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: Pearson, Inc.

Sponsor: SP000

Effective date: January 01, 2019

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".**
Telexpreso	This is your direct contact with Triple-S Salud. This automated line helps you solve health plan issues at any time. Just by calling (787) 774-6060, you may conduct your health plan management quickly. With the Telexpreso system, you may: • Check your eligibility and that of your dependents • Request card duplicates • Check a reimbursement status • Check a precertification status • Obtain guidance for some processes, such as submitting a reimbursement claim, requesting card duplicates, and certifications, among others

	For additional information, please contact the Call Center, available Monday thru Friday, from 7:30 AM to 8:00 PM, Saturday from 9:00 AM to 6:00 PM, and Sunday from 11:00 AM to 5:00 PM. You just need to call (787) 774-6060 or 1-800-981-3241 (toll free).

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.

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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.

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 be effective from the date he was hired by the employer. The insurance application must include the document proving the eligibility date of the employee. 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.

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

For the coverage options in this policy, participating hospitals of the Triple-S Salud Network have been grouped in two levels according to the cost of the hospital facilities. Level 1 is the network of preferred hospitals or those low-cost hospitals. Level 2 is the network of non-preferred hospitals whose cost is higher. Level 3 is the network of hospitals whose cost I higher. Depending on the cost of the hospital facility, it will be the responsibility of the member for the payment for the admission.

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.

In both cases, the member will be responsible for paying the coinsurance established in the section of Extended Coverage for Services in the United States.

Please refer to additional rules about the coverage in the section of Extended Coverage for Services in the United States.

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.**

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 the 90-day delivery of some maintenance medications. Triple-S Salud policyholders will have the flexibility to select the preferred option for the receipt of some maintenance medications through: participating pharmacies.

- **Mail Order Program:** Under this program the insured will receive 90 days of their maintenance medications in their home or other place of preference and may order the repetitions of their medications by mail or by phone. In addition, the shipping of the medications is free of cost and the insured obtains savings on their co-payments. **To receive information and register for the medication program by mail, call 787-774-6060.**

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

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]

[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.

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.

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. You and your physician will use the Formulary or Drug List as reference, 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 SERVICE COVERAGE

This policy covers the preventive services required by the following federal laws: Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA), and the Health Care and Education Reconciliation Act of 2010 (HCERA), Public Law No. 111-152, as established by the United States Preventive Services Task Force (USPSTF). The preventive care services listed below are included in our basic coverage, and they entail a $0 copayment or 0% coinsurance, as long as they are rendered by participating physicians and providers in Puerto Rico. You may access this list, as well as more information about these services, at the following link: https://www.healthcare.gov/coverage/preventive-care-benefits/.

PREVENTIVE SERVICES FOR MINORS

A preventive health care visit for minors normally includes the following services: medical history, measurements, sensory screening, development/behavior evaluation, physical examination, anticipatory guidance (such as nutritional counseling), and dental referrals, among others. The minor has the following services available, according to age and other established guidelines, as listed below:

Preventive Service	Indication
Alcohol and drug use	Evaluation to detect the use of alcohol and drugs in adolescents 11 years of age or older
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 in adolescents	Screening for depression disorders in adolescents 12-18 years of age, to establish a system that can properly diagnose the necessary treatment, including psychotherapies and follow-up visits
Development screening	Screening for children under 3 years of age and monitoring throughout childhood
Dyslipidemia	Screening for minors at risk for lipids disorders. Ages: 1-4 years, 5-10 years, 11-14 years, 15-17 years
Prevention of dental cavities and oral fluoride supplements	Fluoride application to primary teeth for children under 5 years of age, starting at the eruption of primary teeth. Oral Fluoride Supplements for preschool-age children, from six (6) months up to five (5) years of age.
Gonorrhea	Preventive medication for the newborn's eyes
Hearing screening	Universal Neonatal Hearing Screening
Screening of growth in height, weight, and body mass index	Screening for the following ages: Ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years
Hematocrits or hemoglobin	Screening for minors
Sickle cell disease	Screening for newborns
Human Immunodeficiency Virus (HIV) screening test	Screening for adolescents 13 years of age or older, once every 5 years or annually for high-risk adolescents

Lead screening	Screening for minors, from 1 to 5 years of age, with a high concentration of lead in the blood, regardless of whether they are high-risk, and screening for members during pregnancy
Medical history	For all minors during development: Ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years
Obesity	Obesity screening for children 6 years of age or older, and comprehensive counseling, intensive behavioral interventions to promote improvement in the minor's weight
Oral health	Risk assessment for newborns and up to 10 years of age
Phenylketonuria (PKU)	Screening for genetic disorders in newborns
Sexually transmitted diseases	Prevention counseling and screening for at-risk adolescents
Tuberculin	Tuberculin test on minors at risk for tuberculosis, from 0 to 17 years of age
Vision	Vision screening at least one (1) time between 3 and 5 years of age to detect amblyopia and its risks
Skin cancer	Counseling for minors, adolescents, and young adults with light skin, aged 10 to 24 years old, to minimize their exposure to ultraviolet radiation and reduce their risk for skin cancer
Tobacco use	Interventions, including education and counseling, for minors and adolescents to cease tobacco use

PREVENTIVE SERVICES FOR ADULTS

Preventive Service	Indication
Screening for abdominal aortic aneurysm (AAA)	One (1) service per ultrasonography for AAA screening, for members 65 to 75 years of age who are smokers or were smokers at some point
Alcohol abuse	Screening and counseling on alcohol abuse
Counseling and aspirin supply to prevent the risk for cardiovascular disease and colorectal cancer	Low-dosage aspirin for adults 50 to 59 years of age as primary prevention for cardiovascular disease and colorectal cancer
Hypertension screening (HBP)	Hypertension screening for adults 18 years of age and older.
Colorectal cancer screening	Occult blood test for colorectal cancer screening; sigmoidoscopy or colonoscopy in adults, starting at the age of 40 years up to 75 years old
Depression screening	Evaluation for depression screening. It applies to adults who believe they are depressed, including members during pregnancy or postpartum. The screening must implement adequate diagnosis systems, effective treatment, and adequate follow-up visits.

Diabetes screening	Screening for abnormal blood sugar levels as part of the cardiovascular risk evaluation in overweight or obese adults aged 40 to 70 years old. This includes intensive behavioral counseling to promote a healthy diet and physical activity. It also includes screening for adults with sustained blood pressure over 135/80 mm/Hg.
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 for those who are high-risk
Obesity	Counseling and screening for all adults. Physicians may refer patients or provide intensive behavioral interventions with multiple components, for 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 at a high risk of contracting related diseases.
Statins to prevent cardiovascular events	Low or moderate dose of statins for adults aged 40 to 75 years old with no history of cardiovascular disease, who exhibit one or more risk factors (dyslipidemia, diabetes, hypertension, or smoking) and a calculated risk of 10% or more for a cardiovascular event within 10 years. Detecting dyslipidemia and calculating a 10-year risk for a cardiovascular event requires a general lipid screening for adults between 40 and 75 years old. Statins are covered by the pharmacy coverage. Please refer to the Pharmacy Benefit section.
Tobacco use	Screening for all adults, and interventions to stop tobacco use. For those using products to cease tobacco use, this plan covers medications to cease smoking that are approved by the Food and Drugs Administration (FDA) for ninety (90) consecutive days in one single attempt, and up to two (2) attempts per year.
Syphilis	Syphilis screening for high-risk adults
Hepatitis B Virus	Screening for adults at high risk for infection.
Lung cancer	Annual lung cancer screening through computerized tomography, for adults aged 55 to 80 years old with a smoking history of 30 years or more, who currently smoke or have stopped smoking in the last 15 years.
Hepatitis C Virus	Screening for adults at high risk of HVC infection. Recommended for adults born between 1945 and 1965.
Fall prevention and recommendation to use vitamin D	Screening for adults, for exercises and physical therapy, to prevent falls in adults over 65 years old at risk of suffering falls. The use of vitamin D is recommended as a supplement to prevent the risk of falls.

Healthy diet and physical activity to prevent cardiovascular disease	Offerings and referrals for overweight and obese adults for intensive behavioral counseling to promote a healthy diet and physical activity, to prevent cardiovascular disease.
TB screening test	Screening for adults at high risk for infection

PREVENTIVE SERVICES FOR ADULTS, INCLUDING PREGNANCIES

Preventive Service	**Indication**
Anemia	Routine screening for iron deficiency for members showing symptoms during pregnancy.
Bacteriuria (or urinary tract infection)	Screening for pregnant members showing no symptom of bacteria in urine culture, at 12 to 16 weeks of pregnancy, or during their first prenatal visit if it occurs after 16 weeks of pregnancy.
BRCA	Genetic screening and counseling through tools that identify family history of breast cancer, ovarian cancer, fallopian tube cancer, or peritoneal cancer. After a member is identified as high-risk for a genetic mutation (BRCA1 and BRCA2), the provider will determine if the member's case merits a BRCA test.
Preventive medications for breast cancer	Clinical guidance for patients at high risk of developing breast cancer, allowing them to decide, along 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, such as tamoxifen or raloxifene, for patients that are found to be at high risk of developing the disease and have a low risk of having adverse reactions to the medications.
Breast cancer screening mammography	Every one (1) or two (2) years for members over the age of 40, biannually for members 50 to 75 years of age.
Discussion of preventive medications for breast cancer	Counseling for high-risk members
Breastfeeding	Support and counseling through a provider trained in breastfeeding (pediatrician, obstetrician/gynecologist, family doctor) during pregnancy and/or postpartum. Breastfeeding equipment is covered with a physician’s order after the third trimester of pregnancy and up to the first year after delivery. Additional supplies for breastfeeding machines are covered, and the equipment is available through contracted providers.
Cervical cancer screening	Members aged 21 to 65 years old must undergo a Papanicolaou test every three (3) years; or every five (5) years in combination with the Human Papillomavirus (HPV) test, for members aged 30 to 65 years old who want to have the test done less frequently.

Chlamydia infection screening	Screening for members under 24 years old, or members over 25 years old who are high-risk, and members during pregnancy.
FDA-approved contraceptive methods	Includes implants, hormonal and barrier methods, sterilization procedures, and the insertion and removal of intrauterine devices. It also includes guidance and education. The Plan B Medication (known as the "morning after pill") is covered through contracted pharmacies. Prescription is required. Sterilization surgeries and the surgical insertion of sterilization implants are covered under the basic coverage. All other contraceptive methods are covered under the pharmacy coverage.
Screening and counseling for domestic and interpersonal violence	Screening and counseling regarding domestic and interpersonal violence
Folic acid supplements	Members who are planning or are able to become pregnant.
Gestational diabetes screening tests	For members who are 24 to 28 weeks pregnant and on the first prenatal visit for members identified as high-risk for diabetes.
Gonorrhea	Gonorrhea infection screening for sexually active members, including pregnant members if they have risk factors for infection (for example, if they are young or if they have other individual or community risk factors).
Hepatitis B Virus	Screening for pregnant members on their first prenatal visit.
Human Immunodeficiency Virus (HIV) counseling and screening test	Covered every 5 years for all sexually active members over 13 years old, or annually for high-risk members. According to administrative order No. 307 of August 14, 2013 of the Puerto Rico Department of Health, the test shall be performed on members during their pregnancy as follows: a. First HIV test during the first trimester of pregnancy or on the first prenatal visit b. Second test during the third trimester of pregnancy (between 28 and 34 weeks of pregnancy)
Test on high-risk individuals for Human Papillomavirus (DNA Test)	It applies to members with normal cytology results. This screening test must be performed starting at 30 years of age, and then every three (3) years.
Osteoporosis	Osteoporosis screening for members over 65 years old, and for younger members whose risk for fractures is equal to or greater than the risk of a 65-year-old white member who does not have any additional risks.

Blood group classification - Rh D factor	Screening for Rh D blood type and antibodies, for all pregnant members during their first prenatal visit. The USPSTF also recommends repeating the antibody test on pregnant members with non-sensitized Rh D negative tests at 24 to 28 weeks of pregnancy, unless the biological father is known to be Rh D negative.
Tobacco use (pregnant members)	Screening for tobacco users, and extended interventions for pregnant members who are tobacco users.
Sexually transmitted diseases	Annual counseling for sexually active members.
Syphilis	Screening for all members during their pregnancy, or other high-risk members.
Preventive visits for members	Annual preventive visit to obtain the recommended preventive services (including prenatal care and services necessary for prenatal care), and additional visits, if necessary, to obtain these services, depending on the member's health, needs, and other risk factors.
Preeclampsia screening	Screening for members during their pregnancy
Preeclampsia prevention	Use of low-dose aspirin as prevention for pregnant members who are at 12 weeks of gestation and at risk for preeclampsia.

STANDARD VACCINE COVERAGE FOR MINORS, ADOLESCENTS, AND ADULTS

The table on this page summarizes Triple-S Salud's standard vaccine coverage. For more information, please call our Customer Service Department or visit our website www.ssspr.com.

Vaccines, including catch-up immunizations, are covered according to the vaccine itinerary established by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices of the Puerto Rico Department of Health, and as established by the Commissioner of Insurance of Puerto Rico:

Covered vaccines with $0 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)
- **Menomune** – Meningococcal Polysaccharide Vaccine (90733)
- **MCV** – Meningococcal Conjugate Vaccine – Menactra and Menveo (90734)
- **PPV** – Pneumococcal Polysaccharide Vaccine (90732)
- **FLU** – Influenza Virus Vaccine (90654, 90655, 90656, 90657, 90658, 90662, 90685, 90686, 90688, 90673)
- **PCV** – Pneumococcal Conjugate Vaccine - Prevnar 13 (90670)
- **DTaP** – Diphteria, Tetanus Toxoid and Acellular Pertussis Vaccine (90700)
- **DT** – Diptheria, Tetanus Toxoid (90702)
- **HPV*** – Human Papilloma Virus (Gardasil (90649), Cervarix (90650), 9vHPV (90651))
- **Tdap** – Tetanus, Diphtheria and Acellular Pertussis (90715)
- **Zoster** – Zostavax (90736)
- **MMR** – Measles, Mumps and Rubella Vaccine (90707)
- **VAR** – Varicella Virus Vaccine (90716)
- **HEP A** (Hepatitis A Vaccine) (90633, 90634)
- **Td** – Tetanus and Diphteria Toxoid Adsorbed (90714)
- **HEP B** – Hepatitis B Vaccine (90740, 90743, 90744, 90746, 90747)
- **Meningococcal B** (90620, 90621)
- **Pentacel** (90698)
- **DtaP-IPV-HEP B** (Pediarix, 90723)
- **Kinrix** (90696)

Covered vaccine with 20% coinsurance.

Immunoprophylaxis for respiratory syncytial virus (Synagis, Palivizumab 90378) – Requires precertification following the protocol established by Triple-S Salud.

*** For members aged 9 to 27 years old, or younger with a history of sexual abuse or assault.**

Note: The vaccine codes included are shown as published in the latest review of the Current Procedural Terminology (CPT) Manual. Any further updates could change the included codes. For an updated version, please 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, 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	$10.00 copayment for visit to a general practitioner $15.00 copayment for visit to a specialist $20.00 copayment for visit to a sub-specialist
• Visits to audiologists	$15.00 copayment per visit
• Visits to optometrists	$15.00 copayment per visit
• Visits to podiatrists	$15.00 copayment per visit
• Visits to clinical psychologists	$10.00 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.	$75.00 copayment for illness or accident $35.00 copayment 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 • X-Rays	25% coinsurance
Tests such as: • 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 • Gastrointestinal endoscopies • Electroencephalograms • Non-invasive cardiovascular tests • Vascular non-invasive tests • Electrocardiograms and echocardiograms • 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. • 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	30% coinsurance
• 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.	Nothing
Vision Care	
• Ophthalmologic diagnostic tests	30% coinsurance
• Refraction test, one (1) test per insured member, per policy year, as long as the test is performed by an ophthalmologist or an optometrist.	Nothing

• Eyeglasses for insureds up to 21 years of age, one (1) pair per policy year within the collection contracted, including high-potency corrective lenses for insureds that have a significant loss of vision, but are not totally blind. It covers one (1) visual aid device (prescribed magnifying glasses, double or single-lens telescopes) for insureds up to age 21 with significant vision loss, but that are not totally blind, available through the network of Optics exclusively contracted to offer this benefit to the pediatric population. • Eyeglasses and contact lenses, for insured persons over age 21, up to a maximum amount of $100.00 every 12 months.	Nothing
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)	$15.00 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	30% 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	$10.00 copayment
Allergy care	
• Allergy tests, up to a maximum of fifty (50) tests per policy year, per member	Nothing
Treatment Therapy	
• Radiotherapy	10% coinsurance per therapy
• 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.	10% coinsurance
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 to two (2) daily sessions for a maximum of twenty (20) sessions per policy year, per member	$7.00 copayment per therapy
Manipulations/ Physical, Occupational and Speech Therapies (Habilitation and Rehabilitation)	
• Manipulations rendered by chiropractors	$7.00 copayment per visit
• Physical therapies provided by physiatrists (or under their supervision or billed by them) or chiropractors • Occupational and speech therapies These therapies will be covered up to 20 combined therapies per insured member, per policy year.	$7.00 copayment per manipulation or therapy
Durable Medical Equipment (DME)	
Rent or purchase, subject to a Precertification: • 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. • FDA-approved glucometers ordered by the endocrinologist, one per policy 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 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.	Nothing
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.	25% coinsurance

• **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.**	
Nutrition Services	
• Triple-S Health will pay for nutrition services or metabolic diseases or licensed nutritionists. The visits will be covered up to a maximum of 6 visits, per insured person per year.	Nothing
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 - 30% coinsurance • Immunology - 25% coinsurance • Genetic testing - 25% coinsurance • Laboratory tests for autism - 25% coinsurance • Services of gastroenterology - 30% 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) - $10.00 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**.	Nothing
• Diagnostic services • Treatments • Administration of anesthesia • Specialists consultation • Gastrointestinal endoscopies • Sterilization services • Hearing evaluations, including Neonatal Hearing Screening Test	Nothing
• Chemotherapy in all its modalities of administration (intravenous, oral, injectable or intrathecal) and radiotherapy	10% coinsurance
• Invasive cardiovascular tests • Lithotripsy procedure (ESWL); Precertification required	30% coinsurance

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

- Triple-S Salud participating hospitals have been grouped in three tiers, according to the cost of the hospital facilities. Tier 1 is the preferred network or those low cost hospitals. Tier 2 is the non-preferred hospital network with the highest cost. Tier 3 is the hospital network whose cost is higher. Depending on the cost of the hospital admission, it will be the insured member's responsibility on the payment for admission.

- 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.	Level 1: $100.00 Level 2: $200.00 Level 3: $450.00
• 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

• Blood for transfusions	Nothing, these services are included in the payment of the hospitalization copayment.
• Chemotherapy in all its modalities of administration (intravenous, oral, injectable or intrathecal) and radiotherapy	10% coinsurance
• 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.	10% coinsurance
• Lithotripsy procedure (ESWL); precertification required	30% coinsurance
• Ambulatory surgery	$100.00 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.	Level 1: $100.00 Level 2: $200.00 Level 3: $450.00
• Obstetrics services • Use of maternity ward • Production and interpretation 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.	Level 1: $100.00 Level 2: $200.00 Level 3: $450.00 $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)	$10.00 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)	$15.00 copayment per visit
• Visits for group therapy (of patients), according to the justified medical necessity	$7.00 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.	Level 1: $100.00 Level 2: $200.00 Level 3: $450.00 $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)	$10.00 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)	$15.00 copayment per visit
• Visits for group therapy (of patients)	$7.00 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.	Level 1: $100.00 Level 2: $200.00 Level 3: $450.00

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.

Deductibles:

a. **$100.00** per person, per policy year

b. **$300.00** per family, per policy year

Coinsurance:

a. Each insured member shall be liable, after the deductible is accumulated, of 20% of the covered medical expenses, up to a maximum amount of **$2,000.00** per policy year.

b. Each insured family will be responsible, after the deductible is accumulated, of 20% of the covered medical expenses, up to a maximum amount of **$6,000.00** per policy year.

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. The members must first cover the cash deductible, provided that, they will be covered subject to the limitations established in this coverage.

2. After the disbursement,of the amount established in Deductibles (a) and Coinsurance (a) in the section of Covered Services (due to accumulation of the deductible and coinsurance responsibility of the insured member) for medical expenses covered and incurred by the main member or his/her dependents insured during a policy year, we will refund 100% of the covered medical expenses that exceed that amount to the person in this situation during the remaining policy year.

3. After the disbursement of the quantity established in Deductible (b) and Coinsurance (b) in the section of Covered Services (due to accumulation of the deductible and coinsurance responsibility of the insured member and his/her dependents insured) for medical expenses covered and incurred by the insured member and the members of his/her family insured during a policy year, we will refund 100% of the medical expenses covered with respect to all insured members of his/her family during the remaining policy year.

4. The cash deductible separately applies to the employee and each one of his/her insured dependents per each policy year, except that:

    a) If two (2) or more members of his/her family are injured in the same accident, only one cash deductible (amount corresponding as deductible per person) will be applied for that policy year against all the expenses incurred as a result of such accident.

    b) No more than the total cash deductibles for a family contract, as established in the Limitations section, will be applied to all expenses made by family members of the member during any policy year.

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:** the medical expenses covered for services outside the hospital due to mental conditions, drug addiction and alcoholism will be reimbursed based on the dispositions established for any other illness.

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 (FV-19)

- 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, 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»,insulin, Accutane, Retin A, prenatal vitamins, growth hormones, immunosuppressives and products for dermatological conditions such as pediculosis and scabicides. 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, even when the physician writes original or do not substitute in the prescription, the member will pay the generic 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.

- 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. 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.

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. 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 $750 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 without a List of Medications	$5.00 for generic drugs $20.00 for brand-name drugs 30% for specialized drugs 10% 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 $40.00 for brand-name drugs

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 medication Retin A will be covered up to 24 years of age of the insured member.

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 (DH-55)

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
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 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	Nothing, except for: 30% coinsurance • Composite resin restorations on posterior teeth; • Surgical repositioning of impacted teeth 50% coinsurance • Rebase • Reline • Alveoloplasty

15. Oral surgery and extractions (pre and post-operative care) 16. Surgical repositioning of impacted teeth 17. Alveoloplasty 18. Occlusal adjustment 19. Hospital visit	

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	Nothing Maximum benefit of $1,000, per policy year, per member

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.	
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 provided by residential treatment facilities outside Puerto Rico, with no medical justification or precertification 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 dental services. In addition, hospital services are excluded, medical-surgical procedures and complications associated with these.

40. *Doppler Color Flow*.

41. 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.

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

43. New diagnostic or therapeutic services or procedures approved by the FDA, and equipment and devices that become available after the effective date of this policy.

44. Complications related to body piercings and any other related procedures.

45. Any other service or treatment not explicitly described as a covered benefit, except for services and benefits required by law to be offered in the health care coverage.

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. Dental services for the care and treatment of the teeth and gums.
4. Eyeglasses, orthopedic and orthotic devices, except those that are required because of an accidental injury.
5. 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.
6. Services of a social worker including a psychologist or psychiatric social worker; except in cases of autism.
7. Services provided by an air ambulance, which are covered in the Basic Coverage.

   The services provided by a marine ambulance are also excluded.
8. 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.
9. Expenses for copayments or coinsurances applicable to the basic policy of hospitalization, medical-surgical and ambulatory services and their riders.
10. Expenses for post-hospital services received in a Skilled Nursing Care Facility or in a Home Health Care Agency.
11. Expenses for immunizations, radioactive treatment and tympanometry.
12. 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.
13. 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 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. Medications that do not contain the inscription: «Caution: Federal law prohibits dispensing without prescription» (Over-the-Counter- OTC), except those included in the Triple-S Salud OTC Program and certain aspirin dosages for members aged 50 to 59 years old.

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 minors aged 6 months to 5 years old), 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), **except prenatal vitamins which are covered**, 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. Blood and its components (hetastarch6%/nacl IV, rehomacrodex IV, human albumin and fractions of plasma proteins).

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

13. Nutrients *(Dextrose, Lyposyn, Fructose, Alanicem, L-Carnitine, Trytophan).*

14. 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 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 may ask Triple-S Salud to make an exception to the coverage rules, provided that the medication is not an exclusion. There are medications that are classified as a "categorical exclusion". This means that the plan has established a specific provision for the non-coverage of a prescription medication, identifying it by its scientific or commercial name.

Types of exception

There are several types of exceptions that the member may request:

- To cover their medication even if it is not in our Drug List or Formulary.

- To cover a medication that has been or will be discontinued from the Drug List or Formulary for reasons not related to health care or because the manufacturer cannot provide it or has withdrawn it from the market.

- For a management exception, which implies that the prescription drug will not be covered until the step therapy requirements are met, or because it has a limit in the amount allowed.

- For a duplicate therapy exception if there is a change in dosage or if the physician prescribes another drug within the same therapeutic category.

- For medications whose uses are not approved by the Food and Drug Administration (FDA). These medications are not usually covered, except for health conditions where there is medical or scientific evidence that the drug is effective for such purposes, according to the reference books including the medical categories for approval or denial.

How to make a request

The member, his/her authorized representative, or his/her physician may request an exception via:

- **Phone call to (787) 749-4949** – They will offer you guidance on the process you should follow to request an exception.
- **Fax** the Pharmacy Department to **(787) 774-4832** – You should send all the documentation needed to evaluate the request, including the contract number.

- **Mail** to the following address: Triple-S Salud PO Box 363628 San Juan, PR 00936-3628.

Information required to approve your exception request

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

- Name of the patient
- Contract number
- Primary diagnosis
- Reason why you cannot use any prescription medication in the Formulary that would be a clinically acceptable alternative to treat the member's disease or medical condition.
- The alternative prescription medication included in the Formulary or required according to the step therapy:

- Has been ineffective in treating the disease or medical condition; or, based on clinical, medical, and scientific evidence, the member's known relevant physical and mental features, and the known features of the prescription medication regime, it is very likely that it will be ineffective, or that the efficiency of the prescription medication or the patient's adherence will be affected.

- Has caused or, according to clinical, medical and scientific evidence, is very likely to cause an adverse reaction or other harm to the member.

- The member was already at a more advanced step therapy level under another health plan, so it would be unreasonable to require that they begin again at a lower step therapy level.
- The available dosage, according to the

prescription dosage limitation, has been ineffective in treating the member's disease or medical condition; or, based on clinical, medical and scientific evidence, the member's known relevant physical and mental features, and the known features of the prescription medication regime, it is very likely that it will be ineffective, or that the efficiency of the prescription medication or the patient's adherence will be affected.

How does Triple-S Salud process a prescription drug by exception?

1. Triple-S Salud will have 72 hours from the date they receive the request or notice to notify the member or his/her authorized representative about their determination for the exception request. This period shall not exceed 36 hours for controlled medications. If the required clinical information is not received within 72 hours, we will close the request and notify you immediately. Nonetheless, closing the request does not mean the member may not file this request again.

   In order to evaluate the request, Triple-S Salud shall ask the physician or the pharmacy for the required clinical information via phone, fax, or by any other electronic means.

   If it was the member who submitted the request, and additional information is needed to complete the evaluation of the medication, the member shall receive a phone call where he/she will obtain instructions on the additional information needed from the physician in order to evaluate the case, the deadline to receive it, and the fax number to send it.

2. If the information is not received within 72 hours, the case shall be closed due to insufficient information. Notice shall be provided to the member, his/her authorized representative, and the prescribing physician, if applicable. This notification will include further details about the missing information. Closing the request does not mean the member may not submit the information again.

   The exception request form is available free of charge at www.ssspr.com. You may find it under the Tools for You section, which is located at the bottom of the main page, under Member Forms, as well as in the Drug List or Formulary.

3. The medical exception request will be reviewed by adequate health care professionals with experience in medication management, according to the health condition for which the exception has been requested.

4. The health care professional evaluating the request shall use documented clinical review criteria based on:
   a. Firm clinical, medical, and scientific evidence
   b. Relevant practice guidelines
   c. Policy benefits and exclusions

5. If Triple-S Salud does not make a determination regarding the medical exception request or notify it within the aforementioned time period, the member shall be entitled to a 30-day supply of the prescribed medication for which the request was submitted, as per the supply was requested or prescribed; or in case of step therapy, for the term provided by the coverage.

6. If the insurer or health insurance company does not make a determination regarding the medical exception request or notify it before the member finishes his/her medication supply, it should maintain coverage continuously and under the same terms, as long as the medication continues being prescribed to the member and is considered safe to treat the member's illness or health condition, unless the applicable benefit limits have been exhausted.

7. If Triple-S Salud approves a medical exception, it will provide coverage for the medication and will not require the member to request authorization for refills or new prescriptions to continue using the same medication, provided that the medication is prescribed for the same illness or health condition and that it is deemed safe throughout the policy year.

8. Triple-S Salud shall not establish a level of copayment or coinsurance that is applicable only to those medications approved by medical exception requests. If your exception request is approved, the highest coinsurance or copayment established in your coverage will apply.

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

   a. The member or his/her personal representative, if applicable, in writing or by electronic means, if the member has agreed to receive information that way.

   b. To the prescriber by electronic means at his/her request, or in writing.

10. In the denial notice, we will inform the member of his/her right to file a request to appeal the denial, as established in this policy.

11. Process to notify the coverage determination:

    The process to notify denials for cases that do not meet the criteria established by the coverage, such as missing forms, preauthorization, step therapy, amount limits, duplicate therapies, and use not approved by the FDA, among others, shall include:

    a. The specific reasons for the denial;

    b. References to the evidence or documentation, which include the clinical review criteria and the practice guidelines considered to deny the request;

    c. Instructions on how to request a written statement of the clinical, medical, or scientific reasons for the denial;

    d. Description of the process and procedures to file a request to appeal the denial.

12. The Triple-S Salud Pharmacy Department keeps written or electronic records that document the process for medical exception requests.

APPEALS FOR ADVERSE BENEFIT DETERMINATIONS

RIGHT TO APPEAL AN ADVERSE DETERMINATION

What is an Adverse Determination?

- A determination made by the insurer or a utilization review organization, to deny, reduce, or terminate a benefit, or to not pay the benefit in part or in full, since in applying the utilization review techniques, based on the information provided and according to the health plan, the requested benefit does not meet the requirements for medical necessity and appropriateness, the place where the service is provided, or the level or effectiveness of care, or it is determined that it is experimental or investigative in nature;
- The denial, reduction, termination, or absence of payment for a benefit, either partial or in full, by the insurer or utilization review organization, based on the determination of the member's eligibility to participate in The health plan; or
- The determination resulting from a prospective or retrospective review in which the benefit is denied, reduced, terminated, or not paid, in part or in full.
- Coverage rescission: the decision to terminate your contract with retroactive effect to the effective date or any other date prior to the termination notice, provided that the reason for such determination is not a default on premiums, fraud, or misrepresentation, as prohibited by the plan and made intentionally. Cancellations must be notified in writing thirty (30) days before their effective date.

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

RIGHT TO APPEAL AN ADVERSE DETERMINATION

If you disagree with an Adverse Determination from Triple-S Salud, whether it is related to a reimbursement request, a precertification request, coverage rescission, or a denial of the benefits described in your policy, you may appeal Triple-S Salud's determination.

APPEALS PROCEDURE

1. First Internal Level of Appeals

You or your authorized representative must submit the appeals in writing within 180 calendar days from the date you received the first written notice of the adverse determination to have it evaluated regardless of whether it is accompanied with all the information necessary to make the determination. In your appeals, you may request assistance from the Commissioner of Insurance, the Advocate of Health, or your preferred lawyer (at your own expense).

To request assistance, please contact:

Office of the Commissioner of Insurance
Investigations Division
B5 Calle Tabonuco Suite 216 PMB 356
Guaynabo PR 00968-3029
Phone number: 787-304-8686
Advocate of Health
PO BOX 11247
San Juan PR 00910-2347
Phone number: 787-977-0909

You must include any other evidence or information that you consider relevant to your appeals, and send it via email, fax, or to the following address:

Triple-S Salud, Inc.
Department of Grievances and Appeals
PO Box 11320
San Juan, PR 00922-9905
Fax number for Appeals: 787-706-4057
Email address: qacomercial@ssspr.com

If you need information about your request, please contact the number provided in the adverse determination notice you received.

Triple-S Salud will acknowledge receipt of the appeals request to the member no

later than three (3) business days after receiving it. The member shall also be informed of his/her rights on filing the appeals.

If the appeals arises as a result of an adverse determination related to a utilization review, Triple-S Salud will appoint one or several clinical counterparts belonging to the same or a similar specialization as the health professionals that normally handle the case that obtained said adverse determination, and who did not participate in the initial adverse determination or are not subordinates to such individuals. Triple-S Salud will also ensure that the clinical counterparts for the review have the adequate expertise for its evaluation.

The reviewer(s) will consider all comments, documents, and records, as well as any information related to the submitted review request, regardless of whether the information was presented or considered when making the initial adverse determination.

Aside from submitting written comments, documents, records, and other materials related to the appeals, you have the right to receive free access or copies of all documents and records. This includes any information that is relevant to filing the appeals and that:

- was used in the initial determination

- was presented, considered, or generated in regard to the adverse determination, even if the benefit determination did not depend on these documents, records, or other information;

- demonstrates that, in making such determination, Triple-S Salud consistently followed the same administrative procedures and guarantees that are followed with other members under similar circumstances; or

- constitutes statements of policy or plan guidelines related to the denied health care service or treatment and the member's diagnosis, regardless of whether they were taken or not into account when making the initial adverse determination.

Triple-S Salud will notify the member, or his/her personal representative, of its decision in writing within a reasonable amount of time, according to the established terms and the member's medical condition:

- an appeals requesting a first-level review of an adverse determination related to a prospective review, within a reasonable amount of time, and according to the member's medical condition, but never more than fifteen (15) calendar days after receiving the appeals.

- an appeals requesting a first-level review of an adverse determination related to a retrospective review, within a reasonable amount of time, but never more than thirty (30) calendar days after receiving the appeals.

This determination will include:

- The titles and credentials of the reviewers who participated in the evaluation

- A statement of the interpretation made by the reviewers

- The reviewers' determination with the medical justification or contractual basis to allow the member or his/her personal representative to respond to the claims;

- Evidence or documentation used as basis for the determination

If it is an adverse determination, it must also include:

  - The specific reasons for an adverse determination;
  - Reference to the health plan's specific provisions on which the determination is based;
  - A statement about the member's rights to access or obtain free copies of the documents, records, and other relevant information used in the evaluation of the appeals, including any rules, guidelines, internal protocols, or any other similar
  - criteria used to substantiate the etermination.
  - If the adverse determination is based on medical necessity or the treatment's experimental or investigative nature, or on a similar exclusion or limitation, a written explanation of the scientific or clinical rationale followed to make the determination, or a statement saying an explanation will be provided to the member or, if applicable, to his/her personal representative, free of charge, at his/her request.

- If applicable, it should also include instructions to request a copy of the rules, guidelines, internal protocols, or any other similar criteria on which the determination was based, an explanation of the scientific or clinical rationale followed to make the determination, and a description of the process to obtain an additional voluntary review, as well as any relevant deadlines, in case the member wishes to request it. It must also include a description of how to obtain an independent external review, in case the member decides not to request a voluntary review, and the member's right to initiate a lawsuit before a competent court.
- If also applicable, it must include the following statement, indicating other available options to voluntarily resolve disputes, such as mediation or arbitration, and your right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health to obtain guidance and request assistance, as well as the contact information for such cases.

If your case is considered urgent, Triple-S Salud shall notify its decision within no more than 48 hours from the moment the expedited review request is filed with the insurer or health insurance organization, regardless of whether the request includes all the required information to make a determination. Urgent case appeals means requests for appeals corresponding to medical services or treatments that, if held to the regular deadlines to respond to an appeals: (a) put the member's life, health, or full recovery in serious danger; or (b) in the opinion of a physician with full knowledge of the member's medical condition, it could subject the member to severe pain that cannot be handled adequately without the medical care or treatment that is the object of the appeals.

If the appeals does not have all the information necessary to make a determination, Triple-S Salud will tell the member or his/her personal representative about the additional documents or information the member must submit within 45 days from the date of notification. If Triple-S Salud does not receive the additional information requested within the provided term, Triple-S Salud can make a decision based on the submitted documents and information. Triple-S Salud may also notify that the appeals is being considered but that additional time will be needed. In such cases, Triple-S Salud will have 15 additional calendar days to respond to the appeals. Once you have been notified of Triple-S Salud's decision, you will have the right to ask Triple-S Salud to reveal the names and titles of the officers or experts who participated in the evaluation of your appeals, as well as an explanation of the basis for their decision.

You have the right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health to request assistance. The contact information for these Offices is included at the end of this Section, under Right to Assistance.

2. **Second Internal Level of Appeals**

If you are not satisfied with Triple-S Salud's response to your first appeals, you have the right to submit a second internal appeals before Triple-S Salud within 60 calendar days from the date you received notice of the adverse revised determination for your first appeals.

In this second appeals, you should include copies of all documents related to your first appeals along with an explanation of your reasons to state that Triple-S Salud erred in denying your first appeals. You may also include any additional evidence you may have to support your claims.

Your second appeals shall be evaluated by individuals who were not involved in evaluating the first appeals nor are subordinates of such individuals. Triple-S Salud's prior decisions shall not be taken into consideration either. You are entitled to ask Triple-S Salud to reveal the names and titles of the officers or experts who were involved in the evaluation of your second appeals, as well as an explanation of the basis for their decision.

If this is an appeals for an urgent case (as previously defined), Triple-S Salud shall respond to your request within 48 hours. If this is an appeals for a precertification, Triple-S Salud shall respond to your second appeals within 15 calendar days from the date they receive your appeals. For any other cases, Triple-S Salud shall respond within 30 days from the date they receive your appeals.

You have the right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health to request assistance. The contact information for these Offices is included at the end of this Section, under Right to Assistance.

3. Voluntary Review Level

If you are not satisfied with Triple-S Salud's response, you may submit a written request for a voluntary review no later than fifteen (15) business days after receiving the adverse determination notice. At the voluntary level, you may add any additional information not included in your case at the previous internal review level.

Upon receiving the request for an additional voluntary review, Triple-S Salud shall acknowledge receipt and notify the member or personal representative about his/her right to:

- Request, within the specified time, an opportunity to appear in person before the review panel appointed by the insurer or health insurance organization
- Receive copies of all documentation, provided it is not confidential or privileged, related to the request for an additional voluntary review
- Present his/her case before the review panel
- Submit written remarks, documents, records, and other materials related to the request for additional voluntary review, to be considered by the panel both before and during the review meeting
- If applicable, ask questions to the review panel representatives
- Obtain assistance or representation from anyone, including a lawyer

Triple-S Salud shall not condition the member's right to obtain a fair review and attend the review meeting.

Once the member receives our receipt acknowledgement for his/her request, he/she may submit a written request stating his/her interest to appear in

person before the review panel, within 15 business days from the receipt.

Triple-S Salud shall appoint a review panel to consider your request, and you or your authorized representative may appear before this panel in person or via telephone to explain your request. If Triple-S Salud receives assistance from its legal representatives, you shall be notified at least 15 calendar days before the date of the review meeting, and you will receive confirmation that you may be assisted by your own legal representative. Any insured person or member, or their personal representative, who wishes to appear in person before the review panel shall submit a written request to the insurer or health insurance organization no later than fifteen (15) business days after receiving the notification.

If the hearing takes place, the panel will conduct its evaluation and take into account all comments, documents, records, and any other information related to the request for additional voluntary review submitted by you or your authorized representative, regardless of whether the information was presented or considered to make a determination in previous reviews. The review determination shall be issued no later than 10 calendar days after the hearing. If a hearing does not take place, Triple-S Salud will disclose the panel's determination no later than 45 days from: 1) the date the person stated he/she would not request a hearing, or 2) the deadline date for the person to request a hearing before the panel. After being notified of Triple-S Salud's decision, you will have the right to ask Triple-S Salud to reveal the names and titles of the officers or experts involved in the evaluation, as well as an explanation of the basis for their decision.

The panel has legal authority to require Triple-S Salud to abide by the panel's determination. If twenty (20) calendar days have elapsed without Triple-S Salud abiding with the review panel's determination, the panel will be required to notify the Office of the Commissioner of Insurance.

You have the right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health to request assistance. The contact information for these Offices is included at the end of this Section, under Right to Assistance.

4. <u>External Review Process</u>

Triple-S Salud has opted to use the process of External Grievance Review through the Commissioner of Insurance (OCI). If, after exhausting all internal appeals levels, you are not satisfied with the final determination, you may file a request for an independent external review with the Office of the Commissioner of Insurance of Puerto Rico. As part of the external review process, you will pay a nominal fee no greater than $25.00 for each review. Furthermore, the fees for a single member may not exceed seventy-five dollars ($75.00) per policy year. The amount you pay will be refunded if this results in a favorable opinion for you.

Standard External Review Procedure

You or your authorized representative may request an independent review after exhausting the Internal Review process and receiving a final Adverse Determination. The Adverse Determination shall include the External Review form and the form of Authorization of Use and Disclosure of Protected Health Information, which should be completed and returned by fax, mail, or email to the Commissioner of Insurance at the following:

By fax: 787-273-6082

By mail:

Office of the Commissioner of Insurance
Investigations Division
B5 Calle Tabonuco Suite 216 PMB 356
Guaynabo, PR 00968-3029

By email: salud@ocs.pr.gov

Preliminary Evaluation

After receiving the request for external review, the external review examiner shall request the following documents from Triple-S Salud, which were taken into account when making the adverse benefit determination, including:

- Certificate of coverage or benefits;
- Copy of final Adverse Benefit
- Determination;
- Summary of claim;
- An explanation from the plan or from the person who issued the Adverse Benefit Determination;
- All documents and information taken into account for the internal Adverse Benefit Determination or final Adverse Benefit Determination, including any additional information furnished to the plan or issuer of the determination, or taken into account during the external appeals process.

Triple-S Salud must provide the examiner with the aforementioned information within five (5) business days. The examiner will review the information received from Triple-S Salud and may request additional information, if considered necessary for the external review. If the examiner requests additional information, Triple-S Salud will furnish the information within 5 business days from the date the request was received..

The examiner will check your external review request to determine whether:

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

The examiner will notify you in writing, within one (1) business day after completing the review, whether the adverse determination is eligible for external review and if additional information is needed. If additional information is needed, you must furnish it by the later date between: the deadline of 120 calendar days to submit the application, as described above, or 48 hours after receiving the notification.

Review Process

The external review examiner will review the information provided by Triple-S Salud and send all the documents the claimant directly provided, within one (1) business day. Once Triple-S Salud receives all the documents, it may reconsider its original decision about the claim. The external review may only be terminated if Triple-S Salud decides to reverse its adverse benefit determination and provide coverage or payment. Triple-S Salud must provide the claimant and the examiner with a written notification of its determination within 1 business day after deciding to overturn its decision. The examiner shall consider the external review concluded upon receipt of this notification.

However, if the external review is not concluded for the aforementioned reasons, the examiner shall continue the review and notify you and Triple-S Salud about the final determination within forty-five (45) days from the date you requested the external review. This notification shall include:

- a general description of the reason to request an external review, including sufficient information to identify the claim, the date the IRO (Independent Review Organization) received the request for external review, and the date of its decision;
- reference to the evidence or documentation that was taken into account to make the decision; the reasons for the decision, including any evidence-based standard used as a basis for such decision;
- a statement saying the determination is binding, except if there are remedies available under federal or state law; and a

- statement indicating that judicial review could be available.

If the decision made by the IRO overturns the adverse benefit determination, the Plan shall accept the decision and provide the benefits for the service or procedure, according to the Plan's terms and conditions. However, if the decision confirms Triple-S Salud's adverse benefit determination, the Plan will not be required to provide such benefits for the service or procedure.

Expedited External Review

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

- you have received an adverse benefit determination involving a medical condition where the completion deadline for an internal accelerated appeals (as described above) could endanger your life, health, or ability to regain maximum function, and you have submitted a request for an expedited internal appeals;

- you have received an adverse benefit determination regarding a medical condition, and the deadline to complete the standard external appeals process might endanger your life, health, or ability to regain maximum function; or

- an adverse benefit determination regarding admission, availability of care, or a service or device for which you have received emergency services, but have not been discharged from the facility. The examiner will continue the aforementioned review process and must provide notification of the final decision within 72 hours from the date your expedited external review request was received. However, if the request is related to an urgent care situation, and you are in a treatment course for the condition, the final decision must be notified within 24 hours. In these cases, the examiner may provide verbal notification, but must issue a written notification to you and the Plan within 48 hours.

You have the right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health to request assistance. The contact information for these Offices is included at the end of this Section, under Right to Assistance.

Voluntary External Review

Your decision whether to submit a claim or not for voluntary external review will have no effect on your rights under the plan and the information about applicable regulations, the process of selecting who makes the decisions, and the circumstances, if any, that might affect the impartiality of the person making the decision, such as a financial or personal interest in the result of any past or current relationship with any of the parties participating in the review process. You will not have to pay any fees or charges as part of this voluntary external review.

If you choose not to submit a claim for voluntary external review, the Plan shall not uphold that you failed to exhaust all administrative remedies within the Plan's framework. If you submit a claim for voluntary external review, the Plan accepts that it will inform you of any applicable statutes of limitations if you decide to pursue the case in court.

You may call the Commissioner of Insurance at (787) 304-8686 to obtain more information about the voluntary external review process.

The Commissioner of Insurance will keep your case record for 5 years, and it shall be available for evaluation at your request.

If your case does not meet the criteria established in the second paragraph of this section, you have the right to request a case investigation at the Federal District Court for the District of Puerto Rico, under §502(a) of the Employee Retirement Income Security Act

(ERISA), or at the Office of the Commissioner of Insurance of Puerto Rico.

You will be required to exhaust all internal appeals procedures previously described before filing your claim with the Office of the Commissioner of Insurance, the IRO, or in court.

- a written statement including the description of the process to obtain an additional voluntary review, in case the member wants to request it, as well as the procedure to follow and the corresponding deadlines
- a notice of the right assisting members to contact the Commissioner's Office or the Office of the Advocate of Health to request guidance and help, including information on how to contact them if necessary.

You have the right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health to request assistance. The contact information for these Offices is included at the end of this Section, under Right to Assistance.

Ordinary Reviews of Grievances Not Related to Adverse Determinations

You or your personal representative have the right to request an ordinary review for grievances not related with an adverse benefit determination (for example, a grievance related to the policy's subscription or cancellation processes, services provided by our staff).

Triple-S Salud will inform you of your rights within three (3) business days from receiving the grievance, and it will appoint one or more people who have not previously managed the issue that is object of the grievance. Triple-S Salud will also provide you or your personal representative, if applicable, with the name, address, and phone number of the people assigned to conduct the ordinary grievance review.

Triple-S Salud will notify you in writing of its determination, no later than thirty (30) calendar days after receiving the grievance. Once you have been notified of Triple-S Salud's decision, the determination shall include the names and titles of the officers or experts involved in the evaluation of your grievance, as well as an explanation of the basis for their decision. It must also include:

- the determination of the examiners in clear terms, and the contractual base or medical justification so you may respond to these considerations;
- Reference to the evidence or documentation used as basis for the determination;
- If applicable:
  - a written statement including the description of the process to obtain an additional voluntary review, in case the member wants to request it, as well as the procedure to be followed and the corresponding deadlines
  - a notice of the right assisting members to contact the Commissioner's Office or the Office of the Advocate of Health to request guidance and help, with information on how to contact them if necessary.

You have the right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health to request assistance. The contact information for these Offices appears below.

RIGHT TO ASSISTANCE

You have the right to assistance from the Office of the Commissioner of Insurance or the Office of the Advocate of Health in the aforementioned appeals processes.

- The Office of the Commissioner of Insurance is located at GAM Tower, Urb. Caparra Hills Industrial Park 2,

Calle Tabonuco Suite 400, Guaynabo, PR, or you may call (787) 304-8686.

- The Office of the Advocate of Health is located at Mercantil Plaza, 1501 Ponce de León Ave, Hato Rey, PR, or you may call (787) 977-0909 (Metro area) or toll-free at 1-800-981-0031.

RIGHT TO APPOINT A REPRESENTATIVE

You are entitled to appoint a representative to act on your behalf before Triple-S Salud. The representative appointment must include all the items listed below:

- Member's name and contract number
- Name of the person appointed as authorized representative, and their address, telephone number, and relation to the member
- Specific action for which the representative is appointed
- Date and member's signature to grant the appointment
- Expiration date of the appointment

Triple-S Salud may require additional information from the authorized representative to help authenticate him/her if he/she calls by phone or visits our Offices.

The member or his/her authorized representative will be required to notify Triple-S Salud in writing if the appointment is revoked before the expiration date.

As a result of the appeals process, the member shall be entitled to the established benefits, according to the determination.

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.

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW THIS NOTICE CAREFULLY.

THE PROTECTION OF YOUR INFORMATION IS IMPORTANT TO US.

OUR LEGAL RESPONSIBILITY

Triple-S Salud, Inc. is required by law to maintain the confidentiality, privacy, and security of your health information. We are also required by law to inform you about our privacy practices and your rights regarding your health information. We will follow the privacy practices described in this notice while it is in force.

This notice includes examples of the information we collect, and it describes your rights and the types of uses and disclosures we may make.

This notice includes illustrative examples, which should not be considered a complete outline of how our information management practices.

Triple-S Salud is required to abide by the terms in this Notice. However, we reserve the right to change our privacy practices and the terms of this notice. Before we make any significant changes to our privacy practices, we will amend this notice and send it to all our active subscribers by the date the change becomes effective. **This notice shall be effective as of September 1, 2017.**

SUMMARY OF PRIVACY PRACTICES

Our commitment is to limit the information we collect to what is strictly necessary to manage your insurance coverage or benefits. As part of our administrative functions, we collect personal information from different sources, such as:

- Information you provide in applications and other documents to obtain a product or service
- Information originating from transactions performed with us or our affiliates
- Information provided by credit agencies
- Information from health care providers
- Government health programs

Protected Health Information (PHI) is information that identifies you (name, last name, social security number), including demographic information (such as address or zip code) obtained from you through an application or any other document in order to provide a service, created or received by health care providers, health plans, mediators processing you health care bills, business associates, and that is related to: (1) your past, present, or future mental or physical health or condition; (2) health care services provided to you; (3) past, present, or future payments in exchange for health care services. For the purposes of this Notice, this information shall be referred to as PHI. This Notice has been created and amended in tune with the HIPAA Act Privacy Rule. Any term not defined in this Notice has the same meaning as the term as it appears in the HIPAA Act Privacy Rule. We also have policies and procedures to handle your PHI, which you may examine upon request. We do not use or disclose genetic information in order to assess or underwrite risks.

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 suffering from some medical condition.

HITECH: The Health Information Technology for Economic and Clinical Health Act provides for the adoption of electronic medical records and the procedures regulated entities should follow in case a security incident occurs that would expose personal financial, insurance, and health information.

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

USE AND DISCLOSURE OF HEALTH INFORMATION

Triple-S Salud shall not disclose or use your information for any purpose other than what is stated in this Notice, unless you provide your written authorization. Triple-S Salud shall not disclose information for fundraising purposes.

Triple-S Salud may use and disclose PHI for:

Disclosures to you: We are required to disclose most of your PHI to you. This includes, but is not limited to, all information related to your claims history and plan utilization. For example: You have the right to request your claims history, medication history, and any other information related to your protected health information.

As part of our insurance or benefit management functions, we may use and disclose information, without your authorization, for activities related to your medical treatment, medical service payments, and health care operations. For example:

Treatment: We may disclose information to a health care provider so that he/she may provide your treatment, and provide, coordinate, or oversee your health care services, as well as other related services. For example, the plan may disclose health information to your provider to help coordinate treatments.

Payment: We may disclose information to pay for health services provided to you, determine eligibility under your policy, coordinate benefits, collect premium payments, and other related activities. For example, the plan may use or disclose information to pay claims for health care services received by you, or to provide eligibility information to your health care provider whenever you receive treatment.

Health care operations: We may disclose information for legal and auditing services, including compliance and fraud and abuse detection, administrative and business management activities, patient safety activities, credentialing, disease management, and training for medical or pharmacy students. For example: The plan may use or disclose your health information to contact you and remind you of meetings, appointments, or treatment information.

We may use or disclose your health information to other entities related to you, subject to federal or local laws on confidentiality.

Affiliated covered entities: As part of our functions as insurance or benefit administrators, we may use and disclose PHI to Triple-S Salud, Inc.

Business partners: Triple-S Salud may share information with our business partners, who provide services on behalf of Triple-S Salud and partake from operations to manage your insurance or coordinate your benefits.

Your employer or organization sponsoring your group health plan: We may disclose your health information to your employer or the organization sponsoring your group health plan, in order to help manage the plan and the plan membership. We may also disclose a summary of your health information. This summary includes your claim history, claim or coverage expenses, or types of claims involving plan participants.

For investigative purposes: We may use or disclose your PHI to researchers, if an institutional review board or ethics committee has reviewed the research proposal and established protocols to guarantee your information privacy, and has approved the research as part of a limited data set that does not include individual identifiers.

As required by law: We may use or disclose PHI as required by federal, state, or local law. In this Notice, the term "as required by law" is defined as provided by the HIPAA Act Privacy Rule. Your authorization, or the opportunity to approve or object, will not be required for these purposes. The information shall be disclosed in compliance with the safeguards established and required by law.

Legal proceedings: We may use or disclose your PHI during any court or administrative proceeding: in response to a court or administrative order (inasmuch as such disclosure is explicitly authorized), or in response to a summons, a request for discovery of evidence, or any other process authorized by law.

Forensic pathologists, funeral directors, and organ donor cases: We may use or disclose your PHI to forensic pathologists in order to help identify deceased people, determine cause of

death, or carry out other duties as authorized by law. We may also disclose information to funeral directors so they may carry out their duties regarding the deceased, and to organizations that manage the acquisition, storage, or transplant of organs, eyes, or tissue.

Workers compensation: We may disclose your PHI to comply with worker compensation laws and other similar programs established by law, that provide benefits for work-related injuries or diseases, regardless of fault.

Assistance in case of disasters or emergencies, government benefit programs: We may disclose your PHI to public or private entities, as authorized by law or the statutes involved in the efforts to provide aid in case of a disaster. This way, your family may be notified about your health condition and location in case of a disaster or any other emergency.

Monitoring activities by regulatory agencies: We may disclose health information to regulatory agencies, such as the Department of Health and Human Services (DHHS), for auditing purposes, to monitor compliance with the regulations, licensing, and investigations or inspections. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, governmental programs, and compliance with civil rights laws.

Public health and safety: We may use or disclose your health information as permitted or required by law for the following purposes (your authorization or opportunity to approve or object will not be required for these purposes):

- Public health activities, including the statistic reports on diseases and vital information and specialized government functions, among others;
- Monitoring regulatory agencies and preventing fraud;
- Reporting domestic violence, abuse, or negligence against children or adults;
- Carrying out regulatory agency activities;
- Responding to judicial or administrative orders;
- Providing information to law enforcement or national security officers;
- Preventing an imminent threat to public health or safety;
- Storing or transplanting organs, eyes, or tissue;
- For statistical investigations;
- For purposes related to descendants;
- As required or permitted by the applicable laws.

Military and national security activities, protection services: We may disclose your PHI to military command authorities if you are a member or veteran of the armed forces. We may also disclose it to authorized officials who carry out activities related to national security, intelligence, counterintelligence, and other activities to protect the president and other authorities or heads of state.

Services related to your health: We may use your health information to offer you information about benefits and services related to your health, or treatment alternatives that could be of interest. We will use your information to call or write to you to remind you of your medical appointments or the preventive tests you need, according to your age or health condition.

With your authorization: You may authorize us, in writing, to use or disclose your information to other people for any purpose. Your authorization is required for activities such as the marketing of non-health-related products or the sale of health information. In these cases, the insurance policies and their benefits will not be affected if you deny authorization.

The authorization must be signed and dated by you, and it should state the person or entity authorized to receive the information, a brief description of the information to be disclosed, and the expiration date of the authorization, which shall not exceed 2 years from the date it was signed. Unless the authorization was signed for one of the following purposes:

- To support a benefit request under a life insurance policy, or to reinstate or change its benefits, in which case the authorization will be valid for thirty (30) months or until the request is denied, whichever occurs first; or

- To support or facilitate the communication of ongoing treatments for chronic illnesses or diseases, or for injury rehabilitation.

The information disclosed according to your authorization could be disclosed by the receiver and not be protected by the applicable privacy laws. You have the right to revoke the authorization in writing at any time, but its revocation will not affect the uses or disclosures allowed by your authorization while it was valid. We will keep record of the authorizations or revocations granted by you.

To your family and friends: Unless you request a restriction, we may disclose limited information about you to your family or friends involved in your medical care or responsible for paying medical services.

Prior to disclosing your health information to anyone regarding your health care or payment for health services, we will give you the opportunity to object such disclosure. If you are not present or are incapacitated or in an emergency, we will use our professional judgment in disclosing information in a manner we understand will be in your best interest.

Termination of service relationship: We do not share the information of those people who no longer maintain accounts, policies, or services with us, except as permitted by law.

YOU HAVE THE FOLLOWING RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Access: You have the right to examine and obtain a copy of your personal, financial, insurance, or health information regarding a subscription or claim, within the limits and exceptions provided by law. To do this, you must submit your request in writing to us. After receiving your request, we will have thirty (30) days to do any of the following:

- Request additional time
- Provide the information requested, or allow you to examine the information during working hours
- Inform you that we do not have the information requested, in which case we will tell you where to go, if we have such information
- Deny the request, partially or completely, because the information comes from a confidential source or was compiled in preparation for litigation or investigation by law enforcement officers, anti-fraud units, quality assurance programs, or whose disclosure is prohibited by law. We will notify you in writing about the reasons for the denial. We will not be required to notify you in cases where it is part of a legally and duly appointed investigation, or in preparation for a judicial process.

The first report you request will be free of charge. We reserve the right to charge for subsequent copies.

Disclosure report: You have the right to receive a list of the instances where we or our business partners have disclosed your health information due to matters not related to medical treatments, health service payments, health care operations, or as per your authorization. The report shall state the date the disclosure was made, the name of the person or entity to whom your information was disclosed, a description of the information disclosed, and the reason for disclosure. If you request this report more than once within twelve (12) months, we could charge you for the costs to process any additional requests. The report only covers the last six (6) years.

Restrictions: You have the right to ask us to implement additional restrictions in the way we manage your health information. We do not have to agree with your request, but if we accept it, we shall abide by it (except in case of emergency). Your request and our agreement to implement additional restrictions in the management of your health information must be made in writing.

Confidential communications: You have the right to request that our communications to you regarding your health information be made through alternative methods or addressed to alternative addresses. You must submit a written request. We may accept your request if it is reasonable and specifies the alternate forms or addresses for communication.

Amendment: You have the right to ask us to amend your health information. Your request must made be in writing and contain an explanation or evidence to justify the amendment. We will answer your request within sixty (60) days. If we need additional time, we will send a written notice before the original term expires.

We may reject your request if we do not generate the information you wish to amend and whoever generates it is available to receive your request, or for other reasons. If we deny your request, we will provide a written explanation. You may request to include a statement from you expressing your disagreement with the determination made by us. If we accept your request, we will make reasonable efforts to inform others, including our business partners, and will include such amendment in any future disclosures of such information.

Notice in case of a breach of privacy and security where your information is at risk: We shall promptly notify you if an incident occurs that would compromise the privacy, security, and confidentiality of your protected health information.

Notice by electronic means: If you received this notice through our website www.ssspr.com or by e-mail, you are entitled to receive a printed copy of it.

QUESTIONS AND COMPLAINTS

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

If you understand we or any of our business partners have infringed on your privacy rights, or you disagree with any of our decisions regarding access to your health information, you may submit your complaint to the following address:

Contact office: Compliance Office
Attention to: Privacy Officer
Phone number: 1-888-620-1919
Fax: (787) 993-3260
E-mail: privacidad@ssspr.com
Address: P. O. Box 11320 San Juan, PR 00922

You may also submit a written complaint to the Office for Civil Rights (OCR) of the Department of Health and Human Services (DHHS) to the following address:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

Email to: OCRComplaint@hhs.gov

Customer Response Center: (800) 368-1019
Fax: (202) 619-3818 TDD: (800) 537-7697

We support your right to the privacy of your health information. We will not take any kind of retaliation if you decide to file a complaint with us or with the OCR.

If you would like to receive this notice in Spanish, please contact us at the address above or visit our website at https://salud.grupotriples.com/politica-de-privacidad/.

NOTICE TO INFORM INDIVIDUALS ABOUT THE REQUIREMENTS FOR NON-DISCRIMINATION AND ACCESS, AND STATEMENT OF NON-DISCRIMINATION: DISCRIMINATION IS AGAINST THE LAW

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

Triple-S Salud, Inc.

- Offers free assistance and services to persons with disabilities so they may communicate effectively with us, such as:
  - Certified sign language interpreters,
  - Information written in other formats (large letters, audio, and accessible electronic formats, among others).
- We offer free linguistic services to people whose first language is not English, such as:
  - Qualified interpreters,
  - Information written in other languages.

If need to receive these services, please contact a Customer Representative.

If you consider that Triple-S Salud, Inc. has not provided you with these services or has otherwise discriminated on the basis of race, nationality, color, age, sex, or disability, please contact:

Compliance and Privacy Office
P.O. Box 11320, San Juan, PR 00922-9905
Phone number: (787) 620-1919 ext. 4183
Fax: (787) 993-3260
E-mail: privacidad@ssspr.com

You may also submit your grievance by mail, fax, email, or in person. If you need help to submit your grievance, one of our Customer Representatives will be available to help.

You may also submit a grievance for infringement of civil rights before the Office of Civil Rights of the Department of Health and Human Services of the United States electronically, at their website: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , by mail, or by calling:

200 Independence Ave, SW Room 509F, HHH Bldg Washington, D.C. 20201
Phone number: 1-800-368-1019, TDD: 1-800-537-7697

Call the customer service number on your ID card for assistance.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Gọi số dịch vụ khách hàng trên thẻ ID của quý vị để được hỗ trợ bằng Tiếng Việt.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오 .

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

اتصل برقم خدمة العملاء الموجود على بطاقة هُويتك للحصول على المساعدة باللغة العربية .

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Pour une assistance en français du Canada, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

Ligue para o número de telefone de atendimento ao cliente exibido no seu cartão de identificação para obter ajuda em português.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

日本語でのサポートは、 ID カードに記載のカスタマーサービス番号までお電話でお問い合わせください。

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Rufen Sie den Kundendienst unter der Nummer auf Ihrer ID-Karte an, um Hilfestellung in deutscher Sprache zu erhalten.

برای دریافت راهنمایی به زبان فارسی ، با شماره خدمات مشتری که بر روی کارت شناسایی شما درج شده است تماس بگیرید .

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 some 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. **CASH DEDUCTIBLE:** The annual amount in cash which must accumulate before being entitled to the benefits provided by the insurance of major medical expenses.

2. **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.

3. **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.

4. **ORTHOPEDIC DEVICES:** Those devices that are used after a surgical or mechanical correction of curvatures, deformities and fractures in general.

5. **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.

6. **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.

7. **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.

8. **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. **ACUTE DRUGS:** Medications prescribed to treat a non-recurrent disease (for example: antibiotics). These medications have no refills.

2. **BRAND NAME PRESCRIPTION DRUGS:** Prescription Drugs offered to the public under a commercial name or trademark.

3. **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).

4. **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.

5. **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.

6. **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.

7. **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.

8. **NON-PARTICIPATING PHARMACY:** Any pharmacy that has not subscribed a provider contract with Triple-S Salud.

9. **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.

10. **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.

11. **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.

12. **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.

13. **PARTICIPATING PHARMACY:** Any pharmacy that has subscribed a provider contract with Triple-S Salud.

14. **PHARMACY**: Any establishment legally authorized to supply drugs.

15. **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.

16. **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.

17. **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.

18. **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.

19. **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.

20. **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.

21. **PRESCRIPTION DRUGS WITH REFILLS:** A prescription with written instructions from the prescribing physician authorizing the pharmacy to dispense a prescription drug more than once.
22. **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.

23. **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.

24. **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.

25. **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.

26. **PHARMACY AND THERAPEUTICS COMMITTEE:** A committee or similar body consisting of an uneven number of employees or external consultants hired by an insurer or health insurance organization. The members of the pharmacy and therapeutics committee are health care professionals, such as physicians and pharmacists, with knowledge and expertise regarding:

    The adequate manner, from a clinical perspective, of prescribing, administering, and overseeing the use of prescription drugs for outpatients; and

Reviewing and assessing the use of these drugs, as well as intervening with such usage.

If the pharmacy and therapeutics committee includes members who represent the pharmacy benefit administrator or the insurer or health insurance organization, these members may only contribute with operational or logistics concerns, but they will not have a vote in any decisions regarding the inclusion or exclusion of prescription drugs in the drug list.

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.