GROUP HEALTH PLAN:** Means a policy, insurance contract or certificate issued by Triple-S Salud or an insurer for the benefit of a employer, or a group of employers, through which health care services are provided to eligible employees and their dependents.

34. **HEALTH INFORMATION**: Means whether oral or recorded information or data in any form or medium:

a. That is created or received by the insurer or the health services organization, related to physical, mental, or behavioral health, or past, present or future conditions of the person, or dependent, the provision of health care to an individual, or past, present, or future payments for the provisions of health care to an individual.

b. About the payment for health care services provided to an individual.

Health information also includes demographic and genetic information, and information about financial exploitation or abuse.

35. **HEALTH PROFESSIONAL**: Means a physician or any other professional in the health field that is licensed in Puerto Rico, accredited or licensed by the corresponding entities to provide certain healthcare services and medical care, according to state laws and regulations, such as physicians, surgeons, podiatrists, naturopathic doctors, chiropractors, optometrists, psychologists, dentists, pharmacists, nurses, and medical technologists.

36. **HIPAA (Health Insurance Portability and Accountability Act of 1996):** Public Federal Law Number 104-191 of August 21, 1996. It regulates everything related to the portability and continuity of insurance coverage in the group and individual markets; contains clauses to avoid fraud and abuse of health insurance coverage and the benefit of health services, as well as the administrative simplification of health plans.

37. **HOME CARE:** Is the care provided to an individual at his home, by a licensed health professional or a professional caretaker to help the individual in daily life activities such as bathing, dressing, eating, getting in and out of bed or a chair, moving, using the bathroom, preparing meals, eating meals, and taking medications.

38. **HOME HEALTH CARE AGENCY:** An agency or organization that provides a program of home health care and which:

    a. Is approved as a Home Health Agency under Medicare, or

    b. Is established and operated in accordance with the applicable laws of the jurisdiction in which it is located and where licensing is required, has been approved by the regulatory authority having the responsibility of licensing these agencies in accordance with the law, or

    c. Meets all of the following requirements:

        1. An agency that holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing support services to the home.
        2. It has a full-time administrator.
        3. It keeps written records of services provided to the patient.
        4. Its staff includes at least one (1) Registered Nurse (R.N.)
        5. Its employees are bonded and provided with malpractice and professional liability insurance.

39. **HOSPICE:** Special care for persons with terminal diseases whose life expectancy is six months or less.

40. **HOSPITALIZATION PERIOD**: Means the term in which the insured member was confined in a hospital. This period corresponds to the number of days between the day the person was admitted to the hospital and the day the person was discharged.

41. **HOSPITALIZATION SERVICES**: Services covered by this policy that the insured member receives while admitted in a hospital.

42. **HOST BLUE:** Blue Cross or Blue Shield plan of the area where services are rendered under the BlueCard Program.

43. **ILLNESS:**

    a. Any non-occupational illness contracted by the insured member. Illnesses, for which hospitals are unable to admit the patient by law or regulation once they have been diagnosed, are not covered under this policy.

    b. Maternity and conditions that are secondary and related to the pregnancy will be considered illnesses for the coverage offered by this policy, subject to the following conditions:

        1) That services are rendered to the female member regardless of her marital status
        2) Any service rendered for a therapeutic abortion.

44. **INDEMNIFICATION:** Amount of money that the member receives for a claim submitted to the health plan for a covered service received.

45. **INDIVIDUAL CONTRACT:** The insurance that provides benefits to any eligible single or married person not including the spouse of the member, as defined in clause 25, Direct Dependents. Said employee will have the option to include in his/her insurance contract any eligible direct dependent, as

defined in clause 25 of this section, through the payment of the corresponding premium.

Dependents may only be included at the time the policy is bought or on the policy renewal date, except for those cases indicated in the Changes in Enrollment or Special Enrollment sections of this policy, as otherwise indicated in any other law.

46. **INITIAL PSYCHOLOGICAL INTERVIEW:** Collects the problems of the patient, his/her main complaint, medical history, personal history, history of development, the state of interpersonal relationships, mental state, establishing a diagnosis and a treatment plan with recommendations on strengths and limitations.

47. **INJECTABLE PRESCRIPTION DRUG ANTINEOPLASTIC AGENTS:** A prescription drug that inhibits or prevents the development of cancer preventing the growth, maturation or proliferation of malignant cells; which is administered through infusion.

48. **INJURIES:** Any accidental injury suffered by the member not due to an automobile or on-the-job accident that requires hospitalization and medical treatment.

49. **MEMBER OR INSURED MEMBER:** Any eligible and enrolled person, either the policyholder or a dependent (direct) who is entitled to receive the services and benefits covered under this policy.

50. **INTENSIVE CARE UNIT:** Separate, clearly designated service area reserved for patients in critical condition, seriously ill, requiring intensive monitoring, as prescribed by the treating physician. Additionally, it provides room and nursing care by nurses whose responsibilities are concentrated in the care and accommodation of intensive care patients and special equipment or supplies available immediately at any moment for the patient confined in this unit.

51. **LICENSED PHYSICIAN:** A person that requests and is authorized to exercise medicine and surgery in Puerto Rico after obtaining a license by the Board of Medical Licensure and Discipline of Puerto Rico, in accordance with the provisions of the law and this regulation.

52. **MAXIMUM OUT-OF-POCKET AMOUNT:** It is the maximum amount stated in the policy that a person must pay during the policy year. Before the person reaches the out-of-pocket amount stated in this policy, the person will pay the deductibles, copayments, or coinsurances for essential medical-hospital care and prescription drugs, as described in the table of benefits, received from the plan participating providers. Once the insured member reaches the maximum out-of-pocket amount stated in the policy, the plan will pay 100% of the medical expenses covered under this policy. Services rendered by non-participating providers, payment for medical expenses not covered under this policy and the premium paid to Triple-S Salud for the plan, are not considered eligible expenses for the accumulation of the out-of-pocket maximum.

53. **MEDICALLY NECESSARY SERVICES:** Those services that are provided by a participating physician, physicians group, or provider to support or restore the member's health, and are determined and provided according to standards of good medical practice.

54. **MEDICARE:** Federal law on Health Insurance for the Elderly, Title XVIII of the 1965 Amendments to the Social Security Act as constituted or amended thereafter.

55. **METABOLIC SYNDROME:** Is the group of several diseases or risk factors in a person that increase the chance of developing a cardiovascular disease or diabetes mellitus. Persons that have the metabolic syndrome have at least three of the following risk factors: excessive fat in the abdomen, hypertension, and abnormal lipid levels in the blood which include cholesterol and triglycerides and hyperglycemia (high sugar levels in the blood).

56. **MORBID OBESITY:** It is the excess of fat in the body determined by a body mass index (BMI) of 35 or higher. It is a condition that is part of the metabolic syndrome and it is a risk factor for the development of other conditions such as hypertension, heart diseases, orthopedic problems, sleep apnea, skin problems, circulation problems,

diabetes mellitus, acid reflux, psychological problems, anxiety, infertility, and pulmonary embolism, among others. Studies indicate that it is a condition of multifactorial origin, such as genetic, environmental and psychological, among others. This means that it can be caused by factors such as overeating, metabolic alterations or hereditary factors.

57. **NON-COVERED SERVICES:** Means those services that:

    a. are expressly excluded in the member's policy;

    b. are an integral part of a covered service;

    c. are rendered by a medical specialty which the plan has not recognized for payment;

    d. are considered experimental or investigational by the corresponding entities, as stated in the policy;

    e. are provided for the convenience or comfort of the member, the participating physician or the facility.

58. **NON-PARTICIPATING PHYSICIAN OR PROVIDER:** Physician, hospital, medical group or provider that does not have a valid contract with Triple-S Salud.

59. **NUTRITION SPECIALIST:** Health professional specialized in nutrition and alimentation certified by the government entity designated for said purposes.

60. **OPTIONAL DEPENDENTS:** In addition, under a family contract, an optional dependent will be a person who for some reason does not qualify as a direct dependent, but is handicapped, and the insured member has a final judgment granting custody or guardianship.

61. **PARTIAL HOSPITALIZATION:** Facilities and services organized to care for patients with mental conditions that require hospital care through day or evening programs of less than twenty-four (24) hours.

62. **PARTICIPATING PHYSICIAN OR PROVIDER:** Physician, hospital, primary care centers, diagnostic and treatment centers, dentist, laboratory, pharmacy, emergency medical care centers or any other person or entity in Puerto Rico, authorized to provide medical care and that under direct contract with Triple-S Salud or through a third party renders health services to member's or beneficiaries of Triple-S Salud.

63. **POLICYHOLDER:** The person that has an insurance policy or contract with Triple-S Salud, who for the purposes of this policy is the employer.

64. **POLICY YEAR:** Period of twelve (12) consecutive months for which employer purchases or renews Triple-S Salud insurance.

65. **PREAUTHORIZATION**: It means the process of obtaining prior approval of the health insurance organization or insurer, which is required under the terms of the coverage of the health plan, for the dispensing of a prescription medication.

66. **PRECERTIFICATION:** Advanced authorization from Triple-S Salud for the payment of any of the benefits covered under this policy and its riders, in cases Triple-S Salud deems necessary. Some of the objectives of the precertification are: evaluate if the service is medically necessary, evaluate the adequacy of the service location, verify the eligibility of the member for the requested service, and its availability in Puerto Rico. Precertifications will be evaluated based on the precertifications policies that Triple-S Salud has set forth through time. Medications that require preauthorization are usually those that must meet clinical criteria, given that they have a potential for toxicity, are candidates for inappropriate use or are related to an elevated cost.

    Triple-S Salud will not be liable for payment of services that have been rendered or received without this authorization from Triple-S Salud.

67. **PREEXISTING CONDITION:** Means a condition, regardless of its cause, for which treatment was recommended or for which a diagnostic, care or treatment was recommended or received six months prior

to enrollment in the health plan. This policy does not exclude or discriminate its members for preexisting conditions, regardless of the age of the member.

68. **PREMIUM:** Means the specific money amount paid to the insurance company, in this case Triple-S Salud, as the condition to receive the benefits of a health plan for the eligible employees of an employer. The premium collected from an member cannot be changed during the contract year, unless there is a change in the affiliation of the employer, the family group of the eligible employee or the benefits of the health plan requested by the employer.

69. **PREVIOUS QUALIFYING COVERAGE OR EXISTING QUALIFYING COVERAGE**: Means benefits or coverage provided by one of the following:

    a) Medicare Program, Medicaid, Civilian Health and Medical Program of the Uniformed Services (TRICARE) or any other program sponsored by the government.

    b) Group health plan issued by a health insurance organization or insurer, a prepaid hospital plan or medical insurance of the Health plan of the Auxilio Mutuo, that provides benefits that are similar or exceed the benefits of the basic coverage, as long as the coverage has been in effect during at least one year.

    c) A self-insured plan sponsored by the employer that provides benefits that are similar or exceed the benefits of the basic health insurance plan as long as the coverage has been in effect during at least the last 12 consecutive months, if:

        - The employer opted for a health plan that participates in the Health Plans Insurers Association; and,

        - The employer complied with all the participation requirements of the operational plan of the Health Plan Insurers Association.

    d) An individual health plan or a plan of a bona fide association that includes coverage provided by a health insurance organization or insurer or the plan of the Sociedad de Auxilio Mutuo that provides similar benefits or exceed the benefits of the basic health plan with a silver level coverage, if the coverage has been in effect during at least the last twelve (12) consecutive months; or

    e) The state coverage provided by a Health Plan for Non-Insurable Persons if the coverage has been in effect for at least one year.

70. **PROSPECTIVE REVIEW:** Means the utilization review made before the health care service or treatment is rendered to the patient, as required by the insurer for the approval, in whole or in part, of the service or treatment, before it is rendered.

71. **PSYCHOANALYSIS:** Psychoanalysis is based on a set of theories related to the conscious and unconscious mental processes and the interaction between these. It is a modality of therapy used to treat people who present/display chronic life problems in a scale of slight to moderate. Psychoanalysis should not be used as synonymous for the psychotherapy, since they do not pursue the same objective. This service is not covered in this policy, as expressed in the Exclusions section.

72. **PSYCHOLOGICAL EVALUATION:** Initial interview to obtain personal and clinical history of the member, as well as his/hers description of symptoms and problems. The psychological evaluation must be performed by a Psychologist with a master's or doctoral degree in Psychology, licensed from a duly accredited graduate program, and with valid license, issued by the Puerto Rico Board of Psychologist Examiners.

73. **PSYCHOLOGICAL TEST:** Use of instruments designed to measure the intellectual abilities or the capability of an individual to master a specific area. Psychological tests to be administered in each specific case will be subject to the

professional judgment of the psychologist, with a master's or doctoral degree, who has the knowledge to administer, correct and interpret them, who must be graduated from a duly accredited graduate program and must have a valid license issued by Puerto Rico Board of Psychologist Examiners.

74. **PSYCHOLOGIST:** A professional with a master's (MA) or PhD in Psychology, graduated from an accredited university, college, or center who has been authorized by the Puerto Rico Board of Psychologist Examiners to exercise this practice in Puerto Rico.

75. **PSYCHOTHERAPY:** Methods used for the treatment of mental and emotional disorders through psychological techniques instead of using physical means. Some of the objectives of the psychotherapy are to change maladaptive behavior models, improve the interpersonal relations, and solve the internal conflicts that bring about personal suffering, modify inaccurate ideas of the self and the environment, and foster a defined feeling of self-identity that favors the individual development of an existence that is pure and full of meaning.

76. **REASONABLE CHARGE:** A charge is reasonable when it satisfies the usual and customary criteria or it may be reasonable if, in the opinion of an appropriate Review Committee, it deserves special consideration according to the complexity of the management of the particular case.

77. **RECONSTRUCTIVE SURGERY:** Surgery performed in abnormal body structures for improving functional defects and appearance, which are the result of congenital defect, illness or trauma.

78. **RESCISSION OF COVERAGE:** Triple-S Salud may decide to terminate its contract with retroactive effect on the basis of fraud or intentional misrepresentation of substantial data as prohibited by this plan. The termination shall be notified in writing thirty (30) days in advance and the participant or member has the right to request review of this termination.

79. **RESIDENTIAL TREATMENT:** A high level, high intensity, restrictive care services for patients with mental health conditions, including drug abuse and alcoholism and comorbid conditions that are difficult to manage in their home or communities, because the person has not responded to less restrictive treatment. It integrates clinical and therapeutic services organized and supervised by an interdisciplinary team within a structured environment. 24 hours a day, 7 days a week.

80. **REST HOME OR CONVALESCENCE HOME**: A private residential institution equipped for the care of people who cannot look after themselves such as the elderly or persons with chronic conditions.

81. **RETROSPECTIVE REVIEW:** Means the review of a benefit request performed after the health care service was rendered. A retrospective review does not include the review of a claim that is limited to the evaluation of the reliability of the documentation or the use of the correct codes.

82. **SECONDARY CONDITIONS:** A secondary condition is a medical condition resulting from an underlying medical condition, which does not appear on its own.

83. **SERVICE AREA:** The area within which the insured member is expected to receive the majority of the medical/hospital services. In this policy, the service area is Puerto Rico, since benefits provided in this policy are available only to those people residing permanently in Puerto Rico.

84. **SERVICES NOT AVAILABLE IN PUERTO RICO:** Means treatment at facilities, or with medical-hospital equipment not available in Puerto Rico, in case of an insured patient who, because of his health condition, requires these services.

85. **SESSIONS:** Two or more modalities of physical or respiratory therapy treatments.

86. **SKILLED NURSING FACILITY:**

a. It is a specialized nursing facility, as defined by Medicare, which is qualified to participate, and is eligible to receive payments under and in accordance with the provisions of Medicare; or

b. An institution that fully meets all of the following criteria:

1) Is operated in accordance with the applicable laws of the jurisdiction in which it is located.

2) Is supervised full-time by a licensed physician or a registered nurse (R.N.)

3) Is regularly engaged in providing room and board, and provides skilled nursing care 24-hour a day to sick and injured persons, while recovering of an injury or disease.

4) Keeps a medical record of each patient under the care of a duly licensed physician.

5) Is authorized to administer medications and provide treatment to patients following the orders of a duly licensed physician.

6) It is not, other than incidentally, a home for the aged, blind, or deaf, a hotel, a home care facility, a maternity home, or a home for alcoholics, or drug addicts, or the mentally ill.

7) It is not a hospital

87. **SPECIAL ENROLLMENT:** Instance in which the employee and his/her eligible dependents can subscribe to the health plan at any time, as a result of a specific qualifying event such as marriage, birth, and death, among other events.

88. **SPECIAL NURSES:** Are nurses devoted to specialized care of certain patient population (Ex. nurse anesthetists).

89. **SPORTS MEDICINE:** Branch of medicine that deals with illnesses or injuries caused by sports activities, which includes the preventive and preparatory phases necessary to maintain good physical and mental condition.

90. **SPOUSE:** Means the person of the same sex or of different sex with whom the health plan member is legally married.

91. **TELECONSULTA:** A service that Triple-S Salud provides to its members through which the plan member can receive orientation on their health related questions. Calls are answered by nursing professionals seven (7) days a week, twenty-four (24) hours a day. When calling this line, if the member receives a recommendation to visit the emergency room, he/she will be provided with a registration number that must be presented when receiving the services. In case of illness, when presenting this number at the emergency room, the member will pay a lower copayment to use the facilities. The telephone number to call Teleconsulta is located on the back of the Triple-S Salud's identification card.

92. **TRANSPLANT:** A procedure or series of procedures through which an organ or tissue is:

a) removed from the body of a person called donor and implanted in the body of another person called recipient; or

b) removed and implanted in the body of the same person

93. **TREATMENT PLAN:** Detailed report of the procedures recommended by the physician or dentist to treat the medical needs of the patient based on the findings of the medical examination made by the same physician or dentist.

94. **USUAL CHARGE:** A usual charge is the charge a particular physician or service provider most usually makes to patients for a specific service.

MAJOR MEDICAL COVERAGE

1. **IMPLANT:** A device, object or material that is placed inside the body with the purpose of preserve configuration, offer stability, or offer temporary or permanent stimulus to a body part. They are covered as it is established in the policy.

2. **MEDICAL MATERIALS OR SUPPLIES:** Those, which, for their diagnostic or therapeutic characteristics, are essential for the effectiveness of the care plan, ordered by the physician for the treatment or diagnosis of the patient's illness or injury.

3. **ORTHOPEDIC DEVICES:** Those devices that are used after a surgical or mechanical correction of curvatures, deformities and fractures in general.

4. **ORTHOTIC DEVICES:** External accessories that restrict, eliminate or redirect the movement of a weak or ill part of the body, as, for example: claps, bracers, corsets, splints, casts for injured ligaments, etc.

5. **PROSTHESIS:** External replacement for a dysfunctional body part, that is fabricated and adapts to the measures and individual necessity of the person who is receiving it, with the purpose of providing function or mobility. It may substitute a part of the body that does not work properly or is missing. These are covered as it is established in the policy.

6. **SURGICAL ASSISTANCE:** When a licensed physician actively assists the lead surgeon in performing a covered surgical procedure, which because of its complexity justifies the necessity of assistance.

7. **SCALE OF MEDICAL BENEFITS:** Scale based on which services covered and received by the insured member will be paid, when such services cannot be paid under the concept of usual, customary and reasonable charge. The Scale of Medical Benefits will apply in Puerto Rico.

ORGAN AND TISSUES TRANSPLANT

1. **PRE-EXISTING CONDITIONS:** physical or mental condition suffered by a member which were initially manifested prior to the issuance of the policy; or that existed prior to the issuance and for which the member received treatment.

2. **ORGAN TRANSPLANT INSURANCE:** An insurance independent from the health plan that the eligible member may have with Triple-S Salud. Said provides coverage for the organ transplant only, as defined in the Benefits Section of this policy. The covered benefits will be payable by indemnization or assignation of benefits. To be eligible for this benefit, you will have to be subscribed in the basic coverage.

3. **PRE-TRANSPLANT**: Evaluation and preparation of an member to receive a tissue or organ transplant.

4. **PROCUREMENT:** Those expenses incurred in connection with locating, removing, preserving and transporting an organ or tissue including also the evaluation before the surgery and surgical removal of the donor organ or tissue. Benefits will be provided only for procurement of a donor organ or tissue that is used for a transplant for which benefits are provided under this rider, unless the scheduled transplant is canceled because of the member's medical condition or death and the organ or tissue cannot be transplanted to another person. These expenses will only be covered only if the recipient is covered by the Plan. For bone marrow transplant, the term donation is used instead of procurement.

5. **SECOND MEDICAL OPINION**: Requirement that Triple-S Salud or his authorized representative makes an opinion from a physician other than the physician in charge of the case and selected by Triple-S Salud, in cases in which Triple-S Salud determines that there was a need for such an opinion, before the insured member receive the service. Triple-S Salud may require a second medical opinion, by doctors appointed by this, for those procedures in which in the opinion of Triple-S Salud or his authorized representative may need to obtain such an opinion.

6. **TRANSPLANT:** Means a procedure or a series of procedures by which an organ or tissue is either:

    a. Removed from the body of one person called a donor and implanted in the body of another person called a recipient; or

    b. Removed from and replaced in the same person's body.

PHARMACY COVERAGE

1. **BRAND NAME PRESCRIPTION DRUGS:** Prescription Drugs offered to the public under a commercial name or trademark.

2. **GENERIC DRUGS:** A generic drug has the same active ingredient in its formula as the brand-name drug. Generic drugs are usually less expensive than brand-name drugs and have the approval of the Federal Food and Drugs Administration (FDA).

3. **COINSURANCE:** Percentage of fees to be paid by the member at the moment services are rendered, as his/her contribution to the cost of the services received, as established in the policy and notified to the participating pharmacy. This amount is not reimbursable by Triple-S Salud.

4. **COPAYMENT:** The fixed preauthorized amount to be paid by the insured member to at the moment services are rendered, as his/her contribution to the cost of the received services, as established in the policy and notified to the participating pharmacy. This amount is nor reimbursable by Triple-S Salud.

5. **MAINTENANCE PRESCRIPTION DRUGS:** Those prescription drugs that require a prolonged therapy, and are unlikely to change in dose or therapy because of side effects. Other prescription drugs considered maintenance drugs are those whose common use is to treat chronic diseases for which the end of the therapy cannot be determined.

6. **NEW PRESCRIPTION DRUGS:** Are new drugs entering the market. They are generally evaluated by the Pharmacy and Therapeutics Committee within a period not exceeding 90 days from their approval by the Food and Drugs Administration.

7. **NON-PARTICIPATING PHARMACY:** Any pharmacy that has not subscribed a provider contract with Triple-S Salud.

8. **NON-PREFERRED BRAND DRUGS:** A drug is classified as Non-Preferred because there are other choices in previous levels with lesser reactions or are more cost effective. If get a brand-name drug, you will have to pay more for that drug.

9. **NON-PREFERRED PRESCRIPTION DRUGS:** This tier includes generic and non-preferred brand-name drugs that have a higher cost. They are classified as non-preferred because there are alternatives in the previous tiers with fewer side effects or that are more cost-effective. If the member obtains a non-preferred generic drug or a brand-name drug, he will have to pay a higher cost for the prescription drug.

10. **NON-PREFERRED SPECIALTY PRODUCTS:** Identifies prescription drugs or products of the Prescription Drug List or Formulary that are offered under the Special Condition Prescription Drug Program. The cost of the prescription drugs in this tier is higher than Preferred Specialty Products. They are used to treat chronic and high risk conditions that require special management and administration.

11. **OVER-THE-COUNTER (OTC) DRUGS:** Are those medications that do not have a federal legend and can be dispensed to the customer without a prescription from the physician.

12. **PARTICIPATING PHARMACY:** Any pharmacy that has subscribed a provider contract with Triple-S Salud.

13. **PHARMACY**: Any establishment legally authorized to supply drugs.

14. **PHARMACY PROGRAM OF DISPENSING A 90 DAY SUPPLY AT THE PHARMACY**: A voluntary program that allows the member to obtain a supply of ninety (90) days of his/her maintenance medications through participating pharmacies of the program.

15. **PHARMACY PROGRAM OF SENDING MEDICATIONS BY MAIL:** A voluntary program that allows the member to receive his/her maintenance medications through the Postal Service of the United States of America.

16. **PREFERRED BRAND DRUGS:** Brand-name drugs that have been classified by the Pharmacy and Therapeutics Committee as preferred agents after in-depth review in terms of safety, efficiency and cost. In those therapeutic classes where no generic drugs are available, we suggest you to use as first choice those drugs named as preferred.

17. **PREFERRED PRESCRIPTION DRUGS:** Includes generic and brand-name drugs that have been chosen by the Pharmacy and Therapeutics Committee as preferred agents after evaluating their safety, efficiency and cost. In those therapeutics classes where there are no generic drugs available, we encourage members to use prescription drugs identified as preferred as the first option.

18. **PREFERRED SPECIALTY PRODUCTS:** Identifies prescription drugs or products in the Prescription Drug List or Formulary that are offered under the Special Condition Prescription Drug Program. Prescription drugs in this tier include generic, biosimilar (generics for biological products) and brand-name drugs at a lower cost and with a special arrangement for their dispensing. These products are used for the treatment of chronic and high risk conditions that require special management and administration.

19. **PRESCRIPTION DRUG:** A prescription drug approved or regulated by the Food and Drugs Administration (FDA) that allows its marketing and for which Puerto Rico and United States laws require that it must be dispensed by prescription.

20. **PRESCRIPTION DRUGS WITH REFILLS:** A prescription with written instructions from the prescribing physician authorizing the pharmacy to dispense a prescription drug more than once.

21. **PRESCRIPTION DRUG LIST OR FORMULARY:** A guide to the prescription drugs chosen by Triple-S Salud Pharmacy and Therapeutics Committee, which contains the therapies necessary for a high quality treatment. The benefits on the prescription drug coverage are determined according to the prescription drugs included in the Prescription Drug List or Formulary. This selection is based on the safety, effectiveness and cost of the prescription drugs that ensure the quality of the therapy, reducing inadequate utilization, which may adversely affect the health of the patient.

22. **THERAPEUTIC CLASSIFICATION:** Are the categories used to classify and group prescription drugs in the Drug List or Formulary by the conditions they treat or the effect these drugs have in the human body.

23. **PRESCRIPTION:** A written request for medicines issued by a person licensed, certified or legally authorized to issue prescriptions for medications, addressed to a pharmacist for the dispensing of a prescription drug.

24. **PREAUTHORIZATION:** drugs that require prior authorization are usually those that must meet the clinical criteria as they may present a potential for toxicity, are candidates for the improper use or are related to a high cost.

DENTAL COVERAGE

1. **COINSURANCE**: The percentage of the established fees that the insured member will pay directly to the dentist at the time services are received.

2. **DENTIST:** An odontologist that is legally authorized to practice dentistry.

3. **EMERGENCY SERVICES**: Services provided due to a sudden and unexpected condition requiring dental care. Such assistance should be received immediately after the onset of the condition or as soon as possible.

4. **MAXIMUM BENEFIT**: The maximum amount of benefits to be paid for life.

5. **MAXIMUM LIMIT**: The maximum amount of benefits to be paid per policy year

6. **NON-PARTICIPATING DENTIST:** A dentist that has not signed a contract with Triple-S Salud to render dental services.

7. **ORTHODONTICS**: Branch of odontology, related to the diagnosis and necessary treatment to correct a malocclusion

8. **PARTICIPATING DENTIST**: A dentist with a regular license issued by the governmental entity assigned for such purposes, and member of the Dental Surgeons College of Puerto Rico; who has signed a contract with Triple-S Salud to render dental services.

9. **PERIODONTICS**: Branch of the odontology related to the diagnosis, treatment of gum diseases and other tissues that form part of the dental support.

10. **TREATMENT PLAN**: Means a detailed report of the procedures recommended by the doctor or surgeon-dentist for the treatment of medical or dental needs of the patient, found in the physical examination done by the same physician or surgeon-dentist.

11. **BENEFIT PREDETERMINATION:** Evaluation of the treatment plan suggested by the dentist before the services are rendered, to determine the eligibility of the member, the scope of the benefits covered, the limits, exclusions and copayments that apply under the member's contract.

12. **FEE SCHEDULE**: The fixed amount used by Triple-S Salud to pay participating dental surgeons for covered services given to member's when these are not attributed by any other payment method.