INTRODUCTION

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

Triple-S Salud, Inc., (hereafter referred to as Triple-S Salud), insures active eligible employees of **Toys R Us** and the eligible dependents of the previously stated employees. These beneficiaries are entitled to receive the services in accordance to the terms and condition herein this policy/certificate (which from this point on will be addressed to as policy) and the guidelines established by Triple-S Salud. The same will cover expenses related to medically necessary services rendered by medical-surgical during periods of hospitalization services rendered while the policy is active, caused by an injury or an illness suffered by the beneficiary. This policy is issued taking under consideration the declarations stipulated in the contract and the corresponding advanced payment of the premiums provided by the employer.

This policy is issued to bona fide residents of Puerto Rico whose permanent residency is located within the Service Area, as defined in this policy, for the period of one (1) year from the effective date of **July 01, 2016**. This insurance policy may be continued, for equal, consecutive, and additional periods through the payment of the corresponding premiums, which is the responsibility of the employer, as the main-holder of the policy and the employee as the beneficiary and user of the health insurance, described further in this document. All terms and conditions within this coverage policy begin and end at 12:01 a.m., based on Puerto Rico's standard 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. This policy is not a supplementary policy or contract to the Federal Health Service Program for the Elderly (Medicare). Review the Health Insurance Guide for persons with Medicare available through the health insurer.

The President signs this policy in behalf of Triple-S Salud.

Madeline Hernández Urquiza, CPA
President

Keep this document in a safe place; the same includes the benefits entitled to a beneficiary of Triple-S Salud. This document is modified by riders for such reason we exhort you to keep this certificate for future references of amended sections. Always refer to the riders attached to this policy as they contain the accurate information concerning the benefits included in your Health Plan.

CONTACTS

Customer Service Department	
Customer Service Telephone	**787-774-6060 (TTY 787-792-1370)**
Fax- Customer Service	**787-706-4014 / 787-706-2833**
Fax - Reeimbursement	**787-749-4032**
Teleconsulta	**1-800-255-4375**
BlueCard	**1-800-810-2583** **www.bcbsa.com**
Call Center Operating 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.
Customer Service Postal Address	**Triple-S Salud, Inc.** **Customer Service Department** PO Box 363628 San Juan, PR 00936-3628
Web page:	**www.ssspr.com**
E-mail address:	**customerservice@ssspr.com**
Plan Approvals (Precertifications):	**Triple-S Salud, Inc.** **Precertification Departament** PO Box 363628 San Juan, PR 00936-3628

Service Centers

Plaza Las Américas
(Segundo nivel frente a Relojes y Relojes)
Lunes a viernes: 8:00 a.m.-7:00 p.m.
Sábado: 9:00 a.m. – 6:00 p.m.
Domingo: 11:00 a.m. – 5:00 p.m.

Plaza Carolina
(Segundo nivel al lado de Sears)
Lunes a viernes: 9:00 a.m. – 7:00 p.m.
Sábado: 9:00 a.m. – 6:00 p.m.
Domingo: 11:00 a.m. – 5:00 p.m.

Caguas
Edificio Angora
Ave. Luis Muñoz Marín Esq.
Calle Troche
Lunes a viernes: 8:00 a.m. – 5:00 p.m.

Arecibo
Edificio Caribbean Cinemas, Suite 101
Carretera #2
Lunes a viernes: 8:00 a.m. – 5:00 p.m.

Ponce
2760 Ave. Maruca
Lunes a viernes: 8:00 a.m. – 5:00 p.m

Mayagüez
Carretera 114 Km. 1.1
Barrio Guanajibo
Lunes a viernes: 8:00 a.m. – 5:00 p.m.

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 (beneficiaries).

Request your employer a copy of the Summary Plan Description (SPD) and information on the additional benefits that he has available for his 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 beneficiaries
- 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 or the disability plan denies a benefit, the denial must be informed in writing 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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BASIC COVERAGE

ELIGIBILITY

Every active employee of the employer is eligible for the insurance offered under this policy; this is subject to any limitations stipulated by the employer.

DATE OF COVERAGE

The employee and his/her eligible dependents will be covered on the date of this policy if the individual application for insurance of the employee, in which he/she has included said eligible dependents, if any, is attached to the employer's official application form which will be provided by Triple-S Salud through the official in charge of the employer's personnel. After this date, the employee will not participate of this policy until the next renewal date. Triple-S Salud can verify the eligibility of the beneficiary to ensure the compliance of the requirements necessary to obtain the benefits provided by this policy.

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

CHANGES

Once the enrollment period ends, the employee cannot disenroll unless an employment termination occurs. In addition, changes are not permitted upon the request of the employee or the employer except for the following reasons:

1. Death of any of the beneficiaries: If a beneficiary dies while this contract is active, a requisition of change to terminate the coverage should be submitted within thirty days (30) after the date in which the death occurred, such is evidenced by the a Death Certificate. The change shall be effective on the first day of the following month in which the event occurred.

2. Divorced of the main holder: If the participant employee divorces while this contract is still valid, a request for change to terminate the plan together with the Divorce Decree issued by the court must be submitted within thirty (30) days following the date of the divorce. The change will be effective on the first day of the month after the date Divorce Decree was issued by the court and notified, or if the divorce was declared valid by other means, the ruling was issued by a court in another jurisdiction.

3. A child, under the definition of direct dependent of this contract, ceases to be eligible as direct dependent of the participant employee.

    a. The child attains age twenty-six (26). The birth date will be taken as date of the request for change to end the plan coverage. The change will be effective on the first day of the month following the birth date.
    b. When a child enters in the Armed Forces of the United States of America, the date of entry will be taken as the date of request to the cessation of the safe. It will be effective the first day of the month following that which the event occurred.

It is understood that a request for insurance coverage is complete when the employee has entirely filled out the application and submitted the same to the official in charge of personnel assigned by the employer. The same procedures are applicable when submitting a request for change to the policy. The exception to this procedure is when a change of age occurs; in this case, Triple-S Salud executes the change. The official in charge of personnel assigned by the employer is responsible of providing to Triple-S Salud all applications for insurance, requests for change, and a certified summary of all-new applications and changes to be performed and of returning the insurance card of those employees that are disenrolled from the policy. Triple-S Salud is entitled to verify the eligibility of the persons for whom enrollment has been requested in order to validate their compliance with the requirements established to obtain the benefits this policy provides.

SPECIAL INSCRIPTIONS

An active employee and his eligible dependents (direct or optional) 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 employees, 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 mother 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 thirty 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.

      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 or optional) 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, 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 insured.

h. The person lost eligibility under the Health Plan of the Government of Puerto Rico (Mi Salud).

In all of these cases, the active employee as well as his eligible dependent shall be entitled to special enrollment under this policy within thirty days from the date in which the event took place. To be eligible 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 with the plan enrollment application 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 or optional) 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 mother or father of minors listed as dependents under the policy, or when the insured 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 insured.

COVERED SERVICES

The benefits provided by this policy are contained in the general classification as follows. These benefits are subject to the terms and conditions already specified for them and will only be provided to insureds living within the Service Area.

The policy of the employee and his/her insured direct dependents would be the same as respects to coverage.

Under our plan, there is a maximum of disbursements that people pay for medical services and hospital covered according to their type of contract. The maximum amount of disbursement is $6,350 in an individual contract and $12,700 in contract couple or family. This is the maximum amount that the insured pay during the year policy by concept of essential medical services and hospital care covered under the policy when you visit providers inside the network, including the purchase of prescription drugs and payment for dental services, as described in the Table of Benefits. Once the person reaches the amount that applies according to the type of contract, he/she will not have to do additional disbursements for rest of the policy year. Services provided through non- participating providers, payments made by the insured person for services not covered under this policy as well as the monthly premium paid to Triple-S Salud by the plan, are not considered eligible expenditure for the accumulation of pocket maximum.

In addition, they are not considered eligible expenditure for the accumulation of maximum payout the following services:

- Alternative medicine (Triple-S Natural)

- Organ and Tissues Transplant
- Services of non-participants in and outside of PR

Active employees and their spouses, over the age of sixty-five (65), who are insured by both Parts of the Medicare Program, can be insured under the benefits of this policy.

Triple-S Salud does not select the participating physician, hospital or laboratory the insured requires. Benefits covered by this policy are not cumulative or subject to waiting periods.

The insureds, physicians and participating facilities will be notified about hospital admissions that require a Precertification or notification within 24 hours or as soon as reasonably possible. Some studies, diagnostic tests and surgical procedures will require a Precertification from Triple-S Salud. The insureds, physicians and participating facilities will be notified about those procedures for which a previous authorization is required. Services received in an Emergency Room as a result of a medical emergency will not require Precertification.

In those cases in which Triple-S Salud requires Precertification for services rendered, Triple-S Salud will not be responsible for the payment of said services if they are rendered or received without Triple-S Salud' authorization.

Triple-S Salud may require a second medical opinion from physicians it designates for those procedures in which, according to Triple-S Salud, said opinion is necessary.

Services covered under this policy that are rendered by non-participating physicians or providers will only be covered in case of emergency and will be paid directly to the provider based on the lowest amount between the expense incurred and the fee Triple-S Salud would have paid to a participating provider.

Triple-S Salud can establish, as means for authorizing the payment for covered services, payment policies for health conditions that require a specialized management and for which Triple-S Salud requires a particular contract with a provider to be able to manage such cases. There are certain conditions that, because of their particular characteristics, require that Triple-S Salud closely monitors the utilization of those services closely, to avoid fraud towards the insurer or abuse of those services. Triple-S Salud' policies are directed to achieve an adequate administration of these particular cases to guarantee a fair treatment for all insureds under similar conditions, at the same time guarantee a cost effective management. This clause must not be interpreted as an elimination or reduction of benefits covered under this policy.

Services Covered By Federal Or State Law

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

This policy covers preventive services required by Federal Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA) and the Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152 (HCERA) and as established by the United States Preventive Services Task Force (USPSTF). These preventive care services, as detailed below, are included in the basic coverage and have $0 copayment or 0% coinsurance, as long as they are provided through participating physicians and providers only in Puerto Rico:

- A lifetime screening for abdominal aortic aneurysm (AAA) by ultrasonography in men aged 65 to 75 who have ever smoked
- Screening and behavioral counseling interventions to reduce alcohol in adolescents for alcohol and substance abuse, for alcohol in adults of 18 years of age or older who are engaged in risk patterns or in danger of falling in a risky or hazardous drinking pattern of alcohol consumption, including behavior interventions
- Aspirin supplements for men and women of certain ages

- High blood pressure screening in children of all ages and adults aged 18 years or older
- Cholesterol or lipid disorders screening for men age 20 to 35, if they are at risk of coronary heart disease; men aged 35 or older; women aged 45 or older, if they are at high risk of coronary heart disease, children of all ages
- Occult blood test for colorectal cancer screening, sigmoidoscopy or colonoscopy in adults from 50 to 75 years of age
- Depression screening for adults and screening for severe depression disorder for adolescents (aged 12 to 18), when the procedure has been established to ensure a precise diagnostic, psychotherapy (cognitive, behavioral or interpersonal) and follow up
- Screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated with greater 135/80mmg)
- Nutritional counseling for adults at high risk of chronic diseases
- HIV screening tests in adolescents and adults at higher risk from age 15 to 65 years. Younger adolescents and older adults who are at increased risk must also be screened, as well as all pregnant women
- Screening for obesity on adults and those with a body mass index of 30kg/m2 or higher, must be referred to intensive multicomponent behavior interventions
- Preventive counseling on sexually transmitted infections for high risk adults
- Tobacco use screening for all adults and cessation interventions for tobacco users, and expanded counseling to pregnant tobacco users
- Syphilis screening for all adults and pregnant women at high risk
- Routine screening iron deficiency for anemia in asymptomatic pregnant women
- Screening for asymptomatic bacteriuria with urine culture to pregnant women between 12 to 16 weeks of gestation or on the first prenatal visit, if later
- Breast cancer genetic test counseling for women at higher risk of breast or ovarian cancer
- Mammography screening for breast cancer every one to two years for women over 40 years of age; biennial screening for women between 50 and 75 years of age
- Counseling on preventive chemotherapy for breast cancer for women at high risk
- Breastfeeding support and counseling by a trained professional during pregnancy or post-partum period, including breastfeeding equipment
- Cervical cancer screening for sexually active women between 21 and 65 years of age through cytology (PaP, every three years); Human papilloma virus screening combined with cytology every five (5) years for women aged 30 to 65
- Chlamydia infection screening to pregnant women age 24 or under and other women at higher risk, whether pregnant or not
- Food and Drug Administration approved contraceptive methods, sterilization procedures, oral contraceptives, patient education and counseling for women with reproductive capacity. As prescribed.
- Screening and counseling for domestic and interpersonal violence
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and on the first prenatal visit for women at high risk of developing gestational diabetes
- Gonorrhea screening for sexually active women, including those who are pregnant if they are at high risk of contracting the infection
- Hepatitis B screening to pregnant women at their first prenatal visit
- Human Papilloma virus ADN test every three (3) years in woman, with normal cytology results, who are thirty (30) or older
- Osteoporosis screening for women age 65 or older and in younger women, whose risk of bone fractures is equal to, or greater than that of a 65 years old white woman who has additional risk factors
- Rh(D) blood typing and antibody testing to all pregnant women at their first prenatal care visit; repeated antibody testing for all unsensitized Rh(D) negative women at 26 to 28 weeks' gestation, unless the biologic father is known to be Rh(D) negative

- Preventive annual care for adult women in order to obtain the recommended preventive services that are age and developmentally appropriate, including preconception care and many services for prenatal care. This well-woman visit is annual, although Health and Human Services (HHS) recognizes that several visits may be needed to obtain all necessary recommended preventive services depending on a woman's health status, health needs and other risk factors
- Autism screening for children at 18 and 24 months of age
- Behavioral assessment for children of all ages
- Cervical dysplasia screening for all sexually active females
- Congenital hypothyroidism screening for newborns
- Developmental screening and monitoring for children less than 3 years of age
- Dyslipidemia screening for children of all ages at higher risk of lipid disorders
- Fluoride chemoprevention supplements for children without fluoride in their water sources
- Hearing screening tests for all newborn
- Medical history for all children throughout their development: 0 to 11 months, 1 to 4 years and 5 to 10 years
- Hematocrit or Hemoglobin screening for children
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Screening for lead for children at risk of exposure
- Screening for obesity in children age 6 and older as well as referrals to comprehensive intensive behavioral interventions to promote improvement in weight status
- Gonorrhea preventive medication for the eyes of all newborns
- Height, Weight and Body Mass Index measurements for children of all ages
- Hemoglobinopathies or sickle cell screening for newborns
- Oral Health risk assessment for young children, ages 0 to 11 months, 1 to 4 years, 5 to 10 years
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- High-intensity behavioral counseling and screening to prevent sexually transmitted infection (STI's) for all sexually active for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for all children at least once between the ages 3 to 5 to detect amblyopia
- Vaccines; for specific coverage information, please refer to the Vaccines section at the end of the section Ambulatory Medical-Surgical and Diagnostic Services

For more information about the preventive services covered, you can access the following link: http://www.healthcare.gov/center/regulations/prevention.html.

This policy also covers the annual preventive visits, the preventive screening tests and vaccines as set forth by the Centers for Medicare and Medicaid Services (CMS), in accordance with 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 of the Puerto Rico Department of Health. These include some of the preventive services and vaccines mentioned in the previous paragraphs, as well as the following services:

- Influenza vaccines, without age limit
- Hepatitis B vaccines, without age limit

This policy also complies with the requirements of Law 239 of September 13, 2012, for covered services as detailed in this policy, shall be offered by professional psychologists trained at master's or doctoral levels, who have training and experience to offer health services and who are duly licensed by the Puerto Rico Board of Psychologist Examiners.

In accordance with the requirements of the Act No. 107 of 2012, this policy establishes equality of coverage for the treatment of chemotherapy against cancer in their various methods of administration such as intravenous, oral, injectable or intrathecal; depending on the order of the medical specialist doctor or oncologist.

In compliance with the Law for the Welfare, Development and Integration of People with Autism (known as Ley BIDA, for its acronym in Spanish), this policy covers all services for the diagnosis and treatment of people with disorders within the autism spectrum such as genetics, neurology, immunology, gastroenterology and nutrition, speech and language therapy, psychological, occupational and physical therapy. These services include medical visits and medical reference tests. These services are offered without limitation to all persons who have been diagnosed with any of the conditions within the Autism Spectrum, but may be subject to applicable copays or coinsurance, as stated in the Table of Benefits that appears in this policy.

This policy covers all the preventive services and benefits listed under the ACA federal law for early detection of breast cancer. Pursuant to Law No. 275 of September 27, 2012, this policy also covers studies and monitoring for breast cancer such as visits to specialists, breast clinical exams, mammographies, digital mammographies, magnetic resonance mammography and sonomammography.

It also includes, but does not limit to, treatments such as mastectomy, reconstructive surgery after a mastectomy for the reconstruction of the breast removed, the reconstruction of the other breast to achieve a symmetric appearance, breast prosthesis, treatment for physical complications during all the stages of a mastectomy, including lymphedema(an inflammation that sometimes occurs after breast cancer), as well as any other reconstructive surgery for the physical and emotional recovery of the patient.

The insured person will be responsible of paying directly to the participating provider the copayment or coinsurance stated in the Table of Benefits that appears in this policy.

This policy provides any eligible insured, including those diagnosed with HIV or AIDS, or that are physically or mentally disabled, every coverage offered under this policy.

COMPENSATION TO THE INSURED

If any person entitled to the benefits under this policy receives services outside Puerto Rico and United States of America, Triple-S Salud will pay directly to the insured the amount that would have been paid to a participating professional / facility or according to the amount specified for the benefit.

If the service is rendered in the United States of America by a participating professional, and is not preauthorized or an emergency, or it is available in Puerto Rico, the insured person will have to pay for the service and it will not be covered.

If the service is rendered in the United States of America by a non-participating professional and is not an emergency, the insured person will pay the total cost of the services and they will not be covered by Triple-S Salud.

The insured person will have to submit all the regulatory reports required in these cases.

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	$4.00 copayment for visits to a general practitioner $7.00 copayment for visits to a specialist $10.00 copayment for visits to a sub-specialist
• Visits to an audiologist	$4.00 copayment per visit
• Visits to an optometrist	$4.00 copayment per visit
• Visits to a podiatrist	$4.00 copayment per visit
• Visits to a clinical psychologist	$7.00 copayment per visit
• Visits to a chiropractor	$7.00 copayment per visit
• In-home medical services by physicians who render this service.	$15.00 copayment per visit
• Intra-articular injections will be limited to two (2) daily injections up to a maximum of twelve (12) injections per policy year, per insured.	Nothing
• Services at hospital emergency rooms, materials and medications included in suture trays contracted with Triple-S Salud. It also covers medications and materials in addition to those included in the suture tray, provided in emergency room because of accident or illnesses. Copayment applies for illness or accident. Insured members may call Teleconsulta and if they recommend going to an emergency room, they will provide a registration number with which the insured will pay a lower copayment for the use of the facilities. For non-routine diagnostic tests provided in emergency rooms, that are not X-rays and laboratories, coinsurances and /or limits applies for the outpatient benefit apply, including X-rays interpretation; as specified in this policy.	Nothing copayment for illness $20.00 copayment for accident Nothing, if recommended by Teleconsulta
• Cryosurgery of the uterus limited to one (1) procedure per policy year, per insured. • Services for tuberculosis conditions • Sterilization	Nothing
• Preventive services with no copayment or coinsurance, required by federal laws *Patient Protection and Affordable Care Act, Public Law No*. 111-148 (PPACA) and the *Health Care and Education Reconciliation Act* de 2010, *Public Law No*. 111-152 (HCERA) and according to the United States Preventive Services Task Force are covered under this policy.	Nothing

VACCINE’S STANDARD COVERAGE FOR CHILDREN, ADOLESCENTS AND ADULTS

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

A. Preventive Vaccines

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

Federal Health Reform – Standard Preventive Vaccines without copay
From 2 months of age: • **ROTA** (Rotavirus Vaccine)(90680) – Up to 8 months of age • **ROTA** (Rotavirus Vaccine, human - Rotarix) (90681) – Up to 8 months of age • **IPV*** (Inactivated Poliovirus Vaccine – injectable (90713) – Up to 18 months of age • **Hib*** (Haemophilus Influenza B Vaccine) (90645; 90646; 90647, 90648) – Up to 6 years of age
From 2 years of age: • **PPV** (Pneumococcal Polysaccharide Vaccine) (90732) • **Menomune** (Meningococcal Polysaccharide Vaccine) (90733) • **MCV** (Meningococcal Conjugate Vaccine - Menactra) (90734)
Up to 5 years of age*: • **PCV** (Pneumococcal Conjugate Vaccine - Prevnar) (90669) • **PCV** (Pneumococcal Conjugate Vaccine - Prevnar 13) (90670)
Up to 7 years of age*: • **DTaP** (Diphteria, Tetanus Toxoid and Acellular Pertussis Vaccine) (90700)
From 11 years of age: • **Tdap*** (Tetanus, Diphtheria and Acellular Pertussis)(90715) – Up to 19 years of age • **HPV*** (Human Papilloma Virus) (Gardasil-90649, Cervarix-90650) – Up to 27 years of age
From 60 years of age: • **Zoster** (Zostavax) (90736)
Variable ages • **FLU** (Influenza Virus Vaccine) - (90654) From 18 to 65 years of age* - (90655, 90657) Up to three (3) years of age (2 doses) - (90656, 90658) From 3 years of age - (90660, 90672) (for intranasal use) • **MMR** (Measles, Mumps and Rubella Vaccine) (90707) – without age limit • **VAR** (Varicella Virus Vaccine) (90716) – without age limit • **DT (**Diphtheria, Tetanus Toxoid) (90702) – From 4 months of age • **HEP A** (Hepatitis A Vaccine): - (90633, 90634) – From one (1) year of age - (90632) – From 18 years of age • **Td** (Tetanus and Diphteria Toxoid Adsorbed) (90714; 90718) – without age limit • **HEP B** (Hepatitis B Vaccine): - (90744) – Up to 20 years of age* - (90746) –From 20 years of age - (90747) – without age limit

***Vaccine is covered until the individual reaches the age indicated.**

B. OTHER VACCINES

Vaccines with $0.00 copay
• **Pentacel*** (90698) – Up to 5 years of age **(PPACA)** • **DtaP-IPV-HEP B*** (Pediarix) (90723) Up to 7 years of age **(PPACA)** • **Kinrix*** (90696) Up to 7 years of age **(PPACA)** • **Tetanus Toxoid** (90703) – without age limit
Vaccines with 25% coinsurance
• **Palivizumab*** (**Synagis**) (90378) – Up to two (2) years of age. Covered with a precertification, following the protocol established by Triple-S Salud.

***Vaccine is covered until the individual reaches the age indicated.**

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

Laboratories, X-Rays and Other Diagnostic Tests	
Tests such as: • Clinical Laboratories • X-Rays • Nuclear medicine tests • Computerized Tomography • Sonogram • 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. • Electromiogram • Electrocardiogram • Polysomnography (study of sleeping disorders)up to one test of each type, per life. • Other diagnostic tests • Color dopler flow • Ophthalmologic diagnostic tests • Electroencephalograms • Non invasive cardiovascular tests • Vascular non-invasive tests	25% coinsurance
• Gastrointestinal endoscopies • Colonoscopy • Flexible Sigmoidoscopies	20% coinsurance
• *Estereotatic breast biopsy* • The refraction exam is covered when it is made by a specialist in ophthalmology or optometry and up to one (1) exam per year policy, per insured.	Nothing
• Preventive services with no copayment or coinsurance, required by federal laws *Patient Protection and Affordable Care Act, Public Law No*. 111-148 (PPACA) and the *Health Care and Education Reconciliation Act* de 2010, *Public Law No*. 111-152 (HCERA) and according to the United States Preventive Services Task Force are covered under this policy.	Nothing

Maternity Services	
• Services without waiting periods • Prenatal and postnatal services	$7.00 copayment for the visit to the specialist for prenatal and postnatal visits
• Hospitalization • According to the Law on Protection of Mothers and Newborns, admissions to the hospital in case of delivery will be covered for a minimum of 48 hours in case of vaginal delivery and 96 hours in case of cesarean section delivery, unless the physician, after consulting with the mother, orders the discharge of the mother and/or the newborn	$50.00 copayment for birth hospitalization
• Obstetrics services • Use of Maternity Ward and Fetal Monitoring production • Use of Well Baby Nursery • Use of the Step Down Unit	Nothing
• Visits for well baby care during the insured baby's first year.	$7.00 copayment per visit
• Biophysical Profile, up to one (1) per pregnancy, per insured with right to maternity	25% coinsurance for Biophysical Profile
• Preventive services with no copayment or coinsurance, required by federal laws *Patient Protection and Affordable Care Act, Public Law No*. 111-148 (PPACA) and the *Health Care and Education Reconciliation Act* de 2010, *Public Law No*. 111-152 (HCERA) and according to the United States Preventive Services Task Force are covered under this policy.	Nothing
Allergy care	
• Allergy tests, up to fifty (50) test per policy year, per insured person	Nothing
Treatment Therapy	
• Brachytherapy	25% coinsurance
• Chemotherapy in their methods of administration (intravenous, oral, injectable or intrathecal), depending on the order of the specialist physician or oncologist. The oral chemotherapy is covered under the pharmacy benefit.	Nothing
• Radiotherapy • 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 insured became eligible for this policy for the first time; or b. the date in which he/she received the first dialysis or hemodialysis. This will apply when subsequent dialysis or hemodialysis are related to the same clinical condition.	Nothing

Respiratory Therapy	
• 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 insured.	$7.00 copayment per therapy
Chiropractor services and Physical Therapies	
• Up to one (1) initial visit per each three (3) year period. Subsequent visits are coverd up to one (1) per policy year. Physical therapies are covered up to a maximum of fifteen (15), per policy year, per insured person.	$7.00 copayment per visit Nothing If the insured receives services from a non-participating chiropractor, they will be reimbursed at 100% from Triple-S Salud established fees. Besides, services may be covered through Assignment of Benefits.
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. 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
Mechanical Ventilator	
• Includes the services of a skilled nurse with knowledge in respiratory therapy, physical and occupational therapy for insured patients under the age of twenty (21). • These services are covered subject to the presentation, by the insured patient or his/her representative, of justified medical evidence and proof of registration in the registry established by the Health Department for these patients. • The services of a skilled nurse with knowledge in respiratory therapy, acquainted with the use of a mechanical ventilator, and physical and occupational therapies are covered up to a maximum of eight (8) hours of service per day.	Nothing

Home Health Care	
The following services and supplies are covered: • **Home Health Care** - the following services and supplies provided in the home of the patient by an Agency of Home Health Care certified by the Health Department of Puerto Rico. These services will be covered if they begin within the fourteen (14) days of being discharged from a hospitalization of at least three (3) days and if they are rendered because of the same condition or in relation to the condition by which he/she was hospitalized. These conditions do not apply for the services related to the mechanical ventilator. • **Nurse Services** - partial or intermittent, provided or under the supervision of a graduate nurse, up to a maximum of two (2) daily visits. • **Home Health Care for Auxiliary Services** - partial or intermittent, rendered primarily for the care of the patient. A visit by a member of the Agency of Home Health Care in the home or four (4) hours of service by an assistant, will be considered as one visit in the home. • **Physical, Occupational and Speech Therapy** - will be covered up to a maximum of forty (40) visits per policy year. A visit by a member of a home health care team or four (4) hours of home health aid service will be considered as one home health care visit. **Note**: A surgeon-physician must supervise these services and certify in writing the medical necessity. He/she must recertify the medical necessity when Triple-S thus requires it.	25% coinsurance
Nutrition Services	
• **NUTRITION SERVICES TREATMENT**: Triple-S Salud will pay for nutrition services rendered in Puerto Rico by physicians specialized in nutrition or metabolic illnesses. Visits to these specialists, duly certified by the Commonwealth's governmental entity designated for this purpose, will be covered as long as they are medically necessary. Visits will be limited to a maximum of three (3) visits per policy year.	Triple-S Salud will reimburse up to a maximum of **TWENTY DOLLARS ($20.00)** for each 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 • 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 evaluations and tests	• Neurological tests - 25% coinsurance • Immunology - 25% coinsurance • Genetic testing - 25% coinsurance • Laboratory tests for autism - 25% coinsurance • Services of gastroenterology - 25% coinsurance • Services of nutrition - $0.00 copayment • Physical therapy - $7.00 copay • Occupational therapy and speech therapy- $7.00 copay • 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) - $7.00 copay. • Psychological evaluations and tests - $10.00 copay

Triple-S Natural

It covers a model program that combines therapies and an integrated alternative treatment to traditional health systems. The program covers the following services, only in the contracted facility for these purposes:

- Primary conventional medicine - conventional medical care offered by specialists in family medicine, Chinese medicine and acupuncture.
- Complementary and integral health - Use of conventional medicine, incorporated with therapy, treatment, modalities and therapeutic approaches that promote optimal health status of a person.
- Medical Acupuncture
- Therapeutic Massage
- Bioenergetic Medicine (Pranic Ealing)
- Botanical medicine- Using plants or their derivatives with medicinal properties for treatment of a disease.
- Aromatherapy
- Music Therapy
- Hypnotherapy
- Traditional Chinese Medicine
- Chiropractic
- Reflexology
- Clinical Nutrition

These services are limited to six (6) visits per contract year. The participant should call the facility and coordinate the appointment. A $15.00 copayment applies for each visit.

Preventive Service Centers

This benefits offers the services required by the federal Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA) and Health Care and Education Reconciliation Act de 2010, Public Law No. 111-152 (HCERA), as set forth by the United States Preventive Services Task Force (USPSTF) *at participating centers*. The insured persons must coordinate an appointment with the Participating Center to receive the services provided under their policy. It also includes an initial evaluation and another evaluation after the tests are performed.

Among the services offered, there are the following:

Evaluation	✓ Medical history ✓ Physical exam ✓ Screening for depression ✓ Counseling on: Alcoholism, Tobacco, Risky behaviors, Sexuality, Cancer, Domestic violence, Prevention of falls, Diet and Nutrition		**$0.00 copay**
Preventive Screening Tests 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 copay, refer to sub-section on Services Covered by Federal or Local Law in the benefit certificate.	CBC Cholesterol PAP (cervical cancer) Chlamydia	Gonorrhea Syphilis HIV Glycosylated Hemoglobin Visual Examination	**$0.00 copay**
Referrals	✓ Screening mammography ✓ Vaccines ✓ Bone density scan	✓ Colonoscopy ✓ Sigmoidoscopy ✓ Others	**According to coverage**

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 copays or coinsurances that correspond to your coverage will apply. Please refer to the Table of Benefits. 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.

MEDICAL-SURGICAL SERVICES DURING PERIODS OF HOSPITALIZATION

- Triple-S Salud agrees to pay based on the rates established for those services covered herein that are rendered to the insured during hospitalization periods by physicians freely chosen by the insured. Only surgeon services that are normally available in the hospital in which the insured is hospitalized shall be covered during any hospitalization period.

- No person insured under this policy that is hospitalized in a semi-private room of the hospital, shall be bound to pay any amount to a participating surgeon for services covered hereby rendered by the surgeon. Medical fees in these cases shall be paid directly by Triple-S Salud to the participating surgeons based on the fees established for said purposes.

Benefits Description	You Pay
Medical Surgical Services	
During periods of hospitalization, the insured will have the right to receive the following medical/surgical services, among others: • Surgery • Diagnostic services • Treatment • Administration of anesthesia • Epidural anesthesia • Specialists consultations • Surgical assistance	Nothing
• Skin, Bone and Corneal Transplants: Expenses to obtain and transport materials necessary for skin, bone and corneal transplants will be covered by reimbursement to the insured. Triple-S Salud will pay 100% of the fees it has established for these services. • Gastrointestinal endoscopies • Color Doppler flow • Rhinoplasty services • Sterilization • Hearing evaluations, include Neonatal Hearing Screening Test • Chemotherapy in their methods of administration (intravenous, oral, injectable or intrathecal) and radiotherapy. The oral chemotherapy is covered under the pharmacy benefit. • Surgical assistance • Catheterism, preauthorization required.	Nothing
• Orthognatic surgical (Mandibular and maxillary osteotomy [Le Fort]). Excludes expenses related with materials for orthognatic surgical (Mandibular and maxillary osteotomy [Le Fort]). • 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.	Nothing

• Gastric Bypass Surgery for the treatment of morbid obesity, up to one (1) surgery per lifetime, as long as the services are available in Puerto Rico. Requires precertification.	Nothing
• Invasive cardiovascular tests	25% coinsurance
• Lithotripsy procedure (ESWL), Precertification required	Nothing

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

- It is required that the person to be hospitalized for an injury or illness pay the participating hospital the admission copayment at the time of admission. This amount is not reimbursable by Triple-S Salud. For the calculation of any period of hospitalization, the day of admission shall be counted, but the day in which the patient is released by the physician-surgeon in charge of the case will not be counted.
- Triple-S Salud shall not be responsible for the services received by any insured if he/she remains in the hospital after being discharged by the physician-surgeon in charge of the case, nor will it be responsible for any day or days that may be granted to the patient to be absent from the hospital during the same hospitalization period.
- Hospitalization services shall be extended in case of maternity or secondary conditions to pregnancy, only if the person is entitled to the maternity benefit. Ambulatory Surgery Center services will be covered in accordance with policy established by Triple-S Salud.
- In those cases where an insured chooses to use a private room in a participating hospital, Triple-S Salud Inc. will pay up to a semi-private room contracted cost. The insured will pay only for the difference between the semiprivate and private room charge, in addition to the applicable copayment or coinsurance; nor for additional charges.

Benefits Description	You Pay
Hospitalizations	
Triple-S Salud pays for services contracted with the corresponding hospital institution during the hospitalization of the insured during the effectiveness of the insurance of the eligible person, as long as that hospitalization is ordered in writing by the physician in charge of the case and it is medically necessary. The basic services contracted with a participating hospital include: • Semi-private or isolation room up to a maximum of three hundred and sixty-five (365) days for regular hospitalizations.	$50.00 copayment for regular admission
• Ambulatory surgeries	Nothing
• Meals and special diets • Use of telemetric services • Use of Recovery room • Use of *Step Down Unit* • General nursing services • Administration of anesthesia by non-medical personnel • Clinical laboratory services	Nothing, these services are included in the payment of the hospitalization copayment.

Hospitalizations (cont.)	You Pay
• Medications, biological products, healing materials, products related to hyperalimentation 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 insured 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. • Use of Intensive Care units, Coronary Care, Pediatric Intensive Care, and Neonatal Intensive Care. • 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 insured became eligible for this policy for the first time; or b. the date in which he/she receives the first dialysis or hemodialysis. This will apply when subsequent dialysis or hemodialysis are related to the same clinical condition. • Chemotherapy in their methods of administration (intravenous, oral, injectable or intrathecal) and radiotherapy. • Blood for transfusions • Sterilization services for male or female.	Nothing, these services are included in the payment of the hospitalization copayment.
• Lithotripsy procedure (ESWL), Precertification required	Nothing

Skilled Nursing Facilities (SNF)	
These services will be covered if they start no further than fourteen (14) days after the insured is released from a hospital, having been hospitalized at least three (3) days and, if the services are provided due to the same condition or in relation to the condition for which he/she was hospitalized. • Will be covered up to a maximum of one hundred twenty (120) days per policy year, per insured. • Services provided by non-participating facilities in Puerto Rico or non-participating of the *Blue Cross and Blue Shield Association,* will be paid by indemnization based on the fees established for the rendered service. **Note**: A physician must supervise these services and certify in writing his/her medical necessity. He/she must recertify the medical necessity when Triple-S Salud therefore requires it.	Nothing
Ambulance	
• Air ambulance services in Puerto Rico, subject to medical necessity	Nothing
• **AMBULANCE SERVICES**: Over ground ambulance services rendered in or outside of Puerto Rico are covered based on reimbursement to the insured of the corresponding fees as determined by Triple-S Salud, according to the distance covered. When services are used through 911, 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 Definition Section, AMBULANCE SERVICES; 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 that includes the diagnostic; and, d) the invoice for this service indicates the place where the insured was picked up and where he/she was taken. These benefits are 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 - this if the institution that transfers or authorizes the discharge is not the appropriate facility for the covered service; c) from the hospital to the insured's home.	Up to a maximum of **EIGHTY DOLLARS ($80.00**) per case, by reimbursement.

MENTAL HEALTH AND SUBSTANCE ABUSE

This policy covers the mental health services and substances abuse under the State and Federal laws, State Law 183 of August 6, 2008 and Federal Law Mental Health Parity and Addiction Equity Act of 2008.

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 admission • Partial admission	$50.00 copayment for regular admission $50.00 copayment for partial admission
• Electroshock therapy for mental conditions will be 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 participating psychiatrist are covered without limits, subject to medical necessity.	$7.00 copayment per visit
• Visits of immediate family members (collaterals) are covered without limits, subject to medical necessity.	$7.00 copayment per visit
• Visits for group therapy (of patients) are covered without limits, subject to medical necessity.	$5.00 copayment per therapy
Others Psychological Evaluations	
• **Psychological evaluation**	$10.00 copayment
• **Psychological test:** The psychological tests required by the Law Num. 296 of September 1, 2000, known as the Law of Conservation of the Children and Adolescents' Health is covered.	$10.00 copayment

Substances Abuse (drug addiction and alcoholism)	
• Regular admission • Partial admission • Hospitalizations for drug addiction and alcoholism including detox treatment and partial hospitalizations are covered without limits, subject to medical necessity.	$50.00 copayment for regular admission $50.00 copayment for partial admission
• Patient's visits to the office of the participating psychiatrist are covered without limits, subject to medical necessity.	$7.00 copayment per visit
• Visits of immediate family members (collaterals) are covered without limits, subject to medical necessity.	$7.00 copayment per visit
• Visits for group therapy (of patients) are covered without limits, subject to medical necessity.	$5.00 copayment per visit
Residential Treatment	
• Covers residential treatment for drug abuse and alcoholism up to a maximum of ninety-(90) days per policy year, per insured person, as long as there is a medical justification and the services are available in Puerto Rico. Requires precertification.	Nothing

MAJOR MEDICAL COVERAGE

Benefits Description

Individual Eligibility/Coverage Date

A. INDIVIDUAL ELIGIBILITY:
Every employee and his/her direct dependents insured under Triple-S Salud's basic policy for hospital, medical-surgical, and ambulatory services, will be eligible for coverage under major medical insurance. Optional dependents are not eligible for benefits offered under this coverage.

B. DATE OF COVERAGE
Any eligible dependent will be covered on the employee's effective date or on the date in which the person became eligible as a dependent, whichever date is later.

Benefits

This 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 do not conflict with the benefits and conditions of this coverage.

This Major Medical coverage provides benefits for some limited or excluded services in the basic coverage as stated in Paragraph B of Covered Medical Expenses and services rendered outside of Puerto Rico as long as the established conditions are fulfilled on this coverage for said services.

Medical expenses covered under the Major Medical Insurance will be paid directly to the insured or through Assignment of Benefits according to Triple-S Salud established fees and to the following amounts applicable to the insured and each one of his/her eligible dependents.

Each insured or family will be responsible, after accumulating the cash deductible, for the covered medical expenses.

Each insured or family will be responsible for the difference between the incurred expenses and the established fees for the reimbursement of the covered medical expenses.

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

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 insureds that live permanently in the service area.

Major Medical Benefits Covered (Cont.)

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 Health for such purposes; if the service is provided outside of Puerto Rico, 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 participating participants of the BCBSA, except otherwise specified in this policy. Services provided through non- participating providers outside of Puerto Rico will not be covered, except in cases of emergency. In these cases, will be covered on the basis of the applicable fee for non-participating providers established by the plans of the BCBSA. The insured person can apply for a Benefit Assignment for such services. Hospital and facilities non-participating of the Blue Cross Blue Shield Association that accept the Benefit Assignment will bill Triple-S Salud directly for the services rendered to the insured.

All services rendered outside of Puerto Rico will be paid only through this coverage subject to 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 insured based on Triple-S Salud established fees for participating providers or through Assignment of Benefits.

The services that require preauthorization in the basic cover maintained this requirement in this cover of major medical expenses.

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

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 insured or his/her dependent while insured. The insured must first cover the cash deductible and subject to the limitations established in this coverage rider.

2. After a disbursement of the amount established in the Limitations Section of cash expenses (as a result of the accumulation of the deductible and coinsurance for which the insured is responsible) for covered medical expenses incurred by the insured or his dependent during a policy year, a 100% reimbursement covered medical expenses that exceed said amount will be paid to the person in such situation during the remaining policy year.

3. After a disbursement of the amount established in the Limitations Section of cash expenses (due to the accumulation of the deductible and coinsurance responsibility of the insured and dependents) for covered medical expenses incurred by the insured or insured members of his/her family during a policy year, a 100% reimbursement of the covered medical expenses regarding the insured members of his/her family will be paid 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 insured during any policy year.

B. COVERED MEDICAL EXPENSES: Medical expenses for treatment of injuries and illness suffered by the insured will be covered when approved and recommended by the attending physician.

1. **Anesthesia and its administration**

2. **Durable medical equipment (only for services outside Puerto Rico):**

   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.

   Purchase option for these equipments require Triple-S Salud's Precertification.

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. **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 insured's immediate family or does not reside in the insured home. The reimbursement request must include a medical necessity certification where the need of the service is established. The receipt must indicate the license number of the nurse, the detail of the work hours, and dates of service. Maximum benefit of $1,000.00 per policy year.
6. **Hospital Services**: Semi-private room and meals, plus other service and supplies for regular hospitalizations, mental conditions, drugs and alcoholism.
7. **Hospital – private room:** difference is covered, up to $25, daily.
8. **X-ray and laboratory services** - For diagnostic and treatment purposes.
9. **Ambulatory Services for mental conditions, drug addiction and alcoholism**.
10. **Physiotherapy and rehabilitation services** - Of the type and duration prescribed by the attending physician and provided by or under the supervision of a physiatrist. In these cases, supervision does not require the direct intervention (face to face) of the physician, but needs to be available in the location to evaluate and recommend a change in the treatment plan.
11. **Chiropractor manipulations: are covered, up to $500 per policy year.**
12. **Services in ambulatory surgical centers**
13. **Orthotic training** - Recommended by a physician in written form and provided by a qualified technician or optometrist.
14. **Radioactive Treatment**

Major Medical Benefits Covered (Cont.)

15. 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. 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.

b. Allergy test and inmunizations

c. 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.

d. Services rendered by non-participant facilities and providers.

e. Intravenous or inhaled anesthetics applied at the dentist's or dental surgeon's office.

f. Pre and postnatal services

g. Tuboplasty

h. Vasovasostomy

i. Respiratory therapy

j. Artificial eyes, lenses after a cataract extraction surgery

k. Intraocular lenses

l. Orthopedic shoes covered, up to two (2) pairs, per policy year, and orthopedic materials

m. Nuclear medicine test

n. SPECT covered up to one (1) test per policy year.

o. Magnetic Resonance (MRI) covered up to one (1) test per policy year.

p. Computerized Tomography

q. Non-participant provider Hospitals: Cover the differences between the semi-private room and ancillary services in non-participating hospitals in Puerto Rico.

r. Participating Provider Hospitals: Cover semiprivate room, other services and supplies. It also covers the difference through the room, up to $50.00 per day.

Major Medical Limitations

1. Each person or insured family member is responsible for the 20% coinsurance of the major medical expenses.

2. Cash Deductible:

   a. Per person -$100.00 per policy year
   b. Per family - $300.00 per policy year

3. Each insured will be responsible, after accumulating the cash deductible, for 20% of the covered medical expenses, up to a maximum of $5,000 per policy year.

4. Each insured family will be responsible, after accumulating the cash deductible, for 20% of the covered medical expenses.

Tissue and Organ Transplant

ELIGIBILITY
This benefits will be available for all al employees classified as active and the direct dependents insured in Triple-S Salud's basic hospital, surgical-medical and ambulatory service policy; as long as they fulfill the eligibility criteria established by the employer and hose dispositions applicable by law. Optional dependents are not eligible for this coverage.

In case the main insured or its spouse reach sixty-five (65) years of age during the effectiveness of the policy, the premium and applicable coverage of said insured's will be kept unaltered until the insurance renovation date.

BENEFITS
Benefits under this policy are subject to the terms and conditions established for such. Benefits are offered exclusively to those insureds with permanent residence in the Service Area.

The mainholder and its direct dependents will have equal benefits. Triple-S Salud is responsible for the payment of services rendered to the insured subject to the dispositions of this insurance policy and the following conditions:

1. Benefits covered are for each policy year and each person insured by this policy, except established otherwise. The benefits that are not used within a policy year, will not accumulate for the next policy year.

2. Triple-S Salud does not compromise to designate the Transplant Network physician, facility or laboratory to render their services to the insured members.

3. Triple-S Salud or its authorized representative could require a second medical opinion, with physicians designated by the company, when considered necessary.

4. The insured, physician, hospital facility and Transplant Network facility will be informed about the pre-certification procedure. In those cases that Triple-S Salud requires a precertification previous to the rendered services, Triple-S Salud will not be responsible for the payment of such services if they are received without such precertification from Triple-S Salud or its authorized representative.

The benefits are limited to human organ and tissue transplant and are subject to Precertification by Triple-S Salud or its authorized representative. These services are covered only through Triple-S Salud contracted facilities and outside of Puerto Rico. Triple-S Salud covers a 100% of the established fees by Triple-S Salud with these providers and facilities, subject to no coinsurance or deductible.

MEDICAL COVERED EXPENSES

1. **Organ transplant** - heart, heart/lung, lung (single and double), liver, pancreas/kidney and kidney transplant are covered. The expenses for the transplant are covered as follows:

   a. Recipient - expenses directly related to the transplant procedure including evaluation, pre-operative surgical and post-operative care, transplant, and immunosuppressive drugs.

   b. Organs (Procurement) – expense or services rendered or related with the obtainment, conservation, and transportation of the organs to be used in the transplant are covered.

   c. Transportation, meals, and lodging expenses – The maximum limit of covered expenses for transportation, meal, and lodging plan is $10,000 for each kind of transplant.

      1) Transportation – to and from the place of the surgery for the patient and its companion. If the patient age is a minor under nineteen (19) years old, transportation for two companions will be covered (parents or the persons holding the legal custody of the patient).

2) Meal and lodging - up to a maximum of $150 per person or $200 daily for two people (parents or the persons holding the custody of the patient who is under nineteen (19) years old).

d. Re-transplant

Bone marrow transplant- covers allogeneic, autologous, syngeneic, and hematopoietics stock cells transplants are covered if they are related to the following conditions and illnesses: breast cancer, non-malignant hematological disorders as plastic anemia, acute lymphoblastic leukemia, acute non-lymphoblastic leukemia, acute myeloblastic leukemia, acute and cronic myeloblastic leukemia in remission, infantile malignant osteopetrosis, Wiskott-Aldrich syndrome, Hodgkin disease, lymphomas others than Hodgkin's type, advanced step neuroblastomas and severe combined Immunodeficiency.

The following expenses for this transplant are covered:

a. **Receiver:** covers the expenses directly related with the procedure; includes the evaluation, pre-surgical care, transplant, post-surgical care, and immunosuppressive drugs.

b. **Bone marrow donation and storage:** Expenses and services rendered or related with the obtainment, preservation, and transportation of the tissues to be used in the covered transplant.

c. Pre-transplant **chemotherapy and/or irradiation treatment** before the transplant

d. **Ambularoty Care**-Post-transplant outpatient care directly related to the transplant

e. **Transportation, meals, and lodging** – the maximum limit of covered expenses for this transportation, meals, and lodging plan is $10,000.00 for each kind of transplant.

1) Transportation – from and to the place of the surgery for the patient and one companion. If the patient is minor than nineteen (19) years of age, the transportation will be covered for two companions (parents or the persons holding the custody of the patient).

2) Meals and lodging – up to a maximum of $150.00 daily per person or $200.00 daily per two persons (parents or the persons holding the custody of the child if the patient is minor than nineteen (19) years of age).

f. **Re-transplant**

Tissue and Organ Transplant

Precertifications : Precertifications Procedure for Organ and Tissue Transplant cases

1. The prescription for the transplant service will be done immediately via telephone, fax or personally at Triple-S Salud, through the information room.

2. The eligibility and coverage will be verified.

3. Once the coverage is confirmed, the specialty of the physician that made the referral will be verified and if the referral meets all the previous established medical criteria. This is in reference to all limitations and contradictions for the different types of transplants.

4. The Triple-S Salud transplant specialist will offer an initial orientation about the transplant coverage and its alternatives. A precertification will be issued for the referral to one of the Triple-S Salud Transplant Participants Network.

5. Triple-S Salud will coordinate with the selected institution in representation of the insured and the physician, the referral to receive the Transplant services, subject to it (the selected institution) be part of the Triple-S Salud's Transplant network.

6. The Transplant Program of the selected Institution will coordinate a clinical evaluation for the transplant candidate, based on its criteria for patients selection and will keep a direct communication with Triple-S Salud.

7. The insured will request a precertification from Triple-S Salud for the transplant services throughout all its stages.

Triple-S Salud and the selected institution will coordinate all claims for the transplant services.

PHARMACY COVERAGE (FP-17)

Benefits

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

This benefit follows the Food and Drug Administration (FDA) guidelines. These include dosage, drug equivalence and therapeutic classification, among others.

In this coverage, the dispensing of generic drugs is the first option, when the generic drug is available.

This policy covers generic or brand-name medications which label contains the legend «Caution: Federal law prohibits dispensing without prescription», insulin, sex hormones, oral vitamins, drugs for pain (Nubain and Stadol), implants/Zoladex, psoriasis shampoo Capex, drugs for oral or injectable chemotherapy and new drugs in the market. 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 program at participating pharmacies.

Persons insured under an individual plan, a complementary coverage to the Medicare Program (also known as Medigap) or a Medicare Advantage plan, will not be entitled to the benefits offered under this coverage.

The benefits are covered as follows:

1. **Services Rendered by Participating Pharmacies**

   If the medications are supplied by a participating pharmacy, it shall not charge or collect from the insured any amount in excess of the deductible or coinsurance established.

2. **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 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. The medications are covered only when provided by pharmacies located in the United States of America or its possessions.

<table>
<tr><th>Benefits Description</th><th>You Pay</th></tr>
<tr><td>Coverage Type</td><td></td></tr>
<tr><td>This pharmacy coverage has the following principal characteristics:
• Dispatch of medications without to a List of Medications.
• Generic drugs dispatch as first option.
➢ Generic drugs will be dispensed as the first option, except for those drugs not available on the market. If the insured does not choose the generic drugs as first option, he/she will have to pay the copayment for generic drugs in addition to the difference in cost between cost of the brand-name drug and the cost of the generic drug.
➢ This pharmacy benefit requires the use of first line prescription drugs (first step) prior the use of other specific prescription drugs (second line) which are not recommended as an initial treatment to treat the same condition. The edit is assigned by our Pharmacy and Therapeutics Committee, as a clinical protocol for the use of a prescription drug after evaluating its safety, efficacy and cost and do not apply to plan members that are <u>stable</u> with the use of second line prescription drugs.</td><td>$10.00 for generic drugs

$15.00 for brand-name drugs

Nothing for chemotherapy drugs

$0 copayment 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.</td></tr>
<tr><td colspan="2">Supply</td></tr>
<tr><td colspan="2">1. The amount of medications supplied, as originally prescribed, shall be limited to a fifteen (15) uninterrupted day supply for non-maintenance medications.

2. Supply for thirty (30) consecutive days for some maintenance medications and for tranquilizers included in the benzodiazepines family. Refer to the Limitations section.

3. The amount of medication supplied, as originally prescribed and shall be limited to one (1) supply and up to five (5) refills for medications with a thirty- (30) day supply. The prescriptions must include a written notice from the physician surgeon authorizing the repetition.

4. Prescriptions issued by physicians with no instructions for use or amount of medication stated shall only be dispensed for a forty-eight (48) hour supply. Example: A physician writing the following instructions: “Use when necessary (PRN, by its Latin acronym)“

5. Medications shall not be refilled before a 75% of the supply has been used up from the day of the last dispense or after six (6) months from the date of the original prescription, except as otherwise is established by the legislation regulating the dispensing of controlled prescription drugs.</td></tr>
</table>

Limitations

1. The insured receiving services rendered by non-participating pharmacies outside of Puerto Rico, 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. 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 a psychiatrist.

4. The generic drugs will be dispensed as first option, except when they do not exist in the market.

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

6. Over the Counter (OTC) drugs covered include: Prilosec® OTC, Claritin®, Zyrtec® OTC, Zaditor® OTC and its generic version, as well as any other drug Triple-S Salud decides to include. Some doses of aspirin are covered for insured 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.

General Dispositions

- It will be required to present the insured card to the Triple-S Salud participating pharmacy when services are received to obtain benefits under this coverage. When medications are dispensed, the insured shall sign for the services received and present a second identification with photograph.

- If your physician surgeon prescribed a medication not covered in your pharmacy benefit, he/she can make you a new prescription with a covered medication. This applies when therapeutic classification is covered and other treatment options are available.

- The continuous use of medication to treat a chronic disease is not considered as an abuse by the standards of the medical practice. Triple-S Salud reserves the right to cancel the contract or recover expenses made to any insured person when it is identified that the use of a medication is assigned to maintain some condition considered as an addiction or when the use of that same medication establishes an abuse of it, according to the methods accepted in the medical practice, even when this medication has been ordered by a physician surgeon, dental surgeon or podiatrist and aggress with the other terms of the coverage.

- Triple-S Salud pharmacy network will provide covered services to all eligible insured according with the pharmacy benefit manager contracted fees.

- A pharmacy is not obligated to fill a prescription if by any reason according to its professional judgment, the same should not be filled. This does not apply to decisions made by pharmacies related to the fees established by Triple-S Salud.

DENTAL COVERAGE (DF-89)

DENTAL BENEFITS

Basic Services

Triple-S Salud dental coverage provides those services necessary to maintain your oral health in optimum conditions.

This certificate is issued in consideration of the payment in advance, by your employer, of the corresponding premiums and will be subject to the terms and conditions of the basic coverage that are not in conflict with the benefits and conditions of this coverage.

Maximum Benefit: $1,000.00 per insured person, per policy year.

The maximum benefit does not apply to preventive, restorative, extractions, endodontic and diagnostic services rendered to children under nineteen years (19) of age. required by federal laws *Patient Protection and Affordable Care Act, Public Law No*. 111-148 (PPACA) and the *Health Care and Education Reconciliation Act* de 2010, *Public Law No*. 111-152 (HCERA) and according to the United States Preventive Services Task Force are covered under this policy.

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. Dental prophylaxis (cleaning) 7. Topical fluoride treatment for children under nineteen (19) years of age.	20% coinsurance
B. Restaurative, Surgical and Other Services 1. Amalgam restorations 2. Composite resin restorations on anterior and posterior teeth 3. Endodontic services in anterior, premolar, and molar teeth 4. Endodontic retreatment in anterior and premolars and molars 5. Apicectomy on anterior, premolar, and molar teeth 6. Inlays, onlays; porcelain 7. Crown recementation 8. Post and core construction 9. Partial denture repair 10. Bridgework recementation 11. Oral surgery and extractions (pre and post operative care) 12. Surgical repositioning of impacted teeth 13. Alveoloplasty 14. Palliative treatment 15. Occlusal adjustment 16. Occlusal ferula	20% coinsurance, except: Composite resin restorations: on posterior teeth 30% coinsurance Endodontic services, retreatment, apicectomy, inlays, recementation, post and core construction 50% coincurance Bridgework recementation 50% coinsurance Surgical repositioning of impacted teet 50% coinsurance Alveoloplasty 50% coinsurance

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) service, per insured, 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 insured and no more than one (1) pair of bitewing x-rays every policy year, per insured.
4. 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 insured turns nineteen (19) years of age.
5. Amalgam and of composite resin restorations are limited one (1) every two (2) years per tooth per surface.

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 insured (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	50% coinsurance

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 not covered for replacement only after five (5) years from the date the original bridge or denture was made.

Periodontal Services	
COVERED SERVICES 1. Periodontal examination 2. Gingivectomy and gingivoplasty 3. Bone surgery related to periodontal infections 4. Mucogingival surgery 5. Soft tissue and bone grafts; and membranes for tissue regeneration 6. Provisional splinting – extracoronal 7. Scaling and root planing 8. Periodontal maintenance 9. Full mouth debridement. The costs for periodontal service are covered based on the fees designated for such purposes, until the limit established is reached.	50% coinsurance

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	Reimbursement of 50% based on submitted charge.

LIMITATIONS TO ORTHODONTIC SERVICES

1. Benefits will be available to the eligible employee and his/her direct dependents.
2. Orthodontic services are covered up to nineteen (19) years of age of the insured.

REIMBURSEMENT

Orthodontic services are reimbursed based on submitted charge for these purposes based on direct compensation to the insured and subject to the following conditions:

1. Orthodontic services are reimbursed at a 50% of submitted charge until the complete maximum benefit is reached.
2. Maximum benefit - The insured person is entitled to receive orthodontic services covered, until the maximum lifetime benefit of $1,000.00 is reached.

Precertification

The prosthesis, periodontal, and endodontic pretreatment 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 insured, 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 insured 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 Insured

If the service is rendered outside of Puerto Rico by a non-participating dentist, Triple-S Salud will pay the insured 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 an insured, as if the services had been rendered in Puerto Rico.

Individual Eligibility

In this coverage, the eligibility ceases when the insured turns 65 years 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.

BASIC COVERAGE EXCLUSIONS

The 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 insured is not legally obliged to pay. Such services will also be excluded when they are denied by the government agencies concerned 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 commission of a crime or violation of the laws of the Commonwealth of Puerto Rico or any other country by the covered person 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.

6. Services rendered by health professionals, who are not doctors of medicine or odontology, except audiologist, podiatrists, optometrists, clinical psychologists, 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 an insured to any participating provider despite not being required to do so by this contract.

9. Services that are medically unnecessary, services considered experimental or investigative in nature, as defined in the Federal Food and Drug Administration (FDA), U.S. Department of Human and Health Services (DHHS), the Commonwealth's Department of Health, or services that are not in accord with the medical policy established by the Technology Evaluation Coverage Manual (TEC) of the Blue Cross and Blue Shield Association for specific indications and methods ordered.

10. Expenses or services for new medical procedures not considered experimental or of an investigative nature until such time as Triple-S Salud determine its inclusion in the coverage offered under this policy. Besides, medical expenses related to clinical trials, tests and medications administered to be used as part of the studies, are not covered neither the medical expenses that must be paid by the entity carrying out the study. This provision also applies when the insured enrolls to the clinical trial to treat an illness that should threatens his/her life, for which there is no an effective treatment and obtain his/her physician authorization for participate in the study, because this one offers the patient a potential of life. In this case, Triple-S Salud will cover the patient's routine medical expenses, be it understood that Triple-S Salud does not consider the medical expenses related to the clinical trial, the tests to be used as part of the study or the expenses that must be paid by the entity conducting the clinical trial. Once included in coverage, Triple-S Salud will pay for those services an amount that is not greater than the average amount it would have paid if the medical service had been rendered through conventional methods, until such time a fee is established for those procedures.

11. Expenses for cosmetic surgery or beautification, treatment to correct defects of physical appearance, mammoplasties or

plastic reconstruction of the breast to reduce or increase its size (except for a reconstruction after a breast cancer mastectomy), rinoseptoplasty, septoplasty, surgical intervention and medical treatment whose purpose is to control obesity, except for morbid obesity treated in Puerto Rico; liposuction treatment, abdominoplasty and abdominal rhytidectomy, and sclerotic solutions injected into varicose veins of the legs. In addition, hospital, medical/surgical services and complications associated to these are excluded independently of the existence or nonexistence of medical justification for the procedure.

12. Expenses for orthopedic or orthotic devices, prosthesis, or implants (except for breast prosthesis after a mastectomy) among other artificial instruments. Hospital and medical/surgical services necessary for implantation of these will be covered.

13. Expenses for contraceptive methods, except those required by federal laws Patient Protection and affordable Care Act, Public Law No. 111-148 (PPACA) and the Health Care and education Reconciliation Act of 2010, Public Law No. 111-152 (HCERA). In addition, it excludes those related services and the complications associated with these.

14. Surgical intervention whose purpose is to surgically reestablish the ability to procreate. In addition, hospital services and employed complications are excluded.

15. Services for treatment for infertility or related to insemination through artificial means. In addition, hospital and medical/surgical services, and related complications are excluded.

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

17. Expenses brought about by the transplant of organs and tissues (e.g., heart, heart-lung, kidney, liver, pancreas, bone marrow, etc.). Additionally, hospitalization, pre-transplant evaluation, complications, chemotherapy and immune suppressant medications related to transplants are excluded. Those organ and tissue transplants specifically included in the policy will be covered.

18. Expenses for medical services in acupuncture treatment, tympanometry, and interpretation of fetal monitoring.

19. Expenses for sports medicine, natural medicine, musical therapy, psychoanalysis, and cardiac rehabilitation.

20. Expenses for occupational therapy or speech therapy, except for those that are rendered as post-hospitalization services and BIDA Law.

21. Intravenous analgesia services or analgesia administered through inhalation in the office of the oral surgeon or dentist.

22. Dental or odontology. In addition, hospital, medical/surgical services and complications associated to them.

23. Services necessary for the treatment of the temporomandibular articulation syndrome (articulation of the jawbone) whether by the application of prosthesis devices or using any other method to correct the condition.

24. 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 exostosis (mandibular or maxillary torus, etc.).

25. Expenses related with materials for orthognatic surgical (Mandibular and maxillary osteotomy [Le Fort])

26. Expenses for allergy immunotherapy.

27. Services rendered covering an induced abortion.

28. Services rendered in Ambulatory Surgery Centers for procedures that may be performed in the surgeon's office.

29. Hospitalizations for services or procedures that can be performed in an ambulatory manner.

30. Expenses for services resulting from the administration of an employer drug detection program as well as any rehabilitation treatment if the insured

results positive. If the insured enrolls in a rehabilitation treatment because of the positive result in the drug detection test, he/she is eligible to the rehabilitation treatment benefit covered by this policy whenever it is not related to the mentioned program.

31. Expenses brought about by war or international armed conflict.

32. Laboratory tests that do not have codes in the laboratory manual, will be evaluated individually before being considered for payment and Triple-S Salud determines its' inclusion or exclusion in the coverage under this policy. Triple-S Salud will determine the laboratory tests that will be covered under this policy. The laboratory tests considered experimental or investigative will not be considered for payment by Triple-S Salud.

33. Expenses for oral chemotherapy services in ambulatory manner.

34. Immunizations for intentions of trips or against occupational dangers and risks.

35. Expenses for sea ambulanceServices rendered by residential treatment facilities outside of Puerto Rico, whether a medical justification exists or not.

36. Surgeries for the removal of excess skin, except if the physician certifies that it is necessary to remove the skin because it affects a body part function.

37. Expenses for services rendered to optional dependents, be it understood immediate family members of the insured, who are not eligible as direct dependents, except the defined by Law as the definition of optional employees establishes.

38. Genetic tests.

39. Expenses for magnetic resonance (MRI and (MRA).

40. Expenses for Single Photon Emission Computerized Tomography (SPECT).

41. Expenses for home blood glucose monitor and wheelchair.

42. Expenses for Chiropractor manipulations.

43. Keloids.

44. Expenses for studies and laboratories sent out of Puerto Rico.

45. Expenses for acne surgery.

46. Expenses for cryotherapy and amniocentesis.

47. Expenses for intraocular lens, valves and pacemakers.

MAJOR MEDICAL COVERAGE EXCLUSIONS

The exclusions of the Basic Coverage for hospitalization, medical-surgical, and ambulatory services will apply to this coverage, except those services that are specifically mentioned as covered services. The excess of the established limitations in the basic coverage will be covered without limit, (not be covered) or as provided by this coverage.

This coverage does not cover the following expenses:

1. Those caused by war or armed international conflict.
2. Dental services for the care and treatment of teeth and gums.
3. Eyeglasses, orthopedic or orthotics instruments, except those needed due to accidental injuries.
4. Services during confinement in an institution which is, primarily a school, an institution for training, a place of rest, a place for the aged, or a nursing home.
5. Services rendered by a social worker including a psychological or psychiatric social worker.
6. Air or sea ambulance services.
7. Services for chronic renal disease such as dialysis and hemodialysis, including hospital and medical-surgical services and associated complications.
8. Expenses for copayments and coinsurance that are applicable to the basic policy of hospitalization, medical-surgical, ambulatory services, and its riders.
9. Expenses for post-hospitalization services in a Skilled Nursing Facility Care or in a Home Health Care.
10. Expenses for hearing aids and auditory tests (for measure and adjustment of the aids).
11. Sports Medicine.
12. Rent or purchase of a wheel chair; purchase of respiratory therapy device.
13. Magnetic resonance (MRA).
14. Mammoplasty, septoplasty, rinoplasty, and related services.
15. Services render by non-participant providers outside of Puerto Rico.

ORGAN AND TISSUE TRANSPLANT EXCLUSIONS

This policy does not cover the following expenses or services:

1. Services rendered while the policy is not in force.
2. Services available with a federal or state arrangement for which the insured person does not have to pay. Said services will be also excluded when they are denied by the related government agency, regarding breach or violation of the requirements or dispositions of the laws stated before, even when said violation or breach does not constitute a crime.
3. Services for treatment arising from the commission of a crime or violation of the laws of the Commonwealth of Puerto Rico or any other country by the covered person.
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.
6. Services rendered by health professionals, who are not doctors of medicine or odontology, except audiologist, podiatrists, optometrists, clinical psychologists, chiropractors, and others specified in the policy.
7. Reimbursement of expenses covering payments made by an insured to any participating provider despite not being required to do so by this contract.
8. Services that are medically unnecessary, services considered experimental or investigative in nature, as defined in the Federal Food and Drug Administration (FDA), U.S. Department of Human and Health Services (DHHS), the Commonwealth's Department of Health, or services that are not in accord with the medical policy established by the Technology Evaluation Coverage Manual (TEC) of the Blue Cross and Blue Shield Association for specific indications and methods ordered.
9. Expenses or services for new medical procedures not considered experimental or of an investigative nature until such time as Triple-S Salud determine its inclusion in the coverage offered under this policy. Once included in coverage, Triple-S Salud will pay for those services an amount that is not greater than the average amount it would have paid if the medical service had been rendered through conventional methods, until such time a fee is established for those procedures.
10. Expenses and services related to organ and tissue transplant or received without a precertification of Triple-S Salud or its authorized representative.
11. Expenses or services for procedures done to insureds with neurological and severe physical damage, with presence of an existent sickness that may shorten the life expectancy of the insured, or that said insured presents a bad adaptive psychiatrist or social condition.
12. Expenses brought about by war or international armed conflict.
13. Expenses for special nurses services and home visits.
14. Rendered services by air or sea ambulance.
15. Services rendered to optional dependents.

PHARMACY COVERAGE EXCLUSIONS

The exclusions of the basic coverage for hospitalization, medical-surgical, and ambulatory services apply to this coverage, except those services that are mentioned specifically as covered services. Triple-S Salud will not be responsible for the charges that correspond to the following benefits:

1. Medications which do not bear on their labels the legend: *Caution: Federal law prohibits dispensing without prescription ([OTC] over the counter),* except those medications included in the Triple-S Salud's OTC program and some doses of aspirin for insureds of eighteen years and older.

2. Charges for artificial instruments (needles, syringes, lancets strips, glucometers and similar instruments, whether used or not with therapeutically purposes.

3. The following medications are not covered whether or not they bear the federal legend: "*Caution: Federal law prohibits dispensing without prescription*" and are in the List of Medications.

   a. Cosmetic medications or any related products with the same purpose (hydroquinone, minozidil solution, efformitine, finasteride, monobenzone, dihydroxyacetone and bimatropost).

   b. Fluoride products for dental use (except for children between six months and six years of age) and dermatological conditions such as pediculosis or scabies (lindane, permetrine, crotamiton, malathion and ivermectin); dandruff control products including shampoos (phyrithione zinc 1%), lotions and soaps: baldness control treatments as Rogaine® (minoxidil topical soln).

   c. Obesity control and related medications used in its treatment (benzphetamine, diethylpropion, phendimetrazine, phentermine and mazindol).

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

   e. Infertility medications (follitropin, clomiphene, menotropins and urofollitropin), fertility medications, impotence treatment (tadalafil, alprostadil, vardefanil, sildefanil and yohimibna) or implant medications (levonorgestrel implant, goserelin, sodium hyaluronate, hyaluronan and hylan).

   f. Medications used as diagnostic tool (*thyrotropin*, *dipyridamole IV 5mg/ml, gonadorelin HCl, cosyntropin* y *glucagon*) and medications for immunization (hepatitis A & B, influenza, encephalitis, measels, mumps, poliovirus, papillomavirus, rabies, rotavirus, rubella, varicella, yellow fever, zoster, cholera, haemophilus b, lyme disease, meningococcal, plague, pneumococcal, typhoid, tetanous toxoid, diphteria, immune globulin, respiratory syncytial virus, palivizumab, pagademase bovine, staphage lyphates **and it's combinations**, allergy tests).

   g. Products used as vitamins and nutritional supplements for oral use, except for some doses of folic acid for women and some presentations of iron supplements for children between six months and twelve years of age, in compliance with the Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act regulation.

   h. Injectable vitamins (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. Medication classified as alternative medicine treatment (valerian root, european mistletoe, glucosamine-chondroitin-PABA-vitamin E, and alpha lipoic acid).

4. Products that are considered experimental or investigative for the treatment of certain conditions for which the Food and Drug Administration has not authorized their use. In addition, this policy does not cover medical expenses related to clinical trials, nor the tests and medications administered as part of the trials, or the medical and pharmacy expenses that are to be paid by the entities conducting the clinical trials. This clause is applicable even if the plan member has enrolled in a clinical trial to treat a life-threatening condition for which there is not effective treatment and if the physician has approved the plan member's participation in said trial because it offers the patient potential benefit.

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

6. Refills ordered by a dentist or podiatrist.

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

8. Also are excluded trypan blue solution, lacosamide IV, carmutine intracranial implants (wafer), degarelix acetate IV, viaspan, sodium tetradecyl sulfate, polidocanol, morrhuate sodium, intrapleural talc, peritoneal dialysis solution, and homeopathic products in all presentations.

9. Medications for organ and tissue transplant (cyclosporine modified, tacrolimus, sirolimus, cyclosporine, mycophenolate sodium, everolimus, azathropin, belatacept and basiliximab).

10. Blood and its components (hetastarch 6%/NaCl IV, rheomacrodex IV, human albumin and plasma protein fraction).

11. Contraceptives that are not approved by the FDA. In addition, you will not cover contraceptives approved by the FDA without presentation of a doctor's prescription.

12. Acne medications (*adapalene, benzoyl peroxide, isotretinoin, sulfur, tretinoin, clindamycin phosphate topical, erythromycin topical, sodium sulfacetamide/sulfur and it's combinations*).

13. Smoking control products, *(bupropion HCL (smoking deterrent), varenicicline).*

14. Growth hormones *(somatropin, somatrem).*

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

16. Anaphylaxis medications *(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. All dental services that are rendered for beautification purposes.
5. Temporomandibular (TMJ) syndrome treatment
6. Expenses for device replacements or repairs provided under orthodontic services.
7. Expenses for space maintainers, pulp vitality test, and fissure sealants.
8. Expenses for stainless steel crowns in deciduous teeth.
9. Expenses for provisional crowns.

REIMBURSEMENTS PROCEDURE

Claims for reimbursement:

a. Must be sent to: Triple-S Salud, Inc. PO Box 363628, San Juan, PR 00936-3628; and

b. Must include the following:

- Name and contract number of the insured who received the service.
- Date of service
- Diagnosis code (ICD-9)
- CPT code
- National Provider Identifier (NPI)
- Stamp or letterhead with provider's name, address, and specialty
- Number and description of services received
- Amount paid
- Provider or participant signature and licensee
- 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 .
- In cases where surgical assistance was needed, please send a copy of the surgery report indicating the participation of the surgical assistant. If the surgery report does not indicate the participation of the surgical assistant, please submit a certification from the surgeon.

To request reimbursement for pharmacy services include:

- Official receipt from the pharmacy.
- Name and number of the contract of the insured receiving the services.
- Name of the medication
- Daily dosis
- Number of the prescription
- Amount dispensed
- National code of the medication (NDC)
- National Provider Identifier (NPI) of the pharmacy and the doctor who prescribes
- If you paid a participating pharmacy: indicate the reason
- Indicate cost per medication

To request reimbursement for dental services include:

- Service code, tooth number, number of surfaces, and amount paid for each service.
- If the insured pays more than one visit in one receipt, he/she must send the exact dates (**MONTH, DAY, YEAR**) when he/she paid for the services.
- If it is orthodontic treatment plan must include the detail of: first visit, down payment, monthly payments, total cost and duration of treatment.
- Dental prosthesis and periodontal services must include X-rays.

To request reimbursement through Coordination of Benefits add:

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

2. You must send Triple-S Salud written notice of the claim within 20 days following the date the service was received, or as soon as it is reasonably possible for the insured person 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 designated by the insured to receive claims on his behalf will be considered notifications sent to the insured, as long as the authorization is valid and has not been revoked. If the person is not authorized, and receives a notification on behalf of the insured, the person must inform it to the claimant within the next 7 days and must indicate us the name and the address of the person that should receive the notification.

4. Triple-S Salud will conduct the investigation, make the adjustment and solve any claim in the shortest period within 90 days after it received the request. If Triple-S Salud cannot solve the situation within the term 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 delayed unduly and unreasonably.

PRECERTIFICATION

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 establish coordinated care measures to ensure that hospital and ambulatory services are rendered in an adequate place, at the moment needed and by the adequate professional. It also helps to verify the insured's eligibility for the service he/she is requesting.

The physician, hospital, or facility are oriented on those services must be preauthorized. The Precertification may be for a hospital or for ambulatory services.

Requests of preauthorization for studies and procedures will be made by the attending physician, the clinical personnel he/she designates or the facility where you will receive the service. The person may call to Triple-S Salud Preauthorizations Department, Triple-S Salud' call center that attends to these cases Monday to Friday from 7:00 a.m. to 6:00 p.m. Providers can also precertify some tests and procedures using our portal on the Internet www.ssspr.com available 24 hours 7 days.

Some of the services for which you or your physician must request a Precertification to Triple-S Salud, as long as your coverage includes them, are:

Organ and tissue transplants
Services in the United States
Maxillary or mandibular osteotomy

For Precertifications or if now you need a medical service you have any question 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

PRECERTIFICATION PROCEDURE

Triple-S Salud has 15 days from the receipt of the precertification for elective procedures to:

a. Notify their benefit determination; or

b. Request you additional information. You will have 45 days to provide the information requested.

c. Inform you that they need more time to make their determination. This extension may be of up to fifteen (15) days.

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 attending 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 care or treatment for which precertification is requested. In said cases, the attending physician must certify the urgency of the precertification. The request in these cases may be oral or in writing. 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 48 hours 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 date of expiry 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 code of the denial and its meaning, as well as a description of the standards, if any, used for the determination;

- Reference to the specific provisions of the plan on which they based their determination;

- 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 and expedite review procedures, including the terms 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 person free of charge;

- If the adverse determination considered the judgment of medical necessity, in the experimental or investigative 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 person.

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 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 Health 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 that Triple-S Salud requests or the one on which you based 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.

PRECERTIFICATIONS FOR PRESCRIPTION DRUGS

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

The physicians and the pharmacies are instructed on the prescription drugs that must be precertified.

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

PROCEDURE FOR THE TRANSMITTAL OF PRECERTIFICATIONS

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

a. Notify its determination or

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

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

If Triple-S Salud does not make a determination regarding the precertification request or notifies the insured within the established term (72 hours; 36 for controlled prescription drugs) the insured 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 in the coverage.

Triple-S Salud will make a determination regarding the exception request before the person finishes the prescription drug dispensed. If the determination is not made or 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.

EXCEPTION PROCESS FOR PRESCRIPTION DRUGS

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

Types of exceptions

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

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

How to make the request

The insured, his authorized representative, or the prescribing physician can request the exception request through:

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

Information required for the approval of your exception request

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

- Name of the patient
- Contract number
- Primary diagnosis
- Reason for which the insured cannot use none of the prescription drugs:
    - In the formulary that is a clinically acceptable option to treat the illness or the medical condition; e
    - The first step prescription drug in step therapy
- Reason for which a greater dose is required or why the physician prescribes another prescription drug of the same therapeutic category.

How Triple-S Salud processes a prescription drug by exception

Triple-S Salud has a timeframe of 72 hours from the date it receives the request, or the date of receipt of the communication, to notify the insured or his personal representative its determination on the exception request. In case of controlled drugs, the term will not exceed 36 hours. If we do not receive the information, we will proceed to close the request and will send a notification the person. However, closing the application request does not mean that the insured person cannot submit such claim again.

Triple-S Salud will request the prescribing physician or the pharmacy the information necessary to evaluate the request by telephone, fax or any other electronic means.

In case it was the insured the one who submitted the request, the person will be contacted by telephone and will be indicated the additional information that must be provided by the prescribing physician to evaluate the case, the time he has to send it and the fax to which he must send the information.

If we do not receive the information within the timeframe set, we will proceed to close the case for lack of information. We will notify in the denial letter the appeal process and the details of the information that was missing. The notification will be sent to the insured person and, if applicable, to his personal representative and the physician prescribing the prescription. However, closing the request does not mean that the insured person cannot submit said claim again.

If Triple-S Salud, does not make its determination within the timeframe set (72 hours; 36 hours for controlled drugs) the insured will be entitled to receive a 30–day supply of the drug object of the 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 exception request before the person finishes the prescription drug provided. If the determination is not made and the notification is not issued during this period, coverage will be maintained in the same terms and continuously. This, as long as the prescription drug is being prescribed and is considered to be safe, and until the limits of the applicable benefits are fully spent.

Coverage-determination-notification process

The process for notifying a denial in cases that do not comply with the non-coverage criteria of the Formulary, precertification, step therapy, quantity limit, duplicate therapy, use not approved by the FDA, includes:

- The specific reasons for turning the request down;
- References to the evidence or documentation, which include the clinical review criteria, practice guidelines as well as clinical and medical evidence considered to make the determination to deny the request;
- Instructions on how to request a written statement of the clinical, medical or scientific justification for turning the request down; and
- Description of the process and the procedures to submit a grievance to appeal the denial.

The denial will be issued in a manner that the insured person can easily understand, or if applicable, easy to understand to his personal representative. If we turn down an exception request, the insured person or the physician may appeal our determination through the process of Appeals to Adverse Benefits determinations.

APPEALS TO ADVERSE BENEFIT DETERMINATIONS

Adverse determination means:

- A determination made by an insurance organization or health insurer or utilization review organization where a benefit is denied, reduced or terminated, or the benefit is not paid, partly or wholly, as when applying utilization review techniques, based on the information provided, the benefit claimed, according to the health plan, does not meet the requirements of medical necessity and appropriateness, the place where the service is provided or the level of care or effectiveness or is determined to be experimental or investigational in nature;

- The denial, reduction, termination or non-payment of a benefit, either partially or in full, by the health insurance organization or insurer or utilization review organization, based on the determination of the eligibility of the covered person or insured to participate in the health plan; or

- The determination that results from a prospective or retrospective review in refusing, reduce, terminate or not pay, partially or totally, the benefit.

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

RIGHT TO APPEAL AN ADVERSE DETERMINATION

If you disagree with Triple-S Salud's adverse determination related to a request for reimbursement, a request for precertification or any other adverse benefits determination, you may appeal Triple-S Salud's determination following the procedure outlined below:

APPEALS PROCEDURE

1. First level of appeal

You or your authorized representative (refer to the requirements for appointing a representative), you must submit your appeal, in writing, within 180 days from the date you received the initial notification on the adverse determination. When you present your appeal, you may request assistance from the Ombudsman or a lawyer of your preference (at your cost). For your appeal to be considered, it must include the following, if applicable:

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

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

Triple-S Salud will acknowledge receipt of the grievance request no later than three (3) from the date it was received and will confirm the designated representative to coordinate the review on the first level, including the information to contact the person. They will also inform you your rights on filing the complaint.

If the grievance results from an adverse determination related to a utilization review, Triple-S Salud will designate one or more clinical counterparts of the same or similar specialty of the health professionals that would usually handle the case for which the adverse

determination was made, and who did not participate in the initial adverse determination. They will also ensure that the clinical counterparts for the evaluation have the adequate expertise to evaluate the appeal.

The reviewer(s) will consider all the comments, documents and files, as well as any other information related to the review request submitted, regardless if the information was submitted or considered while making the initial adverse determination.

Besides submitting comments in writing, documents, files and other materials regarding the grievance object of the review, you have the right to receive free of charge, access to, or copies of, all the documents and files relevant to the grievance. This includes any information relevant for submitting the grievance and that:

- Were used in the determination of benefits
- Were submitted, considered or generated as a result of the adverse determination, even when the determination on the benefit did not depend on said documents, files or other information;
- Show that when making the determination, Triple-S Salud followed, in a uniform manner, the same procedures and administrative guarantees followed with other covered persons or insureds in similar conditions; or
- Constitute statements of the plan policies and rules regarding healthcare services or treatment denied and the diagnosis of the covered person or insured, regardless if they were considered or not when making the initial adverse determination.

Triple-S will notify its decision, in writing, to the insured person or to his personal representative within a reasonable timeframe, under the terms established and according to his medical condition:

- Grievances in which the insured requests a review of the first level adverse determination regarding a prospective review, within a reasonable timeframe, according to the medical condition of the covered person or insured, but never later than fifteen (15) calendar days from the date the plan received the grievance.
- Grievances in which the insured person requests a review of a first level adverse determination regarding a prospective review, within a reasonable timeframe, but never later that thirty (30) calendar days from the date the plan received the grievance.

Said determination will include:

- The titles and credentials of the evaluators that participated in the evaluation of the grievance;
- A statement on the interpretation the reviewers made on the grievance;
- The determination of the reviewers with the medical justification and the contractual basis for the insured person or his personal representative to respond to the comments;
- The evidence or documentation used as basis for the determination;
- In case of an adverse determination:
    - The specific reason for the adverse determination
    - Reference to the specific provisions of the health plan on which the determination is based
    - A statement on the rights the insured person has to access and obtain free of charge copies of the documents, files and any other relevant information used in the evaluation of the

grievance, including any rule, guideline or internal protocol or any other similar criteria used as basis for the determination.

  - If the adverse determination is based on the medical need or the experimental or investigational nature of the treatment or on a similar exclusion limitation, a written explanation of the scientific or clinical reasoning followed when making the determination, or a statement saying that a written explanation will be provided to the covered person or insured, or, if applicable, to his personal representative, free of charge upon request;

- If applicable, it must also include the instructions to request a copy of the rule, guideline, internal protocol or any other similar criteria on which the determination was based, an explanation of the scientific or clinical reasoning followed when making the determination and the description of the process to obtain an additional voluntary review, as well as the terms for this review, in case the insured person is interested in requesting it. Likewise, it must include a description on how to obtain an independent external review, if the insured person decides not to request the voluntary review and the right of the covered person or insured to file a suit in a competent court.

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

If your case is considered urgent, Triple-S Salud will notify its decision within a period that does not exceed 48 hours, from the date it receives the completed application for appeal. Incomplete applications will not be considered, until they meet the requirements thereof. An urgent appeal is understood to be an appeal request that correspond to services or medical treatment to which if the standard process of appeal is applied, a) may jeopardize the life of the plan member or the ability of a vital organ of his body to function at its maximum capacity, or b) on physician's opinion, the insured will be submitted to severe pain that cannot be adequately managed without the medical care or treatment object of the appeal.

In case of appeals to precertifications, as well as prospective reviews, Triple-S Salud must inform their decision within 15 days from the receipt of your appeal request. In other cases, Triple-S Salud must give an answer within 30 days from the receipt of your appeal request. The time to answer your grievance begins to run as soon as Triple-S Salud receives your appeal request, regardless if you submit all the documentation necessary to make the determination. If the your request for appeal does not include all the information necessary to make the determination, Triple-S Salud will notify the insured person or his personal representative the reasons why the it cannot process the grievance and will indicate the documents or additional information the insured must submit. If additional information is required, you must provide the additional information within 45 days from the date of the notification. If you do not submit the information requested within this period, Triple-S Salud will make its decision based on the documents already submitted. Triple-S Salud may also notify you that your appeal is being considered, but that additional time is needed. In this case, Triple-S Salud will have 15 additional days to notify their decision. Once Triple-S Salud notifies you its decision, you have the right to request Triple-S Salud to disclose the names and positions of the officers or experts that participated in the evaluation of your appeal, as well as an explanation of the criteria on which they based their decision.

You have the right to contact the Office of the Insurance Commissioner or the Office of the

Health Ombudsman to request their help. The information to contact these offices appears at the end of this Section, under subsection, Right to be Assisted.

2. Second level of appeal

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

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

Your second appeal will be evaluated by persons that did not intervene in the determination on the first appeal and are not subordinates of the persons who made the determination on your first appeal. Triple-S Salud previous decisions will neither be considered in the review of your request for a second appeal You have the right to request Triple-S Salud to disclose the names and positions of the officers or experts that evaluated your second appeal, as well as an explanation of the criteria on which they based their decision.

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

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

3. Voluntary Review Level

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

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

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

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

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

Triple-S Salud will appoint a review committee to evaluate your request for you or your appointed representative to appear in person or by phone before the committee to bring your appeal. If Triple-S Salud will be assisted by its legal representation, the insured person will be notified at least 15 calendar days prior to the date of the review meeting and will be told that he may be assisted by his own legal representation. If your appearance at a hearing before the panel is necessary, you will be informed the date prior to the hearing, which will take place no later than thirty days after the receipt of the request for the voluntary level review.

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

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

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

4. External appeal process

Triple-S Salud has chosen to benefit from the federal External Review Process. If after exhausting all levels of internal appeal, you are not satisfied with the final determination, you may request an external review by an Independent Review Organization (IRO), through the MAXIMUS Federal Services, free of charge for you if you comply with certain requirements, as explained below.

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

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

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

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

a) your eligibility;
b) explicit exclusion of benefits
c) defined benefit limits

Standard Independent Review Procedure

You may request an independent review of an adverse benefit determination that meet the requirements set forth in the preceding paragraphs. All requests for external review must be filed within 120 days from the date you received the adverse determination. To request an external review, you or your authorized representative may call to request an external review to the toll-free number 1-877-540-8152. You can also complete the form to request for external review and send it by fax, mail or email to the Office of MAXIMUS Federal Services as follows:

By Fax: 1-888-866-6190

Regular Mail:

MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534

By Email: **ferp@maximus.com**

Remember, the information you provide in the application form will be used to request Triple-S relevant documents, so that the independent review examiner can to complete his evaluation. You also may submit information and documents to support your application such as our denial letter, evidence of benefits (EOB) and letters from your doctors, among others. The independent review organization may also ask us to provide the information we used to make our adverse benefit determination. **If you have any questions during the external review process, you may call the toll-free number 1-888-866-6205.**

Preliminary Evaluation

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

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

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

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

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

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

Review process

The independent reviewer will review the information provided by Triple-S Salud and will send them all documents the claimant sent directly to him, within (1) business day. Once they receive all documents, Triple-S Salud might reconsider its original decision on the complaint. The external review may only end if Triple-S Salud decides to reverse its adverse benefit determination and provide coverage or payment. Triple-S Salud must provide written notice of its determination to the claimant and the reviewer within 1 working day after deciding to reverse its decision. Upon receiving this notification, the evaluator concludes the independent review.
However, if no external review is terminated for the reason stated above, the reviewer will continue the evaluation and will notify you and Triple-S Salud of the final determination within (45) days from the date you requested the external review. The notification shall include:

a) a general description of the reason for the request for external review, including sufficient information to identify the claim, the date the IRO received the request for external review and the date of its decision;

b) reference to the evidence or documentation that it considered in making its decision; The reasons for its decision, including any standard based on evidence on which the decision was based;
c) a statement that the determination is binding, except to the extent that they have remedies available under federal or state laws; and
d) a statement that judicial review may be available;

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

Expedited external review

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

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

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

Voluntary External Review

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

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

Contact Triple-S Salud at the toll-free number listed on your plan ID card, for more information on the voluntary external review process.

OPM will keep the record of your case six years and it will be available for evaluation upon your or our request.

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

You are required to exhaust all internal appeal procedures previously described before filing a complaint with the MAXIMUS Federal Services, the Court or the Office of the Insurance Commissioner.

Standard Review of Grievances not related to adverse determinations

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

Triple-S Salud will inform you about your rights within three (3) business days from the receipt of the grievance, according to said procedure and will appoint one or more persons who have not participated in the initial evaluation of your grievance.

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

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

You have the right to contact the Insurance Commissioner Office or the Office of the Health Ombudsman to request help. The information to contact these offices appears below.

RIGHT TO BE ASSISTED

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

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

RIGHT TO APPOINT A REPRESENTATIVE

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

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

Triple-S Salud may request the authorized representative to provide additional information
The insured or beneficiary is responsible of notifying Triple-S Salud, in writing, if the designation is revoked before the expiration date. The insured is entitled to the benefits to be determined, as agreed, as a result of the appeals process.

PATIENTS BILL OF RIGHTS AND RESPONSIBILITIES

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 medical and hospital health services in Puerto Rico.

Right to high quality health services

The patient has the right to receive services of the highest quality consistent with the generally accepted standards of medical practice.

Rights regarding the obtaining and disclosing of information

The patient has the right to receive accurate, reliable, and easy-to-understand information about his/her health plan such as the:

- premiums and copays to pay
- directory of providers
- 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 healthcare plans and medical-hospital service providers that are adequate and sufficient to guarantee access to high quality healthcare and services that best adjust to their needs without being discriminated for their socioeconomic condition, payment capacity, preexisting medical conditions or medical history, regardless of their age.

- Have access to a network of participating providers that is adequate and guarantees 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 work, including emergency services available 24 hours a day, 7 days a week. Any healthcare plan that offers health care services in Puerto Rico must allow each patient to receive primary healthcare from any primary care service provider the person has chosen, according to the provisions of the healthcare plan.

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

Patient's right to the continuity of health care service

In case of termination of the provider or of cancellation of the health plan, the insured member must be notified of said cancellation 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 confined in a hospital on the cancelation date and the date of release was scheduled before the termination date, the transition period will be extended to 90 days after the date of the release. In case of pregnant women, if the cancellation takes place on the second trimester, the transition period will be extended until the later of the date in which the mother is discharged or the newborn is discharged from the hospital. In case of patients diagnosed with a terminal condition before the plan's termination 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 life of the patient.

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.

- Access to emergency services by non-participating providers, subject to the copays and/or coinsurances established in the insured's policy.

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

- Right to have full participation or the participation of a person you completely trust in the decisions about his 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 comply with your decisions and preferences regarding your treatment.
- No health care plan can impose gag rules, sanctions, 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 prescription drugs, so that you can choose the facility at which you will receive the services.

Right regarding respect and the same treatment

- Right to receive the same treatment from any health service provider at every moment, 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, and only for medical or treatment purposes, unless it is required by a judicial order or specifically authorized by law.

- Obtain a receipt for expenses incurred for the total or partial payment copays or coinsurances. The receipt must specify the date of the service, name, license number and specialty of the provider, name of the patient and of 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 term 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 up to $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 service provider.

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

Rights regarding complaints and grievances

- Every health provider or insurer will have available a procedure to solve, in a fast and fair way, any complaint presented by a plan member and will have appeal mechanisms for the reconsideration of determinations.

Your responsibility as a patient is:

- To provide the necessary information about medical plans and the payment of any account. To know the rules for the coordination of benefits and notify 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.
- To provide the most complete and precise information about your health condition, including previous diseases, medications, etc. To participate in every decision regarding your medical care. To know the risks and limits of medicine.
- To know the coverage, options and benefits and other details of the health plan.
- Comply with your health plan administrative procedures.
- To notify the physician of unexpected changes in your condition.

To adopt a healthy lifestyle.

- To make known that you clearly understand the course of action
- recommended by the health professional.
- To provide a copy of your advance directives.
- To notify the physician if you anticipate problems with the prescribed treatment.
- Recognize the obligation of the provider to be efficient and equitable when providing services to other patients.
- Be considerate, so that your particular behavior does not affect other persons.
- Solve any difference through the procedures established by the insurance company.

PRIVACY PRACTICE NOTICE

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION CAN BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY. THE PROTECTION OF YOUR INFORMATION IS VERY IMPORTANT TO US.

Triple-S Salud is strongly committed to keep the confidentiality of your health information. This notice informs you our privacy practices and your rights regarding health information. We will follow the privacy practices described in this notice while it is valid.

This notice includes examples of the information we can collect and describes how we can use and disclose it. The examples are merely illustrative and should not be considered a full inventory of how we handle information.

We reserve the right to change our privacy practices and the terms of this notice, once submitted to the Office of the Puerto Rico Commissioner of Insurance and approved by the Office for its use in the policies.

Before making any significant change to our privacy policies, we will amend this notice and will mail it to all our active insureds by the date of the change.

Information we collect

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

- Information you provide in applications and other documents to obtain a product or service.
- Information obtained from transactions performed with us or with one of our affiliates.
- Information provided by credit collection agencies.
- Information provided by health care providers
- Information provided by government health programs.

We do not use or disclose genetic information to evaluate or subscribe risks.

Uses and disclosures of health information

We share information with our business partners who provide services on our behalf and participate in administrative functions of the health insurance or the coordination of your benefits. We only share the minimum information necessary, require that each business partner signs contract committing to maintain the confidentiality of the information shared, and limit the use of the information to the purposes stated in the contract. If the business partner goes out of business, we will keep your information to continue providing your services.

In our health insurance or benefits administrative functions, we may use or disclose information without your authorization for activities regarding medical treatment, payment of medical services and health care operations. For example:

Treatment: To a medical services provider to provide you treatment.

Payment: To pay for the services rendered to you, determine your eligibility to the services under the policy; coordinate benefits; collection of premiums and other related activities.

Healthcare Operations: For legal and audit services including detection of fraud and abuse and compliance, as well as planning and development of business, administrative activities and business management, patient safety management, credentialing, disease management and training to medicine and pharmacy students.

We can use or disclose your health information to another entity related to you, which is also

subject to federal or local regulations on confidentiality.

Help in case of disasters and emergencies

Government benefit programs

Health and Public Safety: We can use or disclose health information as allowed or required by law for the following purposes:

- Public health activities, including disease statistics and vital information, among others;
- Report child abuse or negligence or domestic violence against adults
- Activities of regulatory agencies
- Answers to court or administrative orders;
- To law enforcement officers or national security affairs
- To prevent an imminent threat to public health or security
- For scientific research activities
- As authorized by employee work compensation laws
- As required or allowed by applicable laws

Services regarding your health: We can use your health information to offer you information on benefits and services regarding your health or treatment options that may interest you. We will use your information to call or write to you to remind you 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 persons for any purpose. Activities such as marketing of products that are not health related or the sale of health information require your authorization. In these cases the insurance, the insurance policy and your benefits will not be affected if you deny the authorization. The authorization must be signed and dated by you, and indicate the person or entity to receive the information, a brief description of the information to be disclosed and the expiration date, which will not exceed 2 years from the date in which the authorization is signed, unless the authorization was signed for one of the following purposes:

- To sustain a request of benefits under a life insurance policy or for the rehabilitation of said policy or changes of benefits under said policy, in which case the authorization will be valid for thirty (30) months or until the request is denied, whichever happens first; or
- To support or facilitate the continuation of an ongoing treatment for a chronic ailment, chronic disease or the rehabilitation of an injury.

The information used or disclosed according to the authorization provided by you may be disclosed again by the recipient of the information if it is not protected by the applicable privacy laws.

You have the right to revoke the authorization in writing at any moment, but the uses or disclosures allowed by your authorization while it was valid will not be affected. Unless you send us a written authorization, we will not be able to use or disclose your medical information for any other reason described in this notice.

Individual Rights

Access: You have the right to examine and receive a copy of your personal, financial, insurance or health information, related with your subscription or claims within limits and exceptions provided by law. To this end, you must submit a written request. When we receive your request, we will have thirty (30) days to perform one of the options listed below:

1. Request additional time
2. Provide the information requested and if it is not possible, provide a copy or allow you to examine the information during business hours
3. Inform you that we do not have the information requested, in which case we will indicate, if we know, where you should go to request it.
4. Deny it, totally or partially, because the information comes from a confidential source or it was collected in preparation for a trail or during an investigation carried out by law enforcement officers, anti-fraud unit or for quality assurance programs, in which case, disclosure is prohibited by law.

   The actual term will be notified prior the expiration of the original term with an explanation for the delay.

The first report you request will be free of charge. We reserve the right to charge a fee for subsequent reports. If you request the information in an alternate format, other than the one established for this purpose, you may have to pay an additional fee for the requested report.

In case the request is denied totally or partially, we will notify you in writing the reason for our denial. It will not be required to notify you in cases in which the information is part of an investigation duly constituted by law or in preparation for a trial.

Disclosures Report: You have the right to receive a list of the instances, since April 14, 2003, in which us or our business partners have disclosed your health information for issues not related to medical treatment, payment for health services or healthcare operations , or as authorized by you. The report will indicate the date in which the disclosure was made, the name of the person or entity to which your information was disclosed, a description of the information disclosed and the reason for the disclosure. If you request this report more than once during a twelve (12)-month period, we may charge you the costs for processing the additional requests. The report only covers the last six (6) years.

Restrictions: You have the right to request that we implement additional restrictions to our handling of your medical information if said disclosure can constitute a hazard to your safety, such as not disclosing information to a spouse to prevent domestic violence. Unless otherwise provided by the law, if you request it in writing, we will not disclose confidential health information on reproductive health, sexually transmitted diseases, substance abuse, behavioral health, which include notice of appointments sent by mail, home telephone calls to confirm appointments or mailing of invoices or explanations of benefits. We will not disclose, without the expressed consent of a minor that can obtain health care without the consent of one of the parents or guardian, and according to state and federal laws, any confidential information to which the minor has legally consented. Your request and our agreement to implement additional restriction in handling must be in writing and signed by an authorized officer.

Confidential Communication: You have the right to request that we contact you regarding your medical information through alternative means or to alternate locations. You must make your request in writing and must explain why the information could endanger you it is not sent confidentially. We may accept your request if it is reasonable, specifies the alternative means or alternate locations for confidential communication, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits.

Amendment: You have the right to request that we amend your medical information. Your request must be in writing, and must explain and justify the amendment requested. We may deny your request if we do not originate the information you request to be amended or if who originated the information is available to receive your request. If we deny your request, we will provide you a written explanation. You may request to include a statement indicating your disagreement with our determination on your request. If we accept your request, we will make reasonable efforts to inform others, including business partners, and we will include the amendment in any future disclosures of that information.

Going out of Business: In the event we go out of business, we will contact you to inform you how to obtain your claim history and other necessary information.

Notice of security breaches in which your health information may be at risk: You have the right to be notified through any means if the security breach results from not having your information secured by technologies or methodologies approved by the United States Department of Health and Human Services.

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

Questions and Complaints

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

If you understand that we, or any of our business partners, have incurred in a violation to your privacy rights, or you do not agree with any of our decisions regarding access to your health information, you may submit your complaint to the address found at the end of this notice. You may also submit your complaint in writing to the Federal Department of Health (DHHS) to the following address: Region II, Office for Civil Rights, US Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza- Suite 3312, New York, New York, 10278; telephone number: (212) 264-3313; fax: (212) 264-3039; TDD (212) 264 2355

We support your right to the privacy of your information and will not retaliate, in any way, if you decide to submit a complaint with us or with the DHHS.

Contact Office: **COMPLIANCE AND PRIVACY OFFICE**

Telephone: (787) 277-6686

Fax: (787) 706-4004

E-mail: privacidad@ssspr.com

Address: PO Box 363628, San Juan, PR 00936-3628

Si usted desea recibir una copia de este aviso en español, favor de enviar su petición a la dirección indicada o visite nuestro portal en www.ssspr.com

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IMPORTANT NOTICE FOR PERSONS WITH MEDICARE.
THIS INSURANCE PLAN MAY DUPLICATE SOME MEDICARE BENEFITS

This is not a complementary insurance towards Medicare

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

This insurance plan duplicates Medicare's benefits when:

- Some of the services covered by this policy are also covered by Medicare.

Medicare pays for extended benefits for services medically necessary without having the reason for which you may need it. These include:

- **Hospitalization**
- **Medical services**
- **Other approved services**

Before you buy this Insurance

- ✓ Verify the coverage in all of the health insurance policies that you may have.
- ✓ For more information about Medicare and the complementary insurance for Medicare, revise the Health Insurance Guide for persons with Medicare available through the insurance company.
- ✓ In order to receive assistance for the understanding of your health insurance plan, please contact the Office of the Insurance Commissioner of Puerto Rico or with an insurance orientation governmental program for advanced aged persons.

GENERAL DISPOSITIONS

GENERAL PROVISIONS

1. **BENEFIT CERTIFICATES:** Triple-S Salud will issue the policyholder an individual certificate to be given to every insured employee, serving as an individual certificate. In addition, Triple-S Salud will provide a list of Triple-S Salud participating physicians and providers to every insured employee.

2. **BLUECARD PROGRAM:** 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 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 access 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 (Host Blue). In some instances, members may obtain care from non-participating healthcare providers. Payment practices in both instances are described below.
   Under the BlueCard Program, 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, in accordance with applicable Inter-Plan Programs policies then in effect. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances our actions will be consistent with the spirit of this description.

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 amount the participating healthcare provider bills for the covered services or the negotiated price made available 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 negotiated price made available to us by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

i. Negotiated fee. This fixed amount 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 all of its healthcare providers or a similar classification of its providers and

claim-and-non-claim 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 the Group 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.

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 or, 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. 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.

BlueCard Program Fees and Compensation

The group understands and agrees to reimburse Triple-S Salud for certain fees and compensation, which we are obligated under the BlueCard Program to pay to the Host Blues, to the Blue Cross and Blue Shield Association (BCBSA) and/or BlueCard vendors. Fees and compensation under the BlueCard Program may be revised in accordance with the Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by any group. Such revisions typically are made annually as a result of Program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year and, they do not necessarily coincide with your benefit period under this agreement.

Only the BlueCard Program access fee may be charged separately each time a claim is processed through the BlueCard Program. If one is charged, it will be a percentage of the discount/differential Triple-S receives from the Host Blue, based on the current rate in accordance with the Program's standard procedures for establishing the access fee rate. The access fee will not exceed $2,000 for any claim. All other BlueCard Program – related fees are included in the general administrative fee.

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, as determined by Triple-S Salud or by applicable state law. 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, or at its sole and absolute discretion, 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. **BLUE CROSS BLUE SHIELD ASSOCIATION LICENSEE** – The plan member or the insured group and its members, through this means expressly acknowledges and know that: this policy constitutes an agreement solely between the plan member or insured group and Triple-S Salud, which is an independent corporation who operates under a license of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the Association) allowing Triple-S Salud to use the service mark Blue Shield in Puerto Rico; and Triple-S Salud does not have a contract as agent of the Association.

   Moreover, the plan member or the insured group and its members 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 plan member or the insured group, 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.

4. **CIVIL ACTIONS**: No civil action may 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 may 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.

   Triple-S Salud will not be obliged to respond to the insured for any act or omission of fact or right that, due to the negligence of the provider or any other cause, is reason for claim by the insured and circumstance under which the provider may be liable.

5. **CLAIM PAYMENTS:** The benefits provided under this policy will be paid to the participating professional or provider, or directly to the insured if a non-participating facility or provider was used or services were received, even if rendered by participating providers, are paid based on reimbursement, as long as all reports and evidenced required by Triple-S Salud is submitted. All claims must be submitted no later than one (1) year from the date the service was received. Once the notice about the claim has been received, Triple-S Salud will send the insured the model of the Reimbursement Request Form. If this model is not provided within fifteen (15) days from the date Triple-S Salud received the claim notice, Triple-S Salud will not be able to deny the claim for the simple fact that it was not submitted in the model form, as long as the insured presents his claim on time along with all the supplementary documents necessary to process it.

6. **COBRA (Consolidated Omnibus Budget Reconciliation Act):** Provides, in some situations, continued coverage (extended coverage) to covered employees and eligible direct dependents when coverage under the group medical plan ends for reasons established by this legislation (qualified events). The insured employee will 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 misconduct) or resignation, 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 disable within 60 days of enrollment in coverage and his/her disability is certified by the Social Security, 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 period of 36-month 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 be terminated for the following reasons:

   a. The COBRA period ends;

   b. Lack of payment;

   c. Employer terminates the group health plan;

   d. Insured enrolls in Medicare;

   e. Insured enrolls in another health plan that does not have a waiting period;

   f. Insured commits a fault that according to the plan is just cause for cancelling his/her plan (example: submitting a fraudulent claim).

   Transition cases will be included as COBRA cases for group experience purposes.

7. **CONFIDENTIALITY**: Triple-S Salud will maintain the confidentiality of your medical information and claims. Only the following people will have access to it:

   a. Triple-S Salud and its contractors when both are the administrators of the contract;

   b. Public officials investigating or filing a judicial or civil action;

   c. Bona fide individuals participating in an educational or medical investigation in which the identity of the insured is not necessary; or

   d. When according to a federal or state law, a reimbursement related with a National Medical Support Notice and subject to an order or resolution of an authorized administrative agency or court is paid to a different person other than the main holder.

8. **CONVERSION CLAUSE**:

   a. If coverage under this policy ends because of termination of the employee's employment or because the person belongs to a class or classes of eligible for coverage under the policy, that person has the right to have Triple-S Salud issue a Direct Payment Policy without evidence of insurability. Triple-S Direct policies available for conversion are Triple-S Direct or Triple-S Direct Plus Alternative I, exclusively.

      Written application for the Direct Payment Policy will be processed and the first premium will be paid to Triple-S Salud on or before thirty-one (31) days after the end of said cessation, and, in addition:

      1) The insured will be able to select the Direct Payment Policy that is most convenient among the policies offered

under this clause and his/her coverage will be subject to the terms and conditions of the direct payment insurance policy.

2) The Direct Payment Policy premium will be in accordance with the fee in effect at Triple-S Salud applicable to the form and the benefits of the Direct Payment Policy, according to the risk category to which that person belongs at that moment and the age reached by the Direct Payment Policy's effective date. The health at the time of the conversion will not be an acceptable basis on which to determine a risk classification.

3) The Direct Payment Policy should also cover the insured employee's spouse or dependent children if they were covered on the date of termination of the group insurance. At Triple-S Salud' option, a separate Direct Payment Policy may be issued to cover the spouse or dependent children.

4) The Direct Payment Policy will be active upon termination of coverage under the group policy.

5) Triple-S Salud will not be obligated to issue a Direct Payment Policy to cover a person who has the right to receive similar benefits under any insurance coverage or under the Medicare Program of the Social Security Act, as amended, if such benefits, provided simultaneously under the Direct Payment Policy, would result in over insurance according to the insurer's standards.

b. If this group policy ends or is amended in such a way as to terminate the coverage of any category of insured, all persons included in that group policy by the date of termination and whose insurance terminates after having been insured under the policy for at least three (3) years before the date of said cessation, will have the right to have Triple-S Salud issue a Direct Payment Policy subject to the conditions and limitations provided by clause 1 of this section.

c. Subject to the conditions and limitations under clause 1 of this section, the privilege of conversion will be granted to:

1) the spouse or dependent children of the insured whose coverage under the group policy ceases because of the death of that person;

2) the spouse or dependent children of the person whose coverage ceases because they do not qualify as family members under the group policy even though the insured continues to be covered under the group policy;

d. If a person insured under the group policy loses coverage under the Direct Payment Policy described in clause 1 of this section, while he/she qualifies for the Direct Payment Policy issued, but before the Direct Payment Policy is in effect, the benefits for which he/she would be eligible under the Direct Payment Policy will be payable by claim against the group policy although a Direct Payment Policy has not been requested nor payment of the first premium been effected.

e. If an individual insured under this group policy acquires the right to obtain a Direct Payment Policy under the terms of the group policy without evidence of insurability, 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 expires 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 date of expiration 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 according to this paragraph. If an additional period is granted to exercise the right to conversion, as provided here, and if the written application for said Direct Payment Policy, accompanied by the first premium, is made during the additional period, the Direct Payment Policy enter into effect upon termination of insurance under the group policy.

f. Subject to the other conditions stated above, the insured will have conversion rights, as long as the group insurance premium has been paid up to one of the following dates. Provided that, in order to apply to the right of conversion, the insured will update the payment of the premium, in the event that his/her employer has not done so.

1) Date of termination of employment; or

2) Date of termination of his/her condition as a member of a class or classes eligible for coverage under the group insurance; or

3) Date on which the group policy terminates; or

4) Date in which the policy is amended in such a way that it ends coverage of the category of insured to which the person belongs.

g. If the person whose group insurance cover ceases and interested in under another individual policy not specified in this clause, you can fill out application for the same, but their eligibility to the same shall be subject to evidence of insurability.

9. COORDINATION OF BENEFITS: When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

A. (1) The primary plan shall pay or provide its benefits as if the secondary Plan or plans did not exist.

(2) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals paid or provided by the primary plan.

(3) When multiple contracts providing coordinated coverage are treated as a single plan under this regulation, this section only applies to the plan as a whole. The coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with this regulation.

(4) If a person is covered by more than one secondary plan, the order of benefit determination rules of this regulation decides the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall consider the benefits of the primary plan or plans and the benefits of any other plan, which under the rules of this

regulation, has its benefits determined before those of that secondary plan.

B. (1) Except as provided in Paragraph (2), a plan that does not have order of benefit determination provisions that are consistent with this regulation is always the primary plan unless the provisions of both plans, regardless of the provisions of this paragraph, state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. Plan may consider the benefits paid or provided by another Plan only when, under the rules of this regulation, it is secondary to that other plan.

D. Order of Benefit Determination

Each plan determines its order of benefits using the first of the following rules that applies:

(1) Non-Dependent or Dependent

(a) Subject to Subparagraph (b) of this paragraph, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

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

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

(II) Primary to the plan covering the person as other than a dependent (e.g. a retired employee),

(ii) Then the order of benefits inverts, and the plan covering the person as an employee, member, subscriber, policy-holder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

(2) Dependent Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent for the longer period of time is the primary plan.

(b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does,

that parent's spouse's plan is the primary plan. This item shall not apply in regards to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(I) The plan covering the custodial parent;

(II) The plan covering the custodial parent's spouse;

(III) The plan covering the non-custodial parent; and then

(IV) The plan covering the non-custodial parent's spouse.

(c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.

(3) Active Employee or Retired or Laid-Off Employee

(a) The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

(b) If the other plan does not have this rule, and as a result, the plans do not agree on the order benefits will be paid, this rule is ignored.

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

(4) COBRA or State Continuation Coverage

(a) If a person whose coverage is provided through COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person through COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

(b) If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule is ignored.

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

(5) Longer or Shorter Length of Coverage

(a) If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer time is the primary plan and the plan that covered the person for

the shorter time is the secondary plan.

(b) To determine the length of time a person has had coverage under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.

(c) The start of a new plan does not include:

(i) A change in the amount or scope of a plan's benefits;

(ii) A change in the entity that pays, provides or administers the plan's benefits; or

(iii) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

(d) The length of time a person has been covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group will be used as the date from which to determine the length of time the person has had coverage under the present plan.

(6) If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

If you have coverage under more than one health benefit plan, you should file all your claims with each plan.

10. **EXEMPTION OF INSURED'S LIABILITY**: The provider shall not bill the insured for services whose payment Triple-S Salud has denied because of noncompliance with the criteria of reasonableness and medical necessity established by Triple-S Salud.

11. **GRACE PERIOD**: Unless at least thirty-one (31) days prior to the due date of the premium, Triple-S Salud has delivered to the employer or has mailed to the last known address, as it appears in the files of Triple-S Salud, a written notice that it does not intend to keep this policy active beyond the period for which it accepted the premium, a grace period of thirty-one (31) days will be conceded for payment of each premium due after the first, during which the policy will continue in effect, but the employer will be liable to Triple-S Salud for payment of the premium earned for the period in which the policy continues in effect and as soon as the policy is no longer in effect.

12. **IDENTIFICATION**: Triple-S Salud will issue a card to each insured, which they are required to present to any Triple-S Salud participating provider from whom services are requested, so that they may be identified as covered under this policy. In addition, the insured should present a second identification with a photograph.

13. **INDIVIDUAL CANCELLATION:** Triple-S Salud may cancel the insurance of any insured person at any time if the insured person commits fraud or makes false misrepresentation of material facts or has submitted or made someone submit a false claim or any evidence to support said claim for the payment of a claim pursuit to any of Triple-S Salud policies, regardless the date in which said act was committed or the date and the manner in which such act was discovered or when such persons present patterns of fraud in the use of benefits provided by the policy. Cancellation will be notified to the insured through a written notice, which will be delivered or sent by mail to the person's last known address in the files of Triple-S Salud, indicating when said cancellation will be effective, which in any case will be less than thirty (30) days from the notice.

Triple-S Salud will provide the insured employee a certificate of coverage as required by HIPAA. If the insured does not receive said certificate of coverage, the insured person may obtain it through our

Customer Service Department at 787-774-6060.

14. **INDIVIDUAL TERMINATION:** The insured employee is responsible, if he/she ceases or retires from its employment of returning the insured identification cards to Triple-S Salud.

    Triple-S Salud will not cover services used after termination of coverage. The employee will be responsible for payment of these services.

15. **MANDATORY COVERAGE:** This policy is subject to laws and federal and local regulations that may require, while the policy is active, that additional hospital, surgeon-medical services be covered even if they are not a part of the covered services when this policy was effective. This mandatory coverages that are put into effect after the policy is active, may have an impact in costs and premiums.

16. **NOTICE OF CLAIM:** Written notice of claim should be given to Triple-S Salud within twenty (20) days after the occurrence or after this period of time, as soon as reasonably possible by the insured, the employer or by the participating professional or service provider. A written notice given by the insured in his/her name to Triple-S Salud at its main office in San Juan, Puerto Rico or at one of its regional offices throughout the island, or to any authorized Triple-S Salud agent, with enough information so that it may be identified, will be considered notice to Triple-S Salud.

17. **PERSONAL RIGHTS**: The insured may not yield, transfer or waive in favor of third party any of the rights and benefits that he/she may claim by virtue of this policy. Triple-S Salud reserves the right to recover all expenses incurred in case the insured, with express or implicit consent, permits non-insured 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 canceling the insurance contract when illegal use of the card is discovered, nor from filing suit to have the insured or uninsured user of the card prosecuted.

18. **PHYSICAL EXAMINATIONS**: Triple-S Salud will have the right and the opportunity to examine, at its own expense, the insured when and as frequently as it deems necessary, while a claim against this policy is pending.

19. **PREMIUM PAYMENTS**: Both the employer and the employee will be liable for the payment of the premium covering the policy; and it is provided that such liability will cover the entire premium outstanding up to the date of termination of the policy, in accord with the TERMINATION clause.

    Triple-S Salud will have the right to collect the premium due or, at its option, may recover the costs incurred in the payment of claims for services rendered to the insured. It is also provided that both the employer and the insured will be liable for payment of any of the two amounts claimed by Triple-S Salud, except if provisions in the CONVERSION CLAUSE of the policy apply. Triple-S Salud may use the services of collection agencies to collect payment for any debt extant with Triple-S Salud. It is provided, additionally, that the debtor is obliged to pay legal costs, expenses and fees as well as any other additional amount or expense Triple-S Salud incurs to collect the debt.

    Triple-S Salud reserves the right to notify any agency, institution or organism dedicated to credit investigation detailed information regarding lack of payment by an employer or insured.

20. **PROOF OF SERVICE**: Should there be any claim for services by the insured, the latter should submit to Triple-S Salud written proof of said services within ninety (90) days after receiving the services. Not submitting the proof within the required time will not invalidate or reduce any claim if it was not reasonably possible to submit proof within that time, as long as such proof is submitted as soon as reasonably possible and, in no case, except under legal incapacity, later than one (1) year from the date in which the proof is otherwise required. The insured employee agrees and authorizes any professional or service provider to submit to Triple-S Salud reports, to be kept confidentially, regarding the diagnostic and

services rendered to him or her or any insured dependent, to be utilized only and exclusively to determine rights and obligations contracted in the policy.

21. **QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)**: The insured can request from his/her employer a copy of these documents free of charge.

22. **RECOVERY OF PAYMENTS MADE IN EXCESS OR BY MISTAKE:** The insured could receive payments that do not apply or are in excess of what is really owed. The insured has the obligation of notify Triple-S Salud when he/she becomes aware of the mistake. Triple-S Salud will contact the insured when it realizes that a wrong or excessive payment was made. Triple-S Salud has the right to recover payments made in excess or by mistake to a plan member, up to a period of two (2) years retroactively from the date in which Triple-S Salud issued the payment.

23. **REINSTATEMENT**: If payment of any renewal premium is not made within the time allowed 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 with it an application for restoration will serve to renew 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, if such approval is not forthcoming, on the forty-fifth day after the date of said conditional receipt, unless the insurer has notified the insured in writing that said application has not been approved. The reinstated policy will only cover losses resulting from any accidental injury that may have been suffered after the date of reinstatement and losses due to any illness that may begin more than ten days after such date.

    In any other case, the group and the insurer will have the same rights under the policy as they had immediately before due date of the unpaid premium, subject to any provisions endorsed or attached to this document with regard to the reinstatement. Any premium accepted with regard to a reinstatement should be applied to a period for which no premium was previously paid and that do not exceed more than sixty days prior to the date of reinstatement.

24. **RIGHTS AND RESPONSIBILITIES OF THE PATIENT:** Triple-S will required that all insured, or in the case of handicap persons or minors, to parents, tutors, o adults in charge of these persons, to read and familiarize the document *Rights and Responsibilities of the Patient*, or an appropriate and reasonable summary of it, as prepared or authorized by the Health Department. The summary is located at the end of this benefits policy.

25. **RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT:** Any person insured under a group health plan for eighteen (18) months or more are entitled to benefit from a health insurance policy applied to it individually without a waiting period or clause pre-existing conditions.

26. **RIGHTS UNDER THE LAW FOR MOTHERS AND NEWBORNS PROTECTION**: The aforementioned federal laws establish the following:

    a. Mother and newborn hospitalizations due to birth will not be limited to less than 48 hours if birth occurs through natural means or less than 96 hours in case birth occurs through cesarean.

    b. Insurers and group plans may, nevertheless, cover shorter stays, if the physician, after consulting the mother, orders that mother or the newborn leave the hospital before reaching the aforementioned terms.

    c. Neither insurers nor group plans will design benefits or include deductibles or coinsurances that imply a disadvantageous treatment to any portion of the hospitalization.

    d. In addition, the law does not allow the requirement of Precertification for those hospital stays within the scope of the law provisions.

Nevertheless, the law permits the requirement of a Precertification to use some providers or to reduce payments in which the insured might need to incur. Triple-S Salud will not request this Precertification.

27. **TERMINATION:** Triple-S Salud reserves the right to terminate this policy on due date of any premium through the delivery to the employer of a written notice no less than thirty (30) days in advance. The employer may terminate this policy on the due date of any premium through the delivery to Triple-S Salud of a written notification not less than thirty (30) days in advance. Termination will not affect any claim for services rendered before the termination date.

    Triple-S Salud will have the right to collect the premium due or, at its option, may collect the costs incurred in payment of claims for services rendered to the insured and be it provided that the insured principal will be responsible for the payment of any of the two amounts claimed by Triple-S Salud.

    When, at the contract's date of termination, the group to which the plan member belongs has not enrolled in another plan through another insurer or health services organization, nor under a self-insured plan, or if said plan member is ineligible for any other health plan (except through a conversion under this insurance policy), the plan member can continue receiving benefits under this policy during a ninety (90) day transition period, starting after the date of termination.

    In the case of the termination of a provider, the plan member can continue to receive the services of said provider during a ninety-(90) day transition period starting on the date of termination of the provider contract. Once this transition period has concluded, the plan member should seek the services of a participating provider within Triple-S Salud' provider network. After this transition period, Triple-S Salud will not be responsible for any payment to a provider that is not a network provider, except under circumstances established by the policy or in emergency cases.

    The transition period, under the circumstances described below, will take place in the following manner:

    a. If the plan member is hospitalized at the policy's time of termination and the date of discharge was programmed prior to such termination, the transition period will be extended from the policy's date of termination up to ninety (90) days after the plan member has been discharged from the hospital.

       In those cases in which the date of discharge is not programmed prior to the policy's date of termination, Triple-S Salud will assume responsibility for hospital services in accordance with the terms of this policy during the thirty-one (31)day period following the date of termination or until the date of discharge, whichever occurs first.

    b. In the case of a female plan member who is in the second trimester of pregnancy at this policy's date of termination, and whose provider has been offering pregnancy medical treatment prior to the policy's date of termination, the transition period for pregnancy medical services will extend up until the mother's date of discharge from the hospital due to childbirth or the newborn's date of discharge, whichever date is last.

    c. In the case of a patient who is diagnosed with a terminal condition by a Triple-S Salud participating physician prior to the policy's date of termination, and whose provider has been rendering medical treatment related to this condition before said date, the transition period will be extended during the patient's remaining life time or six (6) months, whichever occurs first. Triple-S Salud requires evidence of said diagnosis.

    The period of transition care is subject to the payment of the corresponding premium and it may be denied or terminated if the plan member and/or provider incurs in fraud

against the insurance. The plan member can opt to enroll in a direct payment policy or the transition period for the plan termination. Once the termination transition period ends, the measures established by the Conversion clause will apply.

28. **THIRD PARTY ACTIONS**: If because of fault or negligence of a third party the insured or any of the dependents suffers an illness or an injury covered under the policy, Triple-S Salud will have the right to subrogate in the rights of the insured in order to claim and receive from that third party compensation equivalent to the expenses incurred in treating the insured as a result of such negligent acts.

    The insured is obliged to acknowledge Triple-S Salud' right of subrogation and will be responsible for notifying Triple-S Salud of all actions initiated against the third party; provided that if the insured acts in otherwise, the insured will be responsible to pay for such expenses to Triple-S Salud.

    The insured acknowledges Triple-S Salud' right to transact in his/her behalf actions necessary to recovery of the expenses incurred as a consequence of the blame or negligence of the third party.

29. **TIME LIMITS FOR CERTAIN DEFENSES:**

    a. After two (2) years of having issued this policy, no false declaration (except fraudulent declarations) made by any person insured under the policy may be used to cancel insurance coverage for that person or to deny a claim for services that began after said period of two (2) years.

    b. No claim for services that began after two (2) years from the date this policy was issued will be reduced or denied because of the existence of illness or physical injury before the effective date of this policy that was not excluded from this policy by its specific name or description effective on the date of the service.

30. **TRANSFER OF COVERAGE**: If the insured moves to an area covered by another plan affiliated to the Blue Cross and Blue Shield Association and the insured requests it, Triple-S Salud will handle the transfer to the plan that services the area in which the insured will reside.

    The new plan should offer the insured at least the group policy conversion. This is a type of policy normally offered to insured people who leave a group and request coverage as individuals. Policy conversion offers coverage without the requirement of a medical examination or health certificate.

    If the insured accepts the conversion policy, the new plan will credit the time he/she was insured at 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 others who have the same type of coverage. Fees and benefits available in the new plan may vary significantly from those offered by Triple-S Salud.

    The new plan may offer the insured other types of coverage that are outside the Transfer Plan. These policies may require a medical examination or health certificate to exclude preexisting conditions or they may choose not to apply time insured under Triple-S Salud to waiting periods.

    The insured may acquire additional information about the Transfer Program by calling our offices.

31. **TRIPLE-S SALUD RIGHT TO AUDIT**: Once subscribed to this policy, the insured and his/her dependents accept, acknowledge and understand that Triple-S Salud, as payer of the health services incurred by the main policyholder and his/her dependents, has the authority to access his/her medical information to audit all or any health service claims that Triple-S Salud has paid.

32. **UNIQUE CONTRACT-CHANGES**: This contract, endorsements and attached documents if there are any, constitute the integral text of the insurance contract. No change in this policy will be valid until it has

been approved by the executive official designated by the Board of Directors of Triple-S Salud, 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.

33. **WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)**: This policy provides coverage 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 originated during all mastectomy stages. These benefits will be provided based upon a consultation between the insured female and her physician, and are subject to the coinsurance and deductibles established by the policy.

DEFINITIONS

BASIC COVERAGE

1. **9-1-1 SYSTEM:** A fast emergency call answering system of public security, with the means to assure that the executive agencies who render public security be available to attend any service claims adequate and rapid in emergency situations.

2. **ACTIVE EMPLOYEE**: An employee who renders services for an employer and receives wages, salary, commission, bonus or any other compensation. This employee must meet the following requirements:

   - To be physically present in the work area, as defined by the employer,
   - To be present daily during the scheduled hours required by the employer, and
   - actively perform the main tasks of his/her occupation.

   Be it also understood that an active employee is that who is temporary absent from his/her work area because of a personal or family health condition.

   An employee will not be considered active once he/she quits, abandons his/her employment, is absent due to a leave of absence without pay (except for those exceptional circumstances established by Law, such as the ones established in the Family Medical Leave Act), is terminated of employment, converts from a full time employee to a part time employee, dies, or his/her position be declared vacant by the employer.

3. **AMBULANCE SERVICES**: Transportation services received in a vehicle legally authorized by the corresponding government entity, designed to serve such services.

4. **AMBULATORY SERVICES**: Services covered under this policy, received by the insured while he/she is not admitted as a patient in a hospital.

5. **AMBULATORY SURGERY CENTER:** A specialized institution;

   a. When regulated by law: holding a license from the regulatory agency responsible for granting such permits under the laws and regulations of the jurisdiction of its location; or

   b. When not regulated by law; complying with the following requirements:

      1) To be established, equipped, and operated according to the laws and regulations in effect in the jurisdiction of its location, for the primary purpose of providing surgical services.

      2) To be operated 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 by a qualified doctor, who at the moment of practicing such procedures, holds a similar practice in at least one hospital (as defined) in the area.

      3) To require in all cases, except those requiring local anesthesia, a licensed anesthesiologist to apply the anesthesia and be present during the complete surgical procedure.

      4) To provide two (2) operating rooms and at least one post anesthesia recuperation room; fully equipped to perform x-rays and laboratory diagnostic tests; with trained

personnel and the necessary instruments to face any foreseeable emergencies including a defibrillator, a tracheotomy set and blood bank or any other supplies, but not limited to any one of these.

5) To provide full-time service of one or more trained male and female graduate nurses (R.N.) for the care of patients in the operating rooms and post-anesthesia recuperating rooms.

6) To hold a written contract with at least one hospital in the area for the immediate hospitalization of patients who develop complications or require post-surgery hospitalization.

7) To maintain an adequate 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 those who have undergone a local anesthesia procedure.

6. **BARIATRIC SURGERY:** Surgical procedure to control the morbid obesity, which can be practiced through four techniques, gastric bypass, adjustable band, intragastric balloon and sleeve gastrectomy. Triple-S Salud will only cover, as required by Law, the gastric bypass subject to precertification. Other surgeries will not be covered.

7. **BENEFITS ASSIGNMENT:** Process used when a non participating surgeons, hospitals and facilities of the Blue Cross Blue Shield outside of Puerto Rico, accept to give the necessary services to an insured billing directly to Triple-S Salud according to the reasonable charge of the area on which the services is rendered.

8. **BLUE CROSS PLAN**: Independent concessionary of the Blue Plans Association (Blue Cross/Blue Shield).

9. **BLUE SHIELD PLAN:** Independent concessionary of the Blue Plans Association (Blue Cross/Blue Shield).

10. **BLUECARD PROGRAM**: Program that allows the claim processing for services covered out of the Puerto Rican geographic area and that will be paid based on the negotiated fees bye the Blue Cross Plan or the Blue Shield area.

11. **CLINICAL PSYCHOLOGIST:** Professional licensed by the Board of Psychologists of Puerto Rico, and that owns doctoral degree in clinical psychology of a university, school or credited training center.

12. **COBRA LAW**: Public Law 99-272, Title X, Consolidated Omnibus Budget Reconciliation Act (COBRA), requires that every employer with twenty (20) or more employees who sponsors group medical insurance provide employees and relatives, in certain situations, temporary coverage (called Continued Coverage) when coverage under the plan ends.

13. **COINSURANCE**: The percentage of established fees that the insured will pay to the participating physician or provider or any other provider, at the time services covered are received, as his contribution to the cost of the services received, as established in the policy and notified to the participating physician or provider. This amount is not reimbursable by Triple-S Salud.

14. **COLLATERAL VISITS:** Interviews with immediate relatives of the patient insured hereunder in a psychiatrist's office.

15. **COPAYMENT:** A fixed amount to be paid by the insured to the participating physician or provider or any other provider, at the time covered services are received, as his contribution to the cost of the services received, as established in the policy and has been notified to the participating physician or provider. This amount is not reimbursable by Triple-S Salud.

16. **COSMETIC SURGERY:** That surgery, whose purpose is to improve the individual appearance and not to restore function or correct deformities. Purely cosmetic surgery does not turn into reconstructive surgery for reasons of a psychiatric or psychological reasons.

17. **CUSTOMARY CHARGE**: A charge is considered customary when it falls under the usual charges for a determined service by a large number of physicians or providers of services with similar training and experience in a specific area.

18. **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 law, of the insured employee, included in the Family Contract as long as the policy is in effect and the insured lives permanently with that spouse under the same roof.

    b. Natural or adopted children of the insured employee until they reach twenty-six (26) years old, except those who are working and are eligible to their corresponding employer's health plan. Not eligible under this plan are the children's spouses (son or daughter in-law) of the insured employee, grandchildren of the insured employee, or the in-laws children of the insured employee.

    c. Minors placed in the insured employee's house during the adoption process, until they turn twenty-six (26) years old. The employee must include the adoption papers with the corresponding documentation requested by Triple-S Salud.

    d. Will be eligible as a direct dependent a minor not emancipated that is a grandchild or blood relative of the insured employee, if the permanent custody of the child was adjudicated to the insured employee by a competent court of law with jurisdiction through a firm and final decision, as long as the insured employee has permanent custody and until the minor attains age twenty-six (26). Will also be eligible as a direct dependent a grandchild or blood relative of the insured employee, if such person is declared handicapped by court of law with jurisdiction through a firm and final decision and the custody of such person was adjudicated to the insured employee. In both cases, the insured employee that will want to subscribe a grandchild or blood relative as a direct dependent under this clause, must evidence his/her custodial rights resenting a Final Decree from Court adjudicating the custody.

    e. Foster Children of the insured employee (as defined under Law No. 121 of August 31, 2000) as long as they are totally dependent on the insured employee for their well being and until they attain age twenty-six (26). The foster child status must be evidenced with the documentation requested by Triple-S Salud.

19. **DURABLE MEDICAL EQUIPMENT:** Equipment that can be used repeatedly. Its principle use is to serve a medical purpose, and not to serve the person or the injury. This must be appropriate for using in the patient's home and its medical necessity must be certified. It does not include equipment that is used outside of the home or whose function is limited to convenience.

20. **EXPERIMENTAL OR RESEARCH SERVICES**: Medical treatment that:

    a. is considered experimental or investigative and is not in accordance with the medical policy established by the Technology Evaluation Coverage Manual (TEC) of the Blue Cross and Blue Shield Association on specific indications and methods ordered;

    b. Does not have the final approval of the appropriate regulatory agency (e.g., Federal Food and Drug Administration (FDA), U.S. Department of Human and Health Services (DHHS), the

Commonwealth's Department of Health) or;

c. Scientific evidence is insufficient according to the scientific evidence available, it does not support conclusions on the effect of technology on the medical results obtained;

d. Have positive results reported that are insufficient to counterbalance, in an acceptable manner, the negative results of the treatment;

e. Is not more beneficial than other already established alternate treatment;

f. Does not lead to improvement beyond the investigative phase.

21. FAMILY CONTRACT:

a. The insurance that provides benefits to any eligible employee and his/her direct dependents as defined in clause 18 of this section. The premium under family contracts will apply in these cases.

b. does not exist the eligible spouse, as defined in paragraph 18, the contract of the insured employee with one (1) or more direct eligible dependent may, at its option, be regarded as a contract or family as a single contract with one (1) or more direct dependent; as defined by paragraph 18 of this section. The insured employee may choose between two alternatives that at which the total premium is lower.

c. Should there be no eligible spouse as a direct dependent, as defined in clause 18, the insured employee's contract with one (1) or more direct dependent eligible children 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 number 18 of this section, the employee may choose among both alternatives the one with the lower total premium.

d. Inclusion of dependents may only be done at the time the policy is acquired or on the policy renewal date, except for those cases indicated in the Changes section or Special Inscriptions of this policy, or otherwise indicated in any other Law

22. FEE: The fixed amount used by Triple-S Salud to pay its participating providers for the covered services rendered to the insured when these services are not paid through another payment method.

23. *HIPAA (Health Insurance Portability and Accountability Act de 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.

24. 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 responsibility for licensing under the law, or

c. Meets all of the following requirements:

1) An agency holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive 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 Graduate Nurse (R.N.)

5) Its employees are bonded and provides mal-practice and mal-placement insurance.

25. **HOSPITALIZATION SERVICES**: Services covered by this policy received by the insured while being a patient in a hospital.

26. **HOST BLUE:** Blue Cross Blue Shield plans of the area were services are rendered under the Blue Card Program.

27. **ILLNESS:**

a. Any non-occupational illness contracted by any insured; however, illnesses for which hospitals are unable to admit the patient, by law or regulation, once these illnesses are diagnosed, will not be covered under the policy.

b. Maternity and secondary conditions due to the pregnancy will be considered illnesses under coverage offered by the policy, subject to the following conditions:

1) Services are rendered to the insured employee regardless of her marital status or to the spouse of an insured employee under a family contract which includes both spouses.

2) Any service rendered for an abortion provoked for therapeutic reasons but only if the maternity is covered by the policy.

28. **INITIAL PSYCHOLOGY 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.

29. **INJURIES**: Any accidental injury suffered by the insured not due to an automobile or on-the-job accident that requires hospitalization and medical treatment.

30. **INDIVIDUAL CONTRACT**: The insurance that provides benefits to any eligible single or married employee not including the spouse, as defined in clause 18, Direct Dependent of the insured. The premium corresponding to Individual Contracts will be applied in these cases. The employee will have the option of including in his/her insurance, as a direct dependent, any child, as defined in clause 18 of this section, by payment of an additional corresponding premium.

Inclusion of dependents may only be done at the time the policy is acquired or on the policy renewal date, except for those cases indicated in the Changes Section or Special Inscriptions of this policy, or otherwise indicated in any other Law.

31. **INSURED PERSON**: Any person who holds insurance coverage to whom Triple-S Salud gives him/her the right to the benefits established under this policy issued in the name of the insured group and assumes the established responsibilities under this policy.

32. **INTENSIVE CARE SERVICES**: Services covered by this policy, rendered to the insured in duly authorized facilities for intensive care of interned patients. Includes Intensive Care Units and Coronary Units.

33. **INTENSIVE CARE UNIT**: Separate, clearly designated service area reserved for patients in critical condition, seriously ill, requiring constant audiovisual observation, as prescribed by the bedside physician. Additionally, it provides room and nursing 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 interned in this area.

34. **MEDICAL EMERGENCY**: Sudden and unforeseen onset of a condition that requires medical or surgical attention. This attention should be received immediately after the condition appears or as soon as possible, but in no case after twenty-four (24) hours of its appearance.

35. **MEDICALLY NECESSARY SERVICES**: Those services that are provided by a participating physician, physician group or provider to support or reestablish insured's health and are determinate and provided according to standards of good medical practice.

36. **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

37. **MORBID OBESITY**: It is the excess of fat in the body determined by a corporal mass of 35 or higher.

38. **NON-PARTICIPATING PHYSICIAN OR PROVIDER**: Physician, medical group or provider who does not have an active contract with Triple-S Salud.

39. **NUTRITIONIST:** Health professional specialized in nutrition and certified by the governmental entity designated for said purposes, who specializes in nutrition and alimentation.

40. **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 person does not have a final judgment granting custody or guardianship.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 employee does not have a final judgment granting custody or guardianship. It is the insured employee's responsibility to provide evidence to Triple-S Salud on the eligibility of these dependents.

41. **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, copays and coinsurances for medical care received from the plan participating providers. Once the insured person 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 and the premium paid to Triple-S Salud for the plan, are not considered eligible amounts for the accumulation of the out-of-pocket maximum.

42. **PARTIAL PSYCHIATRIC HOSPITALIZATION**: Facilities and services organized to care for patients with mental conditions who require hospital care in day or evening programs of less than twenty-four (24) hours.

43. **PARTICIPATING PHYSICIAN OR PROVIDER**: Physician, hospital, primary care centers, diagnostic and treatment centers, dentist, laboratory, pharmacy, prehospital emergency medical care centers or any other person or entity in Puerto Rico, authorized to provide medical care under direct contract with Triple-S Salud or through a third party who renders health services to insured's or beneficiaries of Triple-S Salud.

44. **PSYCHOANALYSIS**: The 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 used therapy to treat people who present/display chronic problems of life in a scale of slight to moderate. The psychoanalysis should not be used like synonymous for the psychotherapy, since they do not pursue the same objective. This service is not covered in this policy, as expressed in the section of Exclusions.

45. **PSYCHOLOGICAL EVALUATION**: Initial interview to obtain personal and clinical history of the insured, as well as his/hers description of symptoms and problems. The psychological evaluation must be performed by a Psychologist with a degree of Doctor in Psychology, licensed from a graduated program, duly accredited and with effective

license, issued by the Board of Psychologists of Puerto Rico.

46. **PSYCHOLOGICAL TEST**: Use of instruments solely dedicated to measure the intellectual abilities or capability of an individual to dominate a specific area. Psychological tests to be administered in each specific case will be subject to the Clinical Psychologist's professional opinion. Test must be administered, verified, and interpreted by a Psychologist with a degree of Doctor in Psychology, licensed from a graduated program, duly accredited and with effective license, issued by the Board of Psychologists of Puerto Rico.

47. **POLICY YEAR**: Period of twelve (12) consecutive months for which the employer acquires or renews Triple-S Salud insurance.

48. **PRECERTIFICATION**: Advance authorization from Triple-S Salud for the payment of any of the benefits covered under this policy and its riders, in cases deemed necessary by Triple-S Salud. Some of the objectives of the precertifications are: evaluate if the service is medically necessary, evaluate the adequacy of the place of service, verify the eligibility of the insured for the requested service and if it is available in Puerto Rico. Precertifications will be evaluated based on the precertifications policies that Triple-S Salud established through the time. Triple-S Salud will not be liable for payment of services if they have been rendered or received without this authorization from Triple-S Salud.

49. **REASONABLE CHARGE**: A charge is reasonable when it satisfies the criteria of usual and customary or may be reasonable if, in the opinion of an appropriate Review Committee, it merits special consideration in view of the complexity of handling the particular case.

50. **RECONSTRUCTIVE SURGERY**: Surgery performed in abnormal body structures with the intention of improving functional defects and appearance, which are the result of congenital defect, illness or trauma.

51. **RESIDENTIAL TREATMENT**: Services of high level intensity care and is restrictive, for patients with mental health conditions including drug abuse and alcoholism, and comorbid conditions that are difficult to manage at home or at a community and that have not responded to other less restrictive treatment levels. Also, integrates the clinical and organizational therapeutic services, and are supervised by an inter-disciplinary team in a structured environment 24 hours a day, 7 days a week.

52. **SECOND MEDICAL OPINION**: The requirement of Triple-S Salud of an opinion of a physician other than the physician in charge of the case, chosen by Triple-S Salud in those cases in which Triple-S Salud determines that an opinion is necessary, before the insured person receives the service.

53. **SERVICE AREA**: The area within which the insured person is expected to receive the majority of medical/hospital services. In this policy, the service area is Puerto Rico since benefits provided are available only to those persons who are permanently residents of Puerto Rico.

54. **SERVICES NOT AVAILABLE IN PUERTO RICO**: Treatment within facilities or with hospital-medical equipment not available in Puerto Rico, in the case of a patient whose health condition requires these services.

55. **SERVICES NOT COVERED**: Those services, which are:

    a. Expressly excluded from the insured's policy;

    b. An integral part of another covered service;

    c. Rendered by a medical specialist, that has not been acknowledged for payment.

    d. Are considered experimental or investigative by the corresponding entity as established in the policy.

    e. Are provided for the convenience or comfort of the insured person, participating physician or the facility.

56. SESSIONS: Two or more modes of treatments of physical or respiratory therapy.

57. SKILLED NURSING FACILITY:

a. It is a 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) It is operated in accordance with the applicable laws of the jurisdiction in which it is located.

2) It is under the supervision of a licensed physician, or registered graduate nurse (R.N.), who is devoted full time to such supervision.

3) It is regularly engaged in providing room and board and provides twenty-four hour (24) a day skilled nursing care for sick and injured persons during the convalescence stage of an injury or sickness.

4) It maintains a daily medical record of each patient who is under the care of a duly licensed physician.

5) It is authorized to administer medication and treatment to patients on the order of a duly licensed physician.

6) It is not, other than incidentally, a home for the aged, blind or deaf, a hotel, a domiciliary attendance home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

7) It is not a hospital

58. SPECIAL CASES: The case of an insured patient whose health condition requires treatment within facilities or with medical-hospital equipment not available in Puerto Rico.

59. SPECIAL INSCRIPTIONS: Instance in which the employee and their eligible dependents can subscribe to the health plan at any time as a result of a specific event qualified as marriage, births and deaths, among other events.

60. SPORTS MEDICINE: Branch of medicine that treats illnesses or injuries caused by sports activities including the preventive and preparatory phases necessary to maintain good physical and mental condition.

61. TELE-CONSULTA: A service that Triple-S Salud provides to its insureds through which the plan member may receive orientation on questions related to his/her health. This telephone number is taken care of by nursing professionals, seven (7) days a week, twenty-four (24) hours a day. When calling this line, if the insured receives a recommendation to go to the emergency room, he/she will be provided with a register number that must be presented at the moment of receiving the services. In case of illness, when presenting this number at the hospital, the insured will pay a smaller copayment to use the facilities. The telephone number to call Teleconsulta is located at the back of the identification card of the insured of Triple-S Salud.

62. TREATMENT PLAN: Detailed report of the procedures recommended by the physician to treat the medical needs of the patient based on the medical examination made by the same physician.

63. UNNECESSARY SERVICES: The physician or provider and the medical plan disagree on the patient's need of a particular service, the insurance company does not pay for this service, the medical treatment have not been considered by Triple-S Salud to be included in the policy or there are other reasons not to cover the service billed.

64. USUAL CHARGE: The one most frequently charge patient by physicians/surgeons or particular service providers for a determined service.

MAJOR MEDICAL COVERAGE

1. **BASIC BENEFIT SCHEDULE:** A necessary, reasonable, and customary service or expense, including deductibles, coinsurance, or copayments that are covered in full or in part by the Major Medical Insurance.

2. **CASH EXPENSES:** Any covered medical expense, which can be applied to the annual cash deductible for a policy year, with the exception of expenses for mental disorders in ambulatory basis. The 20% portion of covered medical expenses, which is the insured person's responsibility, is also considered as a cash expense.

3. **CASH DEDUCTIBLE:** The annually cash amount that must be accumulated before having right to the benefits provided by the Major Medical Insurance.

4. **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.

5. **MEDICAL BENEFITS SCHEDULE:** Any covered services under the Major Medical Insurance which is not payable based on usual, reasonable, and customary charge. This medical benefit schedule applies in Puerto Rico.

6. **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.

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

8. **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.

9. **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.

10. **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.

ORGAN AND TISSUES TRANSPLANT

1. **ORGAN TRANSPLANT INSURANCE:** An insurance independent from the health plan that the eligible insured 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 subsc

2. **PRE-TRANSPLANT**: Evaluation and preparation of an insured to receive a tissue or organ transplant.

3. **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.

4. **SECOND MEDICAL OPINION**: The requirement of Triple-S Salud of an opinion of a physician other than the physician in charge of the case, chosen by Triple-S Salud in those cases in which Triple-S Salud determines that an opinion is

necessary, before the insured person receives the service.

5. **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.

7. **WAITING PERIOD:** It is the number of days or months that start at the date

PHARMACY COVERAGE

1. **GENERIC DRUGS (Level 1):** Chemical name or non commercial name of a medication with the same active ingredient and which have identical potential, dosage form, administration, bioavailability and which are considered to be therapeutically equivalent to the brand-name drug.

2. **COINSURANCE:** Percentage of fees to be paid by the insured 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.

3. **COPAYMENT:** The fixed preauthorized amount to be paid by the insured person 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.

4. **DRUGS (MEDICATION):** (a) any substance that bears on its label the following legend as required by federal law: CAUTION: Federal law prohibits dispensing without prescription, and (b) Insulin.

5. **EXCLUSIVE PHARMACIES NETWORK:** Pharmacies network contracted by Triple-S Salud to offer pharmacy services to its plan members. Plan members should receive services from pharmacies that belong to this network, exclusively. **This definition corresponds to the coverage subject to dispensing through Triple-S Salud Exclusive Pharmacies Network.**

6. **LIST OF MEDICATIONS:** Represent a group of registered brand-name drugs that have been evaluated by the Pharmacy and Therapeutics Committee and are considered safe, efficient and cost effective; that they assure the therapy quality, minimizing the inadequate utilization that may harm the patient's health. **This definition corresponds to the coverage subject to a List of Medications.**

7. **MAINTENANCE DRUGS:** Drugs that are less likely to change in dosage or therapy due to side effects, and require a prolonged therapy usage.

8. **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.

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

10. **NON PREFERRED DRUGS (Level 4)**: Evaluated medications for which was determined there was another existing alternative level available in the List of Medications that are safe, effective and have less secondary effects. If you obtain a generic drug or a level 4 medication, you will pay a higher cost for the medication.

11. **OVER THE COUNTER (*OTC)* MEDICATIONS:** Those drugs that do not have a federal legend and, therefore, can be sold to a client without a prescription from the physician. Triple-S Salud added in most of its covers some *Over-the-Counter* (OTC) medications, without any copayment. The Food and Drug Administration (FDA) approved this medications in the using the same dosage (mg by mg), that was previously identified by the FDA as medication with legend.

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

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

14. **PHARMACY AND THERAPEUTICS COMMITTEE**: It is a working Committee, assigned, among other activities, to evaluate the effectiveness of new medications and make recommendations and utilization protocols for them. After the Committee evaluations, it will determine the inclusion of medications within the pharmacy coverage. This Committee is composed of a general practitioner, a pediatrician, an ob-gyn, a registered nurse, clinical pharmacists and pharmacists. If a physician with a specialty in the field of medicine to be evaluated is necessary, assistance is requested from panel of specialists including the subspecialties of cardiology, endocrinology, psychiatry, infectology, pneumology, oncology, nephrology, ENT, ophthalmology and others, as necessary. The Committee holds monthly meetings to share findings in utilization reports and new medications that have been introduced in the market.

15. **PHARMACY PROGRAM OF DISPENSING A 90 DAY SUPPLY AT THE PHARMACY**: A voluntary program that allows the insured 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 insured to receive his/her maintenance medications through the Postal Service of the United States of America.

17. **PREFERRED BRAND-NAME MEDICATION (Level 2):** Brand-name medications which require a lower deductible.

18. **PRESCRIPTION:** Written request for medicines issued by a physician or dental surgeon legally authorized to effect said requisition in the ordinary course of his/her practice.

19. **PRESCRIPTION REFILL:** A prescription that has a repetition indicated in writing by the physician, which allows the pharmacy to dispense a medication in more than one occasion.

20. **REGISTERED MARK:** A medication that is offered to the public as a commercial name or a trademark.

21. **SPECIALIZED PRODUCTS (Level 5):** Medications used for chronic conditions and high-risk require special management and / or handling, due to its complex composition. This is the reason why Triple-S Salud offers the Program for Special Condition Medications. This program has a network of pharmacies dedicated in assuring the proper dispensation and management of these medications.

22. **SPECIALIZED PHARMACY NETWORK:** Pharmacy Networks contracted by Triple-S to provide pharmacy services to their insureds. The insureds must receive services exclusively from the pharmacies within the network. This definition corresponds to the coverage's which deliveries a depend on the SPN.

DENTAL COVERAGE

1. **BENEFITS PRECERTIFICATION:** The review of the treatment plan suggested by the dentist before rendering the services, to determine the insured's eligibility, scope of covered benefits, exclusions, limitations and applicable copayment under the insured contract.

2. **COINSURANCE**: The percentage of the established fees that the insured person will pay directly to the dentist at the time services are received.

3. **DENTAL SURGEON:** An odontologist legally authorized to practice the profession of dental surgeon.

4. **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.

5. **FEE SCHEDULE**: The fixed amount used by Triple-S Salud to pay participating dental surgeons for covered services given to insured's when these are not attributed by any other payment method.

6. **MAXIMUM BENEFIT**: The maximum amount of benefits to be paid for life.

7. **MAXIMUM LIMIT**: The maximum amount of benefits to be paid per policy year

8. **NON PARTICIPATING DENTAL SURGEON**: A dental surgeon who has not signed a contract with Triple-S Salud to render dental services.

9. **ORTHODONTICS**: Branch of odontology, related to the diagnosis and necessary treatment to correct a malocclusion

10. **PARTICIPATING DENTAL SURGEON**: A dental surgeon 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.

11. **PERIODONTICS**: Branch of the odontology related to the diagnosis, treatment of gum diseases and other tissues that form part of the dental support.

12. **TREATMENT PLAN**: A detailed report summarizing the dental procedures the dental surgeon recommended to the patient after performing an examination.

Other special benefits

Triple-S Salud Mobile App

On your smartphone, through the application of Triple-S Salud, can locate participating providers quickly and easily. Download the application to your Apple store or Android. The functions of our application are the following:

- Cover and copayments - The insured can review its cover and their dependents your card always with you - The principal insured can send you by email to your doctor your card of the plan and their dependents.
- Your card always with you - The principal insured can send you by email to your doctor your card of the plan and their dependents.
- Medical Directory - find health care provider near you.
- Acquires a plan - Customers of individual plans can see the prices of our plans and acquire the one that best fits your need.
- Customer service - The insured will have to hand contact information of Triple-S Salud as phone numbers and addresses or send us an email directly from the application. Our Internet Portal, www.ssspr.com our policyholders have the option to register to our portal.

Web Page Portal, www.ssspr.com

Our insured have the option to register to our portal. In this web page shall be allowed to perform transactions, such as:

- Benefits information
- health educational information
- coverage certification
- card identification duplicates request
- address changes
- reimbursements status review
- precertifications status review
- student certification letter
- history services review

Case Management Program

Triple-S Salud, Inc. Case Management Program has two main components: Routine Case Management and Complex Case Management focuses on the coordination of care and services for participants that have experienced a critical event or have had a diagnostic that requires a prolonged use of services. For example, a patient with an acute medical condition may require continuity of care at a post-hospitalization

The objective of this program is the adequate coordination of medical care for those participants and plan members with chronic and high risk conditions. The identification of potential candidates that may benefit of our program is achieved through:

- Clinical analysis
- Medical referrals
- Referral of the hospital review program
- Self-referrals

Complex Case Management involves the coordination of care and services for patients that have experienced critical or catastrophic events that require prolonged hospital car. The Program nursing staff performs a comprehensive evaluation of the patient's condition, identifies potential problems and develops a health care plan that includes the combination of medical services in a post-hospital environment.

In general, Case Management services include:

- Treatment for the patient in an adequate environment for his/her condition.
- Total restoration of the patient's health
- Reduction of non-planned hospital admissions, inappropriate use of emergency room services and reduction in care costs.
- Facilitation of transportation for medical care, if it were necessary.

Some alternate services are:

- Ambulatory Chemotherapy Center
- Ambulatory facilities to treat AIDS
- Partial Psychiatric Hospitalization Program
- Skilled Nursing Facilities
- Home Health Care

Special Conditions Prescription Drug Program

Under this program, drugs for certain conditions are dispensed through the local network of the Special Condition Drug Program: *Axium Healthcare PR Pharmacy* and *CVS Caremark Specialty Pharmacy*. These drugs are used for chronic and high-risk conditions that require specialized clinical management.

Some of the medical conditions or drugs require management through the Special Condition Drug Program as follows:

Cancer (oral treatment)
Hemophilic Factor
Crohn's
Erythropoietin (Deficiency in blood cells)
Fibrocystic Therapy
Psoriasis
Pulmonary Hypertension
Hepatitis C
Rheumatoid Arthritis
Multiple Sclerosis
Gaucher Disease
Osteoarthritis
Osteoporosis

Among the services included in the program are:

- An assessment that identifies particular needs that the patient may have regarding the use of the medicine.
- Clinical interventions that include, among others:
  - Coordination of patient care with the doctor
  - Personalized patient and caregivers education according to condition
  - Management and coordination of preauthorization of drugs
  - Follow up signs and symptoms of the condition
  - Monitoring adherence to therapy
  - Appropriate use of medications
  - Optimizing dose
  - Drug-drug interactions
  - Management of side effects
  - Coordination of repetitions
- Assistance through staff specialized in the condition
- Ease of delivery of medication to the site of patient preference
- Access to pharmacy staff 24 hours a day, 7 days a week
- Educational material about your condition

PHARMACY BENEFIT MANAGEMENT PROGRAM

The Triple-S Salud, Inc. Pharmacy Program is a program administered by MC-21. The objective of the program is to provide pharmacy quality, accessible and cost-effective pharmacy services at a reasonable price.

Major Features:

- **Access to services in Puerto Rico and the United States:** Triple-S Salud, Inc. offers a wide Pharmacy Network in which all our members have access to more than 1,000 pharmacies in Puerto Rico, and more than 65,000 pharmacies in The United States.

- **Flexibility in pharmacy products design:**
  - Traditional pharmacy products of three (3) levels
  - Coverage diversity with combinations of copayments, deductibles and coinsurances
    - Acute and maintenance prescription drugs
    - Brand and generic drugs
    - Brand and generic drugs as first option
  - Comprehensive set of Formulary Management that includes a wide range of options, from standard generic based formularies to more extensive and custom formularies. Our Drug List – includes:
    - A list of prescription drugs by therapeutic class that details brand name and generic drugs.
    - Preferred brand drugs
    - Identification of drugs containing cost containment strategies such as:
      - Pre-authorization (PA)
      - Step therapy (ST)
      - Medical specialty limits (SL)
      - Limits on the amount to be dispensed (QL)
    - These products have five-tiered copayment and/or coinsurance structure:
      - Copayment and/or coinsurance for generic drugs
      - Copayment and/or coinsurance for preferred brand name drugs
      - Copayment and/or coinsurance for brand name drugs
      - Copayment and/or coinsurance for non-preferred drugs
      - Copayment and/or coinsurance for specialty or biotech drugs
    - The insured pays a lower copayment or coinsurance when a drug from the Drug List is prescribed or dispensed. The copayment or coinsurance will be higher when the drug dispensed is not in the Drug List.
    - Triple-S Salud, Inc. Pharmacy Program obtains discounts from the pharmaceutical companies for the drugs included in the Drug List, as long as the requirements established in the negotiation with the pharmaceutical companies are met. The more a product is used in relation to the competition products, the greater the discount or the rebate granted by the pharmaceutical company will be. These negotiations result in better prices for the employer and the plan members.

- **Programs for the Extended Supply of Maintenance Drugs**

Triple-S Salud, Inc. offers programs for the dispatch of up to 90 days for maintenance drugs. Insured members will have the flexibility of selecting their preferred option for the receipt of their maintenance medications: through participating pharmacies of the Flex 90 Program or in the comfort of their homes by registering in the Pharmacy Program Express (Mail Order).

- Flex90®**:** allows the plan member to obtain a 90-day supply for maintenance drugs by visiting any of the Flex90 participating pharmacies of our network.

Flex90® options:

- **Flex90® Voluntary:** If plan members chose to participate, they can visit any of the Flex 90® participating pharmacies of our network. The insured may request the 90 day supply to the pharmacist of the participating pharmacy and benefit from extended supply as well as the savings on copayments and/or coinsurance. The insured should ask his/her doctor to include in the prescription one of the following instructions:
  - 90 days with a refill or
  - 30 days with 5 refills

- **Flex90® Mandatory:** Plan members have to obtain the first supply of their maintenance drugs through one of the program participating pharmacies. After obtaining two supplies for a 30-day treatment, the Program will be activated in the system and subsequent prescriptions will be dispensed for 90 days. The doctor's prescription should include one of the following instructions:
  - 90 days with a refill or
  - 30 days with 5 refills

- **Pharmacy Program Express (Mail Order):** Under this program, the plan member will receive up to a 90-day supply for maintenance drugs at their home or at any other location of their preference. Members will also be able to order their prescription drugs by mail or by telephone. In addition, the mailing of the drugs is free for the plan member and can save money in their copayments.

With Flex 90® and Pharmacy Program Express, employers as well as plan members benefit from the discounts negotiated with the participating pharmacies.

- **Drugs without legend – (Over-the-counter drugs):** Triple-S Salud, Inc. covers some over-the-counter drugs (OTC) through its pharmacy coverage with $0 copayment. The program requires that the plan member presents a prescription for the equivalent OTC drug. The OTC list includes drugs to treat gastric conditions, allergies and ophthalmic drops. The Food and Drugs Administration (FDA) has approved these drugs in the same doses (mg by mg) that it had previously identified as drugs with a legend. Therefore, these drugs these drugs have already proved to be safe and effective and in addition are less expensive. Triple-S Salud, Inc. will update the list periodically according to the changes in the over-the-counter drug market.

<table>
<tr><th>THERAPEUTIC CATEGORY</th><th colspan="2">PRODUCT</th></tr>
<tr><td>PROTON PUMP INHIBITORS</td><td colspan="2">PRILOSEC OTC® (TAB), OMEPRAZOLE OTC(TAB), PREVACID 24H® (CAP 15MG), LANSOPRAZOLE OTC, ZEGERID® OTC, NEXIUM 24HR</td></tr>
<tr><td>OPHTHALMIC ANTIHISTAMINES</td><td colspan="2">ZADITOR OTC®, ALAWAY®, ZYRTEC ITCHY DROPS®, CLARITIN EYE DROPS®</td></tr>
<tr><td>NASAL ANTIHISTAMINES (INTRANASAL STEROID)</td><td colspan="2">NASACORT®, ALLERGY 24HR, FLONASE®, ALLERGY RELIEF</td></tr>
<tr><td rowspan="6">NON-SEDATING ANTIHISTAMINES</td><td>ALLER CLEAR®</td><td>CLARITIN®</td></tr>
<tr><td>ALLERGY RELF®</td><td>CLARITIN-D 12H®</td></tr>
<tr><td>ALLERGY RELF D-24®</td><td>CLARITIN-D 24H®</td></tr>
<tr><td>LORATADINE</td><td>CLARITIN SYR®</td></tr>
<tr><td>LORATADINE SYR</td><td>CLARITIN RDT®</td></tr>
<tr><td>LORATADINE-D 12H</td><td>ALAVERT®</td></tr>
</table>

Therapeutic Category	Product	
	LORATADINE-D 24H	ALAVERT-D®
	TAVIST ND®	ALAVERT ALGY SINUS®
	WAL-ITIN	ALAVERT SYR®
	WAL-ITIN D 12H	ZYRTEC CHILD CHEWABLE®
	WAL-ITIN D 24H	ZYRTEC HIVES®
	CETIRIZINE CHEWABLE	ZYRTEC ALLERGY®
	CETIRIZINE	ZYRTEC D ALLERGY®
	CETIRIZINE-D	ZYRTEC CHILD SYR®
	CETIRIZINE SYR	ZYRTEC HIVES SYR®
	FEXOFENADINE	CHILDREN ALLEGRA®
	FEXOFENADINE D-12H	ALLEGRA D-12®
	ALLEGRA®	ALLEGRA D-24®

- **Step Therapy Program for New Users:** Triple-S Salud, Inc. is committed to providing accessible and high quality pharmacy benefits. Step therapy is a program that promotes cost-effective use of medicines.

For those therapeutic categories to which the Program applies:

- First, the patient uses *Step One* drugs, equally safe and effective, but cheaper.
- Second, if the *Step One* drug does not provide the required therapeutic effect, then *Step Two* drug will be covered.

Among the benefits provided by this program are the following:

- Access to drugs with their effectiveness and safety are been proved.
- Insureds pay a lower copayment (could even be $0.00) for drugs of Step One
- Major savings in drugs promotes compliance with drug therapy

This program applies to policyholders who will use the drug for the first time, or have not been used for six months.

Care on Demand (Teleconsulta)

Triple-S Salud, Inc. has developed a tool that allows the direct participation of plan members in their health care thus reducing the demand for medical services in emergency rooms. Through Teleconsulta[1], they are provided telephone access to medical information 24/7. Teleconsulta has a qualified professional staff that will evaluate the symptoms the plan member presents to determine the most appropriate treatment. This program is available to self-insured groups for minimum fee.

[1] Teleconsulta is an exclusive service it offers its plan members administered by Mckesson Health Solutions, an independent contractor that offers telephone health orientation and information.

Telexpreso

Is your direct contact with Triple-S Salud. This automated line allows you to resolve issues relating to the medical plan at any time. With only call (787) 774-6060 can make the efforts of your medical plan quickly. Through the system Telexpreso can:

- ✓ check your eligibility and dependents eligibility
- ✓ duplicates of card request
- ✓ check the status of a reimbursement
- ✓ check the status of a precertification
- ✓ receive information about some processes such as reimbursement request, plan card duplicates, certifications, among others.

For additional information, contact the Call Center available from Monday to Friday from 7:30 AM to 8:00 PM, Saturday from 9:00 AM to 6:00 PM and Sundays from 11:00 AM to 5:00 PM. Just call at (787) 774-6060 or 1-800-981-3241 (free of charge). Our Internet Portal, www.ssspr.com, our insureds have the option to register to our portal.