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

INTRODUCTION

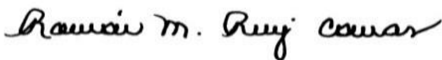
Triple-S Salud, Inc. (hereinafter “Triple-S Salud”) ensures all of the active employees of the employer whose name appear in the group health plan contract, as well as their eligible dependents in accordance with the provisions of this policy/certificate of benefits (hereinafter, “the policy”) and the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

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

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

The Affordable Care Act, guarantees that as of 2014, all non-protected or non-grandfathered plans that are offered in the individual and small group plans, either in or outside an exchange (health insurance exchange market) include a comprehensive service coverage known as essential health benefits, as defined by law and the reference plan in Puerto Rico, in the following ten categories: emergency services; hospitalization; ambulatory patient services; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative service and medical equipment; laboratory services, preventive and wellness services and chronic diseases management; and pediatric services, including oral and vision care.

The Chairperson of the Board of Directors and its President signed it on behalf of Triple-S Salud.



Ramón M. Ruiz Comas
Chairperson, Board of Directors

Pablo Almodóvar Scalley
President and Chief Executive Officer

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

IMPORTANT NOTICE TO PEOPLE WITH MEDICARE

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

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not a supplement insurance to Medicare

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

This insurance plan duplicates Medicare benefits when:

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

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

- Hospitalization
- Medical services
- Other approved items and services

Before you purchase this Insurance

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

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

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ERISA NOTICE FOR PRIVATE EMPLOYEES

ERISA Coverage

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

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

WHO IS ELIGIBLE?

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

DATE OF COVERAGE

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

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

CHANGES IN ENROLLMENT

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

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

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

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

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

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

4. When an optional dependent is no longer eligible, as stated in the definition of optional dependent in this policy:

    a. When an insured optional dependent attains age 65, the date of birth will be taken as the date of the request for termination of the insurance. The change will be effective on the first day of the month following the month in which the event took place.

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

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

SPECIAL ENROLLMENT

An active employee and his/her eligible dependents (direct 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 employee, the plan will cover the newborn from birth with the request for inclusion as a dependent and the submission of the original Birth Certificate. In these cases, if the request for enrollment as a dependent is not received, Triple-S Salud will cover the newborn under the health plan of the 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 30 days from the date of birth while the enrollment process of the child is completed.

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

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

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

      3. The effective date of the adoption.

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

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

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

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

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

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

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

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

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

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

An active employee and his eligible dependents (direct 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 PYMES employer, because at that time he was enrolled in another health plan or had an extended coverage under COBRA from his former PYMES employer.

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

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

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

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

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

g. The previous policy was not cancelled for lack of payment or fraud by the 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 30 days from the date in which the event took place. To be eligible for this special enrollment benefit, loss of eligibility under the other plan should not have arisen by reason of nonpayment of the plan premiums or from unilateral termination by the other plan because of fraud.

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

4. When an insured employee or one of his/her eligible dependents (direct 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.

BASIC COVERAGE

The benefits provided by this policy are contained in the general classifications that follow. These benefits are subject to the terms and conditions specifically set forth for them and are provided only to insureds residing permanently within the Service Area. Triple-S Salud is liable for the payment of the services offered to an insured, subject to the provisions of this policy and the conditions stated below.

Some of the health plan options under this policy have a Preferred Network for clinical laboratories, pharmacies, X-rays and other specialized diagnostic tests and imaging services rendered in ambulatory facilities. In order to receive ambulatory services provided by clinical laboratories, radiology or imaging centers, you must visit participating providers of the Preferred Network identified as *Selective* in Triple-S Salud's Provider and Participant Directory. For the prescription drugs covered in your pharmacy benefit, all health plan options have the Preferred Pharmacy Network. You must visit the Participating pharmacies identified in the Triple-S Salud's Provider and Participant Directory as Preferred Pharmacy Network for the dispensing of your prescription drugs. Services will not be covered when rendered by a non-participating provider or pharmacy of these Preferred Networks. Prior to receiving services, it is important that you review the Triple-S Salud's Provider and Participant Directory to make sure that said provider is part of the Preferred Network. Please refer to the Table of Deductibles, Copayments and Coinsurances at the end of this policy to find out if your plan has the Selective Preferred Network.

The benefits provided under this basic policy are not cumulative and are not subject to waiting periods.

Under our plan, there is an out-of-pocket maximum the insured pay for covered essential medical-hospital services according to their type of contract. The maximum out-of-pocket is $6,350 for individual contracts and $12,700 for couple and family contracts. This is the maximum amount insureds pay during a policy year for essential medical-hospital services covered under this policy when they visit participating providers, including the purchase of prescription drugs and payment for essential dental services, as described in this policy. Once the insured person meets the amount that applies according to his/her type of contract, he/she will not have to pay any additional out-of-pocket expenses for the rest of the policy year. Services rendered by non-participating providers in and out of Puerto Rico, payments for services not covered under this policy, alternative medicine (Triple-S Natural) eyeglasses and contact lenses for insureds above 21 years of age, as well as the monthly premium paid to Triple-S Salud for the plan, are not considered eligible expenses for the accumulation of the out-of-pocket maximum.

The insured employee and all direct dependents will have similar benefits.

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

The insured, physician and participating providers will receive orientation on hospital admissions that require a precertification or notification within 24 hours, or as soon as reasonably possible. Some studies, diagnostic tests and surgical procedures require a precertification from Triple-S Salud. The insured person, and the participating physicians and providers will receive orientation on those procedures that need a precertification. Services received in an Emergency Room facility as a result of a medical emergency will not require Triple-S Salud's precertification.

Services rendered by participating providers will be paid according to the fees set forth for each service, according to the existing contract between the participating provider and Triple-S Salud. The insured must show his/her insurance ID card when requesting a service. The ID card shows the coverage to which the person is entitled.

Services covered under this policy that are rendered by non-participating physicians or providers will only be covered in case of emergency, as required by law, and will be paid directly to the provider, based on the lesser amount between the expense incurred and the fee Triple-S Salud would have paid to a participating provider, after deducting the applicable copayment and/ or coinsurance, as stated in the policy.

In those cases when the insured person receives health care after emergency or post-hospitalization care, which would otherwise be covered under the health plan, except that it is provided by non-participating providers, Triple-S Salud will reimburse the insured person based on the lesser amount between the cost incurred and the fee it would have paid to a participating provider after the applicable copayment or coinsurance, as set forth in the policy, so long as there is a compelling medical reason for which the patient cannot be transferred to a participating provider.

Triple-S Salud may enter in a specific contracting arrangement with a provider to treat health conditions that require, or for which Triple-S Salud requires, specialized management. There are certain conditions that, because of their particular characteristics, require Triple-S Salud close monitoring of the utilization of the services to prevent insurance fraud or abuse of the services. Triple-S Salud policies aim to achieving good administration of these particular cases in order to ensure equal treatment for all insured persons under similar conditions and cost–effective management of the services. This policy shall not be interpreted as an elimination or reduction of the benefits covered under this policy.

Under no circumstances, the participating provider will collect or will attempt to collect from a covered person or insured any amount of money that the insurer owes to said provider.

This policy provides any insured person, including those diagnosed with HIV or AIDS or with physical or mental disability, all the coverages offered in this policy. Besides, this plan does not limit or denies a claim if the insured person is or has been a victim of abuse.

SERVICES COVERED BY FEDERAL OR STATE LAW

This policy covers 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. These services include the general physical exam, vision and hearing screening tests, clinical laboratory tests (including tuberculin test), psychological and screenings for psychosocial assessments, screening for asthma and epilepsy, according to the standards in force established by the Health Department, Medicaid Program, Mother, Child and Adolescent Program and the American Academy of Pediatrics.

This policy covers preventive services 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) 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:

- A one-time screening for abdominal aortic aneurism (AAA) by ultrasonography in men age 65 to 75 who have ever smoked.
- Screening and behavioral counseling interventions 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 pattern of alcohol consumption, including behavior interventions.
- Aspirin supplements for men aged 45 to 79 and women aged 55 to 79.
- 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, as well as women aged 20 to 45.
- 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) higher than 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. Likewise, for all pregnant women the plan will cover a first HIV test during the first trimester of the pregnancy or on the first prenatal visit and a second test during the third trimester of gestation (between 28 and 34 weeks of gestation).
- Screening for obesity in adults and those with a body mass index of 30kg/m2 or higher, must be referred to intensive multicomponent behavior interventions.
- Intensive behavioral counseling interventions for adults who are overweight or obese and have additional cardiovascular disease risk factors to promote a healthful diet and physical activity for cardiovascular disease prevention.
- Preventive counseling on sexually transmitted infections for high risk adults and adolescents.
- Tobacco use screening for all adults and cessation interventions for tobacco users, and counseling, extended to pregnant tobacco users.
- For those who use tobacco cessation products, this plan covers Food and Drug Administration (FDA) approved tobacco cessation medications for one attempt 90-day treatment, and up to two tobacco cessation attempts per year.
- Annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
- Syphilis screening for all adults and pregnant women at high risk.
- Routine screening for iron deficiency 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. Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.
- Screening mammography for breast cancer annually or every other year for women over 40 years of age; biannually 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 younger and other women at higher risk, whether or not pregnant.
- Food and Drug Administration (FDA) 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.
- Low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.
- Gestational diabetes screening for women 24 to 28 weeks pregnant and on the first prenatal visit for women at high risk.

- Gonorrhea screening for sexually active women, including pregnant women if they are at high risk of contracting the infection.
- Hepatitis B screening to pregnant women on their first prenatal visit.
- Human Papilloma virus ADN test every three (3) years in women, with normal cytological 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 not 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 24 to 28 week gestation, unless the biological father is known to be Rh(D) negative.
- Preventive annual care for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception care and the services necessary 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.
- Behavioral assessment for children of all ages.
- Cervical dysplasia screening for all sexually active females.
- Congenital hypothyroidism screening for newborns.
- Development screening and monitoring for children under age 3.
- Screening for lipid disorders for children of all ages.
- Oral fluoride supplementation for children whose water supply is fluoride deficient.
- Fluoride varnish application for children under age 5.
- Hearing screening tests for all newborns.
- 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 aged 6 to 12 months at risk of anemia.
- Lead screening 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, aged 0 to 11 months, 1 to 4 years, and 5 to 10 years.
- Phenylketonuria (PKU) screening to detect this genetic disorder.
- High-intensity behavioral counseling and screening to prevent sexually transmitted infections (STI's) for all sexually active adolescents.
- 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.
- Behavioral counseling on skin cancer for children, adolescents and young adults between ages 10 to 24 who have fair skin, for them to minimize their exposure to ultraviolet rays to reduce the risk of skin cancer.

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 visit, the preventive tests and vaccines as established by the Centers for Medicare and Medicaid Services (CMS), in accordance with Law 218 of August 30, 2012 and as provided 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 paragraph, as well as the following tests or services:

- Influenza vaccine, without age limit.
- Hepatitis B vaccine, without age limit.

This policy also complies with the requirements of Law No. 239 of September 13, 2012, so the covered services detailed in this policy can be offered by psychology professionals trained at master's degree or doctorate level, with trainings and experience to offer health services, who are duly licensed by the Puerto Rico Board of Psychologist Examiners.

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, physical, speech and language therapy, psychological and occupational therapy. These services include medical visits and medical reference tests. These are offered without limits, to all persons who have been diagnosed with any of the conditions within the Spectrum of Autism, but may be subject to applicable copays or coinsurances set forth in the Ambulatory Medical-Surgical and Diagnostic Services Section.

According to the requirements of Law 107 of 2012, this policy provides equal coverage for chemotherapy treatment for cancer in its various methods of administration such as intravenous, oral, injectable, and intrathecal, according to the medical order of the specialist or oncologist.

Pursuant to Law No. 275 of September 27, 2012, Triple-S Salud will not reject or refuse any treatment that is agreed upon and / or within the terms and conditions of health insurance contract signed between the parties to any patient diagnosed with cancer, upon a medical referral for such purposes. It covers all preventive services and benefits listed under the ACA federal regulation for early detection of breast cancer and the studies and monitoring tests for breast cancer, such as visits to specialists, clinical breast exams, mammograms, digital mammograms, breast MRI and sonomammography. It also includes treatment not limited to mastectomy, reconstructive surgery after mastectomy for the reconstruction of the breast removed, the reconstruction of the other breast to achieve an asymmetric appearance, breast prosthesis, treatment for physical complications during all the stages of the mastectomy, including lymphedema (an inflammation that sometimes occurs after breast cancer treatment), as well as any other reconstructive surgery after mastectomy for the physical and emotional recovery of the patient.

The insured person will be responsible for paying directly to the participating provider the copayment or coinsurance stated in the Table of Deductibles, Copayments and Coinsurances at the end of this policy.

INDEMNIFICATION TO THE INSURED PERSON

If any person entitled to the benefits provided under this policy receives covered services from non-participating professionals or facilities outside Puerto Rico, unless otherwise stated in the policy, or services paid by indemnification, Triple-S Salud will pay directly to the insured person the expense incurred up to the amount it would have paid to a participating professional or facility or up to the amount specified for the benefit. If the service is rendered in the United States of America and is not an emergency or is available in Puerto Rico, Triple-S Salud will pay the amount equivalent to the established fee in Puerto Rico. The insured person must provide to Triple-S Salud all the payment reports and receipts required in such cases.

AMBULATORY MEDICAL-SURGICAL AND DIAGNOSTIC SERVICES

Services available when the insured person is not admitted at the hospital. Please refer to the Table of Deductibles, Copays and Coinsurances at the end of this policy, for the copays and coinsurances applicable according to the plan coverage.

Description of the Services
Diagnostic and Treatment Services
• Visits to the office of the general practitioner
• Visits to specialists
• Visits to the subspecialists
• Visits to audiologists
• Visits to optometrists
• Visits to podiatrists, including routine foot care
• Annual preventive visit
• Home medical services by physicians that render this service
• Intra-articular injections, up to two (2) daily injections and a maximum of twelve (12) injections per insured person, per policy year
• Hospital emergency room services, including supplies and medications included in the suture tray contracted with Triple-S Salud. It also covers medications and supplies in addition to those included in the suture tray, provided in the emergency room because of accidents or illnesses. If the insured person calls Teleconsulta and receives the recommendation to go to an emergency room with a registration number; the person will pay a lower copay for the use of said facilities. Psychiatric emergencies will also be covered as well as the transportation between health services providing institutions including ambulances certified by the Public Service Commission and the Department of Health in conformance with what is established in the last paragraph of Article 4.20(b) of Law No. 183 of August 6, 2008 and as indicated in the Ambulance Benefit section that appear under the section Services Provided by a Hospital or Another Facility and Ambulance Services. • For diagnostic tests performed in the emergency room other than laboratory tests and X-rays, the coinsurances and limits that correspond to the ambulatory services, including interpretation of X-rays, will apply as stated in the policy. • Cryosurgery of the cervix, one (1) procedure per policy year, per insured person • Sterilization for men (vasectomy)
Laboratories, X-rays and Other Diagnostic Tests Selective Preferred Network of clinical laboratories and radiology/imaging applies to some plans under this policy. Please see the Provider and Participant Directory for a list of participating facilities. Please refer to the Table of Deductibles, Copays and Coinsurances at the end of this policy to check if the Selective Network applies to your plan.
• Clinical laboratory • X-rays

Specialized Diagnostic Tests:

- PET Scan and PET CT, up to one (1) per insured person, per policy year. In cases related to lymphomas, including Hodgkin's disease, the plan will cover up to two (2) per insured person, per policy year. **Requires precertification.**
- Non-invasive cardiovascular tests
- Non-invasive vascular tests
- Electrocardiograms and echocardiograms
- Nuclear medicine tests
- Computerized Tomography, up to one (1) per anatomic region, per insured person, per policy year
- Single Photon Emission Computerized Tomography (SPECT)
- Sonograms
- Mammographies, digital mammographies or sonomammographies when not rendered as preventive tests as provided by federal law, but as follow-up test to a diagnosis or treatment of a condition
- Angiography by magnetic resonance study (MRA)
- Magnetic Resonance Imaging (MRI) study, up to one (1) per anatomic region, per insured person, per policy year.
- Electromyograms, up to two (2) per anatomic region, per insured person, per policy year.
- Nerve Conduction Velocity Tests, up to two (2) of each, per insured person, per policy year
- Gastrointestinal endoscopies
- Electroencephalograms
- Polysomnography diagnostic test (sleep disorder tests), one (1) test per policy year, per insured person
- Tympanometry, one (1) test per insured person, per policy year
- Bone density test for insured persons under age 65 or when it is not provided as a preventive service as provided by federal law, but as follow-up test to a diagnosis or treatment of a condition.
- Neurological tests and procedures
- Other audiological tests
- Pelvic exams and all types of vaginal cytological tests that may be required by a physician to detect, diagnose, and treat early stages of anomalies that may result in cervical cancer.

Surgeries

- Ambulatory surgeries

Ambulatory Maternity Care (applies to the insured female employee, the insured female spouse and dependent daughters)

- Pre and postnatal care
- Biophysical Profile, one (1) service per pregnancy, per insured woman
- Well-baby care visits

Allergy Care Treatment Therapies

Allergy tests, up to fifty (50) test per policy year, per insured person

Treatment Therapies

- Radiotherapy
- Cobalt
- Chemotherapy in all its administration methods (intravenous, oral, injectable or intrathecal); according to the medical order of the specialist physician or oncologist. Oral chemotherapy is covered under the pharmacy benefit.
- Dialysis and Hemodialysis: Services related to any type of dialysis or hemodialysis, as well as the complications that may arise and the hospital or medical-surgical services that may be needed to treat these complications, will be covered for the first 90 days from:

  a. the date the insured is eligible to this policy from the first time; or
  b. the date in which the person receives the first dialysis or hemodialysis.

This will apply if subsequent dialysis or hemodialysis are related to the same clinical condition.

Respiratory Therapy (administered in the physician's office)

- Respiratory Therapy (provided by physicians with specialty in allergy, pediatric allergy, anesthesia, pneumology, pediatric pneumology), two (2) therapy sessions per day, up to a maximum of 20 therapies per insured person, per policy year.

Durable Medical Equipment (DME)

Purchase or rental, **Requires precertification:**

- Purchase or rental of oxygen and equipment necessary for its administration
- Purchase or rental of wheelchairs or hospital-type beds
- Purchase or rental of respirators, ventilators, and other equipment for the treatment of respiratory paralysis

Mechanical ventilator

- Coverage will include the medical necessary services, tests and equipment for insureds under age 21 and even after age 21 require the use of the technological equipment to keep the patient alive; a minimum of one (1) eight-hour daily shift per patient, of services by skilled nurses with knowledge on respiratory therapy or respiratory therapists with knowledge on nursing; the supplies needed to handle the equipment; physical and occupational therapies needed for the motor development of these patients, as well as the prescription drugs, which must be dispensed by a participating pharmacy, freely chosen by the insured and authorized under the laws of Puerto Rico (under the pharmacy benefit). Coverage provides for each beneficiary to have access to the appropriate laboratory tests and immunization according to the age, sex, and physical condition of the insured.

- These services will be covered subject to insured or his/her representative submitting evidence of medical justification and the registration of the insured in the registry the Department of Health has created to this purpose. It also includes the supplies for the handling of technological equipment of the Mechanical Ventilator.

- The mechanical ventilator services and services by skilled nurses with knowledge of respiratory therapy or respiratory therapists with knowledge on nursing, the supplies necessary for handling the technological equipment, and physical and occupational therapies will be covered at 100%. For the copayments and coinsurances for medical services, treatments, diagnostic tests, and prescription drugs, refer to the Table of Deductibles, Copayments and Coinsurances at the end of this policy.

Post hospitalization services provided by a Home Health Care Agency

Triple-S Salud will cover these services if they begin within 14 days from the date the insured was released from the hospital after a hospitalization of at least three (3) days and if they are rendered for the same condition or for any situation related to the condition for which the insured was hospitalized. It covers the following services and supplies provided at the home of the Patient by a Home Health Care Agency certified by the Health Department of Puerto Rico. **Requires precertification.**

- **Nursing services** - partial or intermittent services provided or under the supervision of a registered nurse.
- **Home Health Auxiliary Services** – partial or intermittent services rendered primarily for the patient care.
- **Physical, occupational and speech therapies (habilitative and rehabilitative)** – a maximum of 40 visits per insured person, per policy year.
- A visit by an employee of the home health care agency or four (4) hours of services by an aide will be considered as a home visit.

  Note: These services must be supervised by a licensed physician and **their medical necessity must be certified in writing.**

Nutrition Services

- Triple-S Salud will pay for nutrition services rendered by physicians specialized in nutrition or metabolic diseases or by licensed nutritionists. The plan will cover a maximum of six (6) visits per insured person, per policy year.

Chiropractic Services

- Visits to the chiropractor

Manipulations/ Physical, Occupational and Speech Therapies (Habilitation and Rehabilitation)

- Manipulations rendered by a chiropractor
- Physical therapies provided by a physiatrist (or under his supervision or billed by him) or chiropractor
- Occupational and speech therapies
  These therapies will be covered up to 20 combined therapies per insured person, per policy year.

Vision Care

- Ophthalmologic diagnostic tests
- Refraction test, one (1) test per insured person, per policy year, as long as the test is performed by an ophthalmologist or an optometrist.
- Eyeglasses for insureds up to 21 years of age, one (1) pair per policy year within the collection contracted, including high-potency corrective lenses for insureds that have a significant loss of vision, but are not totally blind. It covers one (1) visual aid device (prescribed magnifying glasses, double or single-lens telescopes) for insureds up to age 21 with significant vision loss, but that are not totally blind, available through the network of Optics exclusively contracted to offer this benefit to the pediatric population.
- Eyeglasses and contact lenses, for insured persons over age 21, up to the amount stated in the Table of Deductibles, Copays, and Coinsurances at the end of this policy.

Alternative Therapies (Triple-S Natural)

The program is available only through the Program's participating facilities. For a list of the participating facilities, refer to the Provider and Participant Directory. The plan covers up to six (6) visits per policy year, per insured person, and includes the following types of therapies:

- Holistic and Complementary Health
- Medical Acupuncture
- Therapeutic Massage
- Naturopathic Medicine
- Bioenergetics Medicine
- Hypnotherapy
- Traditional Chinese Medicine
- Reflexology
- Clinical Nutrition
- Botanical Medicine
- Aromatherapy
- Music therapy

Other Services for the Treatment of Disorders within the Continuum of Autism

This policy covers services directed to the diagnosis and treatment of persons with Disorders within the Continuum of Autism, without limitations, such as:

- Neurological exams
- Immunology
- Gastroenterology services
- Genetic tests
- Laboratory tests for autism
- Nutrition services
- Physical, occupational, and speech therapies
- Visits to the psychiatrist, psychologist (with a Master degree or doctorate degree and a valid license issued by the Puerto Rico Board of Psychologist Examiners), or social worker.

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 years 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** (Diphtheria, Tetanus Toxoid and Acellular Pertussis Vaccine) (90700)
From 11 years of age: • **Tdap*** (Tetanus, Diphtheria and Acellular Pertussis)(90715) • **HPV*** (Human Papilloma Virus) (Gardasil-90649, Cervarix-90650)
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 Diphtheria 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, according to the Vaccine Schedule established by the U.S. Preventive Services Task Force (USPSTF) and the Department of Health, including catch-up vaccines.**

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 20% 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, according to the Vaccine Schedule established by the U.S. Preventive Services Task Force (USPSTF) and the Department of Health, including catch-up vaccines.**

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

MEDICAL SURGICAL SERVICES DURING HOSPITALIZATION PERIODS

- Triple-S Salud agrees to pay based on the rates established for those services covered under this policy that are provided to the insured member during hospitalization periods by physicians freely chosen by the insured. The physician services covered during any hospitalization period will be those usually available at the hospital where the insured member is admitted.
- No person insured under this policy that hospitalizes in a semi-private room or private room, will be bound to pay any amount to a participating physician for services covered under this policy. Medical fees in these cases shall be paid directly by Triple-S Salud to the participating physicians, based on the fees set forth for the services.
- During hospitalization periods the insured member is entitled to receive the following medical-surgical services, among others:

Benefits Description
Medical-Surgical Services

- Surgeries, including orthognathic surgery
- Skin, Bone ,and Corneal Transplants
- Reconstructive surgery after mastectomy for the reconstruction of the breast removed, surgery and the reconstruction of the other breast to achieve an asymmetric appearance, breast prosthesis necessary before or during reconstruction, treatment for physical complications during all the stages of the mastectomy, including lymphedema (an inflammation that sometimes occurs after breast cancer), as well as any other reconstructive surgery after mastectomy for the physical and emotional recovery of the patient.
- Treatment for morbid obesity. This policy only covers gastric bypass surgery for the treatment of morbid obesity, to a maximum of one lifetime surgery, so long as the services are available in Puerto Rico. Surgeries for the removal of excess skin are covered if the physician certifies that it is necessary to remove the excess of skin because it affects the functioning of a body part. These surgical procedures **require Triple-S Salud's precertification**.
- Diagnostic services
- Treatments
- Administration of anesthesia
- Specialist consultations
- Gastrointestinal endoscopies
- Sterilization services
- Hearing evaluations, including Neonatal Hearing Screening Test
- Surgical Assistant
- Chemotherapy in all its modalities of administration (intravenous, oral, injectable or intrathecal) and radiotherapy. Oral chemotherapy is covered under the Prescription Drug Benefit.
- Invasive cardiovascular tests
- Lithotripsy (ESWL), **Requires precertification**

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

- It is required that an insured person hospitalized because an injury or illness, pays the hospital admission copay to the participating hospital at the time of admission. In addition, the insured member must pay the copays and coinsurances that apply to hospital services. Triple-S Salud will not reimburse this amount.

- To calculate any period of hospitalization, the day of admission shall be counted, but the day in which the patient is released by the attending physician will not be counted. Triple-S Salud will not be liable for the services received by any insured person if he/she stays in the hospital after being discharged by the physician in charge of the case or for any pass 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 maternity benefit.

- The procedures and surgeries provided under this policy that are rendered through an Ambulatory Surgery Facility will be covered according to the policy established by Triple-S Salud.

- When an insured member chooses a private room in a participating hospital, Triple-S Salud will cover the established fee for a semi-private room. The hospital can charge the patient the difference between the usual cost of the private room and the fee for a semi-private room as established by Triple-S Salud, except in those cases in which it is medically necessary and with prior notification to Triple-S Salud. Other hospitalization expenses covered hereby shall be included in the remaining half of the cost contracted between the participating hospital and Triple-S Salud and therefore it could not charge any difference to the insured member. Please refer to the Table of Deductibles, Copays and Coinsurances for any applicable copayments or coinsurances in addition to the hospital admission.

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

Description of Benefits
Hospitalizations

- Semi-private or isolation room up to a maximum of 365 days for regular hospitalizations

  Note: If you are enrolled in a plan that has a variable copayment for hospital facilities (tiers), to look up hospitals in your area visit our webpage at www.ssspr.com, or refer to Triple-S Salud Provider and Participant Directory. If you need additional information, contact Customer Service.

- Meals and special diets
- Use of telemetric services
- Use of Recovery Room
- Use of intermediate care unit for infants (Step Down Unit)
- Use of Intensive Care, Coronary Care, Pediatric Intensive Care and Neonatology Intensive Care units

- General nursing services
- Administration of anesthesia by non-medical personnel
- Clinical laboratory services
- Prescription drugs, biological products, material to tend wounds, hyperalimentation products and anesthesia materials
- Production of electrocardiograms
- Production of radiological studies
- Physical therapy services (habilitation and rehabilitation)
- Use of the services of doctors in training, interns and residents authorized to provide medical services to patients
- Respiratory therapy services
- Use of the Emergency Room when the insured member is admitted to the hospital
- Use of other facilities, services, equipment and supplies usually provided by the hospital and ordered by the physician in charge that are not expressly excluded from the contract with the hospital.
- Hemodialysis facilities. Services related to any type of dialysis or hemodialysis as well as services for any complications that may arise 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 member became eligible for this policy for the first time; or
  b. the date in which he/she receives the first dialysis or hemodialysis.

  This will apply when subsequent dialysis or hemodialysis are related to the same clinical condition.

- Chemotherapy in all its administration modalities (intravenous, oral, injectable or intrathecal) and radiotherapy
- Blood for transfusions
- Lithotripsy (ESWL), **Precertification required**
- Ambulatory surgery center

Maternity Hospital Care – for the insured employee, insured female spouse and dependent daughters). As provided by the Newborns' and Mothers' Health Protection Act, admissions to the hospital in case of vaginal delivery will be covered for a minimum of 48 hours and 96 hours following a delivery by cesarean section, unless the physician, after consulting the mother, orders the discharge of the mother and/or the newborn.

- Semiprivate or isolation room, assistance and physical care for the newborn, education on the care of the newborn for both parents, assistance and training on breastfeeding, orientation on in-home support and the performance of any treatment or medical test for the newborn or the mother.

  Note: If you are enrolled in a plan that has a variable copayment for hospital facilities (tiers), to look up hospitals in your area visit our webpage at www.ssspr.com, or refer to Triple-S Salud Provider and Participant Directory. If you need additional information, contact Customer Service.

- Obstetrics services
- Use of maternity ward
- Production and interpretation of fetal monitoring
- Use of well-baby nursery

Post-Hospitalization Services through a Skilled Nursing Facility

The plan will covered these services if they begin within fourteen (14) days from the date the insured person is discharged from a hospital, after a hospitalization of at least three (3) days and if they are rendered for the same condition or in relation to the condition for which the person was hospitalized. **Requires precertification.**

- They are covered up to a maximum of one hundred twenty (120) days per policy year, per insured member.

Note: These services must be supervised full-time by a licensed physician or a registered nurse **and their medical necessity must be certified in writing.**

Ambulance

- Air ambulance services in Puerto Rico, subject to medical necessity.
- Ground ambulance services are covered based on the corresponding fees determined by Triple-S Salud and according to the distance traveled. According to Law No. 383 of September 6, 2000, when the service is obtained through 911, Triple-S Salud will pay directly to the provider. The service will be covered only if all of the following requirements are met:

    a) the patient was transported by an ambulance service as defined in this policy;

    b) the patient had an illness or injury for which other means of transportation were contraindicated;

    c) the patient forwards the claim to Triple-S Salud with a medical certification on the emergency that includes the diagnostic;

    d) the invoice for this service must indicate the place where the insured was picked up and where the person 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 – in cases where the institution that transfers or authorizes the discharge is not the appropriate facility for the covered service;

    c) from the hospital to the insured's home, if the condition of discharged patient requires it.

    d) Between health services providing facilities, in case of psychiatric emergencies provided by ambulances certified by the Public Service Commission and the Department of Health.

- **The insured pays the full cost and Triple-S Salud will reimburse up to $80 per case.**

MENTAL HEALTH AND SUBSTANCE ABUSE

For some plan options, Triple-S Salud participating hospitals have been grouped in three tiers, according to the cost of the hospital facilities. Tier 1 is the preferred network or those low cost hospitals. Tier 2 is the hospital network with an intermediate cost. Tier 3 is the hospital network with the highest cost. Depending on the cost of the hospital admission, it will be the insured person's liability on the payment for admission.

Description of Benefits

General Mental Conditions

Hospitalizations for mental conditions

- Regular hospitalizations

  Note: If you are enrolled in a plan that has a variable copayment for hospital facilities (tiers), to look up hospitals in your area visit our webpage at www.ssspr.com, or refer to Triple-S Salud Provider and Participant Directory. If you need additional information, contact Customer Service.
- Partial hospitalizations
- Electroconvulsive therapies for mental conditions covered according to justified medical need and the standards of the American Psychiatric Association (APA).

Outpatient Services

- Patient's visits to the office of the psychiatrist or psychologist (with an MA or PhD and a valid license issued by the Puerto Rico Board of Psychologist Examiners)
- Visits of immediate family members (collaterals), including marital counseling, provided by a psychiatrist or psychologist (with a master's or doctorate degree and a valid license issued by the Puerto Rico Board of Psychologist Examiners)
- Visits for group therapies

Other Psychological Evaluations

- Psychological evaluation
- Psychological Tests: Psychological tests required by Law 296 of September 1, 2000, known as the Law for the Conservation of the Health of Puerto Rican Children and Adolescents.

Substance Abuse (Drug Addiction and Alcoholism)

- Regular hospitalizations, including detoxification services

  Note: If you are enrolled in a plan that has a variable copayment for hospital facilities (tiers), to look up hospitals in your area visit our webpage at www.ssspr.com, or refer to Triple-S Salud Provider and Participant Directory. If you need additional information, contact Customer Service.
- Partial hospitalizations
- Patient's visits to the office of the psychiatrist or psychologist (with an MA or PhD and a valid license issued by the Puerto Rico Board of Psychologist Examiners)
- Visits of immediate family members (collaterals), including marital counseling, provided by a psychiatrist or psychologist (with a master's or doctorate degree and a valid license issued by the Puerto Rico Board of Psychologist Examiners)
- Visits for group therapies

Residential Treatment

- Residential treatment is covered as long as there is a medical justification and the services are available in Puerto Rico. **Requires precertification.**

  Note: If you are enrolled in a plan that has a variable copayment for hospital facilities (tiers), to look up hospitals in your area visit our webpage at www.ssspr.com, or refer to Triple-S Salud Provider and Participant Directory. If you need additional information, contact Customer Service.

EXTENDED COVERAGE FOR SERVICES IN THE UNITED STATES OF AMERICA

The benefits provided in this coverage will be available for the insured employee and his/her dependents.

Triple-S Salud will cover expenses incurred for covered medical and hospital services rendered in the United States of America only in case of medical emergencies or when the equipment, treatment or facilities required are not available in Puerto Rico.

To receive services under this coverage in cases in which the equipment, treatment and facilities are not available in Puerto Rico, it is required that the insured person obtains a precertification from Triple-S Salud before the services are rendered. In case of emergency, a precertification is not required, but the services are subject to Triple-S Salud's corroboration of their medical necessity.

Triple-S Salud will cover services under this coverage based on the contracted fees of the Blue Cross Blue Shield Plan of the area, if the provider rendering the services is a participating provider of the Blue Cross Blue Shield plan network.

If the insured person uses a provider that does not participate in the network of the local Blue Cross Blue Shield plan, he will have to pay the full cost of the services, except in case of a medical emergency. In these cases, Triple-S Salud will pay a percentage of the fees for non-participating providers established by the local plan of the Blue Cross Blue Shield Association or the fees Triple-S Salud has established for its participating providers in Puerto Rico.

The insured person is liable to pay the coinsurance set forth in the coverage for services in the United States that appears on the Table of Deductibles, Copays and Coinsurances at the end of the policy.

If the service is rendered in the United States of America and is not an emergency or the service is available in Puerto Rico, Triple-S Salud will pay an amount equivalent to the fee set forth for Puerto Rico, as stated in this policy under the section INDEMNIFICATION TO THE INSURED PERSON.

PRESCRIPTION DRUG BENEFIT

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

- This benefit is ruled by the guidelines of the Food and Drug Administration (FDA). These include dosage, drug equivalency, and therapeutic classification, among others.

- It is required to show the Triple-S Salud ID card at any participating pharmacy when requesting the benefits, so they are covered by this coverage. The participating pharmacy will dispense, upon showing the insured's ID card and a prescription, the covered prescription drugs included in the Prescription Drug List or Formulary, that are specified in the prescription. It will not charge or collect from the insured any amount in excess of the amount set forth in the Table of Deductibles, Copays and Coinsurances found at the end of this policy. When receiving the prescription drugs, the insured person will have to sign for the services received and show a second photo ID.

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

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

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

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

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

This pharmacy coverage has the following characteristics:

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

    a) To include new medications

b) Change medications from a tier with a higher copay/coinsurance to a tier with a lower copay/coinsurance

c) Changes for safety reasons, if the manufacturer cannot supply it or has withdrawn it from market.

- The Prescription Drug List or Formulary details the prescription drugs covered. Because of the dynamic nature of the process, the Pharmacy and Therapeutics Committee evaluates the Prescription Drug List or Formulary and approves changes where new medications are included, medications are changed from a higher copay/coinsurance tier to a lower copay/coinsurance tier or for safety reasons if the manufacturer of the prescription drug cannot supply it or has withdrawn it from market. This Prescription Drug List or Formulary is printed once a year.

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

- The plan will cover over-the-counter prescription drugs, generic drugs, brand-name drugs included in the Prescription Drug List or Formulary whose labels include the legend, “Caution: Federal Law prohibits dispensing without prescription”, Insulin and some over-the-counter drugs included in the Prescription Drug List or Formulary, as detailed in this section and in the section on Prescription Drug Benefit Exclusions.

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

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

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

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

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

- This prescription drug benefit may be subject to an annual deductible (i.e. $50 individual). Please refer to the Table of Deductibles, Copays and Coinsurances at the end of the policy. The **annual**

deductible is the amount the insured person must pay for the prescription drugs before our plan begins to pay its part. When the insured person receives his first dispensing of prescription drugs in the policy year, the person will pay the full cost of his prescription drugs until the person meets the established amount (i.e. $50 individual). In addition, prescription drug coverages may have a first level of coverage (i.e. $800 individual and $1,000 family). This means that:

a. If the prescription drug coverage has an annual deductible, the first level of coverage begins when the insured person has met the deductible and until the plan pays the established amount (i.e. $800 individual and $1,000 family).

b. If the prescription coverage does not have an annual deductible, the first level of coverage begins when the person receives the first supply of his prescription drugs in the policy year until the plan pays the established amount (i.e. $800 individual and $1,000 family).

c. In both cases, once the insured person begins the first level of coverage, he will be liable for the payment of copays and coinsurances according to the tier of the prescription drugs, until the plan pays the established amount (i.e. $800 individual and $1,000 family).

d. Once the person meets the amount established for the first level of coverage (i.e. $800 individual and $1,000 family), the person will pay a coinsurance for all the prescription drugs covered for the rest of the year.

e. These deductibles, copays and coinsurances do not apply to the Preventive Services, which are covered with $0 copay, as required by federal laws Patient Protection and Affordable Care Act and the Healthcare and Education Act, and recommended by the United States Preventive Services Task Force. Refer to the Table of Deductibles, Copays and Coinsurances at the end of the policy.

- There are certain prescription drug coverages to which copays and coinsurances apply up to the annual amount established in the Table of Deductibles, Copays and Coinsurances per person in individual and family or couples contracts. Once this amount is met, other additional coinsurances will apply to all the prescription drugs covered. This does not apply to Preventive Services, which are covered with $0 copay, as required by federal laws Patient Protection and Affordable Care Act and the Healthcare and Education Act, and recommended by the United States Preventive Services Task Force. Refer to the Table of Deductibles, Copays and Coinsurances at the end of the policy.

- The copay for generic drugs will not apply during the 12 months of the year if you change from a brand-name drug to a generic drug in Tier 1 found in the Prescription Drug List or Formulary in one of the following therapeutic categories: Anticonvulsants, Antihypertensives, Antipsychotics, Antidiabetics, Antidepressants, Antihyperlipidemics (Cholesterol), and Platelet Modifiers and prescription drugs for Angina.

- For insureds enrolled in a prescription drug coverage subject to the Prescription Drug List for Commercial Plans, tranquilizers included in the benzodiazepines family (Examples: Xanax®, Tranxene® and Halcion®) will be covered when they are prescribed by psychiatrists. Psychotherapeutic drugs will be covered with supplies for 30 days with refills when prescribed by psychiatrists or neurologists. If prescribed by other specialists, they will be covered only for fifteen (15) days without refills.

- For insureds enrolled in a prescription drug coverage subject to the Prescription Drug List for Coordinated Care Plans (Axis, CCI) and other Free-Choice Commercial Plans, tranquilizers prescription drugs included in the benzodiazepines family (Examples: Xanax®, Tranxene® and Halcion®) will be covered with supplies for 30 days and five refills when prescribed by psychiatrists. Psychotherapeutic drugs will be covered with supplies for 30 days with five refills when prescribed by psychiatrics. Psychotherapeutic drugs classified as anxiolytics and antidepressants will be

covered with supplies for 30 days without refills when prescribed by personal physicians (general practitioners, internists, family practitioners, gynecologist-obstetricians or pediatricians).

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

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

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

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

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

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

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

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

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

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

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

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

TIER STRUCTURES APPLICABLE TO THE PRESCRIPTION DRUG BENEFIT
Copays for 30 days
Tier 1 – Generic Drugs
Tier 2 – Preferred Prescription Drugs
Tier 3 – Brand-Name Prescription Drugs
Tier 3 or 4– Non-Preferred Prescription Drugs
Tier 4 or 5 – Preferred Specialty Products
Tier 5 or 6 – Non-Preferred Specialty Products
Oral chemotherapy
Over-the-Counter Medications Program
Medications required by federal law, including all contraceptives approved by the FDA, with a prescription from the physician
Copays for 90 days
Tier 1 – Generic Drugs
Tier 2 – Preferred Prescription Drugs
Tier 3 – Brand-Name Prescription Drugs
Tier 3 or 4– Non-Preferred Prescription Drugs
Tier 4 or 5 – Preferred Specialty Products
Tier 5 or 6 – Non-Preferred Specialty Products
Oral chemotherapy prescription drugs that are medically indicated for 90-day extended supplies*
Over-the-Counter Medications Program
Medications required by federal law, including all contraceptives approved by the FDA, with a prescription from the physician

*Please refer to the Prescription Drug List. You may access the Prescription Drug List by registering in our insureds' webpage in www.ssspr.com.

- **Refer to the Table of Deductibles, Copays and Coinsurances at the end of this policy for the corresponding copayments and coinsurances, according to your coverage.**

- There may be other requirements of the plan that may affect coverage of certain specific prescription drugs. Refer to the section on Exclusions of the Prescription Drug Benefit or the List of Prescription Drugs or Formulary for additional information.

DENTAL BENEFITS

The dental benefit is designed to provide necessary dental services in compliance with federal laws. A $0.00 copay applies.

Description of Services
Covered Services:

Diagnostic and Preventive Services

1. Initial comprehensive exam by generalist or specialist
2. Routine periodic exams
3. Emergency exam
4. Individual periapical X-rays
5. Bitewings X-rays (single; two)
6. Dental Prophylaxis (cleanings)
7. Fluoride varnish treatment for children under age five (5)
8. Topical fluoride applications for children under age 19
9. Topical fluoride applications only for adults with special conditions

LIMITATIONS TO DENTAL BASIC SERVICES:

1. Initial comprehensive exam (initial evaluation for new patients) is limited to one (1) every three (3) years.
2. Routine periodic exam (follow-up evaluation) emergency services and dental prophylaxis (cleanings) services are limited up to two (2) of each per policy year, per insured person at intervals of no less than six (6) months from the last date of service.
3. Bitewings X-rays are covered up to one (1) pair per policy year, per insured.
4. Fluoride varnish treatment is covered up to two (2) per policy year at intervals of no less than six (6) months for children under age 5.
5. Topical fluoride treatment is limited to two (2) per policy year at intervals of no less than six (6) months, until the insured reaches 19 years of age.

PREDETERMINATION MECHANISM

When the insured person uses the services of participating dentists, they will request Triple-S Salud predetermination before rendering the services mentioned. However, in case you use the services of non-participating dentists outside Puerto Rico, you must pay for the services and request reimbursement to Triple-S Salud. To evaluate the reimbursement request, a detailed receipt that includes the codes of the services received and the X-rays is required.

EXCLUSIONS TO THE BASIC COVERAGE

This policy does not cover the following expenses or services:

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

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

3. Services for treatment arising from the insured person committing a crime or violating the laws of the Commonwealth of Puerto Rico or any other country.

4. Services received without charge or defrayed through donations.

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

6. Services rendered by health professionals, who are not doctors in medicine or odontology, except audiologists, optometrists, podiatrists, psychologists, social workers, 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 physician or participating provider despite not being required to do so by this contract.

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

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

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

12. Expenses or services for new medical procedures or new prescription drugs, not considered experimental or investigational, until Triple-S Salud determines their inclusion in the benefits covered under this policy. The plan will neither cover medical expenses related to investigational clinical treatments or studies (that is, clinical trials) or the examinations and medications administered as part of these studies, nor the medical expenses that must be paid by the entity conducting the clinical trial. This provision applies even when the insured has enrolled to participate in the clinical trial to treat a disease that is threatening his life, and for which there is not an effective treatment and has obtained the approval of his physician for his participation in the study, because it offers a potential benefit to the patient. In this case, Triple-S Salud will cover the "patient's routine medical expenses", being understood that "patient's routine medical expenses" are not the expenses related to the clinical trial or the tests performed as part of the clinical trial or the expenses that must be reasonably paid by the entity conducting the clinical trial. Once included in the coverage, Triple-S Salud will pay for those services an amount that does exceed the average amount it would have paid if the medical service had

been rendered through conventional methods, until a fee is established for these procedures.

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

14. Expenses for contraceptive methods for men; except those indicated as covered in this policy.

15. Services for male or female infertility, conception by artificial means (e.g., in vitro fertilization, intracytoplasmic sperm injection, embryo transfer, donor fertilization) and surgical procedures to restore the ability to procreate. Hospital, medical and surgical services, treatment for any complications that may arise and drugs and hormones used for this purpose are also excluded.

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

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

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

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

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

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

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

23. Expenses for allergy immunotherapy.

24. Services rendered for an induced abortion.

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

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

27. Hospitalizations for services or procedures that can be performed ambulatory.

28. Expenses for services resulting from the administration of an employer drug detection program, as well as any rehabilitation treatment if the insured results positive. Once the insured person participates in any rehabilitation treatment as a result of obtaining positive results in the employment drug testing, the insured will be eligible to the rehabilitation treatment covered by this policy, as long as the treatment is not related to the previously mentioned program.

29. Expenses brought about by war, civil disobedience or international armed conflict.

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

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

32. Expenses for services rendered by sea ambulance.

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

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

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

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

37. Expenses for heavy metals, doping, HLA typing, paternity and fertility labs tests.

38. Expenses for special nursing services.

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

PRESCRIPTION DRUG BENEFIT EXCLUSIONS

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

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

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

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

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

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

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

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

   f. Drugs used in diagnostic tests (*thyrotropin*, *dipyridamole IV 5mg/ml, gonadorelin HCl, cosyntropin* and *glucagon*) and prescription drugs for immunization. Immunizations are included in the basic coverage.

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

   h. Oral vitamins (alone or combined with other vitamins, minerals and folic acid) except prenatal vitamins which are covered, and injectable (niacin, ascorbic acid, thiamine, riboflavin, vitamin E, pyridoxine dihidrotaquisterol, multivitamins with minerals, multivitamins with iron, multivitamins with calcium, B vitamin complex-biotin-D- folic acid, B-complex with vitamin C –folic acid and flavonoids).

   i. Growth hormones

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

4. Products considered experimental or investigational for the treatment of certain conditions for which the Food and Drugs Administration has not authorized its used. Medical or pharmacy expenses related to

clinical trials or the exams or medications administered as part of these studies or the medical or pharmacy expenses, which must be paid by the entity conducting the study. This provision applies even when the person has enrolled in the clinical trial to treat a disease that threatens his/her life, for which there is not an effective treatment and has the approval of the physician to participate in the study because it offers a potential benefit to the patient.

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

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

7. Refills ordered by a dentist or podiatrist.

8. Expenses for injectable antineoplastic agents.

9. Expenses for contraceptives not approved by the FDA. In addition, contraceptives approved by the FDA without a prescription from the physician.

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

11. The following will also be excluded: tripan blue solution, intravenous lacosamide, carmustine intracranial implants, injectable degarelix acetate, viaspan, tetradecil sodium sulfate, polidocanol, sodium murruate, intrapleural talc, solution for peritoneal dialysis and homeopathic products in all their presentations.

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

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

DENTAL COVERAGE EXCLUSIONS

The exclusions of the hospitalization, medical-surgical and ambulatory services policy apply to this coverage, except those services that are mentioned as covered.

Triple-S Salud will not be responsible for the following expenses or services unless otherwise stated:

1. Any service not included as covered in the description of this coverage.
2. Full-mouth reconstruction services.
3. Endodontic treatments.
4. Restorative, surgical, prosthetic, periodontal and orthodontic dental services.
5. Expenses for the replacement or repair of devices.
6. Fluoride varnish and topical fluoride treatments are mutually exclusive treatments.
7. Services rendered by non-participating dentists in Puerto Rico, except in case of emergency.
8. All dental services rendered merely for cosmetic purposes.
9. Treatment for the temporomandibular joint syndrome (TMJ).
10. Root canal not specified in the covered benefits.

PROCEDURE FOR OBTAINING REIMBURSEMENT

1. Claims for reimbursement must be sent to:

   a. Triple-S Salud, Inc. PO Box 363628, San Juan, PR 00936-3628

   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
   - Amount and description of services received
   - Amount paid
   - Provider or participant signature and license
   - Reason for requesting reimbursement
   - In the case of ambulance services, you must include information about the distance traveled, as well as evidence of medical necessity.
   - For services that require a precertification, include a copy of the precertification.

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

   To request reimbursement for dental services you must include:
   - Service code, tooth number, surface number 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, and YEAR) of the services for which he/she paid.
   - In case of orthodontic services, if he/she has the orthodontics coverage must include the detail of the first visit, down payment, monthly payments, total cost and duration of active treatment.
   - If the person has dental prosthesis and periodontal services coverage, must include X-rays.

   To request reimbursement through Coordination of Benefits add:
   - Contract number of the other plan
   - If the reimbursement is for amounts left unpaid by your other plan, you must include the Explanation of Benefits of the other plan.

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

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

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

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

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

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

- Bariatric surgery and surgery post-bariatric surgery (torso and abdomen)
- Lithotripsy
- PET CT Scan or PET Scan
- Reconstructive surgeries and procedures that can be performed ambulatory and for a medical reason need another level of care (change in care level)
- Respiratory syncytial virus immunoprophylaxis
- Durable medical equipment
- Skilled nursing facility
- Home healthcare services
- Residential treatment
- Non-emergency services in the United States

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

You may submit the required information by fax or mail.

Main Office: (787) 749-0265

Regional Service Centers fax numbers:

Arecibo: (787) 817-2609
Caguas: (787) 706-4030
Mayagüez: (787) 833-4960
Ponce: (787) 843-1722

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

PROCEDURE FOR PROCESSING PRECERTIFICATIONS

Triple-S Salud has 15 days from the receipt of the precertification request for the following:

1. Notify their benefit determination; or
2. Request additional information. You will have up to 45 days to provide the information requested.
3. Inform that they need more time to make their determination. This extension can be up to fifteen (15) additional 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 treating physician, may jeopardize your life, health or ability to regain maximum functions or because waiting for the standard precertification process would subject you to severe pain that could not be adequately managed without the treatment for which the precertification is requested. In this case, the treating physician must certify the urgency of the precertification. The request in these cases may be initiated in writing or orally. Triple-S Salud must notify you their decision, either orally or in writing, unless you request it must be in writing, within 24 hours from the receipt of your request. If Triple-S Salud needs additional information to issue their determination, they must notify you orally or in writing, unless you request it must be in writing, within 24 hours from the receipt of your request. You or your representative will have no less than 48 hours from the notification to submit any additional information requested. Once Triple-S Salud receives the additional information, they must give you an answer within 48 hours from the earlier between the date of receipt of the additional information and the expiration date of the term allowed to receive it. If Triple-S Salud does not receive the additional information within the term required, they may deny the certification of the benefit requested.

The notification on the adverse determination will include the following:

- Date of service, provider, amount of the claim, diagnostic and treatment codes, as well as their meanings, if applicable.
- Specific reasons for the adverse determination, including the denial code and its meaning, as well as a description of the standards, if any, used for the determination;
- Reference to the specific plan provisions on which the determination is based;
- Description of all the materials or additional information needed to complete the request, including an explanation on why it is necessary;
- Description of the plan's internal grievance procedures and expedite review procedures, including the timeframes that apply to said procedures;
- If to make the adverse determination, they considered a rule, guideline, internal protocol or other similar criteria, the plan will provide a copy to the insured person; free of charge
- If the adverse determination considered the judgment of medical necessity, in the experimental or investigational nature of the procedure or a similar exclusion or limit, they will include an explanation of the scientific or clinical reasoning considered for the determination when applying the terms of the health plan to the circumstances of the insured 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 Salud internal grievance procedures. The Office of the Insurance Commissioner is located at GAM Tower, Urb. Caparra Hills Industrial Park, 2 Tabonuco Street Suite 400, Guaynabo, PR, and you can contact them at (787) 304-8686. The Office of the Patients Ombudsman is located at Mercantil Plaza, 1501 Ponce de León Ave., Hato Rey, PR and you can contact them at (787) 977-0909 (Metro Area) or the toll-free number 1-800-981-0031.

EXPEDITE (FAST) APPEALS OF PRECERTIFICATIONS DENIED ON URGENT CASES

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

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 relate to high costs.

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

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

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

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

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 the Formulary or Prescription Drug List of his coverage. There are prescription drugs that are classified as categorical exclusions. This means that the plan has established a specific provision for not covering a prescription drug identifying it by its scientific or commercial name.

Types of exceptions

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

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

How to make the request

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

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

Information required for the approval of your exception request

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

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

How Triple-S Salud processes a prescription drug exception

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

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

II. Triple-S Salud Department of Pharmacy has established that only the covered person or his personal representative can make the exception request in writing using Form CSS-AS-04-002, for the following reasons:

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

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

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

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

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

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

   The exception request form is available for free at www.ssspr.com and on the Prescription Drug Lists or Formularies. (..\SOLICITUD DE EXCEPCIÓN MÉDICA COMERCIAL.docx)

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

   a. Name, group number, contract number

   b. Patient history

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

   d. The reason:

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

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

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

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

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

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

   b. Appropriate practice guidelines

   c. The benefits and exclusions of the policy

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

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

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

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

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

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

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

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

XII. In the denial notice, the plan will inform the insured of his right to file a grievance pursuant to the Chapter on Internal Procedures to File Grievances of Health Insurance Organizations or insurers of this code.

XIII. The denial shall set forth:

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

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

Process for notifying the coverage determination

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

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

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

Adverse determination means:

- A determination made by a health carrier or utilization review organization where a benefit is denied, reduced or terminated, or the payment is not provided, in whole or in part, for upon application of utilization review techniques and based upon the information provided, the benefit claimed, according to the health carrier, does not meet the requirements of medical necessity and appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational;
- The denial, reduction, termination or failure to provide or make a payment, in whole or in part, for a benefit based on a determination by the health carrier or utilization review organization of a covered person or insured's eligibility to participate in the health plan; or
- The determination resulting from a prospective review or retrospective review that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit.

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 described in this policy, you may appeal Triple-S Salud's determination:

APPEALS PROCEDURE

1. First level of appeal

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

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

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

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

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

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

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

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

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

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

Said determination will include:

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

scientific or clinical judgment used for making the determination, or a statement saying that an explanation will be provided to the 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 criterion relied upon when making the determination; an explanation of the scientific or clinical reasoning followed when making the determination; and the description of the process to obtain an additional voluntary review, as well as the terms for this review, in case the insured person is interested in requesting it. Likewise, it must include a description for obtaining an independent external review, if the insured person decides not to request another voluntary review and the covered person or insured's right to bring a civil action in a court of competent jurisdiction.

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

If your case is considered Urgent, Triple-S Salud will notify its decision no later than 48 hours, from the receipt of the complete request for appeal. An urgent appeal is an appeal request for services or medical treatment for which waiting for standard process to answer an appeal: a) may jeopardize the life of the plan member or the ability of a vital organ of his body to function at its maximum capacity, or b) on physician's opinion, the 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, including retrospective reviews, Triple-S Salud must give an answer within 30 days from the receipt of the appeal request. The time to answer your grievance will be counted from Triple-S Salud receipt of the appeal request, without regard to whether you submit all the documentation necessary to make the determination. If the request for appeal does not include all the information necessary to make the determination, Triple-S Salud will notify the insured person or his personal representative the reasons why it cannot process the grievance and will indicate the documents or additional information the insured must submit. If additional information is required, the insured must provide the additional information within 45 days from the date of receipt of the notice. If the insured fails to submit the information requested within this period, Triple-S Salud will make its decision based on the documents and information already submitted. Triple-S Salud may also notify you that your appeal is being evaluated, but it needs an extension. In this case, Triple-S Salud will have 15 additional days to notify their decision. Once Triple-S Salud notifies the insured its decision, the insured has the right to request Triple-S Salud to disclose the names and positions of the officers or experts that participated in the evaluation of the appeal, as well as an explanation of the criteria on which they based their decision.

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

2. Second level of appeal

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

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

Your second appeal will be evaluated by reviewers that did not intervene in the determination on the first appeal and are not subordinates of the persons who made the

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

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

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

3. Voluntary Review Level

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

Upon receipt of the request for an additional voluntary review, Triple-S Salud will acknowledge receipt and will notify the insured 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 the review meeting, if applicable.
- If it were applicable, make questions to the review panel representatives; and
- Have the help or the representation of any person, including a lawyer, chosen by the 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) calendar days Triple-S Salud has not complied with the determination of the review committee, the latter has the obligation to

notify the fact to the Insurance Commissioner Office.

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

4. External Appeal Process

Triple-S Salud has chosen to benefit from the 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 MAXIMUS Federal Services, free of charge for you if you comply with certain requirements, as explained below.

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

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

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

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

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

Standard Independent Review Procedure

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

All requests for external review must be filed within 120 days from the date you received the adverse determination. To request an external review, you or your authorized representative may call to request an external review to the toll-free number 1-888-866-6205. You can also complete the form to request for external review and send it by fax, mail or email to 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 Salud relevant documents, so that the independent review examiner can complete his evaluation. You also may submit information and documents to support your application such as our denial letter, evidence of benefits (EOB) and letters from your doctors, among others.

The independent review organization may also ask us to provide the information we used to make our adverse benefit determination. **If you have any questions during the external review process, you may call 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 Salud for the following documents, which it took into consideration in making the adverse benefit determination, including:

- Certificate of coverage or benefits

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

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

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

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

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

Review process

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

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

- a general description on the reason for the request for external review, including enough information to identify the claim, the date the IRO received the request for external review and the date of its decision;
- reference to the evidence or documentation he considered in making his decision; the reasons for his decision, including any standard based on evidence on which the decision was based;
- a statement that the determination is binding, except to the extent that there are remedies available under federal or state laws; and
- a statement indicating that judicial review may be available;

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

Expedited external review

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

- you have received an adverse benefit determination that involves a medical condition for which, the deadline for completion of an expedited internal appeal

(as described above), could jeopardize your life or health, or your ability to regain maximum function and have submitted a request for an expedite internal appeal;

- you have received an adverse benefit determination that is related to a medical condition and the deadline for completing the standard independent appeals process can jeopardize your life, health, or ability to regain maximum function of your body; or

- an adverse benefit determination that is related to an admission, availability of care, or a service or item for which you received emergency services, but have not been discharged from the facility. The examiner will follow the review process described in the preceding paragraphs and shall provide notification of the final decision within 48 hours from the date he received your request for an expedited external review. However, if the request is related to an urgent care situation and you are in the course of treatment for the condition, the final decision must be notified within 24 hours. In these cases, the examiner may provide the notice orally, but must give written notice to you and the Plan within 48 hours.

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

Voluntary External Review

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

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

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

MAXIMUS Federal Services will keep the file of your case for six (6) years and it will be available for evaluation if your or we request it.

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

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

Standard Review of Grievances not related to adverse determinations

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

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

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

- The determination of the reviewers in clear terms and the contractual basis or medical justification, so you can respond to the arguments in it;
- Reference to the evidence or documentation used as basis for the determination.
- If applicable:
  - a written statement that includes the description of the process to obtain an additional voluntary review in case the insured 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 information to contact them in case it were necessary.

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

RIGHT TO BE ASSISTED

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

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

RIGHT TO APPOINT A REPRESENTATIVE

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

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

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

The 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.

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

Services of the highest quality consistent with the generally accepted standards of medical practice.

Rights regarding the collection and disclosing of information

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
- Provider Directory
- access to specialists and emergency services
- process for precertifications and grievances

Right regarding the selection of plans and providers

Every individual has the right to:

- Choose health care plans and medical-hospital health service providers that are adequate and sufficient to guarantee access to high quality health care and services, so they can choose those health plans and providers that best suit their needs without being discriminated for their socioeconomic condition, payment capacity, preexisting medical conditions or medical history, regardless of their age.

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

- Have a health plan that allows the insured 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 health care plan. This includes access to specialists qualified to render services to patients with special conditions or special medical or health care needs, in order to guarantee direct and fast access to qualified providers or specialists those insureds and beneficiaries have chosen within the plan's network of providers to cover their health needs. In this sense, and in case a special authorization under the plan is required to have access to qualified providers or specialists, the plan will guarantee an adequate number of visits to cover the health needs of said insureds and beneficiaries.

Patient's right to the continuity of health care service

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

condition before the plan's termination date, the transition period will be extended for the rest of the patient's life.

Right regarding access to emergency services and facilities

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

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

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 your medical care.

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

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

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

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

Right regarding respect and the same treatment

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

Right to confidentiality of information and medical records

- Contact your medical service providers freely and without apprehensions.

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

- Obtain a receipt for expenses incurred for the partial or full payment of 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 the person paying for the services, detail of the services, amount paid and the signature of the authorized officer.

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

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

Rights regarding complaints and grievances

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

Your responsibility as a patient is to:

- Provide the necessary information about health plans and the payment of any account. Know the rules for the coordination of benefits 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.
- Provide the most complete and accurate information on your health condition, including previous diseases, medicines, etc. Participate in every decision regarding your medical care. Know the risks and limits of medicine.
- Know the coverage, options and benefits and other details of the health plan.
- Comply with your health plan administrative procedures.
- Adopt a healthy lifestyle.
- Notify the physician of unexpected changes in your condition.
- Make known that you clearly understand the course of action recommended by the health professional.
- Provide a copy of your advance directives.
- Notify the physician if you anticipate problems with the prescribed treatment.
- Recognize the obligation of the provider to be efficient and equitable when providing care to other patients.
- Be considerate, so that your individual behavior does not affect others.
- Resolve any difference through the insurer's established procedures.

PRIVACY PRACTICE NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duties

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

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

We reserve the right to change our privacy practices and the terms of this notice. Before we make a significant change in our privacy practices, we will change this notice and send an updated notice to our active subscribers. **This privacy notice is effective as of September 15, 2014.**

- Summary of Privacy Practices. Our pledge is to limit to the minimum necessary the information we collect in order to administer your insurance products or benefits. As part of our administrative functions, we may collect your personal, financial or health information from sources such as:
- applications and other documents you have provided to obtain a product or insurance service;
- transactions you make with us or our affiliates;
- consumer credit reporting agencies;
- healthcare providers;
- Government health programs

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

Uses and Disclosures of Information

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

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

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

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

Health Care Operations: For audits, legal services, including fraud and abuse, business planning, general administration, and patient safety activities, credentialing, disease management, training of medical or pharmacy students.

We may disclose your medical information to another health plan or to a health care provider subject to federal or local privacy protection laws, as long as the plan or provider has or had a relationship with you.

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

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

Disaster relief or emergency situations

Government Sponsored Benefits Programs

Public Health and Safety Activities: We may use and disclose your medical information when required or permitted by law for the following activities:

- public health, including to report disease and vital statistics;
- to report child and/or adult abuse or domestic violence;
- healthcare oversight, fraud prevention and compliance;
- in response to court and administrative orders;
- to law enforcement officials or matters of national security;
- scientific research
- as authorized by state worker's compensation laws; and
- as otherwise required by applicable laws and regulations

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

With Your Authorization: You may give us a written authorization to disclose your medical information to anyone for any purpose. Activities such as marketing of non-health related products or services or the sale of health information must be authorized by you. In these cases your health insurance policy and your benefits will not be affected if you denied the authorization.

The authorization must be signed and dated, mention the entity authorized to provide/receive the information, a brief description of the data to be disclosed and the expiration date, which will not exceed 2 years from the date of signage, except if you signed the authorization for one of the following purposes:

- to substantiate a request for benefits under a life insurance policy, its reinstallation or modifications to such policy, in which case the authorization will be valid for thirty (30) months or until the application is denied, the earlier of the two events; or

- to substantiate or facilitate the communication of an ongoing treatment of a chronic disease or rehabilitation of an injury.

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

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

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

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

Security safeguards: We have implemented physical, technical and administrative safeguards to limit access to your personal information. Our employees and business

associates are trained and know their duty to protect and maintain the privacy of your medical information, and are committed to comply with the highest security and privacy standards to handle your information in a responsible manner.

Individual Rights

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

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

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

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

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

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

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

If we deny your request, we will provide you a written explanation. You have the right to request that we include your statement of disagreement with the determination taken by us in future disclosures of the disputed information. If we accept your request, we will make your amendment part of your record and use reasonable efforts to inform our business associates and others who we know may have and rely on the unamended information.

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

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

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

Questions and Complaints

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

If you are concerned that we or any of our business associates may have violated your privacy rights, or you disagree with a decision we made about access to your health information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your medical information, you may complain to us using the contact information at the end of this notice.
You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services (DHHS) at: Region II, Office of Civil Rights, US Department of Health and Human Services, Jacob Javitz Federal Building, 26 Federal Plaza – Suite 3312, New York, New York, 10278; voice phone: (212) 264-3313; fax (212) 264-3039; TDD (212) 264-2355.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the DHHS.

Contact Office: **TRIPLE-S SALUD COMPLIANCE AND PRIVACY OFFICE**

Telephone: (787) 277-6686

Fax: (787)-706-4004

Email: privacidad@ssspr.com

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

Si interesa una copia de este aviso en español, envíe su solicitud a la dirección arriba indicada o visite nuestra página www.ssspr.com.

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

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

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

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

   Liability calculation method per claim

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

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

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

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

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

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

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

   Host Blues using either an estimated price or an average price may prospectively adjust past prices on claims processed through the BlueCard Program if the payments were underestimated or overestimated. However, the amount paid by the member and the group

is a final price. The BlueCard Program requires that the price submitted by a Host Blue is a final price, irrespective of any future adjustments based on the use of estimated or average pricing.

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

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

Return of Overpayments

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

Non-participating providers outside the service area

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

In some exception cases, we may pay claims from non-participating healthcare providers outside our service area based on the provider's billed charge, such as in situations when the member did not have reasonable access to a participating provider, 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. **CIVIL ACTIONS:** No civil action shall be taken to claim any rights of the person insured under this policy before sixty (60) days have elapsed after written proof of the service has been submitted, according to the requirements of this policy. No action shall be taken after three (3) years have elapsed from the date in which it was required that written proof of the service had to be submitted.

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

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

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

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

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

   a. End of COBRA period;
   b. Lack of payment;
   c. Employer terminates the group health plan;
   d. 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 fraudulent claims).

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

6. **CONFIDENTIALITY**: Triple-S Salud will keep the confidentiality of the insured person's medical and claims in accordance with the policies and procedures set forth in the Privacy Practice Notice included in this policy.

7. **CONVERSION CLAUSE:**

   a. If coverage under this policy ends because the employee is terminated from employment or no longer belongs to an employee class or classes eligible for coverage under the policy, the person is entitled to have Triple-S Salud issue an individual basic coverage, with no risk evaluation, within the different levels of metallic coverages approved for newly insured persons requesting an individual health plan and accepting to pay the premiums of said individual health plan. The written application for enrollment in an

individual plan will be submitted and the premiums paid to Triple-S Salud no later than thirty (30) days from the termination, provided that:

1) If the insured person had a previous qualifying coverage with benefits that do not compare or do not surpass those offered in the coverage of the individual silver health plan, Triple-S Salud will offer an individual basic bronze plan to a person, who is converting his plan between coverage periods, until the next enrollment period. During the enrollment period the insured may choose the individual basic health plan he prefers.

2) The individual policy premium will be in accordance with the rates in effect at Triple-S Salud, applicable to the form and the benefits of the individual policy chosen by the insured. The Health Condition of the insured will not be considered for risk classification.

3) The individual health plan should also cover the insured employee's spouse or direct dependents if they were covered on the termination date of the group health plan. At Triple-S Salud's option, a separate individual policy may be issued to cover the spouse or direct dependents enrolled. Any optional dependent of the insured employee covered on the termination date of coverage will be eligible for an individual health policy.

4) The individual policy will be effective upon termination of coverage under the group policy.

5) Triple-S Salud will not be required to issue an individual policy to a person who:

   a. Does not request the basic individual health plan within thirty days of the qualifying event or no later than thirty (30) days after losing eligibility for his existing qualifying coverage.

   b. Is covered or is eligible for coverage under another health benefit arrangement, whether public or private, including Medicare supplementary policies or the Medicare Program, established in conformance with Title XVIII of the Social Security Act, as amended, or any other federal or state law, except in the case of a person that is eligible for Medicare for a reason other than age.

   c. Is covered or is eligible for coverage under a health plan that provides healthcare coverage offered by the employer of the recently covered person.

   d. Is covered or is eligible for coverage under a health plan that provides healthcare coverage under which the spouse, mother, father or guardian is eligible to be enrolled, except if said health plan is the Government Health Plan known as Mi Salud or any other government health plan that is administered by the Health Insurance Administration.

   e. For the period in which he is covered in accordance with the previous individual health plan and that ends after the effective date of the new coverage.

   f. Is covered or is eligible for an extended group health plan according to Section 4980 b of the Federal Internal Revenue Code, sections 601 to 608 of the Employee Retirement Income Security Act (ERISA) of 1974, as amended, Sections 2201 to 2208 of the Public Health Service Act (PHSA), as amended or any other extended group health plan required by law.

b. Subject to the conditions and limitations under clause (a) of this section, the privilege of conversion will be granted to:

   1) the spouse or direct dependents of the insured, whose coverage under the group policy ceases because of the death of said person;

   2) the spouse or direct dependents of the person whose coverage ceases because he does not qualify as a family member under the group policy even when the insured person continues to be covered under the group policy;

   3) optional dependents.

c. If a person insured under the group policy loses coverage under the individual policy described in clause (a) of this section, during the period he would have qualified for the issuance of said individual policy, but before the individual policy goes into effect, the benefits for which he/she would be eligible under the Individual policy will be payable as claim against the group policy even if the individual policy has not been requested or payment of the first premium has not been made.

d. If an individual insured under this group policy acquires the right to obtain an individual policy under the terms of the group policy, subject to applying and paying the first premium within the period specified in the policy, and if this individual is not notified of the existence of this right at least fifteen (15) days before the date of expiration of this period, the individual will have an additional period during which he/she may exercise the right, but none of this implies continuation of a policy beyond the period provided in the policy.

   The additional period will expire fifteen (15) days after the individual has been notified, but in no case will this period be extended more than sixty (60) days after the expiration date provided in the policy. A written notice delivered to the individual or mailed by the policyholder to the last known address of the individual, will be considered notice for the purpose of this paragraph. If an additional period is granted to exercise the right to conversion, as provided here, and if the written application for said individual policy, accompanied by the first premium, is submitted during the additional period, the individual policy will go into effect upon termination of insurance under the group policy.

8. **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 does 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 an out-of-panel provider, except for emergency services or authorized referrals 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 section.

      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 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 below 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 other contractual disposition states otherwise.

2) A group coverage designed to supplement part of a basic package of benefits may result in the supplemental coverage providing an excess of benefits for other parts of the plan provided under the same contract or policy. Examples of these are major medical policies and coverages, specifically designed to cover services provided by non-participating providers in a closed panel plan.

c. A 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.

(ii) Then the order of benefits inverts, and the plan that covers the person as other than a dependent 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 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,

parent 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. The responsibility of the primary plan will begin prospectively after the notification of the court decree.

(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 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 of this paragraph shall determine the order of benefits.

(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.

i. For a dependent child covered under one or both parents coverage, and who also is covered as a dependent under the spouse's plan, rule in paragraph (5) will be applied.

ii. In case the effective date of the dependent child's coverage under the spouse's plan is the same as the effective date of one or both parents coverage, the order of benefits will be determined by the birthday rule established in paragraph (a) of the parent of the dependent child and the dependent spouse.

d)

i. For a dependent child who has coverage under either or both parent's plan and also has his/hers own coverage as a dependent under a spouse's plan, the rule in paragraph 5 applies.

ii. In the event the dependent child's coverage under the spouse's plan began the same date as the dependent child's coverage under either or both parent's plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent spouse.

3) Active Employee or Retired or Laid-Off Employee

a) The plan that covers a person as an active employee 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 about 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 said group 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.

9. **COVERAGE RESCISSION:** Triple-S Salud may decide to terminate your contract retroactively, because of fraud or misrepresentation of a material fact prohibited by the plan. Rescission will be notified in writing with at least thirty (30) days in advance and the plan member or beneficiary has the right to request a revision of this determination.

10. **EXEMPTION OF INSURED'S LIABILITY:** The insured person is not liable to pay for those services for which the participating provider failed to comply with eligibility procedures, payment policies, or the service protocols established by Triple-S Salud.

11. **GRACE PERIOD:** A grace period of 31 calendar days will be granted for the payment of each premium due after the first premium. During this grace period the policy will remain in force.

12. **IDENTIFICATION:** Triple-S Salud will issue a card to each insured, which they are required to show to any Triple-S Salud participating provider from whom services are requested, for the services to be covered under the policy. In addition, the insured should present a second photo ID card.

13. **INDEPENDENT LICENSEE OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION:** The insured and its members, through this means expressly acknowledges and know that this policy constitutes an agreement solely between the insured and Triple-S Salud, which is an independent corporation that operates under a license of the Blue Cross and Blue Shield Association, an independent association of Blue Cross and Blue Shield Plans, allowing Triple-S Salud to use the service mark Blue Cross and Blue Shield in Puerto Rico and Virgin Islands, and Triple-S Salud does not have a contract as agent of the Association.

    Moreover, the insured 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 insured 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.

14. **INDIVIDUAL CANCELLATION:** Triple-S Salud may cancel the insurance of any insured person who commits fraud or makes false misrepresentations of material facts or has submitted or made someone submit a false claim or any evidence to support it, for the payment of a claim pursuant to any of Triple-S Salud's policies, regardless of the date in which the action was committed or the date and the manner in which it was discovered or when the insured person presents patterns of fraud in the use of the benefits provided by this policy. The insured will be notified of the cancellation through a notice delivered to him or mailed to the last known address in Triple-S Salud's records, indicating when the cancellation will be effective, which will not be less than thirty (30) days after the date on notice.

    Triple-S Salud will issue a certification of coverage to the insured employee, as required by HIPAA. If the insured person does not receive said certification of coverage, he/she may obtain it by calling our Customer Services Department at 787-774-6060.

15. **INDIVIDUAL TERMINATION:** It is the insured employee's responsibility, to return the insurance identification cards to Triple-S Salud if he ceases employment or retires. Triple-S Salud will not cover services received after termination of coverage. The employee will be liable for the payment of these services.

16. **MANDATORY COVERAGES:** This policy is subject to federal and local laws and regulations that may require, during the effectiveness of the policy, that coverage is provided for additional hospital and medical-surgical services that were not a part of the covered services when this policy was effective. These mandatory coverages that take effect after the policy was issued may have an impact in costs and premiums.

17. **MODEL FOR CLAIMS:** When Triple-S Salud receives a claim notice, it will provide the claimant the forms it usually provides for the submission of proofs of loss. If the forms are not provided within 15 days from the receipt of the notice, it will be considered that the claimant met the policy requirements regarding proofs of loss if the person submits written proofs of what happened and the nature and extent of the loss object of the claim, within the time frame established in this policy for submitting the proofs of loss.

18. **NOTICE OF CLAIM:** Written notice of claim should be given to Triple-S Salud, by the insured or the employer within twenty (20) days after a service was received or, as soon as reasonably possible, but within a period that does not exceed a year from the date the service was provided. A written notice given

by the insured on his behalf to Triple-S Salud at its main office in San Juan, Puerto Rico or at any of its Service Centers around the island, or to any Triple-S Salud authorized representative, with enough information, so that it may be identified, will be considered notice given to Triple-S Salud.

19. **PATIENT'S BILL OF RIGHTS AND RESPONSIBILITES:** Triple-S Salud will require its insureds, or in case of disabled persons or minors, to the parents, guardians or trustees of these persons, to read and familiarize with the Patient's Bill of Rights and Responsibilities or an appropriate and reasonable summary of the document, as prepared and authorized by the Department of Health. The summary of this Bill is found in this policy.

20. **PERSONAL RIGHTS:** The insured may not yield, transfer, or waive in favor of a third party any of the rights and benefits that he/she may claim by virtue of this policy. It is provided that Triple-S Salud reserves the right to recover all expenses incurred in case the insured, with expressed or implicit consent, allows non-insureds to use the card issued by Triple-S Salud in his/her favor. It is also provided that recovery of such expenses will not prevent Triple-S Salud from terminating the insurance contract when illegal use of the card is discovered, or from filing a civil action for the prosecution of the insured or the person making unlawful use of the card.

21. **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, for audit purposes or fraud investigations.

22. **PREMIUM PAYMENTS:** Both the employer and the employee will be jointly liable for the payment of the premium covering the policy; provided that such liability will cover all the premiums outstanding to the termination date of the policy, in accordance with the TERMINATION clause.

    Triple-S Salud is entitled to collect from the insured employee the premium due or, the costs incurred in the payment of claims for services rendered to the insured after the cancellation of the person's health plan. Triple-S Salud may use collection agency services to request the payment of any outstanding debt with the plan. It is provided that the debtor is required to pay the costs, expenses and attorney fees, as well as any other additional amount or expense in which Triple-S Salud incurs to collect the debt, except if otherwise provided by court.

    Triple-S Salud reserves the right to provide detailed information regarding lack of payment by an employer or insured to any agency, institution, or organism engaged in credit inquiries.

23. **QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO):** This provision is a requirement of ERISA (Employee Retirement Income Security Act) for group health plans that extend health coverage to the children of employees that are divorced, legally separated, or have never gotten married when required by the State. This provision states that the plan can be required to provide health coverage for a child that is a dependent of the employee. The State or Court may request a group covered by ERISA to extend coverage to a dependent child of an employee using a child support order for health coverage.

24. **RECOVERY OF PAYMENTS MADE IN EXCESS OR BY MISTAKE:** If Triple-S Salud issues a payment for a claim to the insured and said payment was issued by mistake and for an amount higher than the amount claimed by the insured, Triple-S Salud can recover from the insured the amount paid in excess.

25. **REINSTATEMENT:** If payment of any renewal premium is not made within the time granted to the group for its payment, subsequent acceptance of a premium, by the insurer or any duly authorized agent of the insurer to accept such premium, without requiring an application for reinstatement will reinstate the policy. However, if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium paid, the policy will be reinstated upon approval of said application by the insurer or, in the absence of such approval, on the forty-fifth day after the date of said conditional receipt, unless the insurer

has notified the insured in writing that said application has not been approved. The reinstated policy will only cover losses resulting from any accidental injury that may occur after the date of reinstatement and losses due to any illness that may begin more than ten days after such date.

In any other respect, the group and the insurer will have the same rights under the policy they had before due date of the unpaid premium, subject to any provisions endorsed or attached to this document regarding reinstatement. Any premium accepted in relation to a reinstatement shall be applied to a period for which no premium was previously paid and that do not exceed more than sixty (60) days prior to the date of reinstatement.

26. **RIGHT TO GUARANTEED RENEWAL OF THE PLAN**: The employer has the right to request the guaranteed renewal of the health insurance plan of all eligible employees and their dependents, except in the following cases:
    a. Failure to pay premiums, considering the grace period;

    b. When the employer, the eligible employee or any of the eligible dependents performed an act that constitute fraud. In this case, Triple-S Salud may opt not to renew the health plan to the employer, the eligible employee, or the insured person for a period of one year from the date of coverage termination;

    c. When the employer, the eligible employee or the insured person has made an intentional false misrepresentation of important material facts under the terms of the health plan. In this case, Triple-S Salud may opt not to renew the health plan to the employer, the eligible employee or the insured person for a period of one year from the date coverage termination.

    d. Failure to meet the minimum participation requirements set forth by Triple-S Salud;

    e. Failure to meet employer contribution requirements;

    f. In case Triple-S Salud decides to discontinue offering all PYMES market plans in Puerto Rico: In this case, Triple-S Salud must provide written notice to the Office of the Insurance Commissioner of Puerto Rico, PYMES plan sponsors and plan members at least 180 days before the health plan renewal date.

    g. When the Insurance Commissioner determines that continuance of the health plan does not respond to the best interests of the policyholders or will affect the insurer's ability to meet its contractual obligations.

    h. In case of health plans made available to the small group market through a preferred network, when no employee insured of the PYMES employer live, reside or work in the service area of the insurer.

27. **RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT:** Any person insured under a group health plan for more than eighteen (18) months is entitled to enroll in an individual policy without waiting periods or exclusions for preexisting conditions.

    To benefit from this right, the request for enrollment in the plan should be made within a period of time that does not exceed sixty-three days from the date the insured lost coverage under the previous group plan, or lost the employer's contributions, and the termination of the plan must be for one of the following reasons:
    - Loss of eligibility (for resignation or termination of employment)
    - Loss of employer contributions, or
    - Termination of coverage under COBRA

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

    a. Mother and newborn hospital length of stay in connection to childbirth will not be limited to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section.

b. Nevertheless, insurers and group plans may cover shorter stays, if the physician, after consulting the mother, orders the discharge from the hospital of the mother or the newborn before reaching the aforementioned terms.

c. If the mother and newborn are discharged earlier than the period specified in paragraph (a) of this section, but in accordance with clause (b), coverage will provide for one follow-up visit within the next forty and eight (48) hours. The services will include, but will not be limited to, assistance and physical care of the newborn, education on care of the newborn for both parents, training on breast-feeding, orientation on home support for the mother, treatment and medical tests for the newborn and the mother.

d. Neither insurers nor group plans will design benefits or include deductibles or coinsurances that imply unfavorable treatment in any portion of the hospitalization.

29. **TERMINATION:** Triple-S Salud reserves the right to terminate this policy on the due date for lack of payment of any due premium, after the grace period, through written notice to the insured employee no less than thirty (30) days in advance.

    In addition, Triple-S Salud reserves the right to terminate this policy for lack of payment of any premium through written notice to the employer no less than thirty days in advance. If the employer decides to cancel this policy to obtain the plan through another insurer, the employer can cancel this policy by sending written notice to Triple-S Salud at least thirty (30) days prior to the cancellation of the policy. However, if the employer decides not to continue the health plan as part of the fringe benefits, the employer must give written notice Triple-S Salud no less than forty five (45) days prior to the effective date of the cancellation, which will be effective on the last day of the month following the date of receipt of the notice. Termination will not affect any claim for services rendered before the termination date.

    In case the organization offering a healthcare plan ceases to exist or in case of termination or cancellation of a provider, Triple-S Salud will notify this termination or cancellation 30 calendar days prior to the date of termination or cancellation.

    Subject to the payment of any premium, in case of termination of a provider or the policy, the insured employee can continue receiving the services of said provider during a ninety (90)-day transition period from the date of termination of the policy or the provider contract.

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

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

    b. In the case of a female plan member who is in the second trimester of pregnancy on the termination date of the policy and the provider has been providing pregnancy medical treatment prior to the termination date of the policy, the transition period for pregnancy medical services will be extended until the date the mother is discharged from the hospital due to childbirth or the newborn's date of discharge, whichever date comes last.

    c. In the case of a patient diagnosed with a terminal condition by a Triple-S Salud participating physician prior to the termination date of the policy and the person was receiving services for that condition before the termination date of the plan, the transition period will be extended for the remaining life of the patient.

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

choose to enroll in a direct payment policy or choose the transition period for the plan termination. Once the termination transition period ends, the provisions set forth in the Conversion clause will apply.

30. **THIRD PARTY ACTIONS:** If by fault or negligence of a third party the insured person suffers an illness or an injury covered under the policy, Triple-S Salud is entitled to subrogate in the rights of the insured in order to claim and receive from that third party a compensation equivalent to the expenses incurred in treating the insured as a result of such negligent action.

    The insured acknowledges Triple-S Salud's right of subrogation and will be responsible for notifying Triple-S Salud of all actions initiated against the third party; provided that if the insured acts otherwise, the insured will be liable for paying such expenses to Triple-S Salud.

31. **TRANSFER OF COVERAGE:** If the insured moves to the service area of another plan affiliated to the Blue Cross and Blue Shield Association and if the insured requests it, Triple-S Salud will process the transfer to the plan that services the area of the insured's new address.

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

    If the insured accepts the conversion policy, the new plan will credit the time the person was insured under Triple-S Salud against any waiting period. Any physical or mental condition covered by Triple-S Salud will be covered by the new plan without a waiting period if the new plan offers the same feature to other persons who have the same type of coverage.

    The fees and benefits available in the new plan may vary significantly from those offered by Triple-S Salud.

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

    The insured may acquire additional information about the Transfer Program by contacting our Customer Service Department.

32. **TRIPLE-S SALUD'S RIGHT TO AUDIT:** When subscribing to this policy, insured persons accept, acknowledge and understand that Triple-S Salud, as payer of the health services incurred, has the authority to access their medical information to audit all or any health service claims that Triple-S Salud has paid.

33. **UNIQUE CONTRACT-CHANGES:** This policy, riders, and attached documents, if any, constitute the entire text of the insurance contract. No change to this policy will be valid until approved by the executive officer designated by the Board of Directors of Triple-S Salud, and 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.

34. **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 that may arise during all the stages of a mastectomy. These benefits will be provided based upon a consultation between the insured female and her physician, and are subject to the copays and coinsurances set forth in her policy.

1. **9-1-1 SYSTEM:** An answering system to public safety emergency calls, through the 9-1-1 number, created by virtue of law 144 of December 22, 1994, as amended, known as Act for the Speedy Attention of Public Safety Emergency Calls or 911 Calls Act**.**

2. **ACTIVE EMPLOYEE:** Means an employee that renders services to an employer and in exchange he receives a paycheck, salary, wage, commission, bonus or any other compensation, or which is on paid leave such as vacations, sick leave or military training leave, among others, regardless if they carry out his functions at the employer's facilities or outside them, if this employee is permanent, full-time or part time. An active employee is also an employee that is temporary absent from his work because of a personal or family health condition. An employee will become an inactive when he resigns, abandons his job, is on a leave of absence without pay (unless in those exceptional circumstances provided by law such as those provided by the State Insurance Fund and the Family Medical Leave Act) is terminated from employment, retires, dies or his position is declared vacant by the employer. This term includes temporary employees, owners or officers of the PYMES.

3. **AFFORDABLE COVERAGE:** Means a coverage whose total premium or the contributions to the total premium made by an employee/insured person does not exceed 9.5% of his family income.

4. **AMBULANCE SERVICES:** Transportation services received in a vehicle duly authorized by the Public Service Commission and the Department of Health of Puerto Rico to render such services.

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

6. **AMBULATORY SURGERY CENTER:** A specialized institution:

   a. Regulated by law, holds a license from the regulatory agency responsible for granting such permits under the laws and regulations of the jurisdiction of its location; or

   b. Where is not regulated by law, complies with the following requirements:

      1) Is established, equipped, and operated according to the laws and regulations in effect within the jurisdiction in which it is located, for the primary purpose of providing surgical services.

      2) Operates under the supervision of a medical doctor (M.D.) licensed to practice his/her profession, who provides full-time supervision and allows surgical procedures only to be performed by a qualified doctor, who at the moment of practicing such procedures, has a similar practice in at least one hospital in the area.

      3) Requires in all cases, except those requiring local anesthesia, that a licensed anesthesiologist administer the anesthesia and is present during the complete surgical procedure.

      4) Provides at least two (2) operating rooms and at least one post anesthesia recovery room; fully equipped to perform X-rays and laboratory diagnostic tests; with trained personnel and the necessary instruments to face any foreseeable emergencies including, but not limiting to, a defibrillator, a tracheotomy kit and blood bank or any other necessary supplies.

5) Provide full-time service of one or more registered nurses (R.N.) for the care of patients in the operating rooms and post-anesthesia recovery rooms.

6) Has subscribed a contract with at least one hospital in the area for the immediate hospitalization of patients who develop complications or requires post-surgery hospitalization.

7) Maintains an appropriate medical record for each patient, including an admission diagnosis with a report on pre-surgery examinations, a clinical history and laboratory examinations and/or X-rays, an operation report and a report on the release of the patient, except for those who have undergone a local anesthesia procedure.

7. **ASSIGNMENT OF BENEFITS:** Process through which non-participating physicians, hospitals and facilities accept to provide the necessary services to the insured, billing directly to Triple-S Salud for said services based on the rates for participating providers.

8. **BARIATRIC SURGERY:** Surgical procedure to control obesity, which can be done using four different techniques: surgical bypass, adjustable gastric band, sleeve gastrostomy or intragastric balloon. Triple-S Salud will only cover, as required by law, the gastric bypass, subject to precertification. The adjustable gastric band, intragastric balloon and sleeve gastrectomy are not covered.

9. **BENEFIT PREDETERMINATION:** Evaluation of the treatment plan suggested by the dentist before the services are rendered, to determine the eligibility of the insured, the scope of the benefits covered, the limits, exclusions and copays that apply under the insured's contract.

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

11. **BLUE CROSS AND BLUE SHIELD PLAN:** Independent licensee, which through a contract with the Blue Plans Association (Blue Cross/Blue Shield) acquires a license to be a member of the independent plans association and allows it to use their trademarks.

12. **BRAND NAME PRESCRIPTION DRUGS (TIER 3):** Prescription Drugs offered to the public under a commercial name or trademark.

13. **COBRA LAW:** Public Law 99-272, Title X, Consolidated Omnibus Budget Reconciliation Act (COBRA), which requires all employers with twenty (20) or more employees that sponsor group health insurance plans to provide its employees and family members, in some situations, temporary coverage (called Continued Coverage) when coverage under the plan ends.

14. **COINSURANCE:** The percentage of established fees that the insured will pay when purchasing a prescription drug or receiving a covered services from a participating physician or provider or any other provider, as his or her contribution to the cost of the services received, as set forth in the policy and notified to the participating physician or provider. This amount is not reimbursable by Triple-S Salud.

15. **COLLATERAL VISITS:** Interviews at the office of a psychiatrist or psychologist (with a master's or doctorate degree and a valid license issued by the Puerto Rico Board of Psychologist Examiners) with the immediate family of the patient insured under this policy.

16. **CONTRACT HOLDER:** The person that holds an insurance contract with Triple-S Salud that entitles him/her to the benefits issued in his/her name and assumes the responsibilities established in the policy.

17. **COPAYMENT (COPAY):** A fixed predetermined amount to be paid by the insured when purchasing prescription drugs or when receiving services from a participating physician or any other provider, as his/her contribution to the cost of the services received, as set forth in the policy and has been notified to the participating physician or provider. This amount is not reimbursable by Triple-S Salud.

18. **COSMETIC SURGERY:** That surgery, whose purpose is to improve the individual's appearance and not to restore function or correct deformities. A purely cosmetic surgery does not turn into reconstructive surgery for psychiatric or psychological reasons.

19. **CREDITABLE COVERAGE:** It is the health coverage the insured employee has before he/she enrolls under the group health plan, as long as the person has not have a substantial interruption in the coverage. The certificate of creditable coverage is provided:

    a) When the person is no longer covered by the health plan or obtains coverage as per a provision of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) on coverage continuation;

    b) In the case of a person covered according as per a provision of COBRA on coverage continuation, at the moment the person is no longer covered in conformance with said provision; and

    c) At the moment a request is made on behalf of a person, if the request is made within twenty-four (24) months from the date of the termination of coverage as described in sections (1) or (2), whichever date is later.

20. **CUSTODIAL CARE:** Refers to personal attention or assistance, provided permanently to a person, in daily life activities such as bathing, dressing, eating, getting in and out of bed, sitting in and standing up from a chair, moving from one place to another, using the bathroom, cooking and eating meals and taking medications. Custodial care does not require the continuous attention of medical staff.

21. **DEDUCTIBLE:** The annual cash amount the person must reach before he is entitled to the benefits covered under this policy. In this case it applies to certain prescription drug benefits. Each person insured under an individual contract will be liable to pay for covered services until he reaches the annual coverage deductible, after which he will pay the copays and coinsurances set forth in the plan. In family contracts, no cash deductibles other than the deductible set forth for family contracts will be applied, as stated in the Table of Deductibles, Copays and Coinsurances at the end of this policy, against all the expenses incurred by your family members during any policy year.

22. **DENTIST:** An odontologist that is legally authorized to practice dentistry.

23. **DIRECT DEPENDENTS:** The following are considered direct dependents:

    a. The spouse, person with whom one is married, having complied with the ceremonies and formalities required by the law, of the insured person included in a Family Contract as long as the policy is in effect and the insured lives permanently with that spouse under the same roof.

    b. Biologic or adopted children of the insured employee or the spouse of the insured as defined in this clause 23 (a) until they attain age 26. The children or the spouses of the insured's dependents will not be eligible for coverage under this plan, except those included in paragraph 23(d) below, or the children of the spouse of the policyholder's child.

    c. Minors placed in the home of the insured person to be adopted by the insured person. The insured person must evidence the placement for adoption with the documents requested by Triple-S Salud.

d. Any minor not emancipated, such as a grandchildren or other blood relative of the main insured will be considered a direct dependent, as long as the insured person holds permanent custody of said child awarded to the main insured by a court of law through a final and binding judgment; said direct dependent may stay enrolled in the plan until he attains age 26. Any person of legal age that is a grandchild or blood relative of the main insured and has been declared disabled by a court of law through a final and binding judgment; will also be accepted as a direct dependent if the custody of the disabled person was awarded to the main insured by a court of law. If insured wishes to subscribe as direct dependent a grandchild or blood relative under this clause must show proof of its custodian character by presenting the final and binding judgment of court awarding permanent custody or guardianship, as the case may be.

e. Foster children will also be considered direct dependents as long as they totally depend on the insured for their livelihood, until they attain age 26. Foster children status must be shown through the documents Triple-S Salud requests. It will be understood that foster children are those minors, who, without being biologic or adopted children of the insured employee, have lived from their infancy under the same roof with the insured in a parent-child relationship and who are, and will continue to be, totally dependent on the family of said insured for their livelihood as the term is defined in article 142 of the Civil Code of Puerto Rico.

24. **DURABLE MEDICAL EQUIPMENT:** Equipment that can be used repeatedly. Its principal use is to serve a medical purpose, and not to serve the person or the injury. This equipment must be appropriate for use in the patient's home and its medical necessity must be certified. It does not include equipment that is used outside the home of the patient or whose function is limited only to convenience. Durable medical equipment includes, but is not limited to, hospital-type beds, wheelchairs, oxygen equipment and walkers, among others.

25. **EFFECTIVE DATE:** Means the first day of coverage or, if there is a waiting period, the first day of the waiting period, whichever comes first.

26. **ELEGIBILITY WAITING PERIOD:** Period of time which must pass before the insured is entitled to receive certain benefits, under the health plan terms. The waiting period will not exceed 90 days.

27. **ELIGIBLE EMPLOYEE:** It means an employee that works full-time during the minimum hours required by the employer-regular work week of thirty (30) hours or more, or part-time-less than seventeen and a half (17.5) hours per regular work week-for a PYMES employer, in which there is a goodwill relationship between the employer and the employee, which is not established in order to purchase a health plan. In this computation employees that are absent of work because of a leave or a right recognized by law, such as benefits provided by the State Insurance Fund Corporation or the Family Leave Act of 1993. The term eligible employee" does not include temporary employees or independent contractors.

28. **ENROLLMENT PERIOD**: The period of time an eligible employee has to enroll in a PYMES employer health plan.

29. **EXPENSE INCURRED**: The amount the insured pays out-of-pocket for a service received that was not billed to the plan or processed by assignment of benefits.

30. **EXPERIMENTAL OR INVESTIGATIONAL SERVICES:** Medical treatment:

    a. That is considered experimental or investigational as defined by the Technology Evaluation Center (TEC) of the Blue Cross and Blue Shield Association on specific indications and methods ordered or;

b. That does not have the final approval of the appropriate regulatory agency (e.g., Food and Drug Administration (FDA), Department of Human and Health Services (DHHS), the Commonwealth's Department of Health) or;

c. For which scientific evidence is insufficient, according to the scientific evidence available, or does not support conclusions on the effect of treatment or technology on the medical results obtained or;

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

e. Is not more beneficial than other already known alternative treatments or;

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

31. **FAMILY CONTRACT:**

a. The insurance that provides benefits to any insured employee, his/her spouse and his/her direct dependents as defined in clause 23 of this section. The premium for family contracts will apply in these cases.

b. Should there be no eligible spouse as a direct dependent, as defined in clause 23, the insured person's contract with one (1) or more as direct dependents may, at his/her option, be considered a Family Contract or an Individual Contract with one (1) or more direct dependents, as defined in clause 23 of this section. In both alternatives, the premium will be the same.

c. In addition, the insured person may include in his/her Family Contract any optional dependents, as defined in clause 71 of this section, if the applicable premium is paid.

The inclusion of dependents may only be done at the time the policy is purchased or on the policy renewal date, except for those cases indicated in the Changes in Enrollment or Special Enrollment sections of this policy, or if indicated otherwise in any other Law.

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

33. **GENERIC DRUGS (Tier 1):** A generic drug has the same active ingredient in its formula as the brand-name drug. Generic drugs are usually less expensive than brand-name drugs and have the approval of the Federal Food and Drugs Administration (FDA).

34. **GENETIC INFORMATION:** Means information of genes, genetic products and inherited characteristics that may derive from the individual or a family member. This includes information regarding the status of the carrier and information derived from laboratory tests that identify gene or specific chromosomal mutations, physical medical exams, family history and direct analysis of genetic material or chromosomes.

35. **GRIEVANCE:** A written or oral complaint, if it involves a request for urgent care, submitted by an insured person or on behalf of the insured person, in regard to:

a. The availability, rendering or quality of health care, including grievances related to adverse determinations that may result from a utilization review;

b. The payment or handling of claims or indemnification for health care services; or

c. Issues related to the contractual relationship between the covered person or insured and the insurer.

36. **GROUP HEALTH PLAN:** Means a policy, insurance contract or certificate issued by Triple-S Salud or an insurer for the benefit of a PYMES employer, or a group of PYMES employers, through which health care services are provided to eligible employees and their dependents.

37. **HEALTH INFORMATION**: Means whether oral or recorded information or data in any form or medium:
    a. That is created or received by the insurer or the health services organization, related to physical, mental, or behavioral health, or past, present or future conditions of the person, or family member, the provision of health care to an individual, or past, present, or future payments for the provisions of health care to an individual.

    b. About the payment for health care services provided to an individual.

    Health information also includes demographic and genetic information, and information about financial exploitation or abuse.

38. **HEALTH PROFESSIONAL**: Means a physician or any other professional in the health field that is licensed in Puerto Rico, accredited or licensed by the corresponding entities to provide certain healthcare services and medical care, according to state laws and regulations, such as physicians, surgeons, podiatrists, naturopathic doctors, chiropractors, optometrists, psychologists, dentists, pharmacists, nurses, and medical technologists.

39. **HIPAA (Health Insurance Portability and Accountability Act of 1996):** Public Federal Law Number 104-191 of August 21, 1996. It regulates everything related to the portability and continuity of insurance coverage in the group and individual markets; contains clauses to avoid fraud and abuse of health insurance coverage and the benefit of health services, as well as the administrative simplification of health plans.

40. **HOME CARE:** Is the care provided to an individual at his home, by a licensed health professional or a professional caretaker to help the individual in daily life activities such as bathing, dressing, eating, getting in and out of bed or a chair, moving, using the bathroom, preparing meals, eating meals, and taking medications.

41. **HOME HEALTH CARE AGENCY:** An agency or organization that provides a program of home health care and which:

    a. Is approved as a Home Health Agency under Medicare, or

    b. Is established and operated in accordance with the applicable laws of the jurisdiction in which it is located and where licensing is required, has been approved by the regulatory authority having the responsibility of licensing these agencies in accordance with the law, or

    c. Meets all of the following requirements:
        1. An agency that holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing support services to the home.
        2. It has a full-time administrator.
        3. It keeps written records of services provided to the patient.
        4. Its staff includes at least one (1) Registered Nurse (R.N.)
        5. Its employees are bonded and provided with malpractice and professional liability insurance.

42. **HOSPITALIZATION PERIOD**: Means the term in which the insured person was confined in a hospital. This period corresponds to the number of days between the day the person was admitted to the hospital and the day the person was discharged.

43. **HOSPITALIZATION SERVICES**: Services covered by this policy that the insured person receives while admitted in a hospital.

44. **HOST BLUE:** Blue Cross or Blue Shield plan of the area where services are rendered under the BlueCard Program.

45. **ILLNESS:**
    a. Any non-occupational illness contracted by the insured person. Illnesses, for which hospitals are unable to admit the patient by law or

regulation once they have been diagnosed, are not covered under this policy.

b. Maternity and conditions that are secondary and related to the pregnancy will be considered illnesses for the coverage offered by this policy, subject to the following conditions:

   1) That services are rendered to the female insured regardless of her marital status

   2) Any service rendered for a therapeutic abortion.

46. **INDEMNIFICATION:** Amount of money that the insured receives for a claim submitted to the health plan for a covered service received.

47. **INDIVIDUAL CONTRACT:** The insurance that provides benefits to any eligible single or married person not including the spouse of the insured, as defined in clause 23, Direct Dependents. Said employee will have the option to include in his/her insurance contract any eligible direct dependent, as defined in clause 23 of this section, through the payment of the corresponding premium. Said employee may also include in the contract any optional dependents, as defined in clause 71 in this section, if he/she pays the additional premium.

    Dependents may only be included at the time the policy is bought or on the policy renewal date, except for those cases indicated in the Changes in Enrollment or Special Enrollment sections of this policy, as otherwise indicated in any other law.

48. **INITIAL PSYCHOLOGICAL INTERVIEW:** Collects the problems of the patient, his/her main complaint, medical history, personal history, history of development, the state of interpersonal relationships, mental state, establishing a diagnosis and a treatment plan with recommendations on strengths and limitations.

49. **INJECTABLE PRESCRIPTION DRUG ANTINEOPLASTIC AGENTS:** A prescription drug that inhibits or prevents the development of cancer preventing the growth, maturation or proliferation of malignant cells; which is administered through infusion.

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

51. **INSURED OR INSURED PERSON:** Any eligible and enrolled person, either the policyholder or a dependent (direct or optional) who is entitled to receive the services and benefits covered under this policy.

52. **INTENSIVE CARE UNIT:** Separate, clearly designated service area reserved for patients in critical condition, seriously ill, requiring intensive monitoring, as prescribed by the treating physician. Additionally, it provides room and nursing care by nurses whose responsibilities are concentrated in the care and accommodation of intensive care patients and special equipment or supplies available immediately at any moment for the patient confined in this unit.

53. **LICENSED PHYSICIAN:** A person that requests and is authorized to exercise medicine and surgery in Puerto Rico after obtaining a license by the Board of Medical Licensure and Discipline of Puerto Rico, in accordance with the provisions of the law and this regulation.

54. **MAIL ORDER PRESCRIPTION DRUG PROGRAM:** A voluntary program that allows the insured to receive some of his maintenance drugs through the United States Postal Service.

55. **MAINTENANCE PRESCRIPTION DRUGS:** Those prescription drugs that require a prolonged therapy, and are unlikely to change in dose or therapy because of side effects. Other prescription drugs considered maintenance drugs are those whose common use is to treat chronic diseases for which the end of the therapy cannot be determined.

56. **MAXIMUM OUT-OF-POCKET AMOUNT:** It is the maximum amount stated in the policy that a person must pay during the policy year. Before the person reaches the out-of-pocket amount stated in this policy, the person will pay the deductibles, copays, or coinsurances for essential medical-hospital care, prescription drugs and essential dental services, as described in the Table of Deductibles, Copays and Coinsurances, 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 not covered under this policy and the premium paid to Triple-S Salud for the plan, are not considered eligible expenses for the accumulation of the out-of-pocket maximum.

57. **MEDICAL EMERGENCY:** Sudden and unexpected 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 any case no later than twenty-four (24) hours after onset of the condition.

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

59. **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.

60. **METABOLIC SYNDROME:** Is the group of several diseases or risk factors in a person that increase the chance of developing a cardiovascular disease or diabetes mellitus. Persons that have the metabolic syndrome have at least three of the following risk factors: excessive fat in the abdomen, hypertension, and abnormal lipid levels in the blood which include cholesterol and triglycerides and hyperglycemia (high sugar levels in the blood).

61. **MORBID OBESITY:** It is the excess of fat in the body determined by a body mass index (BMI) of 35 or higher. It is a condition that is part of the metabolic syndrome and it is a risk factor for the development of other conditions such as hypertension, heart diseases, orthopedic problems, sleep apnea, skin problems, circulation problems, diabetes mellitus, acid reflux, psychological problems, anxiety, infertility, and pulmonary embolism, among others. Studies indicate that it is a condition of multifactorial origin, such as genetic, environmental and psychological, among others. This means that it can be caused by factors such as overeating, metabolic alterations or hereditary factors.

62. **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 (FDA).

63. **NINETY-DAY PRESCRIPTION DRUGS DISPENSING PROGRAM AT PHARMACIES:** A voluntary program that allows the insured to obtain 90-day supplies for some of his/her maintenance prescription drugs from pharmacies participating in the Program.

64. **NON-COVERED SERVICES:** Means those services that:

    a. are expressly excluded in the insured's policy;

    b. are an integral part of a covered service;

    c. are rendered by a medical specialty which the plan has not recognized for payment;

    d. are considered experimental or investigational by the corresponding entities, as stated in the policy;

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

65. **NON-PARTICIPATING DENTIST:** A dentist that has not signed a contract with Triple-S Salud to render dental services.

66. **NON-PARTICIPATING PHARMACY:** Any drugstore that has not signed a contract with Triple-S Salud to render services to its plan members.

67. **NON-PARTICIPATING PHYSICIAN OR PROVIDER:** Physician, hospital, medical group or provider that does not have a valid contract with Triple-S Salud.

68. **NON-PREFERRED PRESCRIPTION DRUGS (TIER 3 OR 4):** This tier includes generic and non-preferred brand-name drugs that have a higher cost than prescription drugs in tiers 1, 2 or 3. They are classified as non-preferred because there are alternatives in the previous tiers with fewer side effects or that are more cost-effective. If the insured obtains a generic drug or a brand-name drug in tiers 3 or 4, he will have to pay a higher cost for the prescription drug.

69. **NON-PREFERRED SPECIALTY PRODUCTS:** Identifies prescription drugs or products of the Prescription Drug List or Formulary that are offered under the Special Condition Prescription Drug Program. The cost of the prescription drugs in this tier is higher than Preferred Specialty Products. They are used to treat chronic and high risk conditions that require special management and administration.

70. **NUTRITION SPECIALIST:** Health professional specialized in nutrition and alimentation certified by the government entity designated for said purposes.

71. **OPTIONAL DEPENDENTS:** Immediate relatives of the insured person or his/her spouse who do not qualify as direct dependents, but substantially depend on said person for support and have not reached sixty-five (65) years of age. It is the insured's responsibility to provide evidence to Triple-S Salud on the eligibility of these 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 has a final judgment granting custody or guardianship.

72. **ORTHODONTICS:** Specialty of dentistry that diagnoses and provides treatment to prevent and correct malocclusions.

73. **OVER-THE-COUNTER (OTC) DRUGS:** Are those medications that do not have a federal legend and can be dispensed to the customer without a prescription from the physician.

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

75. **PARTICIPATING PHARMACY:** Any pharmacy that has signed a contract with Triple-S Salud to render services to the plan members.

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

77. **PERIODONTICS:** Specialty of dentistry that diagnoses and treats diseases of the gums and other tissues that support the teeth.

78. **PHARMACY:** Any place legally authorized to dispense medicines.

79. **PHARMACY AND THERAPEUTICS COMMITTEE:** It is a working committee composed of health professionals that is designated to evaluate the efficacy of prescription drugs and submit recommendations and utilization protocols for the cost-effective management of therapies and prevent prescription drugs misuse of unnecessary medicines, according to the standards of clinical practice, and abuse or fraud in the use of prescription drugs. The Committee meets

monthly to share the findings in the utilization reviews and evaluate medical literature on prescription drugs available in market.

80. **POLICYHOLDER:** The person that has an insurance policy or contract with Triple-S Salud, who for the purposes of this policy is the PYMES employer.

81. **POLICY YEAR:** Period of twelve (12) consecutive months for which PYMES employer purchases or renews Triple-S Salud insurance.

82. **PRECERTIFICATION:** Advanced authorization from Triple-S Salud for the payment of any of the benefits covered under this policy and its riders, in cases Triple-S Salud deems necessary. Some of the objectives of the precertification are: evaluate if the service is medically necessary, evaluate the adequacy of the service location, verify the eligibility of the insured for the requested service, and its availability in Puerto Rico. Precertifications will be evaluated based on the precertifications policies that Triple-S Salud has set forth through time. Medications that require preauthorization are usually those that must meet clinical criteria, given that they have a potential for toxicity, are candidates for inappropriate use or are related to an elevated cost.

    Triple-S Salud will not be liable for payment of services that have been rendered or received without this authorization from Triple-S Salud.

83. **PREEXISTING CONDITION:** Means a condition, regardless of its cause**,** for which treatment was recommended or for which a diagnostic, care or treatment was recommended or received six months prior to enrollment in the health plan. This policy does not exclude or discriminate its beneficiaries for preexisting conditions, regardless of the age of the insured.

84. **PREFERRED PRESCRIPTION DRUGS (TIER 2):** This tier includes generic and brand-name drugs that have been chosen by the Pharmacy and Therapeutics Committee as preferred agents after evaluating their safety, efficiency and cost. They are identified on the right of the Prescription Drug List as Tier 2. In those therapeutics classes where there are no generic drugs available, we encourage insureds to use prescription drugs identified as preferred as the first option.

85. **PREFERRED SPECIALTY PRODUCTS:** Identifies prescription drugs or products in the Prescription Drug List or Formulary that are offered under the Special Condition Prescription Drug Program. Prescription drugs in this tier include generic, biosimilar (generics for biological products) and brand-name drugs at a lower cost and with a special arrangement for their dispensing. These products are used for the treatment of chronic and high risk conditions that require special management and administration.

86. **PREMIUM:** Means the specific money amount paid to the insurance company, in this case Triple-S Salud, as the condition to receive the benefits of a health plan for the eligible employees of a PYMES employer. The premium collected from an insured can only be changed once during the contract year, unless there is a change in the affiliation of the PYMES employer, the family group of the eligible employee or the benefits of the health plan requested by the PYMES employer.

87. **PRESCRIPTION:** A written request for medicines issued by a person legally authorized to issue prescriptions for medications, addressed to a pharmacist for the dispensing of a prescription drug.

88. **PRESCRIPTION DRUG:** A prescription drug approved or regulated by the Food and Drugs Administration (FDA) that allows its marketing and for which Puerto Rico and United States laws require that it must be dispensed by prescription.

89. **PRESCRIPTION DRUG LIST OR FORMULARY:** A guide to the prescription drugs chosen by Triple-S Salud Pharmacy and Therapeutics Committee, which contains the therapies necessary for a high quality treatment. The benefits on the prescription drug coverage are determined according to the prescription drugs included in the Prescription Drug List or

Formulary. This selection is based on the safety, effectiveness and cost of the prescription drugs that ensure the quality of the therapy, reducing inadequate utilization, which may adversely affect the health of the patient.

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

91. **PREVIOUS QUALIFYING COVERAGE OR EXISTING QUALIFYING COVERAGE**: Means benefits or coverage provided by one of the following:

    a) Medicare Program, Medicaid, Civilian Health and Medical Program of the Uniformed Services (TRICARE) or any other program sponsored by the government.

    b) Group health plan issued by a health insurance organization or insurer, a prepaid hospital plan or medical insurance of the Health plan of the Auxilio Mutuo, that provides benefits that are similar or exceed the benefits of the basic coverage, as long as the coverage has been in effect during at least one year.

    c) A self-insured plan sponsored by the employer that provides benefits that are similar or exceed the benefits of the basic health insurance plan as long as the coverage has been in effect during at least the last 12 consecutive months, if:

        - The employer opted for a health plan that participates in the Health Plans Insurers Association; and,

        - The employer complied with all the participation requirements of the operational plan of the Health Plan Insurers Association.

    d) An individual health plan or a plan of a bona fide association that includes coverage provided by a health insurance organization or insurer or the plan of the Sociedad de Auxilio Mutuo that provides similar benefits or exceed the benefits of the basic health plan with a silver level coverage, if the coverage has been in effect during at least the last twelve (12) consecutive months; or

    e) The state coverage provided by a Health Plan for Non-Insurable Persons if the coverage has been in effect for at least one year.

92. **PROSPECTIVE REVIEW:** Means the utilization review made before the health care service or treatment is rendered to the patient, as required by the insurer for the approval, in whole or in part, of the service or treatment, before it is rendered.

93. **PROTECTED HEALTH INFORMATION (PHI):** Means health information:

    a. That identifies the person object of the information; or

    b. With respect to which there is reasonable basis to believe the information can be used to identify the person to which the information belong.

    The information identifiers include, but are not limited to:

    a. Name or nickname of the person, family members, or employer;

    b. Address, except if the information is provided in aggregate form by municipality;

    c. All elements of date (except year) related to a person in particular including date of birth, admission or discharge dates, date of death;

    d. Telephone and fax numbers, account numbers, social security number, policy or contract number, e-mail address, medical record number, driver's license number;

    e. Biometric identifiers;
    Full-face photos, among others.

94. **PSYCHOANALYSIS:** Psychoanalysis is based on a set of theories related to the conscious and unconscious mental processes and the interaction between these. It is a modality of therapy used to treat people who present/display chronic life problems in a scale of slight to moderate. Psychoanalysis should not be used as synonymous for the psychotherapy, since they do not pursue the same objective. This service is not covered in this policy, as expressed in the Exclusions section.

95. **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 master's or doctoral degree in Psychology, licensed from a duly accredited graduate program, and with valid license, issued by the Puerto Rico Board of Psychologist Examiners.

96. **PSYCHOLOGICAL TEST:** Use of instruments designed to measure the intellectual abilities or the capability of an individual to master a specific area. Psychological tests to be administered in each specific case will be subject to the professional judgment of the psychologist, with a master's or doctoral degree, who has the knowledge to administer, correct and interpret them, who must be graduated from a duly accredited graduate program and must have a valid license issued by Puerto Rico Board of Psychologist Examiners.

97. **PSYCHOLOGIST:** A professional with a master's (MA) or PhD in Psychology, graduated from an accredited university, college, or center who has been authorized by the Puerto Rico Board of Psychologist Examiners to exercise this practice in Puerto Rico.

98. **PSYCHOTHERAPY:** Methods used for the treatment of mental and emotional disorders through psychological techniques instead of using physical means. Some of the objectives of the psychotherapy are to change maladaptive behavior models, improve the interpersonal relations, and solve the internal conflicts that bring about personal suffering, modify inaccurate ideas of the self and the environment, and foster a defined feeling of self-identity that favors the individual development of an existence that is pure and full of meaning.

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

100. **RESIDENTIAL TREATMENT:** A high level, high intensity, restrictive care services for patients with mental health conditions, including drug abuse and alcoholism and comorbid conditions that are difficult to manage in their home or communities, because the person has not responded to less restrictive treatment. It integrates clinical and therapeutic services organized and supervised by an interdisciplinary team within a structured environment. 24 hours a day, 7 days a week.

101. **REST HOME OR CONVALESCENSE HOME**: A private residential institution equipped for the care of people who cannot look after themselves such as the elderly or persons with chronic conditions.

102. **RETROSPECTIVE REVIEW:** Means the review of a benefit request performed after the health care service was rendered. A retrospective review does not include the review of a claim that is limited to the evaluation of the reliability of the documentation or the use of the correct codes.

103. **SECONDARY CONDITIONS:** A secondary condition is a medical condition resulting from an underlying medical condition, which does not appear on its own.

104. **SERVICE AREA:** The area within which the insured member is expected to receive the majority of the medical/hospital services. In this policy, the service area is Puerto Rico, since benefits provided in this policy are available only to those people residing permanently in Puerto Rico.

105. **SERVICES NOT AVAILABLE IN PUERTO RICO:** Means treatment at facilities, or with medical-hospital equipment not available in Puerto Rico, in case of an insured patient who, because of his health condition, requires these services.

106. **SESSIONS:** Two or more modalities of physical or respiratory therapy treatments.

107. **SKILLED NURSING FACILITY:**

   a. It is a specialized nursing facility, as defined by Medicare, which is qualified to participate, and is eligible to receive payments under and in accordance with the provisions of Medicare; or

   b. An institution that fully meets all of the following criteria:

      1) Is operated in accordance with the applicable laws of the jurisdiction in which it is located.

      2) Is supervised full-time by a licensed physician or a registered nurse (R.N.)

      3) Is regularly engaged in providing room and board, and provides skilled nursing care 24-hour a day to sick and injured persons, while recovering of an injury or disease.

      4) Keeps a medical record of each patient under the care of a duly licensed physician.

      5) Is authorized to administer medications and provide treatment to patients following the orders of a duly licensed physician.

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

      7) It is not a hospital

108. **SMALL GROUPS (PYMES):** Any person, firm, corporation, society, for-profit or non-profit association, that has employed at least 50% on business days in the preceding calendar year at least two (2), but no more than one hundred (100) eligible employees. When determining the number of eligible employees, companies that are affiliated or that are eligible to submit a joint income tax return for tax purposes in Puerto Rico, will be considered a single employer. Once the health plan has been issued and to determine eligibility continuity, the size of the PYMES employer will be determined annually.

109. **SPECIAL ENROLLMENT:** Instance in which the employee and his/her eligible dependents can subscribe to the health plan at any time, as a result of a specific qualifying event such as marriage, birth, and death, among other events.

110. **SPECIAL NURSES:** Are nurses devoted to specialized care of certain patient population (Ex. nurse anesthetists).

111. **SPORTS MEDICINE:** Branch of medicine that deals with illnesses or injuries caused by sports activities, which includes the preventive and preparatory phases necessary to maintain good physical and mental condition.

112. **SPOUSE:** Means the person of the same sex or of different sex with whom the health plan insured is legally married.

113. **STEP THERAPY (ST) PROGRAM:** Means the protocol that specifies the sequence in which prescription drugs must be dispensed for a determined medical condition. In some cases, the plan requires that you first use a prescription drug as therapy for your condition before we cover another prescription drug for this condition. For example, If prescription drug A and prescription drug B are both used to treat your health condition, the plan will require that you first use prescription drug A. If prescription drug A does not work for you, then we will cover prescription drug B.

114. **TELECONSULTA:** A service that Triple-S Salud provides to its insureds through which the plan member can receive orientation on their health related questions. Calls are answered by nursing professionals seven (7) days a week, twenty-four (24) hours a day. When calling this line, if the insured receives a recommendation to visit the emergency room, he/she will be provided with a registration number that must be presented when receiving the services. In case of illness, when presenting this number at the emergency room, the insured will pay a lower copayment to use the facilities. The telephone number to call Teleconsulta is located on the back of the Triple-S Salud's identification card.

115. **THERAPEUTIC CLASSIFICATION:** Are the categories used to classify and group prescription drugs in the Drug List or Formulary by the conditions they treat or the effect these drugs have in the human body.

116. **TRANSPLANT:** A procedure or series of procedures through which an organ or tissue is:
   a) removed from the body of a person called donor and implanted in the body of another person called recipient; or
   b) removed and implanted in the body of the same person

117. **TREATMENT PLAN:** Detailed report of the procedures recommended by the physician or dentist to treat the medical needs of the patient based on the findings of the medical examination made by the same physician or dentist.

118. **USUAL AND CUSTOMARY CHARGE:** A charge is customary when it is under the set of usual charges billed by the majority of physicians and service providers with similar training and experience within a specific field.

119. **USUAL CHARGE:** A usual charge is the charge a particular physician or service provider most usually makes to patients for a specific service.

TABLE OF DEDUCTIBLES, COPAYS AND COINSURANCES

The insured person will pay the following copays or coinsurances to participating physicians, providers or facilities when they receive covered services as their contribution to the costs of the services he receives.

BRONZE

	Óptimo Plus Bronze Selective Network
Ambulatory Medical-Surgical and Diagnostic Services	
Description of Benefits	
Diagnostic and Treatment Services	
Visits to the general practitioner	$5.00
Visits to specialist	$10.00
Visits to sub-specialists	$15.00
Visits to audiologists	$10.00
Visits to optometrists	$10.00
Visits to podiatrists, including routine care	$10.00
Preventive services covered by local or federal law, including preventive annual visit, bone densitometry, mammography, digital mammography and sonomammography. You can access these services through the Participating Preventive Centers or participant providers, included in the Directory.	$0.00
Medical services at home of the insured person by the physicians that render this service	$15.00
Intraarticular injections	$0.00
Emergency room: • Accident or Illness • Teleconsulta	 60% 60%
Cervical Cryosurgery Sterilization services for men (vasectomy)	60%
Laboratory services	50% (Selective Network)
X-rays, diagnostic tests and other specialized tests	50% (Selective Network)
Pelvic exams and all vaginal cytological tests required to detect, diagnose, and treat early stage anomalies that may result in cervical cancer	$0.00
Ambulatory surgeries	60%
Pre and postnatal services	$0.00 annual preventive visit. $10.00 copay for visits for routine pre and postnatal care services
Biophysical Profile	50%
Well-baby care visits	$0.00
Allergy tests	$0.00
Chemotherapy in all its modalities of administration (intravenous, oral, injectable or intrathecal), radiotherapy and cobalt	25%
Dialysis and Hemodialysis	25%
Respiratory therapy (administered in the physician's office)	60%
Durable medical equipment	50% up to a maximum of $3,000, 70% afterwards
Mechanical ventilator, supplies and therapies (respiratory, physical and occupational)	$0.00

	Óptimo Plus Bronze Selective Network
Post hospitalization services provided by a Home Health Care Agency	60%
Nutrition services	$0.00
Visits to the chiropractor	$10.00
Manipulations/Physical, Occupational and Speech therapies (Habilitative and Rehabilitative)	60% per therapy 60% per manipulation
Vision Care	
• Ophthalmologic diagnostic tests	50%
• Refraction Test	$0.00
• Eyeglasses for insureds up to age 21	$0.00
• Eyeglasses and contact lenses for insureds over age 21, for a maximum benefit of $50.00 per policy year	$0.00
Alternative Therapies (Triple-S Natural)	$15.00 per visit
Medical screening and screening tests for the detection of autism as part of the preventive services	$0.00
Other services for the treatment of Disorders within the Continuum of Autism • Neurological tests • Immunology • Genetic tests • Laboratory tests for autism • Gastroenterology services • Nutrition services • Physical, occupational and speech therapies • Visits to the psychiatrist, psychologist (with a Master's or PhD and a valid license issued by the Puerto Rico Board of Psychologist Examiners) or social worker (by reimbursement)	 50% coinsurance 50% coinsurance 50% coinsurance 50% coinsurance 50% coinsurance $0.00 copay 60% coinsurance $5.00 copay
Preventive Vaccines	$0.00
Palivizumab (Synagis)	20%
MEDICAL-SURGICAL SERVICES DURING HOSPITALIZATION PERIODS	
Medical-surgical Services	
Surgeries, including orthognathic surgery Skin, bone and corneal transplants Reconstructive surgeries after a mastectomy Treatment for morbid obesity	40%
Diagnostic services Treatments Administration of anesthesia Consultations with specialists Gastrointestinal endoscopies Audiological screenings, includes the Neonatal Hearing Screening Test	$0.00
Chemotherapy in all its administration modalities (intravenous, oral, injectable or intrathecal) and radiotherapy	25%
Surgical Assistance	50%
Invasive cardiovascular tests	50%
Lithotripsy (ESWL)	50%

	Óptimo Plus Bronze Selective Network
SERVICES PROVIDED BY A HOSPITAL OR OTHER FACILITY AND AMBULANCE SERVICES	
Hospitalizations	
Semi private or isolation room for regular and maternity hospitalizations	Tier 1: $975.00 Tier 2: $1,075.00 Tier 3: $1,325.00
• Meals and special diets • Use of telemetric services • Use of recovery room • Use of Step-down Unit for babies • Use of Intensive Care, Coronary Care, Pediatric Intensive Care and Neonatal Intensive Care Units • General nursing services • Administration of anesthesia by non-medical staff • Clinical laboratory services • Medicines, biological products, materials to tend wounds, hyperalimentation products and anesthesia supplies • Production of Electrocardiograms • Production of X-rays • Physical therapy services (habilitative and rehabilitative) • Use of services by hospital physicians in training, interns and residents authorized to render medical services to the patients • Respiratory therapy services • Use of the Emergency Room when the insured person is admitted in the hospital • Use of other facilities, services, equipment and materials • Blood for transfusions	$0.00
Dialysis and Hemodialysis	25%
Chemotherapy in all its administration modalities (intravenous, oral, injectable or intrathecal) and radiotherapy	25%
Lithotripsy (ESWL)	50%
Ambulatory Surgery Center	60%
Post-hospitalization services through a Skilled Nursing Facility	60%
Ambulance	
Air ambulance service in Puerto Rico	$0.00
Ground ambulance services	The insured pays the full cost of the services and Triple-S Salud will reimburse a maximum amount of $80.00 per case
MENTAL HEALTH AND SUBSTANCE ABUSE	
General Mental Conditions	
Hospitalizations for mental conditions Regular hospitalizations	Tier 1: $975.00 Tier 2: $1,075.00 Tier 3: $1,325.00
Partial hospitalizations	40% of the hospitalization cost
Electroconvulsive therapies for mental conditions	$0.00

	Óptimo Plus Bronze Selective Network
Ambulatory services	
Visits to the office of the psychiatrist or psychologist	$5.00
Collateral visits (visits of the immediate family), including marital counseling, provided by a psychiatrist or psychologist	$10.00
Group therapy visits	$10.00 per therapy
Other psychological evaluations	
Psychological evaluation	$10.00
Psychological tests	$10.00
Substance Abuse (Drug Addiction and Alcoholism)	
Regular hospitalizations, including detoxification	Tier 1: $975.00 Tier 2: $1,075.00 Tier 3: $1,325.00
Partial hospitalizations	40% of the hospitalization cost
Visits to the office of the psychiatrist or psychologist	$5.00
Collateral visits (visits of the immediate family), including marital counseling, provided by a psychiatrist or psychologist	$10.00
Group therapy visits	$10.00 per therapy
Residential treatment	Tier 1: $975.00 Tier 2: $1,075.00 Tier 3: $1,325.00

EXTENDED COVERAGE IN THE UNITED STATES

	Óptimo Plus Bronze
Extended Coverage in the United States	The insured person will be liable to pay 50% coinsurance for services received under this coverage and Triple-S Salud will cover 50% of the services rendered by participating and non-participating providers of the BCBSA.

PRESCRIPTION DRUG BENEFIT

	Óptimo Plus Bronze
Prescription Drug Benefit through Preferred Pharmacy Network	
Annual Deductible Note: Does not apply to prescription drugs classified as preventive by federal law	Does not apply
Applies the Prescription Drug List for Coordinated Care Plans (Axis, CCI) and Other Free Choice Commercial Plans	Yes
Copays in the First Level of Coverage for 30 days (Up to $800 individual / $1,000 family)	
Tier 1- Generic Drugs	$8.00
Tier 2- Preferred Drugs	70%
Tier 3- Non-Preferred Drugs	70%
Tier 4- Preferred Specialty Products	70%
Tier 5- Non-Preferred Specialty Products	70%
Oral Chemotherapy	25%
Over-the-counter drugs Program	$0.00
Prescription drugs required by federal law including all contraceptives approved by the FDA with a prescription from the physician	$0.00
Coinsurance for all prescription drugs after the First Level of Coverage	90%
Copays in the First Level of Coverage for 90 days (Up to $800 individual /$1,000 family)	
Tier 1- Generic Drugs	$16.00
Tier 2- Preferred Drugs	53%
Tier 3- Non-Preferred Drugs	53%
Tier 4- Preferred Specialty Products	Does not apply
Tier 5- Non-Preferred Specialty Products	Does not apply
Some oral chemotherapy drugs that are medically recommended for extended 90-day supplies *	25%
Over-the-Counter Drugs Program	Does not apply
Prescription drugs required by federal law including all contraceptives approved by the FDA with a prescription from the physician	$0.00
Coinsurance for all prescription drugs after the First Level of Coverage	90%

* Please refer to the Prescription Drug List. You can access the Prescription Drug List by registering on our insured's webpage www.ssspr.com.

DENTAL BENEFITS

	Óptimo Plus Bronze
Diagnostic and Preventive Services	$0.00

TABLE OF DEDUCTIBLES, COPAYS AND COINSURANCES

The insured person will pay the following copays or coinsurances to participating physicians, providers or facilities when they receive covered services as their contribution to the costs of the services he receives.

SILVER

	Óptimo Plus Silver Selective Network
Ambulatory Medical-Surgical and Diagnostic Services	
Description of Benefits	
Diagnostic and Treatment Services	
Visits to the general practitioner	$10.00
Visits to specialist	$20.00
Visits to sub-specialists	$20.00
Visits to audiologists	$20.00
Visits to optometrists	$20.00
Visits to podiatrists, including routine care	$20.00
Preventive services covered by local or federal law, including preventive annual visit, bone densitometry, mammography, digital mammography and sonomammography. You can access these services through the Participating Preventive Centers or participant providers, included in the Directory.	$0.00
Home medical services at the home of the insured person by the physicians that render this service	$15.00
Intra-articular injections	$0.00
Emergency room: • Accident or Illness • Teleconsulta	 40% $25.00
Cervical Cryosurgery Sterilization services for men (vasectomy)	50%
Laboratory and X-rays	40% (Selective Network)
Diagnostic tests and other specialized tests	50% (Selective Network)
Pelvic exams and all vaginal cytological tests required to detect, diagnose, and treat early stage anomalies that may result in cervical cancer	$0.00
Ambulatory surgeries	50%
Pre and postnatal services	$0.00 annual preventive visit. $20.00 copay per visit for routine pre and postnatal care services.
Biophysical Profile	50%
Well-baby care visits	$0.00
Allergy tests	$0.00
Chemotherapy in all its administration modalities (intravenous, oral, injectable or intrathecal), radiotherapy and cobalt	30%
Dialysis and Hemodialysis	30%
Respiratory therapy (administered in the physician's office)	$10.00
Durable medical equipment	30% up to a maximum of $3,000, 60% afterwards
Mechanical ventilator, supplies and therapies (respiratory, physical and occupational)	$0.00

	Óptimo Plus Silver Selective Network
Post hospitalization services provided by a Home Health Care Agency	50%
Nutrition services	$0.00
Visits to the chiropractor	$10.00
Manipulations/Physical, Occupational and Speech therapies (Habilitative and Rehabilitative)	$10.00 per therapy $10.00 per manipulation
Vision Care	
• Ophthalmologic diagnostic tests	50%
• Refraction Test	$0.00
• Eyeglasses for insureds up to age 21	$0.00
• Eyeglasses and contact lenses for insureds over age 21, for a maximum benefit of $50.00 per policy year	$0.00
Alternative Therapies (Triple-S Natural)	$15.00 per visit
Medical screening and screening tests for the detection of autism as part of the preventive services	$0.00
Other services for the treatment of Disorders within the Continuum of Autism • Neurological tests • Immunology • Genetic tests • Laboratory tests for autism • Gastroenterology services • Nutrition services • Physical, occupational and speech therapies • Visits to the psychiatrist, psychologist (with a Master's or PhD and a valid license issued by the Puerto Rico Board of Psychologist Examiners) or social worker (by reimbursement)	• 50% coinsurance • 40% coinsurance • 40% coinsurance • 40% coinsurance • 50% coinsurance • $0.00 copay • $10.00 copay • $10.00 copay
Preventive Vaccines	$0.00
Palivizumab (Synagis)	20%
MEDICAL-SURGICAL SERVICES DURING HOSPITALIZATION PERIODS	
Medical-surgical Services	
• Surgeries, including orthognathic surgery • Skin, bone and corneal transplants • Reconstructive surgeries after a mastectomy • Treatment for morbid obesity • Diagnostic services • Treatments • Administration of anesthesia • Consultations with specialists • Gastrointestinal endoscopies • Audiological screenings, includes the Neonatal Hearing Screening Test	$0.00
Surgical Assistance	30%
Chemotherapy in all its administration modalities (intravenous, oral, injectable or intrathecal) and radiotherapy	30%
Invasive cardiovascular tests	50%
Lithotripsy (ESWL)	50%

	Óptimo Plus Silver Selective Network
SERVICES PROVIDED BY A HOSPITAL OR OTHER FACILITY AND AMBULANCE SERVICES	
Hospitalizations	
• Semi private or isolation room for regular and maternity hospitalizations	Tier 1: $75.00 Tier 2: $350.00 Tier 3: $500.00
• Meals and special diets • Use of telemetric services • Use of recovery room • Use of Step-down Unit for babies • Use of Intensive Care, Coronary Care, Pediatric Intensive Care and Neonatal Intensive Care Units • General nursing services • Administration of anesthesia by non-medical staff • Clinical laboratory service • Medicines, biological products, materials to tend wounds, hyperalimentation products and anesthesia supplies • Production of Electrocardiograms • Production of X-rays • Physical therapy services (habilitative and rehabilitative) • Use of services by hospital physicians in training, interns and residents authorized to render medical services to the patients • Respiratory therapy services • Use of the Emergency Room when the insured person is admitted in the hospital • Use of other facilities, services, equipment and materials • Blood for transfusions	$0.00
Dialysis and Hemodialysis	30%
Chemotherapy in all its administration modalities (intravenous, oral, injectable or intrathecal) and radiotherapy	30%
Lithotripsy (ESWL)	50%
Ambulatory Surgery Center	30%
Post-hospitalization services through a Skilled Nursing Facility	50%
Ambulance	
Air ambulance service in Puerto Rico	$0.00
Ground ambulance services	The insured pays the full cost of the services and Triple-S Salud will reimburse a maximum amount of $80.00 per case
MENTAL HEALTH AND SUBSTANCE ABUSE	
General Mental Conditions	
Hospitalizations for mental conditions Regular hospitalizations	Tier 1: $75.00 Tier 2: $350.00 Tier 3: $500.00
Partial hospitalizations	$50.00
Electroconvulsive therapies for mental conditions	$0.00
Ambulatory services	
Visits to the office of the psychiatrist or psychologist	$10.00
Collateral visits (visits of the immediate family), including marital counseling, provided by a psychiatrist or psychologist	$20.00

	Óptimo Plus Silver Selective Network
Group therapy visits	$10.00 per therapy
Other psychological evaluations	
Psychological evaluation	$10.00
Psychological tests	$10.00
Substance Abuse (Drug addiction and Alcoholism)	
Regular hospitalizations, including detoxification	Tier 1: $75.00 Tier 2: $350.00 Tier 3: $500.00
Partial hospitalizations	$50.00
Visits to the office of the psychiatrist or psychologist	$10.00
Collateral visits (visits of the immediate family), including marital counseling, provided by a psychiatrist or psychologist	$20.00
Group therapy visits	$10.00 per therapy
Residential treatment	Tier 1: $75.00 Tier 2: $350.00 Tier 3: $500.00

EXTENDED COVERAGE IN THE UNITED STATES

	Óptimo Plus Silver
Extended Coverage in the United States	The insured person will be liable to pay 40% coinsurance for the services received under this coverage and Triple-S Salud will cover 60% of the services rendered by participating and non-participating providers of the BCBS.

PRESCRIPTION DRUG BENEFIT

	Óptimo Plus Silver
Prescription Drug Benefit through Preferred Pharmacy Network	
Annual Deductible Note: Does not apply to prescription drugs classified as preventive by federal law	$125 per insured person
Applies the Prescription Drug List for Coordinated Care Plans (Axis, CCI) and Other Free Choice Commercial Plans	Yes
Copays in the First Level of Coverage for 30 days (Up to $800 individual contract/ $2,100 family contract)	
Tier 1- Generic Drugs	$10
Tier 2- Preferred Drugs	The higher of $30 or 25%
Tier 3- Non-Preferred Drugs	The higher of $45 or 30%
Tier 4- Preferred Specialty Products	30%
Tier 5- Non-Preferred Specialty Products	40%
Oral Chemotherapy	30%
Over-the-counter drugs Program	$0
Prescription drugs required by federal law including all contraceptives approved by the FDA with a prescription from the physician	$0
Coinsurance for all prescription drugs after the First Level of Coverage	90%
Copays in the First Level of Coverage for 90 days (Up to $800 individual contract / $2,100 family contract)	
Tier 1- Generic Drugs	$20
Tier 2- Preferred Drugs	The higher of $60 or 19%
Tier 3- Non-Preferred Drugs	The higher of $90 or 23%
Tier 4- Preferred Specialty Products	Does not apply
Tier 5- Non-Preferred Specialty Products	Does not apply
Some oral chemotherapy drugs that are medically recommended for extended 90-day supplies*	30%
Over-the-Counter Drugs Program	Does not apply
Prescription drugs required by federal law including all contraceptives approved by the FDA with a prescription from the physician	$0
Coinsurance for all prescription drugs after the First Level of coverage	90%

*Please refer to the Prescription Drug List. You can access the Prescription Drug List by registering on our insured's webpage www.ssspr.com.

DENTAL BENEFITS

	Óptimo Plus Silver
Diagnostic and Preventive Services	$0.00

TABLE OF DEDUCTIBLES, COPAYS AND COINSURANCES

The insured person will pay the following copays or coinsurances to participating physicians, providers or facilities when they receive covered services as their contribution to the costs of the services he receives.

GOLD

	Óptimo Plus Gold		
	Option 1 Selective Network	**Option 2**	**Option 3 Selective Network**
Ambulatory Medical-Surgical and Diagnostic Services			
Description of Benefits			
Diagnostic and Treatment Services			
Visits to the general practitioner	$10.00	$10.00	$5.00
Visits to specialist	$25.00	$18.00	$15.00
Visits to sub-specialists	$25.00	$25.00	$20.00
Visits to audiologists	$25.00	$18.00	$15.00
Visits to optometrists	$25.00	$18.00	$15.00
Visits to podiatrists, including routine care	$25.00	$18.00	$15.00
Preventive services covered by local or federal law, including preventive annual visit, bone densitometry, mammography, digital mammography and sonomammography. You can access these services through the Participating Preventive Centers or participant providers, included in the Directory.	$0.00	$0.00	$0.00
Home medical services at the home of the insured person by the physicians that render this service	$15.00	$15.00	$15.00
Intraarticular injections	$0.00	$0.00	$0.00
Emergency room: • Accident or Illness • Teleconsulta	 45% $50.00	 50% $50.00	 45% $50.00
Cervical Cryosurgery Sterilization services for men (vasectomy)	25%	$0.00	20%
Laboratory services	30% (Selective Network)	40%	30% (Selective Network)
X-rays, diagnostic tests and other specialized tests	40% (Selective Network)	40%	30% X-Rays 40% diagnostic and specialized tests (Selective Network)
Pelvic exams and all vaginal cytological tests	$0.00	$0.00	$0.00
Ambulatory surgeries	25%	$0.00	20%

	Óptimo Plus Gold		
	Option 1 Selective Network	Option 2	Option 3 Selective Network
Pre and postnatal services	$0.00 annual preventive visit. Subject to copay per visit for routine pre and postnatal care services. The specialist copay applies.		
Biophysical Profile	50%	50%	50%
Well-baby care visits	$0.00	$0.00	$0.00
Allergy tests	$0.00	$0.00	$0.00
Chemotherapy in all its administration modalities (intravenous, oral, injectable or intrathecal), radiotherapy and cobalt	20%	20%	20%
Dialysis and Hemodialysis	20%	20%	20%
Respiratory therapy (administered in the physician's office)	$10.00	$10.00	$10.00
Durable medical equipment	40% up to a maximum of $3,000, 60% afterwards		60%
Mechanical ventilator, supplies and therapies (respiratory, physical and occupational)	$0.00	$0.00	$0.00
Post hospitalization services provided by a Home Health Care services	$0.00	$0.00	25%
Nutrition services	$0.00	$0.00	$0.00
Visits to the chiropractor	$10.00	$10.00	$10.00
Manipulations/Physical, Occupational and Speech therapies (Habilitative and Rehabilitative)	$10.00 per therapy $10.00 per manipulation		
Vision Care			
• Ophthalmologic diagnostic tests	40%	40%	40%
• Refraction Test	$0.00	$0.00	$0.00
• Eyeglasses for insureds up to age 21	$0.00	$0.00	$0.00
• Eyeglasses and contact lenses for insureds over age 21, for a maximum benefit of $75.00 per policy year	$0.00	$0.00	$0.00
Alternative Therapies (Triple-S Natural)	$15.00 per visit	$15.00 per visit	$15.00 per visit
Medical screening and screening tests for the detection of autism as part of the preventive services	$0.00		

	Óptimo Plus Gold		
	Option 1 Selective Network	Option 2	Option 3 Selective Network
Other services for the treatment of Disorders within the Continuum of Autism • Neurological tests • Immunology • Genetic tests • Laboratory tests for autism • Gastroenterology services • Nutrition services • Physical, occupational and speech therapies • Visits to the psychiatrist, psychologist (with a Master's or PhD and a valid license issued by the Puerto Rico Board of Psychologist Examiners) or social worker (by reimbursement)	• 40% coinsurance • 30% coinsurance • 30% coinsurance • 30% coinsurance • 40% coinsurance • $0.00 copay • $10.00 copay • $10.00 copay	• 40% coinsurance • 40% coinsurance • 40% coinsurance • 40% coinsurance • 40% coinsurance • $0.00 copay • $10.00 copay • $10.00 copay	• 40% coinsurance • 30% coinsurance • 30% coinsurance • 30% coinsurance • 40% coinsurance • $0.00 copay • $10.00 copay • $5.00 copay
Preventive Vaccines	$0.00	$0.00	$0.00
Palivizumab (Synagis)	20%	20%	20%
MEDICAL-SURGICAL SERVICES DURING HOSPITALIZATION PERIODS			
Medical-surgical Services			
• Surgeries, including orthognathic surgery • Skin, bone and corneal transplants • Reconstructive surgeries after a mastectomy • Treatment for morbid obesity	$0.00	$0.00	$0.00
• Diagnostic services • Treatments • Administration of anesthesia • Consultations with specialists • Gastrointestinal endoscopies • Audiological screenings, includes the Neonatal Hearing Screening Test	$0.00	$0.00	$0.00
Chemotherapy in all its administration modalities (intravenous, oral, injectable or intrathecal) and radiotherapy	20%	20%	20%
Surgical Assistance	25%	25%	25%
Invasive cardiovascular tests	40%	40%	40%
Lithotripsy (ESWL)	40%	40%	40%
SERVICES PROVIDED BY A HOSPITAL OR OTHER FACILITY AND AMBULANCE SERVICES			
Hospitalizations			
• Semi private or isolation room for regular and maternity hospitalizations	$350.00	$250.00	$150.00

	Óptimo Plus Gold		
	Option 1 Selective Network	Option 2	Option 3 Selective Network
• Meals and special diets • Use of telemetric services • Use of recovery room • Use of Step-down Unit for babies • Use of Intensive Care, Coronary Care, Pediatric Intensive Care and Neonatal Intensive Care Units • General nursing services • Administration of anesthesia by non-medical staff • Clinical laboratory services • Medicines, biological products, materials to tend wounds, hyperalimentation products and anesthesia supplies • Production of Electrocardiograms • Production of X-rays • Physical therapy services (habilitative and rehabilitative) • Use of services by hospital physicians in training, interns and residents authorized to render medical services to the patients • Respiratory therapy services • Use of the Emergency Room when the insured person is admitted in the hospital • Use of other facilities, services, equipment and materials • Blood for transfusions	$0.00	$0.00	$0.00
Chemotherapy in all its administration modalities (intravenous, oral, injectable or intrathecal) and radiotherapy	20%	20%	20%
Dialysis and Hemodialysis	20%	20%	20%
Lithotripsy (ESWL)	40%	40%	40%
Ambulatory Surgery Center	25%	$250.00	25%
Post-hospitalization services through a Skilled Nursing Facility	$0.00	$0.00	$150.00
Ambulance			
Air ambulance service in Puerto Rico	$0.00		
Ground ambulance services	The insured pays the full cost of the services and Triple-S Salud will reimburse a maximum amount of $80.00 per case		

	Óptimo Plus Gold		
	Option 1 Selective Network	Option 2	Option 3 Selective Network
MENTAL HEALTH AND SUBSTANCE ABUSE			
General Mental Conditions			
Hospitalizations for mental conditions Regular hospitalizations	$350.00	$250.00	$150.00
Partial hospitalizations	$50.00	$50.00	$50.00
Electroconvulsive therapies for mental conditions	$0.00	$0.00	$0.00
Ambulatory services			
Visits to the office of the psychiatrist or psychologist	$10.00	$10.00	$5.00
Collateral visits (visits of the immediate family), including marital counseling, provided by a psychiatrist or psychologist	$25.00	$18.00	$15.00
Group therapy visits	$10.00 per therapy	$10.00 per therapy	$10.00 per therapy
Other psychological evaluations			
Psychological evaluation	$10.00	$10.00	$10.00
Psychological tests	$10.00	$10.00	$10.00
Substance Abuse (Drug addiction and Alcoholism)			
Regular hospitalizations, including detoxification	$350.00	$250.00	$150.00
Partial hospitalizations	$50.00	$50.00	$50.00
Visits to the office of the psychiatrist or psychologist	$10.00	$10.00	$5.00
Collateral visits (visits of the immediate family), including marital counseling, provided by a psychiatrist or psychologist	$25.00	$18.00	$15.00
Visits for group therapies	$10.00 per therapy	$10.00 per therapy	$10.00 per therapy
Residential treatment	$350.00	$250.00	$150.00

EXTENDED COVERAGE IN THE UNITED STATES

	Óptimo Plus Gold Option 1 and 3
Extended Coverage in the United States	The insured person will be liable to pay 40% coinsurance for the services received under this coverage and Triple-S Salud will cover 60% of the services rendered by participating and non-participating providers of the BCBSA.

	Óptimo Plus Gold Option 2
Extended Coverage in the United States	The insured person will be liable to pay 30% coinsurance for the services received under this coverage and Triple-S Salud will cover 70% of the services rendered by participating and non-participating providers of the BCBSA.

PRESCRIPTION DRUG BENEFIT

	Óptimo Plus Gold		
	Option 1 A	**Option 2**	**Option 3 A**
Prescription Drug Benefit through Preferred Pharmacy Network			
Annual Deductible Note: Does not apply to prescription drugs classified as preventive by federal law	No deductible	No deductible	$150 individual
Applies the Prescription Drug List for Members and Group Administrators	Yes	No	Yes
First Level of Coverage	Up to $2,000 individual/$6,000 family	Does not apply	Up to $2,000 individual/$6,000 family
Coverage copayments for 30 days			
Tier 1- Generic Drugs	$7.00	$5.00	$5.00
Tier 2- Preferred Drugs	$15.00	Does not apply	$30.00
Tier 3- Brand-Name Drugs	$30.00	$40.00	$40.00
Tier 4- Non-Preferred Drugs	The higher of $35.00 or 35%	Does not apply	The higher of $35.00 or 35%
Tier 5- Preferred Specialty Products	20%	30%	20%
Tier 6- Non-Preferred Specialty Products	30%	30%	30%
Oral Chemotherapy	20%	20%	20%
Over-the-counter drugs Program	$0.00	$0.00	$0.00
Prescription drugs required by federal law including all contraceptives approved by the FDA with a prescription from the physician	$0.00	$0.00	$0.00
Coinsurance for all prescription drugs after the First Level of Coverage	60%	Does not apply	50%
Copays in the First Level of Coverage for 90 days	Up to $2,000 Individual/$6,000 family	Does not apply	Up to $2,000 Individual/$6,000 family
Tier 1- Generic Drugs	$14.00	$10.00	$10.00
Tier 2- Preferred Drugs	$30.00	Does not apply	$60.00
Tier 3- Brand-Name Drugs	$60.00	$80.00	$80.00
Tier 4- Non-Preferred Drugs	The higher of $70.00 or 27%	Does not apply	The higher of $70.00 or 27%
Tier 5- Preferred Specialty Products	Does not apply	Does not apply	Does not apply
Tier 6- Non-Preferred Specialty Products	Does not apply	Does not apply	Does not apply
Some oral chemotherapy drugs that are medically recommended for extended 90-day supplies*	20%	20%	20%
Over-the-Counter Drugs Program	Does not apply	Does not apply	Does not apply
Prescription drugs required by federal law including all contraceptives approved by the FDA with a prescription from the physician	$0.00	$0.00	$0.00
Coinsurance for all prescription drugs after the First Level of coverage	60%	Does not apply	50%

*Please refer to the Prescription Drug List. You can access the Prescription Drug List by registering on our insured's webpage www.ssspr.com.

	Óptimo Plus Gold	
	Option 1B	Option 3B
Prescription Drug Benefit through Preferred Pharmacy Network		
Annual Deductible Note: Does not apply to prescription drugs classified as preventive by federal law	No deductible	$150.00 individual
Applies the Prescription Drug List for Coordinated Care Plans (Axis, CCI) and Other Free Choice Commercial Plans	Yes	Yes
First Level of Coverage	**Up to $2,000 Individual/$6,000 family**	**Up to $2,000 Individual/ $6,000 family**
Coverage copayment for 30 days	**Option 1B**	**Option 3B**
Tier 1- Generic Drugs	$7.00	$5.00
Tier 2- Preferred Drugs	$15.00	$30.00
Tier 3- Non-Preferred Drugs	The higher of $35.00 or 35%	The higher of $35.00 or 35%
Tier 4- Preferred Specialty Products	20%	20%
Tier 5- Non-Preferred Specialty Products	30%	30%
Oral Chemotherapy	20%	20%
Over-the-counter drugs Program	$0.00	$0.00
Prescription drugs required by federal law including all contraceptives approved by the FDA with a prescription from the physician	$0.00	$0.00
Coinsurance for all prescription drugs after the First Level of Coverage	60%	50%
Copays in the First Level of Coverage for 90 days (Up to $2,000 individual/$6,000 family)		
Tier 1- Generic Drugs	$14.00	$10.00
Tier 2- Preferred Drugs	$30.00	$60.00
Tier 3- Non-Preferred Drugs	The higher of $70.00 or 27%	The higher of $70.00 or 27%
Tier 4- Preferred Specialty Products	Does not apply	Does not apply
Tier 5- Non-Preferred Specialty Products	Does not apply	Does not apply
Oral chemotherapy drugs that are medically recommended for extended 90-day supplies*	20%	20%
Over-the-Counter Drugs Program	Does not apply	Does not apply
Prescription drugs required by federal law including all contraceptives approved by the FDA with a prescription from the physician	$0.00	$0.00
Coinsurance for all prescription drugs after the First Level of Coverage	60%	50%

* Please refer to the Prescription Drug List. You can access the Prescription Drug List by registering on our insured's webpage www.ssspr.com.

DENTAL BENEFITS

	Óptimo Plus Gold
Diagnostic and Preventive Services	$0.00

TABLE OF DEDUCTIBLES, COPAYS AND COINSURANCES

The insured person will pay the following copays or coinsurances to participating physicians, providers or facilities when they receive covered services as their contribution to the costs of the services he receives.

PLATINUM

	Óptimo Plus Platinum				
	Option 1	**Option 2**	**Option 3 Selective Network**	**Option 4 Selective Network**	**Option 5 Selective Network**
Ambulatory Medical-Surgical Services					
Description of Benefits					
Diagnostic and Treatment Services					
Visits to the general practitioners	$10.00	$8.00	$10.00	$5.00	$5.00
Visits to specialists	$15.00	$12.00	$15.00	$10.00	$15.00
Visits to subspecialists	$15.00	$15.00	$20.00	$10.00	$15.00
Visits to audiologists	$15.00	$12.00	$15.00	$10.00	$15.00
Visits to optometrists	$15.00	$12.00	$15.00	$10.00	$15.00
Visits to podiatrists, including routine care	$15.00	$12.00	$15.00	$10.00	$15.00
Preventive services covered by local or federal law, including preventive annual visit, bone densitometry, mammography, digital mammography and sonomammography. You can access these services through the Participating Preventive Centers or participant providers, included in the Directory.	$0.00	$0.00	$0.00	$0.00	$0.00
Home medical services at the home of the insured person by the physicians that render this service	$15.00	$15.00	$15.00	$15.00	$15.00
Intraarticular injections	$0.00	$0.00	$0.00	$0.00	$0.00
Emergency room: • Accident or Illness • Teleconsulta	 $50.00 $25.00	 $50.00 $25.00	 $75.00 $35.00	 $75.00 $35.00	 $50.00 $20.00
Cervical Cryosurgery Sterilization services for men (vasectomy)	$0.00	$0.00	$0.00	$0.00	$0.00
Laboratories, X-rays, diagnostic tests and other specialized tests	25% 30% diagnostic tests, specialized and imaging	25% 30% diagnostic tests, specialized and imaging	25% 30% diagnostic tests, specialized and imaging (Selective Network)	25% 30% diagnostic tests, specialized and imaging (Selective Network)	30% (Selective Network)

	Óptimo Plus Platinum				
	Option 1	Option 2	Option 3 Selective Network	Option 4 Selective Network	Option 5 Selective Network
Pelvic exams and all vaginal cytological tests required to detect, diagnose, and treat early stage anomalies that may result in cervical cancer	$0.00	$0.00	$0.00	$0.00	$0.00
Ambulatory surgeries	$0.00	$0.00	$0.00	$0.00	$0.00
Pre and postnatal services	$0.00 annual preventive visit. Subject to copay per visit for routine pre and postnatal care services. The specialist copay applies.				
Biophysical Profile	50%	50%	50%	50%	50%
Well-baby care visits	$0.00	$0.00	$0.00	$0.00	$0.00
Allergy tests	$0.00	$0.00	$0.00	$0.00	$0.00
Chemotherapy in all its administration modalities (intravenous, oral, injectable or intrathecal) radiotherapy and cobalt	10%	10%	10%	10%	10%
Dialysis and Hemodialysis	10%	10%	10%	10%	10%
Respiratory therapy (administered in the physician's office)	$7.00	$7.00	$10.00	$7.00	$10.00
Durable medical equipment	25% up to a maximum of $5,000, afterwards 60%				30%
Mechanical ventilator, supplies and therapies (respiratory, physical and occupational)	$0.00	$0.00	$0.00	$0.00	$0.00
Post hospitalization services provided by a Home Health Care services	25%	25%	25%	25%	30%
Nutrition services	$0.00	$0.00	$0.00	$0.00	$0.00
Visits to the chiropractor	$7.00	$7.00	$10.00	$7.00	$10.00
Manipulations/Physical, Occupational and Speech therapies (Habilitative and Rehabilitative)	$7.00 per therapy $7.00 per manipulation	$7.00 per therapy $7.00 per manipulation	$10.00 per therapy $10.00 per manipulation	$7.00 per therapy $7.00 per manipulation	$10.00 per therapy $10.00 per manipulation
Vision Care					
• Ophthalmologic diagnostic tests	30%	30%	30%	30%	30%
• Refraction Test	$0.00	$0.00	$0.00	$0.00	$10.00
• Eyeglasses for insureds up to age 21	$0.00	$0.00	$0.00	$0.00	$0.00
• Eyeglasses and contact lenses for insureds over age 21, for a maximum benefit of $100.00 per policy year	$0.00	$0.00	$0.00	$0.00	$0.00
Alternative Therapies (Triple-S Natural)	$15.00 per visit	$15.00 per visit	$15.00 per visit	$15.00 per visit	$15.00 per visit

	Óptimo Plus Platinum				
	Option 1	Option 2	Option 3 Selective Network	Option 4 Selective Network	Option 5 Selective Network
Medical screening and screening tests for the detection of autism as part of the preventive services.	$0.00				
Other services for the treatment of Disorders within the Continuum of Autism • Neurological tests • Immunology • Genetic tests • Laboratory tests for autism • Gastroenterology services • Nutrition services • Physical, occupational and speech therapies • Visits to the psychiatrist, psychologist (with a Master's or PhD and a valid license issued by the Puerto Rico Board of Psychologist Examiners) or social worker (by reimbursement)	• 30% • 25% • 25% • 25% • 30% • $0.00 • $7.00 • $10.00	• 30% • 25% • 25% • 25% • 30% • $0.00 • $7.00 • $8.00	• 30% • 25% • 25% • 25% • 30% • $0.00 • $10.00 • $10.00	• 30% • 25% • 25% • 25% • 30% • $0.00 • $7.00 • $5.00	• 30% • 30% • 30% • 30% • 30% • $0.00 • $10.00 • $5.00
Preventive Vaccines	$0.00	$0.00	$0.00	$0.00	$0.00
Palivizumab (Synagis)	20%	20%	20%	20%	20%
MEDICAL-SURGICAL SERVICES DURING HOSPITALIZATION PERIODS					
Medical surgical services					
• Surgeries, including orthognathic surgery • Skin, bone and corneal transplants • Reconstructive surgeries after a mastectomy	$0.00	$0.00	$0.00	$0.00	$0.00
• Treatment for morbid obesity	$0.00	$0.00	$0.00	$0.00	$100.00
• Diagnostic services • Treatments • Administration of anesthesia • Consultations with specialists • Gastrointestinal endoscopies • Audiological screenings, includes the Neonatal Hearing Screening Test	$0.00	$0.00	$0.00	$0.00	$0.00

	Óptimo Plus Platinum				
	Option 1	Option 2	Option 3 Selective Network	Option 4 Selective Network	Option 5 Selective Network
Chemotherapy in all its administration modalities (intravenous, oral, injectable or intrathecal) and radiotherapy	10%	10%	10%	10%	10%
Surgical Assistance	20%	20%	20%	20%	25%
Invasive cardiovascular tests	30%	30%	30%	30%	30%
Lithotripsy (ESWL)	30%	30%	30%	30%	30%
SERVICES PROVIDED BY A HOSPITAL OR OTHER FACILITY AND AMBULANCE SERVICES					
Hospitalizations					
• Semi private or isolation room for regular and maternity hospitalizations	Tier 1: $25.00 Tier 2: $150.00 Tier 3: $300.00	$150.00	$200.00	Tier 1: $50.00 Tier 2: $200.00 Tier 3:$350.00	$75.00
• Meals and special diets • Use of telemetric services • Use of recovery room • Use of Step-down Unit for babies • Use of Intensive Care, Coronary Care, Pediatric Intensive Care and Neonatal Intensive Care Units • General nursing services • Administration of anesthesia by non-medical staff • Clinical laboratory services • Medicines, biological products, materials to tend wounds, hyperalimentation products anesthesia supplies • Production of Electrocardiograms • Production of X-rays • Physical therapy services (habilitative and rehabilitative) • Use of services by hospital physicians in training, interns and residents authorized to render medical services to the patients • Respiratory therapy services	$0.00	$0.00	$0.00	$0.00	$0.00

	Óptimo Plus Platinum				
	Option 1	Option 2	Option 3 Selective Network	Option 4 Selective Network	Option 5 Selective Network
• Use of the Emergency Room when the insured person is admitted in the hospital • Use of other facilities, services, equipment and materials • Blood for transfusions	$0.00	$0.00	$0.00	$0.00	$0.00
Dialysis and hemodialysis	10%	10%	10%	10%	10%
Chemotherapy in all its administration modalities (intravenous, oral, injectable or intrathecal) and radiotherapy	10%	10%	10%	10%	10%
Lithotripsy (ESWL)	30%	30%	30%	30%	30%
Ambulatory Surgery Center	$50.00	$100.00	$200.00	$250.00	$75.00
Post-hospitalization services through a Skilled Nursing Facility	$0.00	$0.00	$0.00	$0.00	$50.00
Ambulance					
Air ambulance service in Puerto Rico	$0.00	$0.00	$0.00	$0.00	$50.00
Ground ambulance services	The insured pays the full cost of the services and Triple-S Salud will reimburse a maximum amount of $80.00 per case				
MENTAL HEALTH AND SUBSTANCE ABUSE					
General Mental Conditions					
Hospitalizations for mental conditions Regular hospitalizations	Tier 1: $25.00 Tier 2: $150.00 Tier 3: $300.00	$150.00	$200.00	Tier 1: $50.00 Tier 2: $200.00 Tier 3: $350.00	$75.00
Partial hospitalizations	$50.00	$50.00	$50.00	$50.00	$50.00
Electroconvulsive therapies for mental conditions	$0.00	$0.00	$0.00	$0.00	$0.00
Ambulatory services					
Visits to the office of the psychiatrist or psychologist	$10.00	$8.00	$10.00	$5.00	$5.00
Collateral visits (visits of the immediate family), including marital counseling, provided by a psychiatrist or psychologist	$15.00	$12.00	$15.00	$10.00	$15.00
Group therapy visits	$7.00 per therapy	$7.00 per therapy	$10.00 per therapy	$7.00 per therapy	$10.00 per therapy
Other psychological evaluations					
Psychological evaluation	$10.00	$10.00	$10.00	$10.00	$10.00
Psychological tests	$10.00	$10.00	$10.00	$10.00	$10.00

	Óptimo Plus Platinum				
	Option 1	Option 2	Option 3 Selective Network	Option 4 Selective Network	Option 5 Selective Network
Substance Abuse (Drug Addiction and Alcoholism)					
Regular hospitalizations, including detoxification	Tier 1: $25.00 Tier 2: $150.00 Tier 3: $300.00	$150.00	$200.00	Tier 1: $50.00 Tier 2: $200.00 Tier 3: $350.00	$75.00
Partial hospitalizations	$50.00	$50.00	$50.00	$50.00	$50.00
Visits to the office of the psychiatrist or psychologist	$10.00	$8.00	$10.00	$5.00	$5.00
Collateral visits (visits of the immediate family), including marital counseling, provided by a psychiatrist or psychologist	$15.00	$12.00	$15.00	$10.00	$15.00
Group therapy visits	$7.00 per therapy	$7.00 per therapy	$10.00 per therapy	$7.00 per therapy	$10.00 per therapy
Residential treatment	Tier 1: $25.00 Tier 2: $150.00 Tier 3: $300.00	$150.00	$200.00	Tier 1: $50.00 Tier 2: $200.00 Tier 3: $350.00	$75.00

EXTENDED COVERAGE IN THE UNITED STATES

	Óptimo Plus Platinum Option 1 and 2
Extended Coverage in the United States	The insured person will be liable to pay 25% coinsurance for the services received under this coverage and Triple-S Salud will cover 75% of the services rendered by participating and non-participating providers of the BCBSA.

	Óptimo Plus Platinum Option 3 and 4
Extended Coverage in the United States	The insured person will be liable to pay 30% coinsurance for the services received under this coverage and Triple-S Salud will cover 70% of the services rendered by participating and non-participating providers of the BCBSA.

	Óptimo Plus Platinum Option 5
Extended Coverage in the United States	The insured person will be liable to pay 20% coinsurance for the services received under this coverage and Triple-S Salud will cover 80% of the services rendered by participating and non-participating providers of the BCBSA.

PRESCRIPTION DRUG BENEFIT

	Óptimo Plus Platinum				
	Option 1A	Option 2	Option 3A	Option 4A	Option 5A
Prescription Drug Benefit through Preferred Pharmacy Network					
Annual Deductible Note: Does not apply to prescription drugs classified as preventive by federal law	No deductible	No deductible	No deductible	$50.00 individual	No deductible
Copays for 30 days					
Applies the Prescription Drug List for Insureds and Plan Administrators	Yes	No	Yes	Yes	Yes
Tier 1- Generic Drugs	$5.00	$5.00	$5.00	$5.00	$4.00
Tier 2- Preferred Drugs	15% minimum $15.00	Does not apply	$15.00	$15.00	$20.00
Tier 3- Brand-Name Drugs	25% minimum $25.00	$25.00	$25.00	$25.00	$30.00
Tier 4- Non-Preferred Drugs	30% minimum $30.00	Does not apply	$40.00	30% minimum $30.00	$30.00
Tier 5- Preferred Specialty Products	20%	30%	20%	20%	30%
Tier 6- Non-Preferred Specialty Products	30%	30%	30%	30%	30%
Oral Chemotherapy	10%	10%	10%	10%	10%
Over-the-counter drugs Program	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription drugs required by federal law including all contraceptives approved by the FDA with a prescription from the physician	$0.00	$0.00	$0.00	$0.00	$0.00
Copays for 90 days					
Tier 1- Generic Drugs	$10.00	$10.00	$10.00	$10.00	$8.00
Tier 2- Preferred Drugs	12% minimum $30	Does not apply	$30.00	$30.00	$40.00
Tier 3- Brand-Name Drugs	19% minimum $50	$50.00	$50.00	$50.00	$60.00
Tier 4- Non-Preferred Drugs	23% minimum $60.00	Does not apply	$80.00	23% minimum $60.00	$60.00
Tier 5- Preferred Specialty Products	Does not apply				
Tier 6- Non-preferred Specialty Products	Does not apply				

		Óptimo Plus Platinum			
	Option 1A	Option 2	Option 3A	Option 4A	Option 5A
Oral chemotherapy drugs that are medically recommended for extended 90-day supplies*	10%	10%	10%	10%	10%
Over-the-counter drugs Program	Does not apply				
Prescription drugs required by federal law including all contraceptives approved by the FDA with a prescription from the physician	$0	$0	$0	$0	$0

*Please refer to the Prescription Drug List. You can access the Prescription Drug List by registering on our insured's webpage www.ssspr.com

		Óptimo Plus Platinum		
	Option 1B	Option 3B	Option 4B	Option 5B
Prescription Drug Benefit through Preferred Pharmacy Network				
Annual Deductible Note: Does not apply to prescription drugs classified as preventive by federal law	No deductible	No deductible	$50.00 individual	No deductible
Copays for 30 days				
Applies the Prescription Drug List for Coordinated Care Plans (Axis, CCI) and Other Free Choice Commercial Plans	Yes	Yes	Yes	Yes
Tier 1- Generic Drugs	$5.00	$5.00	$5.00	$4.00
Tier 2- Preferred Drugs	15%,minimum $15.00	$15.00	$15.00	$20.00
Tier 3- Non-Preferred Drugs	30%, minimum $30.00	$40.00	30%, minimum $30.00	$30.00
Tier 4- Preferred Specialty Products	20%	20%	20%	30%
Tier 5- Non-Preferred Specialty Products	30%	30%	30%	30%
Oral Chemotherapy	10%	10%	10%	10%
Over-the-counter drugs Program	$0.00	$0.00	$0.00	$0.00
Prescription drugs required by federal law including all contraceptives approved by the FDA with a prescription from the physician	$0.00	$0.00	$0.00	$0.00
Copays for 90 days				
Tier 1- Generic Drugs	$10.00	$10.00	$10.00	$8.00
Tier 2- Preferred Drugs	12% minimum $30.00	$30.00	$30.00	$40.00
Tier 3- Non-Preferred Drugs	23% minimum $60.00	$80.00	23%, minimum $60.00	$60.00

		Óptimo Plus Platinum		
	Option 1B	**Option 3B**	**Option 4B**	**Option 5B**
Tier 4- Preferred Specialty Products	Does not apply			
Tier 5- Non-Preferred Specialty Products	Does not apply			
Oral chemotherapy drugs that are medically recommended for extended 90-day supplies*	10%	10%	10%	10%
Over-the-counter drugs Program	Does not apply			
Prescription drugs required by federal law including all contraceptives approved by the FDA with a prescription from the physician	$0.00	$0.00	$0.00	$0.00

*Please refer to the Prescription Drug List. You can access the Prescription Drug List by registering on our insured's webpage www.ssspr.com.

DENTAL BENEFITS

	Óptimo Plus Platinum
Diagnostic and Preventive Services	$0.00

CONTACTS

Webpage: **www.ssspr.com**

E-mail address: **customerservice@ssspr.com**

Mailing Address:
Customer Service

Triple-S Salud, Inc.
Customer Service Department
PO Box 363628
San Juan, PR 00936-3628

Precertifications

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

Contact telephone numbers and fax numbers:

Customer Service — **787-774-6060 (TTY 787-792-1370)**

Business Hours of the Cost Center:
Monday to Friday: 7:30 a.m. to 8:00 p.m.
Saturday: 9:00 a.m. - 6:00 p.m.
Sunday: 11:00 a.m. - 5:00 p.m.

Fax – Customer Service — **787-706-4014 / 787-706-2833**
Fax - Reimbursements — **787-749-4032**

Service Centers

Plaza Las Américas
(Second floor in front of Relojes y Relojes)
Monday to Friday: 8:00 a.m. - 7:00 p.m.
Saturday: 9:00 a.m. – 6:00 p.m.
Sunday: 11:00 a.m. – 5:00 p.m.

Plaza Carolina
(Second floor, next to Sears)
Monday to Friday: 9:00 a.m. - 7:00 p.m.
Saturday: 9:00 a.m. – 6:00 p.m.
Sunday: 11:00 a.m. – 5:00 p.m.

Caguas
Angora Shopping Center
Luis Muñoz Marín Ave. on the corner of Troche St.
Monday to Friday: 8:00 a.m. - 5:00 p.m.

Arecibo
Caribbean Cinemas Building
Road #2, Suite 101
Monday to Friday: 8:00 a.m. - 5:00 p.m.

Ponce
2760 Maruca Avenue
Monday to Friday: 8:00 a.m. - 5:00 p.m.

Mayagüez
Road. 114, Km. 1.1
Guanajibo Sector
Monday to Friday: 8:00 a.m. - 5:00 p.m.

Teleconsulta — **1-800-255-4375**

BlueCard — **1-800-810-2583**
www.bcbsa.com