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

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Employer/Policy Holder: Petsmart

Sponsor: SP0003239

Effective date: January 1, 2021

Triple-S Salud, Inc. (hereinafter referred to as Triple-S Salud) insures the active employees of the employer in the group insurance contract and the eligible dependents of said employees in accordance with the provisions of this policy / Certificate of Benefits (hereinafter policy) and the payment policy established by Triple-S Salud, against medically necessary medical-surgical and hospitalization expenses, provided while the policy is in force, due to injuries or illnesses suffered by the insured member. This policy is issued in consideration of the statements in the group insurance contract, to the payment by the employer of the corresponding premiums in advance and according to the date on which the employer subscribes 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 term of one (1) year as of the date shown on the insurance contract group This insurance may be continued for equal, consecutive and additional periods, through the payment of the corresponding premiums, for which the employer would be responsible in the first place, as the holder of the policy and the employee as insured and user of the medical plan, as available. ahead. All the terms of coverage will begin and end at 12:01 a.m., Official Time of Puerto Rico.

Triple-S Salud will not deny, exclude or limit the benefits of an insured member due to a pre-existing condition, regardless of the insured's age. This policy is not a policy or contract complementary to the Federal Program for Health Services for the Elderly (Medicare). Check the Health Insurance Guide for people with Medicare available through the insurance company.

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

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

Madeline Hernández Urquiza, CPA
President

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

CONTACTS

Customer Service Department Our Customer Service Department is available whenever you have questions or concerns about the benefits or services Triple-S Salud offers to the members enrolled in this policy. They can also answer your questions, help you to understand your benefits, and provide information about our policies and procedures.	
Customer Service Phone Number	**787-774-6060 or 1-800-981-3241 (toll-free)** **TTY users call TTY 787-792-1370 or** **1-866-215-1999 (toll-free)**
Business Hours for **Call Center:**	• Monday to Friday: 7:30 a.m. - 8:00 p.m. (AST) • Saturday: 9:00 a.m. – 6:00 p.m. (AST) • Sunday: 11:00 a.m. - 5:00 p.m. (AST)
Fax – Customer Service	**787-706-2833**
Teleconsulta	**1-800-255-4375 (24/7)**
BlueCard	**1-800-810-2583** www.bcbs.com
Mailing Address **Customer Service**	**Triple-S Salud, Inc.** **Customer Service Department** PO Box 363628 San Juan, PR 00936-3628
Email Address:	servicioalcliente@ssspr.com
Precertifications	**Triple-S Salud, Inc.** **Precertification Department** PO Box 363628 San Juan, PR 00936-3628 **Fax: (787) 774-4824**
Case Management Program	**787-706-2552** **TTY users call 1-800-981-4860** **Monday to Friday: 8:00 a.m. to 7:00 p.m. (AST)** **Fax: 787-744-4820**
Programs for Chronic Condition Management (asthma, diabetes, heart failure, prenatal, hypertension, COPD	**1-866-788-6770**

(Chronic Obstructive Pulmonary Disease), Living without Smoke	

Service Centers	
Plaza Las Américas (second floor, North Parking Lot entrance) Monday to Friday: 8:00 a.m. - 7:00 p.m. (AST) Saturday: 9:00 a.m. – 6:00 p.m. (AST) Sunday: 11:00 a.m. – 5:00 p.m. (AST)	**Plaza Carolina** (Second level, next to the Post Office) Monday to Friday: 9:00 a.m. – 7:00 p.m. (AST) Saturday: 9:00 a.m. – 6:00 p.m. (AST) Sunday: 11:00 a.m. – 5:00 p.m. (AST)
Caguas Angora Building Luis Muñoz Marín Ave. & Troche St. (corner) Monday to Friday: 8:00 a.m. – 5:00 p.m. (AST)	**Arecibo** Caribbean Cinemas Building, Suite 101 PR-2, Km. 81.0 Monday to Friday: 8:00 a.m. – 5:00 p.m. (AST)
Ponce 2760 Ave. Maruca Monday to Friday: 8:00 a.m. – 5:00 p.m. (AST)	**Mayagüez** PR-114 Km. 1.1 Barrio Guanajibo Monday to Friday: 8:00 a.m. – 5:00 p.m. (AST)
Personas con necesidades especiales debido a: • **El inglés no es su lenguaje primario** • **Necesidades especiales**	Esta información está disponible en español, libre de costo. Además, si necesita servicios de interpretación para hablar en otro idioma que no sea inglés o español, favor de comunicarse con Servicio al Cliente al 787-774-6060. Llame a Servicio al Cliente si necesita ayuda en otro idioma o formato. Si necesita ayuda para leer o entender un documento, le podemos ayudar. Los materiales impresos pueden estar disponibles en otros formatos. Usuarios TTY pueden llamar al 787-792-1370 o 1-800-215-1999 (libre de costo) durante el siguiente horario: • Lunes a viernes: 7:30 a.m.- 8:00 p.m. (AST) • Sábados: 9:00 a.m.- 6:00 p.m. (AST) • Domingos: 11:00 a.m. - 5:00 p.m. (AST)
People with Special Needs	Call Customer Service if you need help in another language or format. If you want to speak in another language or need help to read or understand a document, we can help you. Printed materials may be available in other formats. TTY users can call our Customer Service Department at TTY 787-792-1370 or 1-866-215-1999 (toll-free) during the following hours: • Monday to Friday: 7:30 a.m. - 8:00 p.m. (AST) • Saturday: 9:00 a.m. – 6:00 p.m. (AST) • Sunday: 11:00 a.m. - 5:00 p.m. (AST)
Internet Portal	www.ssspr.com Our members may register to our website, where they may complete transactions such as: • Obtain information about their benefits • Health education information • Obtain a Coverage Certification • Request identification card duplicates • Check reimbursement status • Obtain a student certification letter

	• Review your service history
Mobile Application, Triple-S Salud	Download our mobile app to access important information about your health plan coverage. The Triple-S Salud app lets you: • View and email your plan ID card to your doctors, so you can get the services you need even if you don't have your card with you. • View your health plan coverage and benefits. • See the health care services you've received. This way, you can keep a log of the health services you and your family have received. • Find your nearest health care provider to fit your needs. • Easily find contact information for Triple-S Salud, such as phone numbers, office locations, and email address. Access the link for your type of phone below to download the app: Apple: https://apple.co/2Uv3taP Android: https://bit.ly/2XTMeSX IMPORTANT: All Triple-S Salud members may download our app; the plan's primary policyholder will have access to all the plan cards and coverage information.
Telexpreso	This automated phone line helps you solve issues regarding your health plan at any time of day. You just need to call (787) 774-6060 or 1-800-981-3241 (toll-free) to: • Check your eligibility and that of your dependents • Check a reimbursement status • Obtain guidance for some processes, such as submitting a reimbursement claim, requesting card duplicates, and certifications, among others

AST: Atlantic Standard Time

IMPORTANT NOTICE FOR PEOPLE WITH MEDICARE

All the forms needed to exercise your rights are available at www.ssspr.com
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not a supplement insurance to Medicare.

If you are eligible for Medicaid, examine the Health Insurance Guide for People with Medicare.

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

This insurance plan duplicates Medicare benefits when:

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

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

- Hospitalization
- Medical services
- Other approved items and services

Before you purchase this Insurance

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

To receive assistance in understanding your health insurance, contact the Office of the Insurance Commissioner of Puerto Rico or a government insurance guidance program for the elderly.

NOTICE ABOUT ERISA FOR THE EMPLOYEES OF THE PRIVATE COMPANY

The federal Employee Retirement Income Security Act (known as ERISA) governs benefits such as pension, health and disability plans; the benefits in case of death; compensation plans; prepaid plans to obtain legal services; funds for education and training programs, as well as child care centers operated by the private employer. The federal Department of Labor is the one that oversees compliance with this Law.

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

Ask your employer for a copy of the Summary Plan Description (SPD) and information about the additional benefits available to your employees. The certificate of benefits issued by Triple-S Salud covers the benefit of the health plan.

ERISA Scope

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

ERISA Requirements

ERISA generally states that benefit plans must be operated fairly and financially reasonably. Private employers and entities that manage and control labor benefit plans are required to do the following:

- Handle such funds for the "exclusive benefit" of participants and insured members of the plan;
- Avoid conflicts of interest when making investments or making decisions about benefits;
- Inform, both the government and the participants, certain information about the plans; Y
- Comply with the specific guidelines that regulate how and when the funds of the plan should be invested.

Triple-S Salud as an insurer does not manage or make decisions, administer, control, invest or distribute the funds of the plan used to finance the medical plan. Ask your employer for the SPD to acquire more details.

Each plan must notify the participants about the procedure to apply for benefits, and the established standards they must meet to receive the benefits. Such standards may, for example, include criteria to determine when someone is disabled and entitled to receive disability benefits, how soon an employee can retire and is entitled to claim pension benefits, how quickly such benefits are granted to the employee after the plan has been paid, and how quickly a participant can claim the benefits of the medical plan for an illness or injury to be covered. An employer or administrator (such as a disability insurance or retirement investment company) cannot make significant changes to the plan without notifying the participants. Ask your employer for the SPD to acquire more details if these benefits are available.

Claim of Benefits

Under ERISA, claims have to be met within a statutory deadline. If the health or disability plan denies any benefit, the denial must be in writing and state the reasons justifying the denial. In addition, it should guide you in the presentation of the case again so that a fair review of it is made. We encourage you to read the section entitled Adverse Benefits Determinations Appeals in this policy issued by Triple-S Salud regarding claims related to the health plan.

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

CHANGES IN THE EFFECTIVE PLAN IN YOUR NEW YEAR POLICY

Below, we present a summary of the changes to your plan for this new policy year. Review carefully the changes in the Benefits Sections of your different coverages.

- **There are no changes in benefits for the 2021 policy year.**

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ELIGILITY

¿WHO IS ELEGIBLE?

Every active employee of the employer and their dependents are eligible for the insurance offered by this policy. Triple-S Salud can verify the eligibility of the insured member so that the necessary requirements to obtain the benefits provided by this policy are met. Active employees and their spouses, over sixty-five (65) years of age, who are covered by both parts of the Medicare Program, can be insured under the benefits of this policy.

DATE OF COVERAGE

The employee and his / her eligible dependents (direct) are insured on the effective date of this policy, if the employee's individual application for insurance, that includes said eligible dependents, if any, is accompanied by any other document related to the hiring, and which are provided by Triple-S Salud through the official in charge of the personnel or the Benefits Administrator of the employer. After this date, the employee cannot enter the insurance until the next renewal date of this policy or if a special subscription event is presented.

Any new employee, whose eligibility date for this insurance is after the date of this policy, has an eligibility waiting period that will not exceed 90 days from the date he began working with the employer. The application for insurance must be accompanied by the corresponding document proving that the employee's eligibility date. The insurance in these cases is effective immediately the next day past the waiting period of 90 days. If the insurance is not requested, the employee may request an entry on the next renewal date of the policy or if a special subscription event occurs.

CHANGES IN ENROLLMENT

After the subscription period has expired, the employee cannot unsubscribe at any time during the period of the policy unless he ceases his employment, except in cases in which he understands that the existing coverage under his eligible group employer plan already it is not an affordable coverage or that is notified that its coverage does not provide an actuarial minimum value (60%) for the next renewal. In addition, you cannot make changes to your insurance, nor can the employer request them, unless such changes are necessary for any of the following reasons:

1. Death of any of the plan members: When a member dies during the term of this policy, the change request for the cessation of the insurance must be done within thirty (30) days after the date of death, which must be proved with a Death Certificate. The change will be effective on the date of the event.

2. Divorce of the insured employee: When the insured employee divorces during the validity of this policy, the request for a change to terminate the insurance must be made within thirty (30) days following the date on which the divorce occurred; which must be accredited with the Divorce Judgment and its corresponding Notification. The change is effective on the first day of the month following the month in which the event occurred.

3. That a child, grandchild, consanguineous relative or foster child, according to the definition of a direct dependent of this policy, ceases to be eligible as a direct dependent of the insured employee:

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

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

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

SPECIAL ENROLLMENT

An active employee and his / her eligible dependents (direct) can subscribe to this policy at any time, when any of the following conditions, terms and limitations are met.

1. Marriage of the insured employee: When the insured employee marries during the term of this policy, it may include his spouse under his insurance and those dependents who become eligible by virtue of the marriage, if the request for change is filed in Triple- S Health within thirty (30) days after the date of marriage, and it is certified with the Marriage Certificate and evidence that accredits new dependents as eligible, as the case may be. In this case, the insurance is effective the first day of the month following that in which the application is received in Triple-S Salud.

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

    a. When the insured employee procreates a biological child, legally adopts a minor, places a minor in their home for the purpose of being adopted by the insured employee, or is awarded legal custody or guardianship of a minor, the insured employee may include it under this policy. The event must be evidenced by the original birth certificate, sentence or resolution of the Court, or the official document issued by the corresponding government agency or authority, as the case may be.

    b. In the case of newborns who are biological children (as) of the insured employee, the plan covers the newborn from birth. If the application for admission as a dependent is not received in these cases, Triple-S Salud covers the newborn under the health plan of the insured of the newborn in the case of the individual contract or the health plan of the insured employee or spouse of the insured employee in the case of a family contract during the first thirty (30) days of birth while the process of signing the child is completed.

    c. In the case of newly adopted children by insured members as of the first of the following dates:

        1. The date on which they are placed in the home of the insured employee for the purpose of being adopted and remain in the home under the same conditions as other dependents, unless the placement is interrupted before legal adoption and transferred to the minor of the home where he had been placed;

        2. The date an order was issued providing custody of the child to the insured employee who intends to adopt it; or

        3. The effective date of the adoption.

    d. Coverage for newborns, newly adopted children or minors placed for adoption:

        1. includes healthcare services for injuries or illness, which includes the care and treatment of birth defects and abnormalities diagnosed by a physician; and

        2. is not subject to any exclusion based on preexistent conditions.

    e. In the cases of newborns:

        1. If paying a premium or specific subscription fee is required to provide coverage to a newborn, the plan may require the insured employee to notify the child of the child's birth, with the request for inclusion as a dependent and the presentation of the Minute. Original of Birth, and that provides the payment of the charges or the required premium no later than thirty (30) days of the date of birth.

2. If the insured employee does not provide notice or premium payment, the plan may choose not to continue providing coverage to the dependent minor beyond the thirty (30) day period. However, if no later than four (4) months from the child's date of birth, the insured employee issues all payments owed, the child's coverage is reinstated.

3. If, on the other hand, the plan does not require payment of a premium, you can request a notification of the birth, but you cannot refuse or refuse to continue providing the coverage, if the insured employee does not provide such notification.

f. In cases of newly adopted children or minors placed for adoption, the health insurance organization or insurer is obliged to provide the insured employee with reasonable notice about the following:

1. If paying a premium or specific subscription fee is required to provide coverage for a newly adopted child or a minor placed for adoption, the plan may require the insured employee to notify about the adoption or placement in a home for adoption and that provides payment of the required premium or charges no later than thirty (30) days from the date the coverage is required to begin.

2. If the insured employee does not provide the notice or payment described in the preceding paragraph within the thirty (30) day period, the plan cannot treat the adopted child or the child placed for adoption less favorably than other dependents, who are not newborns, for whom coverage is requested later than the date the dependent became eligible for coverage.

g. 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 subscription for loss of eligibility under another group plan or termination of employer contributions to cover the premiums of another group health plan

An active employee and his / her eligible dependents (direct or optional) can subscribe to this policy in a special subscription period in the event of any of the following events:

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

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

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

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

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

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

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

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

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

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

4. When an insured employee or one of his/her eligible dependents (direct 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 program 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 the main insured (non-custodian) of minors listed as dependents under the policy, or when insured members who are of legal age but who appear as eligible dependents under the policy, request compensation payment directly to your person for having paid for the covered medical services that are claimed, Triple-S Salud can remit the payment directly to said non-custodial parent or insured member.

HOW DOES YOUR PLAN WORK

Your coverage under this policy / certificate

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

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

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

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

Free Choice Plan

You, as an insured member of Triple-S Salud, are subscribed to a Free Selection plan. This means that you can access your medical care freely within the Triple-S Salud Participant and Provider Network without the need for a referral from a primary physician or other physician.

However, we recommend that you always select a family doctor to coordinate your services with other providers. It helps you identify the medical care you need to coordinate with other specialist doctors and providers in the Triple-S Salud Participants and Providers network that are part of the Board.

You must visit participating doctors and providers in the Triple-S Salud network to have your services covered, except in cases of emergency as required by law.

There are certain Triple-S Health plan rules that you must follow to have services covered, such as: visiting certain providers to receive specific services, precertification for services before you receive them, use of the Drug List or Formulary, medications generic as a first option and use of doctors and network providers, among others.

Medically Necessary Services

Triple-S Salud covers the benefits described in this policy / certificate, as long as they are medically necessary. Medically necessary services are services provided by a participating physician, a group of physicians or a provider to maintain or restore the health of the insured member and which are determined and provided according to the standard of good medical practice.

Please refer to the Appeals of Adverse Benefits Determinations section for your right to an appeal of an adverse determination of the benefits of a service considered not medically necessary.

Medical-Surgical Services during a Hospitalization

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

No person insured under this policy, who is hospitalized in a semiprivate or private room of the hospital, is obliged to pay any amount to a participating doctor for the services covered by this policy that the doctor provides. The payment of medical fees in these cases is made directly by Triple-S Salud to the participating doctors based on the rates established for such purposes.

Inpatient Hospital Services

If an insured member in this plan requires a hospitalization because of an injury or illness, it is a requirement that at the time of his or her income, he pay the hospital the copayment or coinsurance established by the admission. In addition, it is responsible for the payment of any other service, provided during the hospitalization, that requires a copayment or coinsurance, as defined in this policy. Copayments and coinsurances are not refundable.

For the calculation of any hospitalization period, the day of admission is counted, but the day in which the patient is discharged by the doctor in charge of the case is not counted. Triple-S Salud is not responsible for the services received by any insured member if they remain in the hospital after being discharged by the attending physician. Neither is he responsible for any day or days of pass that are granted to the patient to be absent from the hospital during the same period of hospitalization.

Participating Providers in our Network

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

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

- Verify in the Participants and Providers Directory of the Triple-S Salud Network you may have available.
- Visit our internet portal www.ssspr.com.
- Access our **mobile application** for your Smartphone (Android or Apple), Triple-S Salud. Once you complete the registration process, you can access the Provider Directory.
- Call Customer Service at the number listed on the back of the member identification card for questions of a specific provider.

Special Contracts for Management

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

Compensation to Network Providers

The services provided by participating providers are paid based on the rate established for each of the services, in accordance with the contract in force between the participant and Triple-S Salud. When requesting a service, the insured member is obliged to show the identification card of the plan that accredits him as an eligible person to receive services from the provider. This stipulates the coverage to which you are entitled.

If you need additional information about fees or fees paid to a participating physician or provider for a specific service, call the Customer Service Department at the number on the back of the insured member's ID card.

Services outside the Network in Puerto Rico

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

In the event that the insured member receives post-emergency or post-stabilization health care services that are covered under the health care plan of the non-participating provider, Triple-S Salud reimburses the insured member based on from what is less between the expense incurred and the fee that would have been paid to a participating provider, after deducting the applicable copayment and / or coinsurance as established in this policy, provided there is a weighty medical reason why the patient cannot be transferred to a participating provider.

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

Transition

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

In case of cancellation of the provider (voluntary or involuntary) or that the health plan ceases, the insured member is notified of such cancellation at least 30 days before the effective date of the cancellation. In case of cancellation, subject to the payment of the premium, the insured member has the right to continue receiving the benefits for a transition period of 90 days. In the event that you are hospitalized at the time of the cancellation date and the discharge date has been scheduled before the termination date, the transition period extends 90 days after the date of discharge.

In the case of a person insured during pregnancy and the cancellation occurs in the second trimester, the transition period extends until the date of discharge of the insured member after delivery or the date of discharge of the newborn, whichever is last. In the case of patients diagnosed with a terminal condition, prior to the plan's termination date and who continue to receive services for that condition prior to the plan's termination date, the transition period extends during the remaining time of the patient's life.

New insured members with ongoing treatment

If the insured member is in an ongoing treatment with a non-participating provider when the coverage of this policy / certificate becomes effective, the insured member can receive their covered services for ongoing treatment with the non-participating provider for up to 60 days. days after the effectiveness of the coverage with Triple-S Salud.

This course of treatment must be for a life-threatening illness or condition or a degenerative and disabling condition or disease. Insured members may continue the care of a non-participating provider if they are in the second or third trimester of pregnancy, when the coverage of this policy / certificate becomes effective.

The insured members can continue with the medical care until the date of delivery and any post-delivery services directly related to it.

In order to continue receiving services from a non-participating provider under the circumstances described above, the provider must accept as payment our fees for those services. The provider must agree to provide the necessary medical information related to the medical care of the insured members and to accept our policies and procedures, including those to ensure the quality of health care, obtaining a precertification and an approved treatment plan. the plan. If the provider agrees to these conditions, the insured members receive the covered services as if they were provided by a participating provider. The insured member is responsible only for the copayments and coinsurance applicable to their coverage.

Your Right to participate in decision making about your treatment

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

Your doctor or health care provider must respect and abide by your treatment decisions and preferences.

Our plan cannot impose gag, penalty or other clauses that interfere with communication between you and your doctor. Your doctor (s) or health professional (s) coordinating your medical care must provide a medical order for lab tests, x-rays, or medications so you can choose the facility in which you will be taking care of them. will receive the services.

Emergency room and emergency services

Materials and medications included in the suture tray contracted with Triple-S Salud. It covers medicines and materials additional to those included in the suture tray, supplied in emergency / emergency rooms due to accident or illness conditions. A copayment or coinsurance applies for illness and accident, according to the Deductibles, Copayments and Coinsurance Table.
In the event that an insured member requires treatment for an emergency condition, Triple-S Salud offers a lower copayment if you visit an emergency room in our provider network instead of an emergency room.

In the event that an insured member requires treatment for an emergency condition, they should seek immediate attention in the emergency room of a hospital or a nearby emergency room facility or call the 9-1-1 System. Emergency services do not require precertification nor are they subject to waiting periods. However, only emergency services for the treatment of an emergency condition are covered in an emergency room and are independently covered by a participating provider.

If the insured member receives emergency services from a non-participating provider, these services will be paid directly to the provider based on the contracted rate paid to a participating provider, after discounting the applicable copayment and / or coinsurance, established in the policy. The non-participating provider is obliged to accept the payment for an amount that will not be less than the one contracted for participating providers to offer the same services.

In the event that the insured member receives post-emergency or post-stabilization health care services that would be covered under the health care plan, except for the fact that it is a non-participating provider , Triple-S Salud will compensate the insured member based on what is less between the expense incurred and the fee that would have been paid to a participating provider, after discounting the applicable copayment and / or coinsurance as established in the policy, always that there is a compelling medical reason why the patient cannot be transferred to a participating provider.

If the insured member when calling Teleconsulta, receives a recommendation to go to the emergency room with a registration number, a lower copayment / coinsurance may apply for the use of said facilities.

Psychiatric emergencies are covered, pursuant to Act No. 183 of August 6, 2008, as well as transportation between health service providers including ambulances that are certified by the Public Service Commission and the Department of Health as established by law. the last paragraph of article 4.20 (b) of Act No. 183 of August 6, 2008 and as indicated in the Ambulance Benefit under the Services Section Provisioned by a Hospital or other Ambulance Facility and Services.

Note: For diagnostic tests provided in emergency rooms, other than laboratories and X-rays, the coinsurance and / or limits corresponding to the outpatient benefit, as specified in this policy, apply.

Admissions in hospitals: If an insured member is admitted to the emergency hospital, they do not have to notify the plan about admission, except if they are outside of Puerto Rico. In these cases, the insured member or some other person must notify the plan to the number on the back of the ID card within forty-eight (48) hours after admission, or as soon as reasonably possible.

Emergency and urgent services in the United States

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

Triple-S Salud covers emergency and urgent services based on contracted Blue Cross Blue Shield Plan rates if the provider providing services is a participant in the Blue Cross Blue Shield plan network.

The insured member is responsible for paying the coinsurance established in the Extended Coverage in the United States that appears in the policy.

Precertification of Services

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

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

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

Maximize your plan benefits

Make the most of your health benefits by following the following recommendations:

- Avoid using the emergency room for services that are emergency or routine and are not an emergency. The visit to the emergency room in these cases can result in higher costs for the health plan and higher outlays for you compared to a medical visit. Observe the following examples:

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

Remember, if you feel **sick**, **hurt**, or **need health advice, call Teleconsulta**. The nursing professionals of this voluntary service offer you advice to decide if you should:

- make a medical appointment,
- visit an emergency room,
- or give you directions so that you can safely and reliably relieve the symptoms you present, in the comfort of your home.

Visit a primary or primary care physician instead of visiting multiple medical specialists to diagnose and treat a condition properly. A primary or primary care physician can be an Internist, a Family Medicine Specialist, a Generalist, a Pediatrician, Gynecologist, Obstetrician Gynecologist or a Geriatrician. It coordinates the necessary and preventive services according to your age and health condition, in addition to the necessary health care with the specialists and other providers of the Triple-S Salud network.

Your primary care physician knows everything about your health and maintains a complete record of your health condition. Remember that you do not need referrals to receive covered services from any provider in the Triple-S Salud network.

- Use generic medications as a first option whenever they are available to treat your condition.

  o A generic drug is a copy of a brand-name drug whose patent has expired. The patent is the one that offers the pharmaceutical company the sole right to sell the drug while it is effective. When the patent expires, companies can sell generic versions of the brand-name drug available.

  o A generic drug has the same use and works in the same way in the body as brand-name drugs. They have the same active ingredient, they are equal in dosage, safety and quality, as required by the Federal Food and Drug Administration (FDA).

  o Generic drugs can mean savings for your pocket, since they cost much less than brand-name drugs. Copayments and / or coinsurance for generic drugs are usually lower. Please note that if you are using a brand name drug for which a generic is available, you may be receiving the same benefits at a lower cost.

- Use OTC medications under the Triple-S Salud program that have $0 copay. The list includes medications for stomach conditions, allergies and eye drops that have been shown to be safe and effective, in addition to representing a lower cost to the health plan. Remember that you must present a doctor's prescription for the OTC medication.

- Evaluate with your doctor the drugs that are part of your treatment and that are included in our Drug List or Formulary. Use the preferred medications which are cost-effective and already proven for the treatment of conditions. In addition, they have been selected by the Pharmacy and Therapeutics Committee for their effectiveness. You have larger outlays when you use

medications that are not preferred. Check your coverage description so you can see how much your out-of-pocket is for copayments and coinsurance.

- Use your preventive services coverage to detect conditions on time.

Our plan offers all the preventive services required by law at no cost to you. This means that you do not pay out of pocket for services like annual physical exams and preventive gynecological appointments, preventive mammograms and other exams, immunizations and more. These are important steps to stay healthy, so you should take advantage of this to detect any health condition early.

- Reduce your disbursements significantly by always using network providers. Triple-S Salud offers you a wide network of providers in and out of Puerto Rico. Remember that our plan covers non-participating providers only in cases of emergency. This means that for non-emergency services, you are responsible for the total cost of the service received by the non-participating provider.

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

TELECONSULTA[1]

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

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

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

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

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

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

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

Precertification of Services / Pre-Authorization of Drugs

There are certain services and medications that require prior approval from Triple-S Salud before the insured member can receive them. The insured member or provider is responsible for requesting a precertification of the service. Please refer to the Precertification Sections, Procedure for Precertification Procedures and Preauthorization for Drugs to obtain a list of services that require a precertification of services or pre-authorization of medications and the process that the insured member or provider must follow to obtain the precertification of the plan.

Get an updated copy of the Drug List or Formulary

Your drug coverage under this policy is subject to a Drug List or Formulary. This List or Form is available on our website at www.ssspr.com.

Call Customer Service if you are interested in an updated copy of the Drug List or Formulary.

Clinical Management

The benefits offered by this Policy / Certificate are subject to precertifications, concurrent and retrospective reviews to determine when the services must be covered by the plan. The purpose of these reviews is to promote the provision of medical care in a cost-effective manner by reviewing the use of medical procedures and, where appropriate, the level or provider that provides the service. Covered services must be medically necessary to be considered covered by the plan.

If a concurrent review determination has been previously certified, it will be considered an adverse determination to reduce or terminate the treatment before the end of the authorized period unless it is due to an amendment to the plan's benefits or termination. Triple-S Salud will notify the insured member in advance of the reduction or termination. The insured member will have the opportunity to file a grievance before the benefit is reduced or terminated. The service will continue until the insured member is notified of the determination related to their complaint.

The retrospective determinations are made within a period of no more than thirty (30) days from the day the request is received. If for reasons beyond the control of Triple-S Salud a determination cannot be made in that period of time, it may be extended for an additional fifteen (15) days. If an extension is necessary, Triple-S Salud will notify the insured member before the end of the initial thirty (30) day period with a justification and will indicate the date on which the determination is expected. If a determination cannot be made due to lack of clinical information, the insured member will be notified, verbally or in writing, of the specific information needed and a period of forty-five (45) days from the date of notification to provide it will be provided.

Prospective determinations are made within a period no longer than fifteen (15) days from the date on which the request is received. If for reasons beyond the control of Triple-S Salud a determination cannot be made in that period of time, it may be extended for an additional fifteen (15) days. If an extension is necessary, Triple-S Salud will notify the person before the end of the initial term of fifteen (15) days with a justification and will indicate the date in which the determination is expected.

Case Management

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

Disease Management Program:

- Diabetes
- Hypertension and Congestive Failure
- Asthma

- Obstructive pulmonary disease
- Prenatal: high risk pregnancy
- Chronic kidney failure

Complex case management:

- Immunological disorders (example: HIV or AIDS)
- Cerebrovascular disease
- Cystic fibrosis
- Degenerative diseases (example: multiple sclerosis, ALS)
- High users
- Organ and tissue transplant, including bone marrow, liver, kidney, heart, lung, and pancreas
- Skin lesions (ulcers III and IV)
- Mental health and substance abuse
- Stroke
- Cystic fibrosis
- Pulmonary hypertension
- Cancer under continuous chemotherapy treatment (head/neck, gastrointestinal, lung, ovary/uterus, brain, metastasis or in terminal phase

Our program is confidential and voluntary. It will help participating members coordinate their benefits, and it will guide them, so they are able to meet their health care needs.

Members may be referred to the program by physicians, social workers, hospitals, discharge planners, relatives, or of their own accord, as well as by other sources.

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

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

To learn more, call 787-706-2552; Fax: 787-744-4820; TTY users call 1-800-981-4860. Our business hours are Monday to Friday: 8:00 a.m. – 7:00 p.m.

Program for Management of Populations with Specific Diseases

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

- **Diabetes Program:** Educational guidance is offered to insured members over 18 years of age diagnosed with diabetes. In the workshops and telephone calls are discussed topics such as what is diabetes, emotional aspects, exercise, nutrition, drugs and prevention of complications, among

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

- **Hypertension Program:** Insured members over 18 who suffer from hypertension (high or uncontrolled high blood pressure) benefit from the educational activities offered by this program. They

learn what hypertension is, its signs or symptoms, lifestyle changes and how to control blood pressure.

- **Heart Failure Program:** Insured members older than 19 who suffer from heart failure (heart disease that causes the pumping of blood to the body is not normal). When the condition is severe, they receive educational material in their home and guidance from our nursing professionals of the Cardiac Failure Management Program, about how to take care of themselves and thus feel better. Insured members whose condition is not severe are cited by health educators for educational activities. All this helps them control their condition, avoid complications and improve their quality of life.

- **COPD Program:** Insured members over 40 with the condition of COPD (acronym in English of Chronic Obstructive Pulmonary Disease) receive guidance on their condition, the use of medications to control it, signs and symptoms of complications and the importance of medical follow-up. Our health professionals help participants to know their condition well and adopt healthy lifestyles to avoid complications and enjoy a better quality of life.

- **Prenatal Program:** The Prenatal program educates insured people about the importance of early prenatal care and about the risk factors to which they must be aware. People insured during their pregnancy status receive educational brochures about pregnancy and baby care. In addition, they receive telephone counseling from a clinical management specialist in the prenatal area and guidance in educational workshops offered by health educators.

- **"Living without Smoke" Program:** The program consists in offering guidance services and general education on the effects of smoking on health, the benefits of modifying or eliminating this addiction. It is aimed at people who suffer from chronic conditions and those who wish to leave this addiction. The Program is offered free of charge to insured members. This program will help the insured member obtain information about the importance and benefit of stopping smoking, which will allow an increase in self-control, help minimize tobacco addiction and reduce the risk of getting sick.

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

Your coverage when you participate in a Clinical Trial

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

Remember, this applies when you have enrolled in a trial or study to treat a life-threatening illness, for which there is no effective treatment, and get the doctor's approval for your participation in the study because it offers a potential benefit.

Our plan covers:

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

Our plan does not cover:

- Expenses for studies or clinical research treatments (clinical trials)
- Apparatus, experimental or investigational drugs administered to be used as part of these studies
- Services or products that are provided for data collection and analysis, and not for the direct management of the insured member
- Items or services without costs for the insured member that is commonly offered by the sponsor of the investigation.

Preventive Centers Program

Through this program, you can get your preventive services at participating Centers, in the same visit without the need for long waits. The insured member must coordinate the appointment with the Participating Center of their interest to receive the covered services in their plan in the Section, Preventive Services Coverage. It includes an initial evaluation and subsequent to the tests carried out.

This program is available only through the SALUS Clinics and other participating facilities. Please refer to the Triple-S Salud Provider and Participant Directory for a list of participating Preventive Centers, visit our website at www.ssspr.com, our mobile application or call the Customer Service Department for information on a Center near you.

Triple-S Natural

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

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

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

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

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

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

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

- **Bioenergetic Medicine (Pranic Healing):** Treatment of different health conditions by balancing the vital energy that surrounds or that our body has internally. This therapeutic method uses as a principle that the body has an energy that gives it life and which many scientists call electromagnetic energy or bioenergy. The therapist provides energy to the patient with the primary purpose of improving the general state of the patient.

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

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

- **Reflexology**: It is a specialized technique that aims to offer treatment for various health conditions through the activation of acupressure points on feet and hands. Such technique has as basis the use of body maps with the acupuncture points of the traditional Chinese medicine.

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

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

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

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

- **Chiropractic**: Is based in the concept that the vital energy of the human being passes through the spinal column and that any alteration in this energy flow causes the pathology that degenerates in disease. The chiropractor through spinal adjustment techniques, restores the normal flow of energy, up to the total or partial disappearance of the symptoms of the patient.

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

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

Educational Materials in the Internet Portal

Search our website www.ssspr.com for the section Our Blog for health and wellbeing information for insured members.

Satisfaction surveys

The opinion of our insured members counts.

Triple-S Salud periodically conducts surveys to insured members to measure satisfaction with the plan at a general level and the care provided by the providers in our network. These studies are carried out with independent organizations at Triple-S Salud. The results of the survey are used by Triple-S Salud for its

continuous efforts to improve the general experience of the insured member with the health plan, including the experience of service and quality of care.

To obtain information and the results of the most recent customer satisfaction survey, call the Customer Service Department.

Benefits not covered by the plan

Your doctor can recommend medical services, treatments or medications that your Triple-S Salud policy does not cover. If you receive non-emergency services and your Triple-S Salud policy does not cover, you are responsible for payment in full for services rendered or medications dispensed.

We recommend that you verify the Exclusion Sections in this policy / benefit certificate before receiving the medical service, treatment or medication, as well as any endorsement that is adhered to to verify whether it is covered or not. We also recommend that you explore with your doctor or alternative treatment service provider that is covered under the plan so that you reduce your out-of-pocket expenses or coverage options under programs with other organizations that can provide you with additional help.

Previous instructions or Advance Directives

The advance directives or the prior declaration of will about medical treatment are legal documents that allow any person of legal age (21 years or older) in full use of their mental faculties, to express in writing their decisions about the care and medical treatment that they provide. you wish to receive in case of suffering a health condition that would not allow you to express yourself during such treatment. This document provides you with greater control over the decisive issues in your quality of life, providing family, friends and doctors with the fundamental information they need to take care of you. Physicians and other health professionals are legally required to follow your advance directives. Under the provisions of the law, you cannot be denied care or discriminated against based on whether you have signed an advance directive.

In the case of a disease that makes you unable to communicate, decisions about your health are made by another person and not always according to what you would have wanted.

Pursuant to the laws in Puerto Rico, the decision to accept or reject medical treatment is made by the next of kin, whose first rank is the spouse of the declarant. So, it's important to take a few moments to draft your advance directives.

For more information about Advance Directives, visit our website at www.ssspr.com or call Customer Service at the number on the back of the insured member's card.

Informed decisions about your health care

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

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

Request an estimate of cost. After your doctor gives you all the details of your condition and treatment alternatives, contact Triple-S Salud to confirm how much your outlay is for treating your condition.

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

COORDINATION OF BENEFITS (COB)

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

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

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

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

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

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

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

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

d. Order of Determination of Benefits

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

1) Non-dependent or dependent

a) Except for what is provided in subparagraph (b) of this paragraph, the plan that covers a person as non-dependent (for example, the plan that covers a person as an employee,

member, subscriber, policyholder, or retired) is the primary plan and the plan that covers the person as dependent is the secondary plan.

b) (i) If the person is a Medicare beneficiary and as result of the provisions of the Title XVIII of the Social Security Law and their regulations, Medicare is:
(I) Secondary to the plan that covers the person as a dependent; and
(II) Primary to the plan that covers the person as non-dependent

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

2) Dependent Child Covered under More than One Plan

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

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

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

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

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

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

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

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

I. The plan that covers the custodial parent;

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

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

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

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

d)

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

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

3) Active Employee or Retired or Former Employee

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

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

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

4) COBRA or Extensions of Coverage Under State Law

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

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

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

5) Longer or Shorter Coverage Time

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

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

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

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

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

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

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

COVERAGE OF SERVICES BY LOCAL OR FEDERAL LAW

Services Covered by Local or Federal Law

This policy provides the insured member, including those diagnosed with HIV or AIDS, with physical or mental disability, with all the benefits offered in this policy, including the services required by local and federal law.

Preventive screening services, according to the child's preschool age, required by Act No. 296 of September 1, 2000, are covered by this policy. According to normative letter No. N-AV-7-8-2001, the Department of Education has the responsibility to ensure that each child has received their annual medical evaluation at the beginning of each school year. Said medical evaluation shall include physical, mental, oral health, vision and hearing screening, in addition to all periodic screenings recommended by the American Academy of Pediatrics.

In compliance with Law 97 of May 15, 2018 (Letter of Rights of People with Down Syndrome), this policy covers the services required for insured with Down Syndrome, including genetic tests, neurology, immunology, gastroenterology and nutrition, medical visits and medically referred tests and therapeutic services with a remediative approach to independent living or assisted living for adults over 21 years of age; Subject to the limits, copayments and coinsurance established in the policy.

PREVENTIVE SERVICE COVERAGE

This policy covers the preventive care services required by the federal Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA) and the Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152 (HCERA), and as established by the United States Preventive Services Task Force (USPSTF). These may be modified throughout the year based on the updates made by HCERA and the USPSTF. The preventive care services listed below are included in our basic coverage, and they entail a $0 copayment or 0% coinsurance, as long as they are rendered by participating physicians and providers in Puerto Rico. To obtain an updated list or additional information about these services, visit: https://www.healthcare.gov/coverage/preventive-care-benefits/.

PREVENTIVE CARE FOR ADULTS

Preventive Service	Note
Abdominal aortic aneurysm (AAA)	One (1) service per ultrasonogram to screen for abdominal aortic aneurysm (AAA), for members 65 to 75 years of age who were smokers at some point
Alcohol abuse	Screening and counseling. Clinical screening for adults over 18 years old for alcohol abuse, as well as behavioral counseling interventions to reduce alcohol use for members who exhibit a pattern of risk or dangerous alcohol consumption.
Aspirin supply to prevent the risk for cardiovascular disease and colorectal cancer: preventive medicine	Use of low-dose aspirin as primary preventive measures against cardiovascular disease and colorectal cancer for adults between 50 and 59 years old who have 10% or more than 10 years of cardiovascular risk, who are not at high risk for bleeding, whose life expectancy is at least 10 more years, and who are willing to take low-dose aspirin every day for at least 10 years.

Preventive Service	Note
Screening for urine bacteria among pregnant individuals	The USPSTF recommends screening for asymptomatic bacteriuria through the use of urine cultures among pregnant individuals.
Colorectal cancer	Colorectal cancer screening via occult blood test, sigmoidoscopy, colonoscopy, or serological test, in adults 50 to 75 years old. The risks and benefits of these screening methods may vary.
Depression Screening for adults	Depression screening for adults, including members in their pregnancy or post-partum. The screening must be performed through an adequate system to guarantee an accurate diagnosis, an effective treatment, and an appropriate follow-up.
Diabetes screening	Screening for abnormal blood sugar levels as part of the cardiovascular risk evaluation in overweight or obese adults aged 40 to 70 years old. Doctors must offer or refer members with abnormal blood sugar levels to intensive behavioral counseling interventions to promote a healthy diet and physical activity.
Fall prevention in elderly adults: exercise or physical therapy	Exercise and physical therapy to prevent falls in adults over 65 years old at risk of suffering falls.
Healthy diet and physical activity as prevention for cardiovascular disease in adults at cardiovascular risk.	Offer and refer adults who are overweight, obese, or who exhibit additional risk for cardiovascular disease to intensive behavioral counseling interventions to promote a healthy diet and physical activity, in order to prevent cardiovascular disease.
Hepatitis B screening: screening for teenagers and adults who are not pregnant	Hepatitis B screening for adults at high risk of infection.
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C (HCV) infections among adults who are 18 to 79 years old.
Hypertension screening	Hypertension screening for adults 18 years of age and older. These measures must be obtained outside the clinical setting so as to confirm the diagnosis before starting treatment.
Pre-exposure prophylaxis for HIV to prevent HIV infection	The USPSTF recommends doctors to offer pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to individuals at high risk of contracting HIV.
Human Immunodeficiency Virus (HIV) screening: teenagers and adults who are not pregnant	Human Immunodeficiency Virus (HIV) screening for adults 13 to 65 years old, as well as younger teenagers and older adults at a higher risk. As required by Act 45-2016, this includes an HIV test per year as part of the routine medical check-ups, except for members who are pregnant and to whom the USPSTF requirements apply.

Preventive Service	Note
Immunization	Vaccines. The recommended doses, ages, and populations vary: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza, MMR, Meningococcus, Pneumococcus, Tetanus, Diphtheria, Whooping Cough, and Chickenpox. Follow-up or "catch up" vaccines are covered.
Lung cancer screening	Annual lung cancer screening through computerized tomography, for adults aged 55 to 80 years old with a history of smoking thirty (30) packs a year, who are currently smoking or stopped smoking within the last 15 years. The screening will be discontinued after 15 consecutive years have elapsed since the person stopped smoking or if they develop a health problem that would substantially limit their life expectancy or their ability or possibility of undergoing surgery to treat the cancer.
Screening and counseling for obesity in adults	Obesity screening for adults. Doctors may offer or refer patients with a Body Mass Index (BMI) of 30 kg/m2 or more to intensive multi-component behavioral interventions.
Sexually transmitted diseases	Intensive behavioral counseling for sexually active teenagers and adults who are at high risk for sexually transmitted diseases.
Statins to prevent cardiovascular events in adults: Preventive Drugs	For adults without any history of cardiovascular disease (such as symptomatic coronary artery disease or ischemic stroke), to use low- or moderate-dose statins to prevent cardiovascular events and death if all the following criteria are met: • They are 40 to 75 years old, • Have one or more risk factors (dyslipidemia, diabetes, hypertension, or smoking), and • Have a calculated 10-year risk of having a cardiovascular event of 10% or more. Detecting dyslipidemia and calculating a 10-year risk for a cardiovascular event requires a general lipid screening for adults between 40 and 75 years old.
Syphilis screening for non-pregnant members	Syphilis screening for members who are at high risk of infection
Ceasing tobacco use and medications: adults who are not pregnant	Based on USPSTF recommendations, physicians should ask all adults about their tobacco use, advise them to stop using it, and offer behavioral interventions and medications approved by the Food and Drug Administration (FDA) to cease smoking. For those using products to cease tobacco use, this plan covers FDA-approved medications to cease smoking for ninety (90) consecutive days in one single attempt, and up to two (2) attempts per year.
TB screening test: adults	Screening for tuberculosis infection in high-risk populations.

Preventive Service	Note
Harmful drug use	Screening for harmful drug use among adults aged 18 years and over, including pregnant members, providing brief interventions for behavioral counseling, accurate diagnosis, effective treatment, and adequate care in order to reduce the use of harmful drugs among individuals who engage in risky or dangerous consumption.
Harmful alcohol use: adults	Screening for harmful alcohol use at primary care facilities for adults over 18 years old, including pregnant members, by providing brief guidance behavioral counseling interventions to reduce harmful alcohol consumption in people who engage in dangerous or risky consumption.

PREVENTIVE SERVICES FOR ADULTS, INCLUDING PREGNANCIES

Preventive Service	Note
Urinary incontinence screening tests among women	The Women's Preventive Services Initiative recommends testing women to detect urinary incontinence as a preventive service. Factors associated with a higher risk of urinary incontinence include increasing parity, advancing age, and obesity; however, these factors should not be used to limit screening. Several screening tools demonstrate fair to high accuracy in identifying urinary incontinence in women. Although minimum screening intervals are unknown, given the prevalence of urinary incontinence, the fact that many women do not volunteer symptoms, and the multiple, frequently-changing risk factors associated with incontinence, it is reasonable to conduct screening tests annually.
Counseling and Screening for Human Immunodeficiency Virus	Annual counseling and screening for human immunodeficiency virus infection for all sexually active women.
Screening of urinary tract infection for pregnant members	Screening for pregnant members showing no symptoms of bacteria in their urine culture, between 12 to 16 weeks of pregnancy, or during their first prenatal visit if it occurs after the aforementioned term.
BRCA: Risk Assessment	Primary care providers should screen people whose relatives have had breast, ovarian, fallopian, or peritoneal cancer, through tools designed to identify any family history that could be linked to an increased risk for potentially harmful mutations in the breast cancer susceptibility genes (BRCA1 or BRCA2). Members who obtain a positive result should get genetic counseling and, if deemed appropriate after counseling, undergo the BRCA test.

Preventive Service	Note
Breast cancer: preventive drugs	Clinical guidance for high-risk patients. The USPSTF recommends that all physicians involve their patients at high risk for breast cancer in making the decision whether to use drugs that would reduce the risk of developing the disease. The physician should offer to prescribe medications to reduce the risk of developing breast cancer, such as tamoxifen or raloxifene, for patients that are found to be at high risk of developing the disease and have a low risk of having adverse reactions to the medications.
Breast Cancer Screening (Diagnosis and screening of breast cancer)	Act No. 10 of January 3, 2020, "Law on the Right to Effective Breast Cancer Screening," establishes that the following be included among the preventive care benefits: • One mammography, for women who are thirty-five (35) to thirty-nine (39) years old. • One annual mammography for women who are forty (40) years old or over. • One annual mammography and follow-up treatment or supplementary diagnostic tests (MRI/sonomammograms), for women who are forty (40) years old or over whose breast tissue is classified as heterogeneously dense or extremely dense.
Diabetes mellitus screening after pregnancy	Screening for diabetes mellitus among women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and have not been previously diagnosed with type 2 diabetes mellitus. It would be ideal for initial tests to be performed within the first year after birth, and they may be done as soon as 4 to 6 weeks after delivery.
Breastfeeding	Support and counseling through a provider trained in breastfeeding during pregnancy and/or postpartum, as well as access to breastfeeding equipment and supplies, per delivery. Interventions during pregnancy and after delivery to support breastfeeding.
Cervical cancer screening	Cervical cancer screening for members aged 21 to 29 years old along with the Pap test every three (3) years; or every five (5) years in combination with the Human Papilloma Virus (HPV) test, for members aged 30 to 65 years old who want to get the test less frequently.
Chlamydia screening	Chlamydia screening for all members who are pregnant or for members who are sexually active and under 24 years old or older if at a high risk of infection.
Contraceptive Methods	All FDA-approved contraceptive methods, sterilization procedures, counseling and education for members of reproductive age, as prescribed. Insertions and removals of all devices are covered.

Preventive Service	Note
Screening for domestic violence: members who are at a reproductive age	Screening for violence in the intimate romantic relationships of members of a reproductive age, such as domestic violence, and offering and referring people with a positive screening result to the corresponding intervention services. This recommendation applies to members who exhibit no signs or symptoms of abuse.
Folic acid	All female members who may or are planning to get pregnant should take a daily folic acid supplement of 0.4 to 0.8 mg (400 – 800ug)
Gestational Diabetes Mellitus	Screening for gestational diabetes mellitus in pregnant people showing no symptoms after 24 weeks of pregnancy and for those identified as high-risk for gestational diabetes mellitus.
Gonorrhea screening	Gonorrhea screening for members who are sexually active and under 24 years old or older if at a high risk of infection.
Hepatitis B screening: pregnant members	For pregnant members, screening of Hepatitis B virus infection during the first prenatal visit.
Human Immunodeficiency Virus (HIV) screening: members during their pregnancy	Doctors must perform an HIV screening for all pregnant members, including those who are just showing up for delivery and who have not had the screening done before, and whose HIV status is unknown. The following tests are covered without copay for pregnant members: a. First HIV test during the first trimester of pregnancy at the first prenatal visit, and b. Second test during the third trimester of pregnancy (between 28 and 34 weeks of pregnancy)
Osteoporosis screening	Osteoporosis screening with bone densitometry tests for members over 65 years old and post-menopause members under 65 years old who are at a higher risk of osteoporosis, to prevent fractures.
Osteoporosis Screening: post-menopause members under 65 years old at a higher risk for osteoporosis.	Osteoporosis screening with bone densitometry test to prevent osteoporosis fractures in post-menopause members under 65 years old who are at a higher risk for osteoporosis, as determined through a formal clinical risk assessment tool.
Osteoporosis screening: members over 65 years old	Osteoporosis screening with bone densitometry test to prevent osteoporosis fractures in members over 65 years old.
Perinatal Depression: counseling and intervention	Clinical staff are advised to provide interventional counseling or refer pregnant members or members after birth who are at a risk for perinatal depression.

Preventive Service	Note
Pre-eclampsia prevention: aspirin	Use of low-dose aspirin (81 mg/d) as a preventive drug after 12 weeks of pregnancy in members at a high risk of pre-eclampsia.
Pre-eclampsia screening	Pre-eclampsia screening for pregnant members, with blood pressure monitoring throughout the pregnancy.
Rh(D) Incompatibility Screening	Screening for Rh(D) blood type and antibodies, for all pregnant members at their first prenatal visit. Includes repeating the antibody test for pregnant members with non-sensitized RH(D) negative tests at 24 to 28 weeks of pregnancy, unless the biological father is Rh(D) negative.
Anxiety screening tests	The Women's Preventive Services Initiative recommends anxiety screening tests for teenage and adult women, including those who are pregnant and postpartum. Optimal screening intervals are unknown, and clinical judgment should be used to determine screening frequency. Given the high prevalence of anxiety disorders, lack of recognition in clinical practice, and multiple problems associated with untreated anxiety, physicians should consider screening women who have not been recently screened.
Screening for syphilis infection during pregnancy	Screening for syphilis infection for all members during their pregnancy The USPSTF recommends screenings for the early detection of syphilis infection in all pregnant members.
Tobacco use and smoking cessation for pregnant members	Physicians should ask all members during their pregnancy about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for tobacco use cessation to members who are tobacco users.
Preventive visits for members	Annual preventive check-up (depending on the member's health condition and requirements and any other risk factors) for adult members receiving the preventive services that are recommended and suitably developed for their age, including prenatal care and any services necessary to provide prenatal care. This preventive annual check-up should, if appropriate, include other listed preventive services. If the doctor determines that the patient requires additional visits, these shall be covered with no copay.

PREVENTIVE SERVICES FOR MINORS

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

Preventive Service	**Note**
Alcohol abuse	Screening and counseling Clinical screening for adults over 18 years old for alcohol abuse, as well as behavioral counseling interventions to reduce alcohol use for members who exhibit a pattern of risk or dangerous alcohol consumption.
Anemia/Iron	Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP Pediatric Nutrition: Policy of the American Academy of Pediatrics (Iron chapter). Iron supplement for minors aged 4 months to 21 years old who are at a risk of anemia.
Autism screening	For minors between 12 and 36 months of age
Behavioral health evaluation	Assessment for minors of all ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years
Cervical displacement	Screening for sexually active members
Hypothyroidism Screening	Congenital hypothyroidism screening for newborns
Screening for cavities for minors up to 5 years old	Oral fluoride supplements, starting at 6 months old, for minors whose water supply is low in fluoride. Topical fluoride (varnish) application on primary teeth for infants and minors, from the eruption of their primary teeth.
Depression screening for teenagers	Screening for depressive disorders in teenagers aged 12 to 18 years old. The screening must be performed through an adequate system to guarantee an accurate diagnosis, an effective treatment, and an appropriate follow-up.
Development screening and monitoring	Screening for children under 3 years of age and monitoring throughout childhood
Dyslipidemia	Screening for minors at risk for lipids disorders Ages: 1-4 years, 5-10 years, 11-14 years, 15-16 years
Eye prophylaxis for gonorrhea: preventive medication	Topical eye medication to prevent gonorrhea in newborns
Hearing	Hearing screening for all newborns
Increase in height, weight, and body mass index	Screening for minors. Ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years

Preventive Service	Note
Sickle cell disease (hemoglobinopathies)	Screening for sickle cell disease in newborns
Vaccines	Recommended vaccines, from birth until 21 years old. The recommended doses, ages, and populations vary: Diphtheria, Tetanus, Whooping Cough, Haemophilus Influenza B, Hepatitis A, Hepatitis B, Human Papilloma Virus (HPV), Inactive Poliovirus, Influenza, MMR, Meningococcus, Pneumococcus, Rotavirus, and Chickenpox. Follow-up vaccines are covered. HPV starts from 9 years old for minors and teenagers with a history of sexual abuse or assault who have not initiated or completed the 3 doses (as recommended by the Advisory Committee on Immunization Practices (ACIP))
Medical history	For any minor during development, from 0 to 21 years old
Screening for obesity in minors and teenagers	For minors and teenagers aged 6 years old and up, intensive comprehensive behavioral interventions to promote an improvement in the minor's weight
Oral health	Risk assessment for minors from 0 to 11 months old, from 1 to 4 years old, and from 5 to 10 years old
Phenylketonuria (PKU) screening for newborns	Phenylketonuria (PKU) in newborns
Skin cancer: Counseling	Counseling for minors, adolescents, and young adults with white skin, aged 6 months to 24 years old, to minimize their exposure to ultraviolet radiation and reduce their risk for skin cancer
Tobacco use in minors and teenagers	Interventions, including education and counseling, for school-age minors and teenagers, to prevent the start of tobacco use
Tobacco, alcohol, and drug use	Screening for minors aged 11 to 21 years old
Tuberculosis	Test for minors at high risk for tuberculosis. Ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-21 years
Vision screening: minors	Vision screening, at least once (1 time) for all minors aged 3 to 5 years old, to detect amblyopia or other risk factors
Lead	Screening for minors aged 1 to 6 years old with high levels of lead in their blood who are at a moderate to high risk, and for pregnant members exhibiting no symptoms.

STANDARD VACCINE COVERAGE FOR MINORS, ADOLESCENTS, AND ADULTS

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

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

Covered vaccines with $0 copayment
• ***Hib-HepB*** *(90748)* • ***ROTA-*** *Rotavirus Vaccine (90680)* • ***ROTA-*** *Rotavirus Vaccine, human – Rotarix (90681)* • ***IPV-*** *Inactivated Poliovirus Vaccine – injectable (90713)* • ***Hib-*** *Haemophilus Influenza B Vaccine (90647, 90648)* • ***Menomune-*** *Meningococcal Polysaccharide Vaccine 90733)* • ***MCV-*** *Meningococcal Conjugate Vaccine – Menactra and Menveo (90734)* • ***PPV-*** *Pneumococcal Polysaccharide Vaccine (90732)* • ***FLU-*** *Influenza Virus Vaccine (90630, 90653, 90654, 90655, 90656, 90657, 90658, 90661, 90662, 90673, 90674, 90685, 90686, 90687, 90688)* • ***PCV-*** *Pneumococcal Conjugate Vaccine - Prevnar 13 (90670)* • ***DTaP-*** *Diphtheria, Tetanus Toxoid and Acellular Pertussis Vaccine (90700)* • ***DT-*** *Diphtheria, Tetanus Toxoid (90702)* • ***HPV*-*** *Human Papilloma Virus (Gardasil (90649), Cervarix (90650), 9vHPV (90651))* • ***Tdap-*** *Tetanus, Diphtheria and Acellular Pertussis (90715)* • ***Zoster-*** *Zostavax (90736), Shingrix (90750)* • ***MMR-*** *Measles, Mumps and Rubella Vaccine (90707)* • ***VAR-*** *Varicella Virus Vaccine (90716)* • ***HEP A*** *Hepatitis A Vaccine (90632, 90633, 90634)* • ***HEP A-HEP B*** *Hepatitis A and Hepatitis B Vaccine (90636)* • ***Td-*** *Tetanus and Diphtheria Toxoid Adsorbed (90714)* • ***HEP B-*** *Hepatitis B Vaccine (90740, 90743, 90744, 90746, 90747)* • ***Meningococcal B*** *(90620, 90621)* • ***Pentacel*** *(90698)* • ***DtaP-IPV-HEP B*** *(Pediarix, 90723)* • ***Kinrix*** *(90696)*
Vaccine subject to 20% coinsurance
Immunoprophylaxis for respiratory syncytial virus (Synagis, Palivizumab 90378**) – Requires precertification** following the protocol established by Triple-S Salud**.**

***** For members aged 9 to 27 years old. It is also covered starting at 9 years old for minors and teenagers with a history of sexual abuse or assault who have not started or completed the series of three (3) doses.

Note: The vaccine codes included are shown as published in the latest review of the Current Procedural Terminology (*CPT*) Manual. Any further updates could change the included codes. For an updated version, please contact our Customer Service Department

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

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

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

Other Benefits required by Law

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

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

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

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

Acts of Improper Discrimination

It constitutes undue discrimination:

- Deny, refuse to issue, renew or reissue, cancel or terminate the plan's coverage or increase the premium or additional charge, based on whether the insured member has been a victim of abuse; or

- Exclude, limit coverage or deny a claim based on the victim's situation of abuse of the insured member.

It is a discriminatory act to request information about acts of abuse or the situation of abuse of the insured member, current or potential, or use such information, regardless of how it is obtained, except for limited

purposes to comply with legal obligations or verify the claim made by the person to the effect that he is a victim of abuse.

It is a discriminatory act to terminate the group coverage of a victim of abuse because the coverage was originally issued in the name of the abuser and the latter has been divorced or separated from the victim of abuse or has lost custody of the victim, or because the coverage of the abuser has been terminated in any other voluntary or involuntary manner. The provisions herein do not prevent Triple-S Salud from requiring that the victim of abuse pay the full premium of the medical plan's coverage or that it requires, as a condition of coverage, that the victim of abuse reside or work within the plan's service area. doctor, if the requirements apply equally to all covered or insured members, current or potential. Triple-S Salud may terminate group coverage after the continued coverage required here has been in effect for eighteen (18) months, if it offers a conversion equivalent to an individual plan. The continued coverage required here may be met with the coverage provided by the "Consolidated Omnibus Budget Reconciliation Act of 1985" (COBRA) and shall not be in addition to the coverage provided

How does your Coverage work?

This plan helps you pay for some of your costs when you are sick or injured. You pay for certain care to help you stay in optimal health conditions and to detect any condition with preventive services.

In addition to the monthly payment you make for your plan - called a "premium" - you pay part of the costs when you get the care that the plan covers. There are different types of costs you must pay out of your own pocket: deductible, copayment, and coinsurance until you reach the maximum outlay on the coverage.

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

The insured member will be responsible for paying directly to the participating provider the copayment or coinsurance stipulated in the benefits table.

AMBULATORY MEDICAL-SURGICAL AND DIAGNOSTIC SERVICES IN AMBULATORY FORM	
• If the person is not admitted in the hospital, he/she will have the right to receive the following services, among others:	
Benefits Description	**You Pay**
Treatment and Diagnostic Services	
Medical professional services: • In the doctor's office, without limits on the number of visits **Note**: Supplies used in a gynecologist's medical office for covered diagnostic tests are included in the copayment of the visit.	$10.00 copayment for visit to a general practitioner $15.00 copayment for visit to a specialist $15.00 copayment for visit to a sub-specialist
• Visits to audiologists	$10.00 copayment per visit
• Visits to optometrists	$10.00 copayment per visit
• Visits to podiatrists	$10.00 copayment per visit
• Visits to clinical psychologists	$15.00 copayment per visit
• Visits to chiropractors	$7.00 copayment per visit
• In-home medical services by physicians who render this service	$15.00 copayment per visit
• Intra-articular injections, up to two (2) daily injections up to a maximum of twelve (12) injections per policy year, per member	Nothing
• Hospital emergency room services, including supplies and medications included in the suture tray contracted with Triple-S Salud. It also covers medications and supplies in addition to those included in the suture tray, provided in the emergency room because of accidents or illnesses. If the insured member calls Teleconsulta and receives the recommendation to go to an emergency room with a registration number; a lower copayment/coinsurance may apply for the use of said facilities. If a nonparticipating provider cannot process the number on his system for the exemption or reduction of the lower copayment/coinsurance, the member will pay it and will request reimbursement to Triple-S Salud for the amount that he would have been exempted or reduced. Psychiatric emergencies will also be covered as well as the transportation between health services providing institutions including ambulances certified by the Public Service Commission and the Department of Health in conformance with what is established in the last paragraph of Article 4.20(b) of Law No. 183 of August 6, 2008 and as indicated in the Ambulance Benefit section that appear under the section Services Provided by a Hospital or Another Facility and Ambulance Services. For diagnostic tests performed in the emergency room other than laboratory tests and X-rays, the coinsurances and limits that correspond to the ambulatory services will apply as stated in the policy.	$75.00 copayment for illness or accident $35.00 copayment if recommended by Teleconsulta
• Cryosurgery of the uterus limited to one (1) procedure per policy year, per member • Services for tuberculosis conditions • Vasectomy	Nothing

Laboratories, X-Rays and Other Diagnostic Tests	
Tests such as: • Clinical laboratory, genetic tests **require precertification** • X-Rays • Nuclear medicine tests • Single Photon Emission Computerized Tomography (SPECT) • Sonograms • Angiography by magnetic resonance study (MRA) • Tympanometry, up to one (1) per policy year, per insured member • Computerized tomography, up to one (1) per anatomical region, per policy year, per insured member. • Magnetic resonance study (MRI), up to one (1) per anatomical region, per policy year, per insured member. • Pet Scan and Pet CT, up to one per policy year, subject to Precertification, except for conditions related to lymphomas, including Hodgkin's disease, for which the plan will cover up to two (2) per policy year, subject to Precertification. • Electromyograms, up to two (2) per anatomic region, per policy year, per insured member • Nerve Conduction Velocity Study, up to two (2) tests of each type, per policy year, per insured member • Gastrointestinal endoscopies • Electroencephalograms • Non-invasive cardiovascular tests • Vascular non-invasive tests • Electrocardiograms • Neurological tests and procedures • Audiological tests such as vestibular function tests and special diagnostic procedures • Polysomnography (study of sleeping disorders), up to one test of each type, per life • Bone density test for insured members under age 65 or when it is not provided as a preventive service as provided by federal law, but as follow-up test to a diagnosis or treatment of a condition • Mammographies, digital mammographies or sonomammographies when not rendered as preventive tests as provided by federal law, but as follow-up test to a diagnosis or treatment of a condition • Other diagnostic tests	25% coinsurance
• Pelvic exams and all types of vaginal cytological tests that may be required by a physician to detect, diagnose, and treat early stages of anomalies that may result in cervical cancer.	Nothing
Vision Care	
• Ophthalmologic diagnostic tests • Refraction test, one (1) test per insured member, per policy year, as long as the test is performed by an ophthalmologist or an optometrist.	25% coinsurance

Maternity Services (applies to the primary member, spouse and dependents) without waiting periods	
• Prenatal and postnatal preventive visits and services as defined by Health Resources and Services Administration (HRSA)	$15.00 copayment for the visit to the specialist
• Obstetrics services • Well baby care preventive services according to the ages and coverage recommended by the United States Preventive Services Task Force (USPSTF)	Nothing
• Sonograms, according to the clinical protocol	25% coinsurance
• Biophysical Profile, up to one (1) per pregnancy	50% coinsurance
Surgeries	
• Surgeries performed on an outpatient basis. **Requires precertification** when necessary for a medical reason change of service level (hospitalization or ambulatory surgery center)	Nothing
Allergy care	
• Allergy tests, up to a maximum of fifty (50) tests per policy year, per member	Nothing
Treatment Therapy	
• Radiotherapy	25% coinsurance per therapy
• Chemotherapy in all its administration methods (intravenous, oral, injectable or intrathecal); according to the medical order of the specialist physician or oncologist. Oral chemotherapy is covered under the pharmacy benefit. • Cobalt	Nothing
• Dialysis and Hemodialysis: Services related to any type of dialysis or hemodialysis, as well as any complications and their corresponding hospital or medical-surgical services, will be covered for the first ninety (90) days from: a. the date in which the member became eligible for this policy for the first time; or b. the date in which he/she received the first dialysis or hemodialysis. This will apply when subsequent dialysis or hemodialysis are related to the same clinical condition.	Nothing
Respiratory Therapy (administered at the doctor's office)	
• Respiratory therapy (provided by physician specialized in allergies, pediatric allergies, anesthesia, pneumology and pediatric pneumology, and laboratories located within a hospital facility), up to two (2) daily sessions for a maximum of twenty (20) sessions per policy year, per member	$5.00 copayment per therapy

Chiropractor services and Physical Therapy	
• Physical therapies and/or manipulations provided by chiropractors are covered up to a maximum of twenty (20) physical therapies or manipulations, as a set, per policy year, per member. In these cases, supervision does not require the direct intervention (face to face) of the physician, but needs to be available in the location to evaluate and recommend a change in the treatment plan.	$7.00 copayment per visit to the chiropractor. Physiatrist visit apply the specialist copayment. $7.00 copayment per therapy or manipulation or physical therapy. If the member receives services from a non-participating chiropractor, they will be reimbursed at 100% from Triple-S Salud established fees, after deducting the applicable copayment. Besides, services may be covered through Assignment of Benefits.
Durable Medical Equipment (DME)	
Rent or purchase, subject to a Precertification: • Maximum benefit of $5,000 per policy year. • Rent or purchase of oxygen and necessary equipment for its administration. • Rent or purchase, according to the criteria established by Triple-S Salud, of wheel chair or hospital type bed. • Rent or purchase, according to the criteria established by Triple-S Salud, respirators, ventilators, and other equipment needed in case of respiratory paralysis. • Glucometers approved by the FDA, up to one per policy year. If the endocrinologist orders a specific meter, due to the treatment of the insured member, the endocrinologist will submit a justification. In this case, the glucometer brand ordered by the endocrinologist will be covered with its accessories in those patients who present a clinical predisposition or a greater number of risk factors for developing the Type I Diabetes Mellitus condition. Services provided by non-participating physicians in Puerto Rico will be paid by indemnization based on the fees established by Triple-S Salud, after the corresponding coinsurance for the rendered service is deducted.	25% coinsurance

The following services are covered policyholders diagnosed with Type 1 Diabetes Mellitus, as required by Law No. 19 of January 12, 2020, to amend Title and Articles 1, 2 and 4 of Law No. 177 of 2016: • Lancets, up to 150 for 30 days • Test Strips, up to 150 for 30 days • Insulin infusion pump and supplies ordered by the endocrinologist for insured persons diagnosed with Type 1 Diabetes Mellitus. The endocrinologist will determine the brand of the insulin infusion pump based on age, level of physical activity and knowledge of the condition of the insured person or caregiver. **Requires precertification.**	20% coinsurance; nothing for the supplies for the insulin infusion pump
Mechanical Ventilator	
• Coverage will include the medical necessary services, tests and equipment for members under age 21 and even after age 21 require the use of the technological equipment to keep the patient alive; a minimum of one (1) eight-hour daily shift per patient, of services by skilled nurses with knowledge on respiratory therapy or respiratory therapists with knowledge on nursing; the supplies needed to handle the equipment; physical and occupational therapies needed for the motor development of these patients, as well as the prescription drugs, which must be dispensed by a participating pharmacy, freely chosen by the member and authorized under the laws of Puerto Rico (under the pharmacy benefit). Coverage provides for each member to have access to the appropriate laboratory tests and immunization according to the age, and physical condition of the member. • These services will be covered subject to member or his/her representative submitting evidence of medical justification and the registration of the member in the registry the Department of Health has created to this purpose. It also includes the supplies for the handling of technological equipment of the Mechanical Ventilator. • The mechanical ventilator services and services by skilled nurses with knowledge of respiratory therapy or respiratory therapists with knowledge on nursing, the supplies necessary for handling the technological equipment, and physical and occupational therapies will be covered at 100%. For the copayments and coinsurances for medical services, treatments, diagnostic tests, and prescription drugs, refer to the table of benefits of this policy.	Nothing

Home Health Care	
Triple-S Salud will cover these services if they begin within 14 days from the date the member was released from the hospital after a hospitalization of at least three (3) days and if they are rendered for the same condition or for any situation related to the condition for which the member was hospitalized. It covers the following services and supplies provided at the home of the Patient by a Home Health Care Agency certified by the Health Department of Puerto Rico. **Requires precertification.** • Nursing services - partial or intermittent services provided or under the supervision of a registered nurse. • Home Health Auxiliary Services – partial or intermittent services rendered primarily for the patient care. • Physical, occupational and speech therapies (habilitative and rehabilitative) – a maximum of 40 visits per insured member, per policy year. • A visit by an employee of the home health care agency or four (4) hours of services by an aide will be considered as a home visit. • Services provided by non-participating facilities in Puerto Rico or non-participating of the Blue Cross Blue Shield Association, will be paid by compensation based on the established fees, after deducting the corresponding coinsurance for the provided service. **Note:** These services must be supervised by a licensed physician and **their medical necessity must be certified in writing.**	25% coinsurance
Nutrition Services	
• **NUTRITION SERVICES TREATMENT OF MORBID OBESITY, RENAL CONDITIONS AND DIABETES**: Triple-S Salud will pay for nutrition services rendered in Puerto Rico by physicians specialized in nutrition or metabolic illnesses. Visits to these specialists, duly certified by the Commonwealth's governmental entity designated for this purpose, will be covered as long as they are medically necessary and are related only with the treatment of morbid obesity, renal conditions and diabetes. Visits will be limited to a maximum of four (4) visits per policy year. Triple-S Salud will reimburse up to a maximum of $20.00 per visit. Renal services will be covered for the first 90 days from the date in which the member became eligible for this policy for the first time or the date in which he/she received the first dialysis or hemodialysis. This will applies when subsequent dialysis or hemodialysis are related to the same clinical condition.	Triple-S Salud will reimburse up to a maximum of **TWENTY DOLLARS ($20.00)** for each visit.
Triple-S Natural	
• The program is available only through the Program's participating facilities. For a list of the participating facilities, refer to the Provider and Participant Directory. The plan covers up to six (6) visits per policy year, per insured member.	$15.00 copayment per visit

Other services for the treatment of disorders within the continuum of Autism	
This policy covers the services targeted for the diagnosis and treatment of persons with disorders within the Continuum of Autism without limits such as: a) Neurological tests b) Immunology c) Genetic testing, subject to precertification d) Laboratory tests for autism e) Services of Gastroenterology f) Nutrition services g) Physical therapy h) Occupational therapy and speech i) Visits to a psychiatrist, psychologist, with master's or doctoral degree and valid license issued by the Board of Examiners of Psychologists of Puerto Rico) or social worker (by reimbursement). j) Psychological tests and evaluations In compliance with the Act for the Hyperbaric Oxygenation Treatment of Individuals with Autism Spectrum Disorders, we cover therapeutic hyperbaric oxygenation treatments for individuals with autism if it is recommended by a medical practitioner and the treatment is allowed by federal law and regulations; and for other related purposes.	a) 25% coinsurance b) 25% coinsurance c) 25% coinsurance d) 25% coinsurance e) 25% coinsurance f) $0.00 copayment g) $7.00 copayment h) $7.00 copayment i) $15.00 copayment. j) $10.00 copayment

Hospice
Services rendered through a hospice for members that have been diagnosed with a life expectancy of six (6) or less months as a result of a terminal health condition. **Note:** These services **require a precertification** from Triple-S Salud and must be evaluated by their Individual Case Management Program for coordination through the network participating providers.

Phenylalanine Free Amino Acid Prepared	
• This policy covers the preparation of phenylalanine-free amino acids for patients diagnosed with the genetic disorder known as phenylketonuria (PKU) without exclusions of the insured's age.	Nothing

Preventive Service Centers	
Evaluation ✓ Medical history ✓ Physical exam ✓ Screening for depression ✓ Counseling on: Alcoholism, Tobacco, Risky behaviors, Sexuality, Cancer, Domestic violence, Prevention of falls, Diet and Nutrition **Preventive Screening Tests** ✓ PAP (cervical cancer) ✓ Chlamydia ✓ Gonorrhea ✓ Syphilis ✓ HIV ✓ Glycosylated Hemoglobin ✓ Visual Screening According to age and gender, and the guidelines of the United States Preventive Services Task Force (USPSTF). For a detailed list of the services with $0 copayment, refer to sub-section on Services Covered by Federal or Local Law in the benefit certificate. **Referrals** ✓ Screening mammography ✓ Vaccines ✓ Bone density scan ✓ Colonoscopy ✓ Sigmoidoscopy ✓ Others Note: For services or tests not rendered as preventive tests as provided by federal law, but as follow-up to a diagnostic or treatment of a condition, the copayments or coinsurances that correspond to your coverage will apply. Some Preventive Centers may refer you to a preferred network provider in cases in which any of the tests needed to complete your screening is not available at their facilities.	$0.00

MEDICAL-SURGICAL SERVICES DURING PERIODS OF HOSPITALIZATION

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

Benefits Description	You Pay
Medical Surgical Services	
During hospitalization periods the insured member is entitled to receive the following medical-surgical services, among others: • Surgeries, including orthognathic surgery • Cornea transplant, skin and bone graft, includes care before and after the procedure • Bariatric surgery: This policy only covers gastric bypass surgery for the treatment of morbid obesity, to a maximum of one lifetime surgery, so long as the services are available in Puerto Rico. Surgeries for the removal of excess skin are covered if the physician certifies that it is necessary to remove the excess of skin because it affects the functioning of any part of the body. These surgical procedures require Triple-S Salud's precertification. • Rhinoplasty services	Nothing
• Diagnostic services • Treatments • Administration of anesthesia • Specialists consultation • Gastrointestinal endoscopies • Sterilization services • Hearing evaluations, including Neonatal Hearing Screening Test • Chemotherapy in all its modalities of administration (intravenous, oral, injectable or intrathecal) and radiotherapy	Nothing
• Invasive cardiovascular tests • Lithotripsy procedure (ESWL); precertification required	25% coinsurance

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

- Triple-S Salud agrees to pay for services contracted with the corresponding hospital during the hospitalization of the insured member while the insurance is in effect, so long as the attending physician orders in writing said hospitalization and it is medically necessary.
- Semi-private or isolation room, up to a maximum of three hundred and sixty-five (365) days for regul hospitalizations
- When an insured member uses a private room in a participating hospital, Triple-S Salud covers what they would have paid for a semi-private room. The hospital may charge the patient the difference between the normal cost of the private room and the rate established by Triple-S Salud for a semi-private room, except in cases that are medically necessary and with prior notification to Triple-S Salud. The other expenses of hospitalization of the insured member covered by this policy are included in the contract between the participating hospital and Triple-S Salud and therefore cannot charge any difference to the insured member. Please check the You Pay column for additional amount for copayments or coinsurance in addition to the hospital admission.

Benefits Description	You Pay
Hospitalizations	
• Semi-private or isolation room up to a maximum of three hundred and sixty-five (365) days for regular hospitalizations	$50.00 copayment for regular admission
• Meals and special diets • Use of telemetric services • Use of Recovery room • Use of *Step Down Unit* • Use of Intensive Care units, Coronary Care, Pediatric Intensive Care, and Neonatal Intensive Care • General nursing services • Administration of anesthesia by non-medical personnel • Clinical laboratory services • Medications, biological products, healing materials, products related to hyper alimentation and anesthesia materials • Production of electrocardiograms • Production of radiological studies • Physical therapy and rehabilitation services • Use of physicians in training, interns and residents of the hospital authorized to render medical services to patients. • Respiratory therapy services • Use of the Emergency room when the member is admitted to the hospital • Use of other facilities, services, equipment and materials usually provided by the hospital and ordered by the physician in charge which have not been expressly excluded from the contract with the hospital	Nothing, these services are included in the payment of the hospitalization copayment

• Services related to any type of dialysis or hemodialysis, as well as any complications and their corresponding hospital or medical-surgical services, will be covered for the first ninety (90) days from: a. the date in which the member became eligible for this policy for the first time; or b. the date in which he/she receives the first dialysis or hemodialysis. This will apply when subsequent dialysis or hemodialysis are related to the same clinical condition. • Chemotherapy in all its modalities of administration (intravenous, oral, injectable or intrathecal) and radiotherapy • Blood for transfusions	Nothing, these services are included in the payment of the hospitalization copayment.
• Lithotripsy procedure (ESWL); precertification required	25% coinsurance
• Ambulatory surgery	$50.00 copayment
Maternity Hospital Care – (for the insured employee, spouse and direct dependents)	
• Semiprivate or isolation room, assistance and physical care for the newborn, education on the care of the newborn for both parents, assistance and training on breastfeeding, orientation on in-home support and the performance of any treatment or medical test for the newborn or the mother. **Note:** To look up hospitals in your area, visit our webpage at www.ssspr.com, or refer to Triple-S Salud Provider and Participant Directory. If you need additional information, contact Customer Service.	$50.00 copayment for birth hospitalization
• Obstetrics services • Use of maternity ward • Production of Fetal Monitoring • Use of Well-Baby Nursery	Nothing
Skilled Nursing Facilities (SNF)	
The plan will cover these services if they begin within fourteen (14) days from the date the insured member is discharged from a hospital, after a hospitalization of at least three (3) days and if they are rendered for the same condition or in relation to the condition for which the person was hospitalized. **Requires precertification.** • They are covered up to a maximum of one hundred twenty (120) days per policy year, per insured member. **Note**: These services must be supervised full-time by a licensed physician or a registered nurse **and their medical necessity must be certified in writing.**	Nothing

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

CANCER SERVICES

In accordance with the requirements of Act No. 107 of 2012, this policy establishes equal coverage for the treatment of chemotherapy against cancer in its various methods of administration such as intravenously, orally, injectable or intrathecal; according to the medical order of the specialist doctor or oncologist. Oral chemotherapy is covered under the pharmacy benefit.

This policy covers pelvic exams and all types of vaginal cytology that may be required to detect, diagnose and treat early stages of abnormalities that may lead to cervical cancer. It also covers outpatient services for the treatment of cancer such as radiotherapy and cobalt.

In compliance with Act No. 275 of September 27, 2012, Triple-S Salud does not reject or deny any treatment that is agreed and / or within the terms and conditions of the health contract signed between the parties to any patient diagnosed with cancer or cancer survivor, when there is a medical recommendation for these purposes. In addition, it covers all the preventive services and benefits mentioned under the federal ACA law for the early detection of breast cancer and also studies and breast cancer screening tests, such as visits to specialists, clinical breast exams, mammograms, digital mammograms , magnetic resonance mammography and sonomamography, and treatments such as but not limited to, mastectomies, reconstructive surgeries after mastectomy for reconstruction of the extracted breast, reconstruction of the other breast to achieve a symmetrical appearance, breast prostheses, treatment for complications physicals during all stages of mastectomy, including lymphedema (inflammation that sometimes occurs after treatment of breast cancer), as well as any postmastectomy reconstructive surgery necessary for the patient's physical and emotional recovery.

In compliance with Act No. 79 of August 1, 2020, also known as the Special Law to Ensure Access to Care and Diagnosis for Cancer Patients in Puerto Rico or the "Gabriela Nicole Correa Law," the following is established:

- Triple-S Salud shall not reject or deny any treatment that is agreed upon and/or included in the terms and conditions of the health care contract signed between the parties to any patient who has been diagnosed with cancer or has survived cancer, when there is a medical recommendation for such purposes. This includes the treatments, medications, and diagnostic tests listed in the National Comprehensive Cancer Network (NCCN) Guidelines and/or approved by the Food and Drug Administration (FDA), as well as those necessary to address and minimize harmful effects, subject to the provisions of this Law. The “Local Coverage Determinations-LCD from First Coast Service Options, INC,” “Medicare Approved Compendia List,” “National Coverage Determinations Alphabetical Index,” and “Milliman Care Guidelines” will also be used.

- Additionally, we shall send your approval or denial for the treatment medications and diagnostic tests listed in the NCCN Guidelines or approved by the FDA within a term of 24 to 72 hours after receiving the request, or within 24 hours in cases marked as urgent or expedited.

MENTAL HEALTH AND SUBSTANCE ABUSE

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

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

Others Psychological Evaluations	
• **Psychological evaluation**	$10.00 copayment
• **Psychological test:** The psychological tests required by the Law Num. 296 of September 1, 2000, known as the Law of Conservation of the Children and Adolescents' Health.	$10.00 copayment
Substances Abuse (drug addiction and alcoholism)	
• Regular admissions • Partial admissions **Note:** Medical-surgical services during hospitalization periods for drug addiction and alcoholism are covered according to the justified medical necessity.	$50.00 copayment for regular admissions $50.00 copayment for partial admissions
• Patient's visits to the office of the psychiatrist or psychologist (with an MA or PhD and a valid license issued by the Puerto Rico Board of Psychologist Examiners)	$15.00 copayment per visit
• Collaterals visits (immediate family), including marital counseling, provided by a psychiatrist or psychologist (with a master's or doctorate degree and a valid license issued by the Puerto Rico Board of Psychologist Examiners)	$15.00 copayment per visit
• Group therapy visits	$5.00 copayment per therapy
Residential Treatment	
• Covers residential treatment as long as there is a medical justification. **Requires precertification.**	Nothing

EXCLUSIONS TO THE BASIC COVERAGE

1. Services provided while the person's insurance is not in force.

2. Services that may be received under Workers' Compensation laws, employer liability, private compensation plans for accidents at work, automobile accidents (ACAA) and services available under state or federal legislation, by which the insured member is not legally obligated to pay. Likewise, such services are excluded when they are denied by the government agencies concerned, due to the breach or violation of the requirements or provisions of the aforementioned laws, although such noncompliance or violation does not constitute a crime.

3. Services for treatments that arise as a result of the insured member committing a crime or not complying with the laws of the Commonwealth of Puerto Rico or any other country, except those injuries resulting from an act of domestic violence or medical condition.

4. Services that are received for free or paid through donations.

5. Personal comfort expenses or services such as telephone, television or custodial care services, rest home, convalescent home or home care except post-hospital services provided through a Home Health.

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

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

8. Reimbursement of expenses caused by payments made by an insured member to any participating doctor or provider without being obliged by this policy to make them.

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 covered without a precertification of Triple-S Salud when it is required, except in cases of emergency, as established in the policy.

11. Services that are not medically necessary, services considered experimental or investigative, according to the criteria of the Food and Drug Administration (FDA), Department of Human and Health Services (DHHS), the Department of Health of Puerto Rico, or the Technology Evaluation Center (TEC) of the Blue Cross Blue Shield Association for the indications and specific methods that are ordered.

12. Expenses or services for new medical procedures or new medications not considered experimental or investigational, except as required by state or federal law. Nor are expenses for research studies or clinical trials (that is, clinical trials), devices, experimental or investigational drugs administered to be used as part of these studies, services or products that are provided for data collection and analysis, and not for

direct patient management, and items or services at no cost to the insured member that is commonly offered by the research sponsor. This applies even when the insured member has enrolled in the study to treat a life-threatening illness for which there is no effective treatment and obtains the physician's approval for participation in the study because it offers the patient a potential benefit. In these cases, Triple-S Salud covers the routine medical expenses of the patient according to the terms and conditions established in this policy. Routine medical expenses are those medically necessary expenses that are required for the study (clinical trials) and that are normally available to persons insured under this plan whether or not they are participating in a clinical trial, as well as services to diagnose and treat the resulting complications of the study, according to the coverage established in this policy.

13. Expenses for cosmetic or beautification surgeries, treatments to correct physical appearance defects, except for care and treatment of congenital abnormalities and defects for newborns, newly adopted or placed for adoption, mammoplasties or reconstruction of plastic surgery of the breast for reduction or increase in size, except mammoplasty and reconstruction after mastectomy for breast cancer), septoplasty, rhinoseptoplasty, blepharoplasty, surgical interventions and medical treatments whose purpose is the control of obesity, except treatment for morbid obesity and the syndrome metabolic, including bariatric surgery, defined by Act No. 212 of August 9, 2008 in Puerto Rico and defined in the Definitions Section of this policy; or; liposuction, abdominoplasty and abdominal rhytidectomy treatments and injections of sclerosing solutions in varicose veins of the legs. In addition, hospital services, medical-surgical services and complications associated with these are excluded, regardless of whether there is medical justification for the procedure.

14. Expenses for orthopedic or orthotic devices, prostheses or implants (except breast prostheses after a mastectomy) and other artificial instruments. The hospital and medical-surgical services necessary for the implementation of the same will be covered.

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

16. Treatment services for infertility, conception by artificial means, and to restore the ability to procreate (for example, in vitro fertilization, intracytoplasmic sperm injections, embryo transfers, donor fertilization). Hospital and medical-surgical services, and the complications associated with these, as well as drugs and hormones, are excluded. Lab tests ordered for infertility treatments will be covered, as long as they are conducted by a laboratory covered under this policy.

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

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

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

20. Intravenous or inhaled analgesia services administered at the oral surgeon's or dentist's office.

21. Services necessary for the treatment of temporomandibular joint syndrome (jaw joint), either through the application of prosthetic devices or any other method.

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

23. Expenses for materials related to orthognathic surgery (mandibular or maxillary osteotomy-Le Fort).

24. Expenses for allergy immunotherapy.

25. Services rendered due to induced abortion.

26. Expenses in excess of the first 30 days for newborns of the direct dependents of the main insured after delivery unless it meets the definition of direct dependent as established in this policy.

27. Services provided in Outpatient Surgery Centers for procedures that can be performed at the doctor's office.

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

29. Expenses related to the administration of the employer's drug detection program such as: coordination, sampling and administration of screening tests even when provided by a participating provider, coordination of services to employees that must be performed by the employer or the entity responsible for administering the program, among others. In addition, the expenses for the care, supplies, treatment and / or services that the insured member obtains from the employer without cost and the services provided by the Employee Assistance Program of the Employer as part of the patron's drug detection program are excluded. Mental health and substance abuse services will be covered once the insured member completes the Patron Drug Screening Program regardless of whether the condition was detected in the program.

30. Expenses caused by war, civil insurrection or armed international conflict; except in those cases where the services received are related to an injury sustained while the insured member was active in the army (service connected), in which case Triple-S Salud recovers the Veterans Administration.

31. Laboratory tests that are not codified in the Laboratory Manual, as well as those considered experimental or investigational, are not recognized for payment by Triple-S Salud.

32. Heavy metals laboratory tests, doping, HLA Typing and paternity tests.

33. Immunizations for travel purposes or against hazards and occupational hazards.

34. Expenses for services provided by maritime ambulance. In addition, expenses for services rendered by an air ambulance, except when the transfer is within Puerto Rico.

35. Services rendered by Residential Treatment Facilities outside of Puerto Rico, without medical justification and without precertification for treatment.

36. Surgeries for removal of excess skin after bariatric or gastric bypass surgery will not be covered, unless the doctor certifies that it is necessary to remove excess skin, because it affects the functioning of some part of the body. Requires precertification.

37. Expenses caused by organ and tissue transplants (Example: heart, heart-lung, kidney, liver, pancreas, bone marrow). In addition, hospitalizations, complications, chemotherapies and immunosuppressive medications related to transplantation are excluded. Transplants of organs and tissues that are specifically included in this policy are covered.

38. Expenses for removal of skin tags, ptosis repair and tendon injection / trigger points.

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

40. Surgical assistance services, regardless of whether there is medical justification for it.

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

42. Expenses for services rendered to optional dependents, understood as immediate family members of the insured, who are not eligible as direct dependents, except those defined by Law as established by the definition of optional dependents.

43. *Doppler Color Flow.*

44. Expenses for medical services in fetal monitoring interpretation.

45. Preventive services rendered by providers outside Puerto Rico.

46. New services or diagnostic or therapeutic procedures that are approved by FDA and equipment and devices that appear available after the effective date of this policy.

47. Complications related to perforations in the body (piercing/ tattoo) and any other related procedure.

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

49. Charges for drugs or medications provided during medical appointments not covered under this policy.

50. Any service related to anti-aging or aesthetic treatment.

51. Genetic tests performed in order to provide genetic counseling (offspring or family planning)

52. Gene therapy: Any FDA-approved treatment, medication, or device whose purpose or condition for which it has been approved involves the alteration of the body's genes, genetic editing, or gene expression.

MAJOR MEDICAL COVERAGE

Benefits Description

Benefits

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

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

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

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

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

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

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

All services provided outside of Puerto Rico will be paid exclusively through this coverage, subject to a Triple-S Salud precertification, except in cases of emergency or otherwise specified in the Limitations section. In cases where services are rendered without said precertification, or are not emergency, they will be paid directly to the insured member or through Assignment of Benefits based on the rates established by Triple-S Salud for its participating providers in Puerto Rico.

Expenses incurred for covered services that arise due to medical emergency while the affected insured member is outside of Puerto Rico, will not require precertification, but will be subject to Triple-S Salud's corroboration of its reasonableness and medical necessity.

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

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

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

Coinsurance:

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

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

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

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

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

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

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

1. Anesthesia and its administration

2. Mental Conditions, Drug Addiction and Alcoholism

a. **Outpatient services for mental conditions, drug addiction and alcoholism**: medical expenses covered by services outside the hospital are reimbursed on the basis of the provisions established for any other disease.

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

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

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

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

4. **Medical materials or supplies:**

    a. Covered drugs prescribed by a physician-surgeon during hospitalization periods

    b. Surgical supplies such as bandages and gauze

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

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

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

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

9. **Physicians services**

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

11. **Services in Ambulatory Surgery Centers**

12. **Other services**: The following services will be covered provided that they are considered medically necessary. Those services that are not considered "medically necessary", are not in accordance with the generally accepted principles of medical practice, are experimental or investigative or are provided in excess of those that are generally required for the diagnostic, prevention or treatment of an illness, injury, malfunction of the organic system, or the condition of pregnancy are excluded. Reimbursement for services provided in Puerto Rico is based on the health benefits scale established by Triple-S Salud for such purposes.

    a. Hearing aids, up to a maximum of two hundred and fifty dollars ($ 250.00) per policy year, per insured member

    b. Prosthetic devices or implants to replace body organs or parts or to aid in their functioning, such as prosthesis, pacemakers and valves, etc.; replacement is excluded

    c. Surgical assistance

    d. Mammoplasties, subject to Triple-S Salud precertification

    e. Sports Medicine, up to a maximum of 20 therapies per insured member, per year

f. Cardiac rehabilitation: These services will be covered if rendered by a physiatrist specialized in exercise physiology and rehabilitation techniques. The purpose is to minimize physical and psychological disabilities, resulting from cardiovascular illness. These services will be reimbursed according the reasonable charges of the area were services are rendered and the medical necessity dispositions established by Triple-S Salud.

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

h. Pre and postnatal services

i. Tuboplasties

j. Vasovasostomies

k. Positron Emission Tomography (PET CT and PET Scan), up to one (1) per policy year, per insured member.

l. Computerized tomography and magnetic resonance (MRI), up to two (2) tests of each, per policy year, per insured member.

EXCLUSIONS FOR THE MAJOR MEDICAL EXPENSES COVERAGE

Exclusions from the Basic Coverage of inpatient, medical-surgical and outpatient services apply to this coverage, except those services that are specifically mentioned as covered services.

This coverage excludes the following expenses:

1. Services in excess of the limits established in the Basic Coverage, except those services expressly indicated in the section of Limitations of the Major Medical Expenses Coverage.

2. Caused by war or armed international conflict.

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

4. Glasses or contact lenses.

5. Orthopedic and orthotic devices, except those that are required due to an accidental injury.

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

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

8. Services provided by an air or maritime ambulance.

9. Services related to any type of dialysis or hemodialysis, as well as related complications, and their respective hospital or medical-surgical services, regardless of the health condition that makes them.

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

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

12. Expenses for immunizations, radioactive treatment and tympanometry.

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

14. Expenses related to organ and tissues transplants.

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

ORGAN AND TISSUES TRANSPLANT COVERAGE

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

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

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

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

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

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

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

Once the services are pre-certified, the insured member can request Benefits Assignment. When accepting the Assignment of Benefits, the doctor, hospital or facility agrees to bill Triple-S Health directly for the covered services to the insured member.

Benefits

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

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

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

ORGAN AND TISSUES TRANSPLANT EXCLUSIONS

This policy does not cover the following expenses or services:

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

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

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

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

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

6. Services provided by health professionals who are not medical doctors.

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

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

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

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

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

12. Services provided by air or sea ambulance.

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

PRESCRIPTION DRUG BENEFIT (FB-23)

The delivery of generic drugs is the first option, except for those brand-name drugs, included in the Drug List, for which there is no generic. If the insured member chooses, or his / her doctor prescribes, a brand-name drug when its generic is available on the market, the insured member pays the brand-name drug copayment and the difference in cost between the brand-name drug and the generic drug.

This benefit is governed by the guidelines of the Food and Drug Administration (FDA), *ANDA (Abbreviated New Drug Application), NDA (New Drug Application), and BLA (Biologics License Application).* These include, dosage, medication equivalence, and therapeutic classification, among others.

This plan will provide for the dispatch of covered medications, regardless of the ailment, injury, condition, or disease for which they are prescribed, as long as the medication is approved by the FDA for at least one indication and the medication is recognized for treatment of the ailment, injury, condition, or disease in one of the standard reference compendiums or in generally accepted peer-reviewed medical literature. However, this plan is not required to cover a medication if the FDA has determined that its use is contraindicated for the for which it is prescribed. It also includes the medically necessary services associated with the administration of the medication.

To ensure your benefits are covered, you must present the Triple-S Salud member card at any participating pharmacy when requesting benefits. Upon presentation of the Triple-S Salud member card and a prescription, the participating pharmacy will provide the covered Drug List or Formulary medications specified in the prescription, and it shall not charge or bill the member any amount in excess of what is established in the Table of Deductibles, Copayments and Coinsurance that appears at the end of this endorsement. Upon receiving the medications, the member shall sign for the services received and present a second photo identification.

If your physician prescribed a medication not covered by your pharmacy benefit, he/she may issue a new prescription with a covered medication, or he/she may request an exception pursuant to the "Process for Exceptions to the Drug List or Formulary" section of this endorsement. This applies when the therapeutic classification (category) is covered and there are other treatment options.

A pharmacy is not required to fill a prescription if, for any reason and according to its professional judgment, it should not be filled. This does not apply to decisions made by pharmacies in terms of the fees applied by Triple-S Salud.

Any medical prescriptions that do not include indications for use or medication amount may only be dispensed for a supply of forty-eight (48) hours. Example: when a physician writes in his indications: “to administer when necessary (PRN, by its acronym in Latin).”

Medications with *refills* may not be dispensed before 75% of the supply has elapsed from the date of the last supply, or after one year from the original date of the prescription, unless otherwise provided by the law governing the dispatch of controlled substances.

This pharmacy benefit has the following characteristics:

- This pharmacy benefit uses a Drug List or Formulary, which is approved by the Pharmacy and Therapeutics Committee for this coverage. Our Pharmacy and Therapeutics Committee comprises physicians, clinical pharmacists, and other health care professionals who meet regularly to evaluate and select the medications to be included in the List by following a rigorous process of clinical evaluation.

The Pharmacy and Therapeutics Committee evaluates the Drug List or Formulary and approves changes when:

a) new medications are included, after being evaluated, within no more than 90 days after being approved by the FDA
b) medications are changed from a higher copayment/coinsurance level to a lower copayment/coinsurance level
c) there are changes for safety reasons, if the prescription drug manufacturer cannot provide the medication or has removed it from the market.

- We shall notify these changes, no later than their effective date, to:

a) All members
b) Participating pharmacies, for the inclusion of new medications, 30 days in advance before the effective date

Pharmacy benefit description

- We will cover preferred generic drugs, non-preferred generic drugs, preferred brand-name drugs, non-preferred brand-name drugs, preferred specialty products, and non-preferred specialty products included in the Drug List or Formulary, whose label contains the phrase *«Caution: Federal law prohibits dispensing without prescription»*, as well as insulin and some *Over-the-Counter (OTC)* medications.

- We will cover preventive services according to the federal laws: *Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA)*, and the *Health Care and Education Reconciliation Act of 2010 (HCERA)*, Public Law No. 111-152, and as established by the *United States Preventive Services Task Force (USPSTF)*. Medications classified as preventive, as listed below, are covered with a $0 copayment if they are prescribed by a physician and dispatched by participating pharmacies in the Triple-S Salud network:

  - Low-dose aspirin (81mg) for adults aged 50 to 59 years old, to prevent the risk of cardiovascular disease and colorectal cancer.
  - Contraceptive methods: It only covers the drugs included in the Contraceptive List of the Formulary, which includes at least one drug for each category defined in the *Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA).* Generic drugs will be covered as the sole option, except in categories where there are no generic versions in the market. Prescription is required.
  - Folic acid supplements (400mcg and 800mcg) for members who are planning or able to become pregnant.
  - Oral fluoride supplements for preschool-age children, six (6) months old to five (5) years old, whose drinking water sources do not include fluoride.
  - Iron supplements for children younger than 4 months to the age of 21, who are at risk of anemia.
  - For those who use products to cease tobacco use, this plan covers the *nicotine nasal spray, nicotine inhaler*, and *bupropion hcl (smoking deterrent)*, for ninety (90) consecutive days per attempt and up to two (2) attempts per year. Generic drugs will be covered as the sole option,

except if there are no generic versions in the market. Does not apply to over-the-counter (OCT) products.

- Preventive drugs for patients at high risk of developing breast cancer, generic equivalents for *tamoxifen* or *raloxifene* in tablets for patients who are at high risk of developing the disease and are at low risk of adverse reactions to drugs.
- Statins to prevent cardiovascular events: low or moderate dose of statins for adults aged 40 to 75 years old with no history of cardiovascular disease, who exhibit one or more risk factors (dyslipidemia, diabetes, hypertension, or smoking) and a calculated risk of 10% or more for a cardiovascular event within 10 years. We cover the generic equivalents of simvastatin 5, 10, 20, and 40 mg; atorvastatin 10 and 20 mg, and pravastatin 10, 20, 40, and 80 mg, Rosuvastatin 5 and 10 mg; Lovastatin 10, 20, and 40 mg; and Fluvastatin 20 and 40 mg.
- Colorectal cancer prevention: prescriptions issued by gastroenterologists for intestinal slides for colonoscopies in adults over 50 years old, only the following prescription drugs will be covered: Suprep and PEG (polyethylene Glycol).
- Medications for Pre-exposure for Prophylaxis for Human Immunodeficiency Virus (HIV PrEP), Descovy and Truvada, these require pre-authorization for diagnostic validation.

For more information about the preventive medications to which these law provisions apply, you may access the following link: http://www.healthcare.gov/center/regulations/prevention.html.

- This plan covers prescription drugs to comply with the federal Act for the Welfare, Integration, and Development of Persons with Autism (known as the BIDA Act), subject to the copayments and coinsurance established in this endorsement.

- Buprenorphine

- The amount of medications provided for an original prescription is limited to a fifteen-day (15) supply for acute drugs and a thirty-day (30) supply for maintenance drugs.

- The maintenance drug amount is provided up to a maximum of 180 days, as per the dispensed original prescription, and up to five (5) refills, all for 30-day supplies. The physician must state the amount of refills in the prescription.

- Ninety-day (90) supplies apply to certain maintenance drugs, such as medications for heart conditions, thyroid, and diabetes, among others; released through the Mail-Order Pharmacy Program or the 90-Day Medication Dispensing Program in Pharmacies. This does not apply to Tier 5 and 6 Specialized Products.

MANAGEMENT PROCEDURES

- Some prescription medications are subject to management procedures. Triple-S Salud will provide its members, and as part of the information provided in this policy, with the Drug List or Formulary, including detailed information about which prescription drugs are subject to management procedures. The following reference guidelines establish the different types of management that could apply:

    a. **Step Therapy Program (ST):** This endorsement requires that the member start by using a first-step medication for his/her condition before we cover another second-step medication for the same condition. This program requires the use of medications without prescription (OTC) or generic drugs as a first step, before we use other second-step medications for certain medical conditions. These are known as first-step medications in the step therapy program. The member may thus be able to access medications with a proven effectiveness and safety, at lower or even zero copayments for first-step medications, and with an improved compliance with the medication therapy.

    The classifications that require an OTC medication as a first step include Proton Pump Inhibitors (PPI), non-sedative antihistamines, and agents to treat eye allergies. The classifications that require a generic medication as a first step include but are not limited to statins for cholesterol, drugs to treat attention deficit and hyperactivity (ADHD), diabetes, oral bisphosphonates for osteoporosis, and nasal corticosteroids for allergies. These medications are also part of the Triple-S Salud Drug List or Formulary.

    This program applies to members who are using the medication for the first time, or if more than 6 months have elapsed since using any of the medications. The program aims to establish when second-step medications will be covered, and not to intervene with the physician's treatment recommendations for the member. Second-step medications are those used after the member has tried the first-step medications, which did not provide the required therapeutic benefit. The member shall be free to discuss all available treatment choices for his/her health condition with his/her physician, and to make informed decisions regarding his/her treatment.

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

    If a member, with or without previous prescription drug coverage under another Health Plan, subscribes to Triple-S Salud and previously used a second-step medication, the member must show evidence that he/she has been using the second-step medication. Either the pharmacy or the member must submit to Triple-S Salud, as soon as possible, copy of one of the following documents: pharmacy claim history or utilization report from the previous Health Plan (explanation of benefits or EOB).

    b. **Medications requiring preauthorization (PA)**: Certain medications need a preauthorization for the patient to be able to obtain them. These are identified in the Drug List or Formulary as PA (Pre-Authorization required), in which case the pharmacy shall process the preauthorization before dispensing the medication to the member. The pharmacy will also contact us to obtain authorization for dosage changes and when charges exceed $750 per dispensed prescription, to avoid billing errors.

Medications requiring preauthorization are usually those with adverse effects, candidates for misuse, or related to high costs.

Medications that have been identified as requiring preauthorization must meet the established clinical criteria as determined by the Pharmacy and Therapeutics Committee. These clinical criteria have been developed according to current medical literature.

c. **Quantity limitations (QL)**: Certain medications have limits to the amounts that can be dispensed. These amounts are established according to what is suggested by the manufacturer, such as the adequate maximum amount not associated with adverse effects that is effective to treat a condition.

d. **Medical specialization limits (SL)**: Some medications have a specialization limit based on the specialized physician who is treating the condition. These specialization limits are established according to current medical literature.

e. **Age limits (AL)**: The drug list or formulary includes medications associated to the initial AL. AL means these medications have an age limit.

- **Specialty Prescription Drug Management Program**

The Specialty Prescription Drug Management Program is coordinated exclusively through participating pharmacies in the Triple-S Salud Specialty Pharmacy Network. The purpose of this program is to help members who have chronic and high-risk conditions requiring the administration of specialized drugs, to receive fully integrated clinical management services for the condition. Some of the medical conditions or medications that require management through the Specialty Prescription Drug Management Program are:

  - Cancer (oral treatment)
  - Antihemophilic Factor
  - Crohn's disease
  - Erythropoietin (blood cell deficiency)
  - Cystic Fibrosis
  - Hepatitis C
  - Rheumatoid arthritis
  - Multiple sclerosis
  - Gaucher Disease
  - Pulmonary Hypertension
  - Osteoporosis
  - Osteoarthritis
  - Psoriasis

Among the services included in the program are the following:

- An evaluation that helps identify any particular needs the patient may have regarding the use of his/her medication.

- Clinical interventions that include, among others:

  - Patient care coordination with his/her physician
  - Personalized education for patients and caregivers, according to the condition

- Management and coordination of drug preauthorization
- Monitoring the condition's signs and symptoms
- Monitoring adherence to therapy
- Adequate use of medications
- Dosage optimization
- Drug-to-drug interactions
- Management of side effects
- Coordination of refills
- Assistance via specialized staff for the condition
- Facilitate drug delivery to the patient's preferred address
- Access to pharmaceutical personnel 24 hours a day, 7 days a week
- Educational material about the condition
- To obtain information about participating pharmacies in the Exclusive Specialty Pharmacy Network, please refer to the Triple-S Salud Providers Directory, visit our website at www.ssspr.com, or call Customer Service.

There may be other plan requirements that could affect coverage for certain prescription medications. Please refer to the Pharmacy Benefit Exclusion Section or the Drug List or Formulary for more information.

TABLE OF DEDUCTIBLES, COPAYMENTS AND COINSURANCES

You are responsible for the following:

Structures of Levels Applicable to the Benefit of Pharmacy	
Supply for 30 days	**Copayments / Coinsurance**
Level 1 - Preferred Generic Drugs	$5.00
Level 2 - Non-Preferred Generic Drugs	$5.00
Level 3 - Preferred Brand Drugs	$10.00
Level 4 - Non-Preferred Brand Drugs	20% minimum $20.00
Level 5 - Preferred Specialty Products	20% maximum $100.00
Level 6 - Specialty Products Not Preferred	20% maximum $100.00
Oral chemotherapy	$0.00
Over-The-Counter Drug Program	$0.00
Medications required by federal law including contraceptives with a doctor's prescription	$0.00

Note: In some cases, you can apply the copayment or coinsurance up to a maximum established by medication or after having consumed a fixed monetary amount per insured member, applies a coinsurance.

Programs for the Extended Supply of Maintenance Prescription Drugs (90 days)

Triple-S Salud offers programs that provide 90-day supplies of certain maintenance medications. Maintenance drugs apply for the following conditions: hypertension, diabetes (oral tablets), thyroids, cholesterol, epilepsy (anticonvulsants), estrogen, Alzheimer's (patches not included), Parkinson's, osteoporosis, and prostate, among others. Does not apply to specialty products.

Triple-S Salud members will be able to select their preferred option to receive certain maintenance medications through participating pharmacies, or in the comfort of their own home, by registering in the Triple-S Salud Mail Order Pharmacy Program or Triple-S en Casa.

90-Day Prescription Drug Dispensing Program: This extended supply program allows members to obtain a 90-day supply of certain maintenance medications through participating pharmacies. The Program has pharmacy network spanning all of Puerto Rico, including chain and independent community pharmacies.

Structures of Levels Applicable to the Benefit of Pharmacy	
Supply for 90 days	**Copayments / Coinsurance**
Level 1 - Preferred Generic Drugs	$10.00
Level 2 - Non-Preferred Generic Drugs	$10.00
Level 3 - Preferred Brand Drugs	$20.00
Level 4 - Non-Preferred Brand Drugs	20% minimum $60.00

Mail-Order Pharmacy Program or Triple-S en Casa: Under this program, members receive a 90-day supply of their maintenance prescription drugs at home or in any other place of preference and **may** order medication refills by mail or phone. The shipment for medications is free of charge, and members will save in their copayments.

Triple-S en Casa: Under this program the person through an application in their smart cell, can manage 90 days of their maintenance drugs at home or other place of preference, with next day delivery. For information call 1-888-525.4842.

Pharmacy For Mail Order	
Supply for 90 days	**Copayments / Coinsurance**
Level 1 - Preferred Generic Drugs	$10.00
Level 2 - Non-Preferred Generic Drugs	$10.00
Level 3 - Preferred Brand Drugs	$20.00
Level 4 - Non-Preferred Brand Drugs	20% minimum $60.00

PREAUTHORIZATIONS FOR PRESCRIPTION DRUGS

Certain medications require the member to obtain preauthorization. Medications requiring preauthorization are usually those with adverse effects, candidates for misuse, or related to high costs.

Physicians and pharmacies have received guidance on which medications need to be preauthorized. The medications that require preauthorization are identified in the Drug List or Formulary with the acronym PA on the column to the right of the medication, in which case the pharmacy will process the preauthorization before dispensing the medication.

For preauthorizations, or if the member needs more information or has any questions regarding whether or not they should request a preauthorization for the medications they need, please contact our Customer Service Department at (787) 774-6060.

PROCEDURE FOR PREAUTHORIZATIONS FOR PRESCRIPTION DRUGS

Triple-S Salud has 72 hours (3 days) after receiving the medication preauthorization request to do the following:

1. Evaluate the documentation received
2. If necessary, additional information will be requested from the physician, insured person or pharmacy
3. Notify you of the determination

If the requested documentation is not received within 72 hours for the evaluation of the medication, Triple S Salud will send a notification which indicated that it has 5 calendar days to provide the information to the insured person, the pharmacy and the physician.

If Triple-S Salud receives all the required information and fails to make a determination regarding the preauthorization request or to notify within the established time (72 hours; 36 hours for controlled drugs), the member will be entitled to the medication supply that was the subject of the request, for thirty (30) days as requested or prescribed, or in the case of step therapy, for the terms established in the coverage.

Triple-S Salud shall make a determination regarding the preauthorization request before the member finishes the medication supplied. If no determination or notification is provided within this period, the coverage will be maintained continuously under the same terms. This, while the medication continues being prescribed and is considered a safe treatment, and until the limits of the applicable benefits have been exhausted.

PROCESS FOR EXCEPTIONS TO THE DRUG LIST OR FORMULARY

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

Types of exception

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

- To cover their medication even if it is not in our Drug List or Formulary and is not an exclusion.
- To cover a medication that has been or will be discontinued from the Drug List or Formulary for reasons not related to health care or because the manufacturer cannot provide it or has withdrawn it from the market.
- For a management exception, which implies that the prescription drug will not be covered until the step therapy requirements are met, or because it has a limit in the amount allowed.
- For a duplicate therapy exception if there is a change in dosage or if the physician prescribes another drug within the same therapeutic category.
- For medications whose uses are not approved by the Food and Drug Administration (FDA). These medications are not usually covered, except for health conditions where there is medical or scientific evidence that the drug is effective for such purposes, according to the reference books including the medical categories for approval or denial.

How to make a request?

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

- **Phone call to 787-749-4949** – They will offer you guidance on the process you should follow to request an exception.
- **Fax** Pharmacy Department to **(787) 774-4832** – You should send all the documentation needed to evaluate the request, including the contract number.
- **Mail** to the following address: Triple-S Salud PO Box 363628 San Juan, PR 00936-3628.

Information required to approve your exception request

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

- Name of the patient
- Contract number
- Primary diagnosis
- Reason why you cannot use any prescription medication in the Formulary that would be a clinically acceptable alternative to treat the member's disease or medical condition.
- The alternative prescription medication included in the Formulary or required according to the step therapy:
- Has been ineffective in treating the disease or medical condition; or, based on clinical, medical, and scientific evidence, the member's known relevant physical and mental features, and the known features of the prescription medication regime, it is very likely that it will be ineffective, or that the efficiency of the prescription medication or the patient's adherence will be affected.

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

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

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

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

1. Upon receiving a request for a medical exception, Triple-S Salud will ensure that it is reviewed by appropriate health professionals, who, in making their determination of the request, will consider the specific facts and circumstances applicable to the insured person to which application was submitted, using documented clinical review criteria that:

    - Will be based on firm clinical, medical and scientific evidence, and relevant practice guides.

2. The health professional designated by Triple-S Salud to review medical exception requests, will ensure that the determinations made correspond to the benefits and exclusions provided in the insured medical plan. These professionals must have experience with medication management. The referred determinations must be included in a report which will state the qualifications of the health professionals who made the determination.

3. Triple-S Salud will make the determination of the application submitted and will notify the insured person or their representative with the urgency required by the medical condition but no later that 72 hours after receiving all the required information from the date of receipt of the request or communication from the physician who issues the prescription, whichever is later. In the case of controlled medications, it will not exceed 36 hours.

    - Triple-S Salud will request the doctor or pharmacy for the clinical information required to evaluate your request by telephone, fax or any other electronic means.

    - In the event that the insured person is the one who submitted the request, and it is necessary to obtain additional information to complete the evaluation of the medication, the insured person is contacted by phone, to inform about the additional information that must be supplied by the physician to evaluate the case, the time to send it and the fax number to which it must be sent.

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

    - The exception request form is available free of charge at www.ssspr.com. You may find it under the Tools for You section,

which is located at the bottom of the main page, under Member Forms, as well as in the Drug List or Formulary.

4. If Triple-S Salud does not make a determination regarding the medical exception request or notify it within the before mentioned time period:

    - The member shall be entitled to a 30-day supply of the prescribed medication for which the request was submitted, as per the supply was requested or prescribed; or in case of step therapy, for the term provided by the coverage.

    - Triple-S Salud shall make a determination regarding the medical exception request before the member finishes consuming the medication supplied.

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

6. If Triple-S Salud approves an exception, it will provide coverage for the medication and will not require the member to request authorization for refills or new prescriptions to continue using the same medication, as long as:

    - the medication is prescribed for the same illness or health condition; and
    - that it is deemed safe within the policy year

7. Triple-S Salud shall not establish a level of copayment or coinsurance that is applicable only to those medications approved by exception requests. If your exception request is approved, the **[Tier 6]** coinsurance will apply.

8. Any denial of an exception request:

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

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

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

9. Process to notify the coverage determination:

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

    a. The specific reasons for the denial;

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

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

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

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

PRESCRIPTION DRUG BENEFIT EXCLUSIONS

The policy exclusions for hospitalizations and medical/surgical and outpatient services apply to this coverage, except for services specifically listed as covered services. Triple-S Salud will not be responsible for the expenses corresponding to the following benefits:

1. Drugs not containing the following script: «*Federal law prohibits dispensing without prescription»* (*Over-the-Counter- OTC*), except those included in the Triple-S Salud OTC Program and certain aspirin dosages for members aged 50 to 59 years old.

2. Charges for artificial instruments, hypodermic needles, syringes, strips, lancets, urine or blood glucose meters, and similar instruments, even if they are used for therapeutic purposes.

3. The following medications are excluded from the pharmacy coverage, regardless of whether they include the federal inscription: «*Caution:*
   Federal law prohibits dispensing without pre scription».

   a. Medications with cosmetics purposes, or any related product with the same purpose (hydroquinone, minoxidil solution, efformitine, finasteride, monobenzone, dihydroxyacetone, and bimatoprost).

   b. Fluoride products for dental use (except for minors aged 6 months to 5 years old)

   c. Dermatological conditions – pediculicides and scabicides (lindane, permethrin, crotamiton, malathion, ivermectin, and spinosad), products to treat dandruff, including shampoo (1% pyrithione zinc, glycolic acid, selenium sulfide, sulfacetamide sodium), lotions and soaps, alopecia (baldness) treatments such as Rogaine® (minoxidil topical solution, finasteride)

   d. Pain medications Nubain® and Stadol®.

   e. Products for obesity control and other medications used in this treatment (benzphetamine, diethylpropion, lorcaserin, orlistat, liraglutide, phendimetrazine, phentermine, sibutramine, naltrexone-bupropion, and mazindol).

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

   g. Medications to treat infertility (follitropin, clomiphene, menotropin, urofollitropin, ganirelix, cetrorelix acetate progesterone vaginal insert), and fertility.

   h. Impotence (tadalafil, alprostadil, vardenafil, sildenafil, yohimbine, avanafil).

   i. Implants (goserelin, mometasone furoate nasal implant, buprenorphine HCl subdermal implant, dexamethasone intravitreal implant, fluocinolone acetonide intravitreal implant, autologous cultured chondrocytes for implantation, testosterone, estradiol, fluocinolone acetonide intravitreal, etonogestrel subdermal implant). In addition, any other that is approved by the FDA.

   j. Intracranial carmustine implant (used to treat malignant gliomas and glioblastoma multiforme, a type of brain tumor) – the injectable version is covered by the basic coverage.

   k. Intrathecal implants (nusinersen, poractant alfa, baclofen, pentetate indium, ziconotide, and calfactant)

   l. Devices (sodium hyaluronate, hyaluronan, and hylan)

   m. Medications used in tests with diagnostic purposes (thyrotropin, dipyridamole IV 5 mg/ml, gonadorelin HCl, cosyntropin, glucagon, barium sulfate, diatrizoate, iohexol, iopamidol, iopromide, iodixanol, iothalamate, ioversol, mannitol, technetium gadoterate, gadopentetate, gadodiamide, trichophyton, tropicamide,

tuberculin, and antigens), leuprolide acetate inj kit 5 mg/ml (1mg/0.2ml)).

n. Medications for immunization (hepatitis A & B, influenza, encephalitis, measles, mumps, poliovirus, papillomavirus, rabies, rotavirus, rubella, varicella, yellow fever, zoster, cholera, haemophilus b, Lyme disease, meningococcal, plague, pneumococcal, typhoid, tetanus toxoid, diphtheria, immune globulin, respiratory syncytial virus, palivizumab, pegademase bovine, stephage lyphates, Rho D immune Globulin) and their combinations, as well as those used for allergy tests. Please refer to the Standard Vaccine Coverage for Minors, Adolescents, and Adults section to learn more about the immunizations covered under your health care coverage.

o. Products used as vitamins and nutritional supplements for oral use *(Dextrose, Liposyn, Fructose, Alanicem, L-Carnitine, Tryptophan, Cardiovid Plus, Glutamine*), except some folic acid dosages for members, in compliance with the regulation *Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act.*

p. Oral vitamins (alone or in combination with other vitamins, minerals and folic acid) (niacin, ascorbic acid, thiamine, riboflavin, vitamin E, pyridoxine, dihydrotachysterol, multiple vitamins with minerals, multiple vitamins with iron, multiple vitamins with calcium, vitamin B complex - biotin - D - folic acid, vitamin B complex with vitamin C - folic acid, flavonoids, and bioflavonoids), except the prenatal vitamins that are covered, and injectables.

q. Growth hormones (somatropin, somatrem, tesamorelin acetate).

r. Wound care products (collagen, dressing, silver pad, balsam, bismuth tribromophenate, wound cleansers or dressings, dimethicone-allantoin)

s. The mixture of two (2) or more medications that already exist separately, or extemporaneous preparations.

t. Sclerosants (intrapleural talc, etha nolamine, polidocanol, sodium tetradecyl)

u. Medications classified as alternative medicine treatments (valerian root, European mistletoe, Glucosamine-Chondroitin-PABA-vitamin E and alpha lipoic acid, coenzyme).

4. Experimental or trial products for the treatment of certain conditions, which have not been authorized by the *Food and Drug Administration*. We also do not cover *clinical trials* or treatments, devices, and experimental or trial drugs administered as part of these studies, services, or products provided for data collection and analysis instead of patient management, as well as items or services free of charge to member, which are commonly offered by the trial sponsor. This applies even if the member enrolls in the study to treat a life-threatening disease for which there is no effective treatment and obtains the physician's approval for participation in the trial because it offers potential benefits. In these cases, Triple-S Salud covers the patient's routine medical expenses, pursuant to the terms and conditions established in this policy. Routine medical expenses are expenses that are medically necessary for clinical trials, and are normally available for members under this plan, regardless of whether they are participating in clinical trials, as well as the services to diagnose and treat complications resulting from the trials, in accordance with the coverage established in this policy.

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

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

7. Refills ordered by a dentist or podiatrist.

8. Expenses for injectable antineoplastic agents; these are covered under the Basic Coverage for hospital, medical-surgical and outpatient services.

9. Triple-S Salud reserves the right to select new medications available in the market to include them in its Drug List or Formulary. No expense for new drugs shall be covered until that medication is evaluated by Triple-S Salud's Pharmacy and Therapeutics

Committee, following the guidelines established in Chapter 4 of the Health Insurance Code of Puerto Rico. This Chapter requires that the Pharmacy and Therapeutics Committee conduct an evaluation of new FDA-approved prescription drugs within no more than 90 days from the date they were approved by the FDA. Triple-S Salud should issue its determination within that time, indicating whether or not it will include the new medication in its Drug List or Formulary. Any new medication included in the excluded therapeutic classifications (categories) will also be considered an exclusion.

10. These will also be excluded: Trypan Blue solution (azoic dye used in histological stains to help differentiate between living cells and dead cells), intravenous lacosamide Vimpat® (medication to treat seizures), degarelix acetate, sodium tetradecyl, morrhuate sodium (solution for peritoneal dialysis), viaspan (cold storage solution to preserve organs before a transplant), sodium tetradecyl sulfate (improves the appearance of varicose veins), polidocanol (treatment of varicose veins), sodium morrhuate (treatment for hemangiomas), intrapleural talc (prevents malignant pleural effusion - accumulation of fluids in the chest cavity of people with cancer or other serious illnesses in people who already have this condition), solution for peritoneal dialysis (to correct the imbalance of electrolytes, fluid overload, and elimination of metabolites in patients with severe renal insufficiency), and homeopathic products in all their presentations (natural products used to treat different conditions on an individual basis).). We also exclude the following: Ocrevus, Exondys 51 (treatment for multiple sclerosis), Vyondys 53 (treatment for muscular dysthrophy de Duchenne), Xuriden (treatment for hereditary orotic aciduria, and antidote for fluorouracil capecitabine), Signifor (treatment for acromegaly and Cushing's Disease), Ruconest (treatment for hereditary angioedema), Cuprimine (treatment for rheumatoid arthritis, Wilson's Disease, and cystinuria), Spinraza (treatment for spinal muscular atrophy), Zolgensma (treatment for spinal muscular atrophy), Austedo (for Chorea-Huntington's disease), intravitreal Lucentis (for ocular diseases) Orkambi (for cystic fibrosis), Keveyis (for glaucoma and periodical paralysis), Uptravi (for pulmonary hypertension), Impavido (for the Leishmaniasis parasite), Darzalex (for multiple myeloma), Emflaza (for muscular dystrophy), Rubraca (for ovarian cancer), Tagrisso (for pulmonary cancer), Lenvima (for renal or thyroid cancer), Odomzo (for skin carcinomas), Dupixent (for atopic dermatitis), HP-Acthar (West's syndrome, multiple sclerosis, gout, sarcoidosis, and amyotrophic lateral sclerosis), and Imlyigic (for melanomas).

11. Medications used for organ and tissue transplants (cyclosporine modified, tacrolimus, sirolimus, cyclosporine, mycophenolate sodium, everolimus, azathioprine, belatacept, and basiliximab).

12. Blood and its components (hetastarch 6%/nacl IV, rheomacrodex IV, human albumin, and plasma protein fractions).

13. Any medication if the FDA has determined that its use is contraindicated for the treatment of the indication for which it is prescribed.

14. Treatment for sudden porphyria attack symptoms related to the menstrual cycle (*Hemin, Panhematin*).

15. Medications covered by the medical part that must be administered by a health professional.

16. Gene Therapy: Any treatment, drug or device that alters, the body's genes, genetic correction, or gene expression.

DENTAL COVERAGE (DA-20)

DENTAL BENEFITS

Basic Services

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

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

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

Covered Services:	You Pay
A. Diagnostic and Preventive Services 1. Initial comprehensive evaluation by a general dentist or specialist 2. Routine periodic evaluations 3. Periodontal evaluation 4. Emergency evaluation 5. Periapical, bitewing, and oclusal x-rays 6. Panoramic or fullmouth x-rays (complete series of x-rays) 7. Pulp vitality tests 8. Dental prophylaxis (cleaning) 9. Topical application of fluoride varnish for children under 5 years of age 10. Topical fluoride treatment for children under nineteen (19) years of age. 11. Topical fluoride treatment for adults only with special conditions 12. Fixed space maintainers (unilateral, bilateral) 13. Fissure sealants in posterior permanent teeth for children under 14 years of age	Nothing, except for: 20% coinsurance • Fixed space maintainers

B. Restorative Services, Endodontics and Basic Prosthodontics 1. Amalgam restorations 2. Composite resin restorations on anterior and posterior teeth 3. Stainless steel crowns on deciduous teeth 4. Provisional crown 5. Re-cement or re-bond post and core 6. Crown repairs 7. Endodontic services in anterior, premolar and molar teeth 8. Endodontic retreatment in anterior, premolar and molar teeth 9. Apicectomies on anterior, premolar and molar teeth 10. Pulpal debridement 11. Complete or partial denture repair 12. Re-cement or re-bond crown 13. Complete and partial denture rebase and reline 14. Repair of fixed bridgework	Nothing, except for: 30% coinsurance • Composite resin restorations on posterior teeth 50% coinsurance • Rebase • Reline
C. Surgical and Other Services 1. Oral surgery (extractions) 2. Surgical oral surgery 3. Surgical repositioning of impacted teeth 4. Alveoloplasty 5. Occlusal adjustment 6. Hospital visit	Nothing, except for: 30% coinsurance • Surgical oral surgery • Surgical repositioning of impacted teeth 50% coinsurance • Alveoloplasty

BASIC SERVICES LIMITATIONS:

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

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

LIMITATIONS TO PROSTHETIC SERVICES

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

Periodontal Services	
COVERED SERVICES 1. Gingivectomy and gingivoplasty 2. Bone surgery related to periodontal infections 3. Mucogingival surgery 4. Soft tissue and bone grafts; and membranes for tissue regeneration 5. Provisional splinting – extracoronal 6. Scaling and root planing The costs for periodontal service are covered based on the fees designated for such purposes, until the limit established is reached.	Nothing Maximum benefit of $1,000, per policy year, per member
BASIC PERIODONTAL SERVICES 1. Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit 2. Periodontal maintenance 3. Scaling in presence of generalized moderate or severe gingival inflammation-full mouth, after oral evaluation	Nothing
Orthodontic Services	
COVERED SERVICES 1. Diagnostic services, including x-rays and study models 2. Active treatment, including necessary devices 3. Retention treatment posterior to active treatment	Nothing Reimbursement or Benefit Assignment

LIMITATIONS TO ORTHODONTIC SERVICES

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

REIMBURSEMENT

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

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

PRECERTIFICATION

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

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

INDEMNITY FOR THE MEMBER

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

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

INDIVIDUAL ELIGIBILITY

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

DENTAL COVERAGE EXCLUSIONS

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

Triple-S Salud will not pay for the following expenses or services, except as otherwise provided:

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

PROCEDURE FOR OBTAINING REIMBURSEMENT

a. Through our website www.ssspr.com. You will find the Member Forms under the Tools for You section located at the bottom of the main page, including information to request a reimbursement online.

b. Via email. For medical services, please send it to: reembolso@ssspr.com. For dental services, please send your documents to: reemdental@ssspr.com.

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

d. You should include the following:

- Full name (including both last names) and contract number of the member who received the service
- Date of service
- Diagnostic Code (ICD-10) and description of received services
- Procedure Code (in force at the time of service)
- *National Provider Identifier* (*NPI*)
- Stamped payment receipt, including provider's name, address, specialization, and license number
- Amount paid for each service
- Signature of the provider or participant who rendered the services
- Reason you are requesting a refund
- For ambulance services, you must include information about the traveled distance and evidence of medical necessity
- If the services require a precertification, copy of such precertification

If you are requesting a reimbursement for medications, you must add:

- Pharmacy's official receipt
- Name and contract number of the member who received the service
- Name of medication
- Daily dosage
- Prescription number
- Amount dispensed
- National Drug Code (*NDC*)
- *National Provider Identifier* (*NPI*) of the pharmacy and prescribing physician
- If you paid a participating pharmacy, state the reason.
- Include the charge for each medication.

If you are requesting a reimbursement for dental services, you must add:

- The service code, tooth number, and restored surfaces (if applicable)
- Amount paid for each service
- If the member pays more than one visit under a single a receipt, he/she must send the exact dates of service **(MONTH, DAY, YEAR)** for which he/she paid.
- Upon requesting reimbursement for the initial visit and down payment for orthodontic services, if subscribed to the coverage that is offered optionally with a corresponding additional premium, you must include the treatment plan with the breakdown of: record visit, down payment, monthly fees, cost and total duration of treatment.
- If you receive dental prostheses and periodontology services, offered as an option for a corresponding additional premium, you must bring the radiographies.

If you are requesting a reimbursement for Coordination of Benefits, you must add:

- Contract number of your primary plan if it is with Triple-S
- If you are requesting reimbursement for the amount not paid by your primary plan, you must include the other plan's Explanation of Benefits

2. You must notify Triple-S Salud in writing about the claim within twenty (20) days after it occurred or, if after such period, as soon as it is reasonably possible for the member, but no later than a year after the date the service was rendered, unless evidence is submitted

justifying that filing the claim within the established term was impossible.

3. Triple-S Salud has up to 15 days to deliver an acknowledgement of receipt after receiving the claim notice by mail. Notifications made to a person appointed by the member shall be considered notifications provided to the member, provided that the authorization is in force and has not been revoked. If the person is not authorized and receives a notification on behalf of the member, he/she must report it within 7 days, stating the name and address of the person who should receive the notification. Should the claim notice be sent by email, the member will immediately receive a system confirmation. Should the claim be submitted at a service center, receipt is given upon delivery of the document.

   Should the claim notice be sent by email, the member will immediately receive a system confirmation. Should the claim be submitted at a service center, receipt is given upon delivery of the document.

4. Triple-S Salud shall conduct the investigation, settlement, and ruling of all claims in the shortest amount of time that is reasonable, no later than 30 days after receiving the request. If Triple-S Salud cannot arrive at a resolution within the aforementioned period, it shall keep record of the documents that prove just cause to exceed such term. The Commissioner of Insurance has the authority to request an immediate ruling if it is understood that the process is being delayed unduly or unreasonably.

PRECERTIFICATIONS

The precertification process guarantees that you and your family will receive an adequate level of care for your health condition. A precertification aims to establish coordination measures to ensure that the hospital and outpatient services are provided at the appropriate place and time, and by the right professional. It also helps verify the member's eligibility for the requested service.

For services to be considered covered by the plan, the member must meet the precertification requirements. If Triple-S Salud requires a precertification or preauthorization for the service to be rendered, it will not be responsible for the payment of such services if they have been rendered without the aforementioned precertification of preauthorization from Triple-S Salud.

Physicians, doctors, and facilities have already been apprised of which services need to be precertified. Precertification may be needed for hospital or outpatient services.

Precertifications for studies and procedures are processed by the attending physician, the clinical personnel appointed by the physician, or the facility where you will go for treatment. They will need to call Triple-S Salud Precertifications, the Triple-S Salud call center that addresses these cases, from Monday to Friday from 8:00 a.m. to 4:30 p.m. Providers may also check the eligibility of the studies and procedures on our website www.ssspr.com, available 24 hours a day, 7 days a week.

Members and participating physicians and providers shall receive guidance about which hospital admissions need to be precertified or notified 24 hours in advance or as soon as reasonably possible. Certain studies and diagnostic or surgical procedures require precertification from Triple-S Salud. The member and the participating physicians and providers shall receive guidance about which services should be precertified**. Services received in an Emergency Room as a result of a medical emergency do not require precertification by Triple-S Salud.**

The services for which you or your physician must obtain precertification directly with Triple-S Salud are:

- Bariatric and post-bariatric surgery (torso and abdomen)
- Lithotripsy
- PET CT Scan or PET Scan
- Reconstructive surgeries and procedures that could be performed on an outpatient basis but, for medical reasons, need another level of service (hospitalization or outpatient surgery center, if it can be performed at an office)
- Immunoprophylaxis for respiratory syncytial virus
- Durable Medical Equipment
- Skilled nursing facility
- Home health care
- Residential treatment
- Non-emergency services obtained in the United States
- General anesthesia and hospitalization services for dental procedures on minors and physically or mentally disabled people who require them.
- Genetic tests
- Insulin infusion pumps for members who have been diagnosed with Type 1 Diabetes Mellitus.

For Precertifications, or if you have any questions or need more information regarding whether or not you should request a precertification for medical services you need, please contact our Customer Service Department at (787) 774-6060.

You may submit your information request via fax or mail

Main Offices: (787) 749-0265

Fax: (787) 774-4824

Mail:

Triple-S Salud, Inc.

Precertification Department
PO Box 363628
San Juan, PR 00936-3628

PROCEDURE FOR PROCESSING PRECERTIFICATIONS

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

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

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

PRECERTIFICATIONS IN URGENT CASES

You may need Triple-S Salud to consider your precertification request urgently. This may be due to a health condition which, according to the opinion of the treating physician, may jeopardize your life, health or ability to regain maximum functions or because waiting for the standard precertification process would subject you to severe pain that could not be adequately managed without the treatment for which the precertification is requested. In this case, the treating physician must certify the urgency of the precertification. Once indicated by the physician, Triple-S Salud will work the request urgently. The request in these cases may be initiated in writing or orally. Triple-S Salud must notify you their decision, either orally or in writing, unless you request it must be in writing, within 24 hours from the receipt of your request.

If Triple-S Salud needs additional information to issue their determination, they must notify you orally or in writing, unless you request it must be in writing, within 24 hours from the receipt of your request. You or your representative will have no less than 48 hours from the notification to submit any additional information requested. Once Triple-S Salud receives the additional information, they must give you an answer within 48 hours from the earlier between the date of receipt of the additional information and the expiration date of the term allowed to receive it. If Triple-S Salud does not receive the additional information within the term required, they may deny the certification of the benefit requested.

The notification on the adverse determination will include the following:

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

You have the right to contact the Office of the Insurance Commissioner or the Health Ombudsman to request help at any moment and have the right to file a lawsuit in a competent court when you exhaust Triple-S Salud internal grievance procedures. The Office of the Insurance Commissioner is located at GAM Tower, Urb. Caparra Hills Industrial Park, 2 Tabonuco Street Suite 400, Guaynabo, PR, and you can contact them at (787) 304-8686.

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

APPEALS FOR ADVERSE BENEFIT DETERMINATIONS

RIGHT TO APPEAL AN ADVERSE DETERMINATION

What is an Adverse Determination?

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

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

RIGHT TO APPEAL AN ADVERSE DETERMINATION

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

APPEALS PROCEDURE

1. <u>First Internal Level of Standard Appeals</u>

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

To request assistance, please contact:

Office of the Commissioner of Insurance
Investigations Division
B5 Calle Tabonuco Suite 216 PMB 356
Guaynabo PR 00968-3029
Telephone: 787-304-8686

Advocate of Health
PO Box 11247
San Juan PR 00910-2347
Telephone: 787-977-0909

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

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

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

Triple-S Salud will acknowledge receipt of the appeals request to the member no later than three (3) business days after receiving it. The member shall also be informed of his/her rights on filing the appeals.

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

- was used in the initial determination
- was presented, considered, or generated in regard to the adverse determination, even if the benefit determination did not depend on these documents, records, or other information;
- demonstrates that, in making such determination, Triple-S Salud consistently followed the same administrative procedures and guarantees that are followed with other members under similar circumstances; or
- constitutes statements of policy or plan guidelines related to the denied health care service or treatment and the member's diagnosis, regardless of whether they were taken or not into account when making the initial adverse determination.

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

- an appeal requesting a first-level review of an adverse determination related to a prospective review, within a reasonable amount of time according to the member's medical condition, but never more than fifteen (15) calendar days after receiving the appeals.
- an appeal requesting a first-level review of an adverse determination related to a retrospective review, within a reasonable amount of time, but never more than thirty (30) calendar days after receiving the appeals.

This determination will include:

- The titles and credentials of the reviewers involved in the evaluation
- A clear explanation of the reviewers' determination.
- The reviewers' determination with medical justification or contractual basis to allow the member or his/her personal representative to respond to the claims;
- Evidence or documentation used as basis for the determination

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

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

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

2. <u>Second Internal Level of Appeals</u>

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

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

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

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

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

3. <u>Ordinary Reviews of Grievances Not Related to Adverse Determinations</u>

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

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

Triple-S Salud will notify you in writing of its determination, no later than thirty (30) calendar days after receiving the grievance. Once you have been notified of Triple-S Salud's decision, the determination shall include the names and titles of the officers or experts involved in the evaluation of your grievance, as well as a statement of the interpretation made by the grievance reviewers.

It must also include:

- the determination of the examiners in clear terms, and the contractual base or medical justification so you may respond to these considerations;
- Reference to the evidence or documentation used as basis for the determination;
- If applicable:
  - a written statement that includes the description of the process an additional voluntary review in case the member requests it
  - The procedure to follow and the terms required for review
  - A description of the procedures to obtain an independent external review, should the member decide not to request a voluntary review.
  - The member's right to file a suit in a competent court.
  - Triple-S Salud and you may have other options to voluntarily resolve controversies, such as mediation or arbitration. Contact the Insurance Commissioner to determine which options are available
  - a notification of the member's right to contact the Commissioner's Office or the Office of the Advocate of Health to seek guidance or help, at the telephone number and address of the Commissioner's Office and the Office of the Advocate of Health. You have the right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health to request assistance. The contact information for these Offices appears below.

RIGHT TO ASSISTANCE

You have the right to be assisted by the Office of the Commissioner of Insurance or the Office of the Advocate of Health in the aforementioned appeals processes.

- The Office of the Commissioner of Insurance is located at GAM Tower, Urb. Caparra Hills Industrial Park 2, Calle Tabonuco Suite 400, Guaynabo, PR. You may also call (787) 304-8686.
- The Office of the Advocate of Health is located at Mercantil Plaza, 1501 Ponce de León Ave, Hato Rey, PR, or you may call (787) 977-0909 (Metro area) or toll-free at 1-800-981-0031.

RIGHT TO APPOINT A REPRESENTATIVE

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

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

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

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

As a result of the appeals process, the member shall be entitled to the determined benefits, as they were determined.

4. <u>Voluntary Level of Review</u>

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

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

- Request, within the specified time, an opportunity to appear in person before the review panel appointed by Triple-S Salud
- Receive from Triple-S Salud copies of all documents, logs, and other non-confidential, non-privileged information regarding the request for an additional voluntary review
- Present his/her case before the review panel
- Submit written remarks, documents, records, and other materials related to the request for additional voluntary review, to be considered by the panel both before and during the review meeting
- If applicable, ask questions to the review panel representatives
- Obtain assistance or representation from anyone, including a lawyer.

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

Once the member receives our receipt acknowledgement for his/her request, he/she may submit a written request stating his/her interest in appearing in person before the review panel, within 15 business days from the receipt.

Triple-S Salud shall appoint a review panel, made up of Triple-S Salud people, employees, or representatives who did not participate in the first-level review, to consider your request. Either you or your authorized representative may appear in person or call in to state your request. Anyone who has participated in the first-level review may only join the panel or appear before it to provide information or answer to the panel's questions. Triple-S Salud will ensure that the people conducting the additional voluntary review are health professionals with relevant expertise, and that said staff is not the member's health insurance provider or has no financial interest in the review's result.

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

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

Should the hearing be held, the panel will conduct an evaluation, taking into account any comments, documents, logs, and any other information related to the request for additional voluntary review you or your authorized representative submitted, regardless of whether the information was submitted or considered when making the determination in prior reviews (first-level). The review determination shall be issued not later than 10 calendar days after the hearing. If a hearing does not take place, Triple-S Salud will disclose the panel's determination no later than 45 days from: 1) the date the person stated he/she would not request a hearing, or 2) the deadline date for the person to request a hearing before the panel. Once Triple-S Salud's decision has been notified, the written determination must include:

The accelerated review determination will be made and notified to the member, or if applicable, to his or her personal representative, with the urgency required by the member's condition, but no later than forty-eight (48) hours after receiving the request for accelerated review.

- Titles and accreditations of the review panel members

- A statement about the interpretation made by the review panel of your request and all pertinent facts.
- The justification for the review panel's determination
- Reference of the evidence or documentation considered by the review panel as a basis for their determination.

It will also include a notification of the member's right to contact the Commissioner's Office or the Health Solicitor's Office to seek assistance at any time, with the telephone number and address of the Commissioner's Office and the Office of the Advocate of Health. The contact information for these Offices is included at the end of this Section, under Right to Assistance.

If the request for additional voluntary review is related to an adverse determination, it shall include:

- The instructions to request a written statement of the medical justification, including the clinical review criteria used to make the decision.
- If applicable, a statement describing the procedures to obtain an independent external review of the adverse determination, pursuant to the Health Insurance Code of Puerto Rico.

If the additional voluntary review is related to an ordinary review, the majority of panel members shall be Triple-S Salud employees or representatives who did not participate in the ordinary review. Triple-S Salud employees or representatives who participated in the ordinary review may join the panel or appear before it to provide information or answer questions.

5. First Internal Level of Expedited Appeals

If your case undergoes an accelerated evaluation, Triple-S Salud will notify the determination to you, or if applicable to your authorized representative, with the urgency required by your medical condition, but no later than 48 hours from the date when the accelerated review request was submitted to Triple-S Salud, regardless of whether the request included all the information required to make a determination. Urgent case appeals means requests for appeals corresponding to medical services or treatments that, if held to the regular deadlines to respond to an appeal: (a) put the member's life, health, or full recovery in serious danger; or (b) in the opinion of a physician with full knowledge of the member's medical condition, it could subject the member to severe pain that cannot be handled adequately without the medical care or treatment that is the object of the appeal.

You have the right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health to request assistance.

To request assistance, please contact:

Office of the Commissioner of Insurance
Investigations Division
B5 Calle Tabonuco Suite 216 PMB 356
Guaynabo PR 00968-3029
Telephone: 787-304-8686

Advocate of Health
PO Box 11247
San Juan PR 00910-2347
Telephone: 787-977-0909

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

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

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

Triple-S Salud establishes written procedures for the accelerated review of benefit utilization and determination, and to notify members of its determinations for urgent care requests. As established in the procedures, if the member fails to follow the procedures to submit a request for urgent care, Triple-S Salud must notify the member of this shortcoming, along with the

procedures they must follow to request the services correctly.

A verbal or written notice (should the member request it in writing) regarding the shortcomings in the request for urgent care should be delivered to the member as soon as possible, but never in later than twenty-four (24) hours after the request is received.

In the case of urgent care requests, Triple-S Salud will notify the member of its determination, adverse or not, as soon as possible, taking into account the member's health condition, but never later than twenty-four (24) hours after the request is received, unless the member has not provided sufficient information for Triple-S Salud to determine whether the benefits claimed are covered and payable under this policy.

Triple-S Salud will deliver the notice in an adequate manner, both culturally and linguistically, as required by federal law.

If the member has not provided sufficient information for Triple-S Salud to make a determination, Triple-S Salud will notify the member of this shortcoming, whether verbally or in writing, if the member so wishes it, stating the specific information needed, as soon as possible, but never later than twenty-four (24) hours after the request is received.

Triple-S Salud will provide a reasonable deadline for the member to submit the additional specified information, but never later than forty-eight (48) hours from the notice of insufficient information.

Triple-S Salud will notify the member of its determination regarding the urgent care request as soon as possible, but never later than forty-eight (48) hours from whichever happens first: the date the insurer or health insurance company receive the specified additional information or the deadline for the member to the submit the specified additional information. Should the member fail to submit the specified additional information before the established deadline, Triple-S Salud may refuse to authorize the benefit requested. If an adverse determination is issued, Triple-S Salud shall notify said determination as explained in this section.

In the case of member requests for concurrent reviews to extend urgent care beyond the originally approved time period or number of treatments, if the request is made less than twenty-four (24) hours before the original term expires of after exhausting the amount of previously approved treatments, Triple-S Salud shall make its determination for the request and notify the member as soon as possible, taking into account the member's health condition, but never later than twenty-four (24) hours from receipt of the request.

In order to calculate the required deadlines for Triple-S Salud to make its determinations, the time periods start on the date Triple-S Salud receives the request, in accordance with the established procedures to file such requests, regardless of whether the request includes all the information required for the determination.

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

- was used in the initial determination
- was presented, considered, or generated in regard to the adverse determination, even if the benefit determination did not depend on these documents, records, or other information;
- demonstrates that, in making such determination, Triple-S Salud consistently followed the same administrative procedures and guarantees that are followed with other members under similar circumstances; or
- constitutes statements of policy or plan guidelines related to the denied health care service or treatment and the member’s diagnosis, regardless of whether they were taken or not into account when making the initial adverse determination.

The determination notice of should include:

- The titles and credentials of the reviewers involved in the evaluation

- A statement of the interpretation made by the reviewers
- The reviewers' determination with medical justification or contractual basis to allow the member or his/her personal representative to respond to the claims;
- Evidence or documentation used as basis for the determination

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

- Sufficient information to help identify the requested benefit or claim filed, including relevant data such as service date, provider, claim amount, diagnostic code and meaning, and treatment code and meaning.

- The specific reasons for the adverse determination, including denial code and meaning, as well as a description of the standards, if any, used for the benefit or claim denial.

- A reference to the specific policy provisions that served as a basis for the determination.

- A description of any additional material or information needed for the member to complete the request, including an explanation as to why said material or information is necessary.

- A description of Triple-S Salud's internal grievance procedures, established according to the Health Insurance Code of Puerto Rico, including the applicable deadlines for these procedures.

- A description of Triple-S Salud's internal accelerated grievance procedures, established according to the Health Insurance Code of Puerto Rico, including the applicable deadlines for these procedures.

- If Triple-S Salud used a rule, guideline, internal protocol, or any other similar criteria as a basis to make the adverse determination, the member shall be provided a copy, free of charge, of said rule, guideline, internal protocol, or similar criteria.

- Should the adverse determination be based on a judgment of the medical necessity for the service or treatment, the experimental or investigative nature thereof, or a similar exclusion or limitation, the notice shall include an explanation of the scientific or clinical reasoning used to make the determination and apply the policy terms to the member's circumstances.

- An explanation of the member's right to contact, as deemed pertinent, the Commissioner's Office or the Advocate of Health to request assistance at any time regarding their right to file legal action in a competent court when Triple-S Salud's internal grievance procedure concludes, including the contact information of the Commissioner's Office and the Advocate of Health.

6. <u>Standard External Review Procedure</u>

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

- **Fax:** 787-273-6082

- **Mail:**

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

  By email: salud@ocs.pr.gov

Preliminary Evaluation

After receiving the request for external review, the external review examiner shall ask Triple-S Salud for the following documents, which were taken into account

when making the adverse benefit determination, including:

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

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

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

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

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

Review Process

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

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

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

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

7. Expedited External Review

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

- you have received an adverse benefit determination involving a medical condition where the completion deadline for an internal accelerated appeal (as described above) could endanger your life, health, or ability to regain maximum function, and you have submitted a request for an expedited internal appeal;
- you have received an adverse benefit determination regarding a medical condition, and the deadline to complete the standard external appeals process might endanger your life, health, or ability to regain maximum function; or
- an adverse benefit determination regarding admission, availability of care, or a service or device for which you have received emergency services but have not been discharged from the facility. The examiner will continue the aforementioned review process and must provide notification of the final decision within 72 hours from the date your expedited external review request was received. However, if the request is related to an urgent care situation, and you are in a treatment course for the condition, the final decision must be notified within 24 hours. In these cases, the examiner may provide verbal notification, but must issue a written notification to you and the Plan within 48 hours.

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

8. External Review Process

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

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

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

Triple-S Salud, Inc.

- Offers free assistance and services to persons with disabilities so they may communicate effectively with us, such as:
    - Certified sign language interpreters,
    - Information written in other formats (large letters, audio, and accessible electronic formats, among others).

- We offer free linguistic services to people whose first language is not English, such as:
    - Qualified interpreters,
    - Information written in other languages.

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

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

Service Centers

PO Box 363628, San Juan, PR 00936-3628
Phone: (787) 749-6060 or 1-800-981-3241 (TTY/TDD), 787-792-1370 o 1-866-215-1999
Fax 787-706-2833
Email: TSACompliance@sssadvantage.com

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

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

200 Independence Ave, SW Room 509F, HHH Bldg. Washington, D.C. 20211
Phone: 1-800-368-1019, TDD: 1-800-537-7697

Call the customer service number on your ID card for assistance.
請撥打您 ID 卡上的客服號碼以尋求中文協助。
Gọi số dịch vụ khách hàng trên thẻ ID của quý vị để được hỗ trợ bằng Tiếng Việt.
한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.
Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.
Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.
اتصل برقم خدمة العملاء الموجود على بطاقة هُويتك للحصول على المساعدة باللغة العربية.
Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.
Pour une assistance en français du Canada, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

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

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

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

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

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

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

Act No. 194 of August 25, 2000, as amended, known as the Patients' Bill of Rights and Responsibilities, states the rights and responsibilities of the users of Puerto Rico's medical-surgical health system.

Right to high-quality Health Services

Services consistent with the generally accepted principles of medicine practice.

Rights regarding the collection and disclosure of information

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

- Covered benefits, limitations, and exclusions
- Payable premiums, deductibles, coinsurances, and copayments
- Provider Directory
- Access to specialists and emergency services
- Precertification and grievance processes
- Education, licensing, and certifications of your health care providers

Rights regarding the selection of plans and providers

Every individual has the right to:

- Select health care plans and providers that are appropriate and best fit his/her needs without being discriminated against based on socio-economic status, ability to pay, preexisting medical conditions, or medical history, regardless of age.
- A network of enough authorized providers to ensure that all the services covered by the plan will be accessible and available without unreasonable delay and in reasonable geographical proximity to the members' residences and workplaces, including access to emergency services twenty-four (24) hours a day, seven (7) days a week. All health care plans offering health service coverage in Puerto Rico must let each patient receive primary health care services from any participating primary service provider selected, pursuant to the provisions in the health care plan.
- Let every member receive the specialized health care services necessary or appropriate to maintain their health, according to the referral procedures established in the health care plan. This includes access to qualified specialists for patients with special conditions or health care needs, to ensure that members will have fast and direct access to the qualified providers or specialists selected from the plan's provider network. If the plan requires a special authorization for such access to qualified providers or specialists, the plan will guarantee an appropriate amount of visits to cover the health needs of these members.

Patient's right to continuity in their health care services

If a provider cancels or the plan ceases, the member has to be notified of such cancellation at least 30 days in advance. In the event of cancellation, and subject to payment of the premium, the member shall be entitled to continue receiving benefits for a transition period of 90 days. If the member is hospitalized on the date of cancellation and the discharge date was scheduled before the termination date, the transition period will be extended 90 days after the member's date of discharge. If a member is pregnant and the cancellation occurs during the second trimester, the transition period will be extended until the member's date of discharge after delivery or the newborn's date of discharge, whichever is last. If a patient is diagnosed with a terminal condition before the plan's termination date and he/she continues receiving services for that condition before the plan's termination date, the transition

period will be extended for the remainder of the patient's life.

Providers who continue to treat the member during this period must accept the payments and fees set by the plan as payment in full for their services.

Right to access emergency services and facilities

- Free and unrestricted access to emergency services and facilities, when and where the need arises, and without precertification or waiting periods.
- Reliable and detailed information regarding the availability, location, and proper use of emergency facilities and services in their respective locations, as well as provisions regarding the payment of premiums and reimbursement of costs related to such services.
- If emergency services are rendered by a non-participating provider, the member will only pay the applicable copayment or coinsurance.

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

- The right to participate, or have your parent, guardian, custodian, caretaker, spouse, relative, legal representative, proxy, or any person designated by court for such purpose to fully participate, in the decisions about your health care.
- Receiving all the necessary information and available treatment options, costs, risks, and chances of success for these options.
- The use of advance directives or guidelines concerning your treatment, or appointing someone to act as your guardian if necessary, to make decisions. Your health care service provider shall respect and abide by your treatment decisions and preferences.
- No health care plan may impose gag clauses, penalties, or any other type of clause that interferes with the communication between patients and physicians.
- All health care providers are required to provide medical orders for laboratory tests, x-rays, or drugs so you may choose the facility where you will receive the services.

Right to respect and equal treatment

- Right to receive a respectful treatment from all health service providers at all times, regardless of race, color, sex, age, religion, origin, ideology, disability, medical information, genetics, social status, sexual orientation, or ability or form of payment.

Right to confidentiality of information and medical records

- To communicate freely, without fear and in strict confidentiality with your health care providers.
- Be confident that your medical records will be kept under strict confidentiality and will not be disclosed without your authorization, except for medical or treatment purposes, by court order, or as specifically authorized by law.
- Obtain receipt for the expenses incurred for total or partial payments, copayments, or coinsurance. The receipt must specify the date of service, name, provider's license number and specialization, name of the patient and the person paying for the services, description of services, amount paid, and signature of the authorized officer.
- Access or obtain a copy of your medical record. Your physician must give you the medical record copies within 5 business days from the date of request. Hospitals will have 15 business days to comply. They may charge you up to $0.75 per page, but no more than $25.00 per record. If the physician-patient relationship is severed, you are entitled to request the original record free of charge, regardless of whether you have outstanding debts with the health service provider.

- To receive a quarterly utilization report including, among other things: member's name, service type and description, date of service and provider, as well as the amount paid for the service. Members may access their quarterly utilization reports, which include an itemization of the services paid for them and their dependents, by registering as member in Triple-S Salud's website (www.ssspr.com).

Rights regarding complaints and grievances

- Every health service provider or insurer shall have an established procedure to quickly and fairly resolve any complaint presented by members, as well as appeals mechanisms for the reconsideration of determinations. Please refer to the section Appeals for Adverse Benefit Determinations.
- Receive responses to your concerns in your preferred language, be it English or Spanish.

Your responsibilities as a patient are:

- Provide the necessary information about health plans and account payments. To know the rules for the coordination of benefits.
- To inform the insurer of any instance or suspicion of fraud against the health insurance. If you suspect fraud has been committed against the health insurance, you must contact our Customer Service Department at 787-774-6060 or through our website www.ssspr.com.
- Provide the most complete and accurate information about your health, including previous illnesses, medications, etc. Participate in every decision related to your health care. To know the risks and limitations of medicine.
- To learn about the health plan's coverage, options, benefits, and other details.
- To comply with your health plan's administrative procedures.
- To adopt a healthy lifestyle.
- To inform your physician about any unexpected changes in your condition.
- To confirm that you clearly understand the course of action recommended by the health care professional.
- To provide a copy of your advance directives.
- To inform your physician if you foresee any problems with the prescribed treatment.
- To recognize the provider's obligation to be efficient and fair in providing care to other patients.
- To be considerate, so that your individual actions do not affect others.
- To resolve any differences through the procedures established by the insurer.

NOTICE OF PRIVACY PRACTICES

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

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

OUR LEGAL RESPONSIBILITY

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

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

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

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

SUMMARY OF PRIVACY PRACTICES

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

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

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

We do not use or disclose genetic information in order to assess or underwrite risks.

LAWS AND REGULATIONS

HIPAA: The Health Insurance Portability and Accountability Act of 1996 established guidelines for the use, storage, transmission, and disclosure of members' protected health information in order to standardize communications and protect the privacy and safety of their personal, financial, and health information.

HITECH: Refers to the act called “Health Information Technology for Economic and Clinical Health” (HITECH). This law promotes the adoption and significant use of health information

technology. It also regulates the privacy and safety in electronic transmissions of health information, partly through several provisions that reinforce the civil and criminal enforcement of HIPAA Guidelines.

Rule of Privacy and Security: These are the standards for the privacy of an individual's identifiable information, as well as the security guidelines for the electronic management of protected information, which are governed by 45 C.F.R. parts 160 and 164.

USE AND DISCLOSURE OF HEALTH INFORMATION

Triple-S Salud shall not disclose or use your information for any purpose other than what is stated in this Notice, unless you provide your written authorization. You have the right to revoke the authorization in writing at any time, but its revocation will not affect the uses or disclosures allowed by your authorization while it was valid. Triple-S Salud shall not disclose information for fundraising purposes.

Triple-S Salud may use and disclose PHI for:

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

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

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

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

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

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

Affiliated Covered Entities: As part of our role as insurance or benefit administrator, we may use and disclose PHI to Triple-S Advantage, Inc.

Business Partners: Triple-S Salud may share information with our business partners, who provide services on behalf of Triple-S Salud and are involved in the administration of your insurance or the coordination of your benefits.

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

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

As required by Law: We may use or disclose PHI as required by Federal, State, or Local Law. In this Notice, the term “as required by law” is

defined as provided by the HIPAA Act Privacy Rule. Your authorization, or the opportunity to approve or object, will not be required for these purposes. The information shall be disclosed in compliance with the safeguards established and required by law.

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

Forensic pathologists, funeral directors, and organ donor cases: We may use or disclose your PHI to Forensic Pathologists in order to help identify deceased people, determine cause of death, or carry out other duties as authorized by law. We may also disclose information to funeral directors so they may carry out their duties regarding the deceased, and to organizations that manage the acquisition, storage, or transplant of organs, eyes, or tissue.

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

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

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

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

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

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

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

With your authorization: You may authorize us, in writing, to use or disclose your information to other people for any purpose. Your authorization is required for activities such as the marketing of non-health-related products or the sale of health information. In these cases, the insurance

policies and their benefits will not be affected if you deny authorization.

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

- To support a benefit request under a life insurance policy, or to reinstate or change its benefits, in which case the authorization will be valid for thirty (30) months or until the request is denied, whichever occurs first; or
- To support or facilitate the communication of ongoing treatments for chronic illnesses or diseases, or for injury rehabilitation.

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

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

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

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

YOU HAVE THE FOLLOWING RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

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

QUESTIONS AND COMPLAINTS

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

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

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

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

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

Email to OCRComplaint@hhs.gov

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

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

If you would like to receive an English version of this notice, please contact us at the address above or visit our website at https://salud.grupotriples.com/en/privacy-policy/.

GENERAL PROVISIONS

1. **ACTIONS FROM THIRD PARTIES:** If by fault or negligence from a third party, the member or any of his/her dependents suffers an illness or injury covered under this policy, Triple-S Salud shall be entitled to subrogate to the member's rights to claim and receive compensation from such third party, equivalent to the expenses incurred in treating the member, caused by such acts of fault or negligence. Triple-S Salud will only claim medical expenses paid in connection with the accident caused by the third party.

   Subrogation is a legal process by which an insurer asserts the member's rights against a third party who has caused them damages. If the member has an accident caused by fault or negligence of a third party (e.g., a school, a grocery store, or any other public or private establishment), they must fill out the Incident Report of the place where the accident happened. The member should provide Triple-S Salud with a copy of this report as soon as possible, including their name and contract number. This information may be sent by email to subrogation@ssspr.com or delivered to your plan administrator, who will then forward the documents to Triple-S Salud.

   This does not apply to car accidents, which are handled by the Automobile Accident Compensation Administration (ACAA, by its Spanish acronym), or to workplace accidents insured by the State Insurance Fund.

   The member recognizes Triple-S Salud's subrogation rights and will be responsible for notifying Triple-S Salud of any actions initiated against said third party; and the member shall be responsible for paying Triple-S Salud for such expenses, should he/she act otherwise.

2. **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)**.**

3. **BLUECARD® PROGRAM AND OUT-OF-AREA SERVICES:** Triple-S Salud has a variety of relationships with other Blue Cross and /or Blue Shield Licensees, referred to generally as "*Inter-Plan Arrangements*." These Inter-Plan arrangements operate under rules and procedures issued by the Blue Cross and Blue Shield Association ("Association"). Whenever members access healthcare services outside the geographic area Triple-S Salud serves, the claim for those services may be processed through one of these Inter-Plan arrangements. The Inter-Plan arrangements are described below.

   Typically, when accessing care outside the geographic area Triple-S Salud serves, members obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, members may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. Triple-S Salud remain responsible for fulfilling our contractual obligations to you. Our payment practices are described below.

   Inter-Plan Arrangements Eligibility – claim types

   All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by Triple-S Salud to provide the specific service.

   A. Bluecard® Program

   The BlueCard® Program is an Inter-Plan Arrangement. Under this arrangement, when members access covered services (within

the geographic area served by a Host Blue/outside the geographic area Triple-S Salud serves), the Host Blue will be responsible for contracting and handling all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described below.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar copayment, the calculation of the member liability on claims for covered services will be based on the lower of the participating provider's billed covered charges or the negotiated price made available to us by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to Triple-S Salud by the Host Blue may be represented by one of the following:

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim-and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

(iii) An average price. An average price is a percentage of billed covered charges in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the member is a final price; no future price adjustments will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by Triple-S Salud in determining your premiums.

B. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

In some instances, federal and state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, Triple-S Salud will include any surcharge, tax or other fee in determining your premium.

C. Nonparticipating Providers Outside Triple-S Salud Service Area

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

D. Blue Cross Blue Shield Global® Core (ONLY FOR MEMBERS WITH MAJOR MEDICAL COVERAGE)

General Information

If members are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of Blue Cross Blue Shield Global Core when accessing covered services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although *Blue Cross Blue Shield Global Core* assists members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when members receive care from providers outside the BlueCard service area, the member will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

Inpatient Services

In most cases, if members contact the Blue Cross Blue Shield Global Core service center for assistance, hospitals will not require members to pay for covered inpatient services, except for their cost-share amounts. In such cases, the hospital will submit member claims to the Blue Cross Blue Shield Global Core service center to initiate claims processing. However, if the member paid in full at the time of service, the member must submit a claim to obtain reimbursement for covered services. **Members must contact Triple-S Salud to obtain precertification for non-emergency inpatient services**.

Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for covered services.

Submitting a Blue Cross Blue Shield Global Core Claim

When members pay for covered services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, members should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the Blue Cross Blue Shield Global Core service center address on the form to initiate claims processing. The claim form is available from Triple-S Salud, the Blue Cross Blue Shield Global Core service center or online at www.bcbsglobalcore.com. If members need assistance with their claim submissions, they should call the Blue Cross Blue Shield Global Core service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

4. **CLAIM NOTICE**: Written notice of the claim must be given to Triple-S Salud within twenty (20) days after the service has occurred or after said term, as soon as reasonably possible by the insured member or the employer A written notice given by the insured member, in your name, to Triple-S Salud, at your main office in San Juan, Puerto Rico or at your Service Centers around the Island, or to any authorized representative of Triple-S Salud , with enough information to be able to identify it is considered as a warning given to Triple-S Salud.

5. **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.

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

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

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

language services to people whose first language is not English.

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

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

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

   a. End of COBRA period;
   b. Lack of payment;
   c. Employer terminates the group health plan;
   d. Member enrolls in Medicare;
   e. Member enrolls in another health plan that does not have a waiting period;
   f. Member commits a fault that according to the plan is just cause for cancelling his/her plan (example: submitting fraudulent claims).

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

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

9. **CONVERSION CLAUSE:**

   a**.** If coverage under this policy ends because the employee is terminated from employment or no longer belongs to an employee class or classes eligible for coverage under the policy, the person is entitled to have Triple-S Salud issue an individual basic coverage, with no risk evaluation, within the different levels of metallic coverages approved for newly insured members requesting an individual health plan and accepting to pay the premiums of said individual health plan. The written application for enrollment in an individual plan will be submitted and the premiums paid to Triple-S Salud no later than thirty (30) days from the termination, provided that:

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

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

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

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

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

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

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

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

   d. Is covered or is eligible for coverage under a health plan that provides healthcare coverage under which the spouse, custodial parent or guardian is eligible to be enrolled, except if said health plan is the Puerto Rico Government Health Insurance Plan (GHIP) or any other government health plan that is administered by the Health Insurance Administration.

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

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

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

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

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

   If a member 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.

c. 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.

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

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 member, which they are required to show to any Triple-S Salud participating provider from whom services are requested, for the services to be covered under the policy. In addition, the member should present a second photo ID card.

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

    Moreover, the member and its dependents agree that it has not entered into this policy based upon representations from any carrier other than Triple-S Salud and that no person, entity or organization other than Triple-S Salud may be responsible for any obligation of Triple-S Salud, towards the member that may arise from this policy.

    What was previously stated will not create any additional obligation on the part of Triple-S Salud, unless these obligations arise from the provisions of this agreement.

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

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

15. **LETTER OF RIGHTS AND RESPONSIBILITIES OF THE PATIENT:** Triple-S Salud requires the insured members, or in the case of incapacitated persons or minors, the parents, guardians, custodians or persons in charge of said persons to read and become familiar with them. the "Patient Rights

and Responsibilities Charter" or an adequate and reasonable summary thereof, as prepared or authorized by the Department of Health.

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

19. **PHYSICAL EXAMINATIONS:** Triple-S Salud will have the right and the opportunity to examine, at its own expense, the member when, and as frequently as it deems necessary, for audit purposes or fraud investigations.

20. **POLICY**: Document that Triple-S Salud issues to the holder of the policy. In addition, Triple-S Salud will provide you with a list of participating Triple-S Salud physicians and providers, as well as the Drug List or Formulary.

21. **PAYMENT OF CLAIMS**: As a rule, the benefits provided under this policy are payable directly to participating providers, except in cases of emergencies where payment is made as provided by law. Of the insured member having used non-participating providers in cases of emergencies, the services provided are paid directly to the provider.

    If the insured member has received post-emergency services, or post-stabilization services, that are covered under the health care plan, except for the fact that it is a non-participating provider, Triple -S Salud reimburses the insured member based on what is less between the expense incurred and the fee that would have been paid to a participating provider, after discounting the applicable copayment and / or coinsurance, as established in this policy. In addition, this policy also contains benefits that are paid based on compensation or reimbursement to the insured member even when the provider is a participant.

    For Triple-S Salud to indemnify or issue a reimbursement to the insured member in these cases, the insured member must give written notice of the claim to Triple-S Salud within twenty (20) days after the occurrence or after of such term, as soon as reasonably possible, but not to exceed one (1) year from the date the service was rendered, unless evidence is presented that it was impossible to submit the claim in the time settled down.

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

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

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:** Triple-S Salud has the right to recover payments made in excess or in error to a member, retroactive for up to two (2) years from the date Triple-S Salud issued the payment. Triple-S Salud will contact the member as soon as it becomes aware that it has issued an erroneous or excess payment. Members will be required to notify Triple-S Salud when they realize they have received an erroneous or excess payment.

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 member in writing that said application has not been approved.

    The reinstated policy will only cover losses resulting from any accidental injury that may occur after the date of reinstatement and losses due to any illness that may begin more than ten (10) 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 member for a period of one (1) year from the date of coverage termination;

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

    d. Failure to meet the minimum participation requirements of 100% of eligible employees working with employers and 75% for employers with 4 to 50 employees;

    e. Failure to meet employer contribution requirements;

    f. In case Triple-S Salud decides to discontinue offering all market plans in Puerto Rico: In these cases, Triple-S Salud must provide written notice to the Office of the Insurance Commissioner of Puerto Rico, plan sponsors and plan

members at least 180 days before the health plan renewal date.

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

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

27. **TRIPLE-S SALUD RIGHT TO AUDIT:** By subscribing to this policy the insured members accept, acknowledge and understand that Triple-S Salud, as payer of the health services incurred by the main insured and their dependents, has the authority to access your medical records to perform audits on all or any claim for health services that Triple-S Salud has paid.

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

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

    - Loss of eligibility (for resignation or termination of employment)
    - Loss of employer contributions, or
    - Termination of coverage under COBRA

29. **RIGHTS UNDER LAW NO. 248 OF AUGUST 15, 1999 TO ENSURE ADEQUATE CARE FOR MOTHERS AND THEIR NEWBORNS DURING THE POSTPARTUM PROTECTION:** The aforementioned federal law establish the following:

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

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

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

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

30. **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. The termination shall not affect any claim for services rendered before the date of termination.

    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 (30) 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 thirty (3)0 calendar days prior to the date of termination or cancellation.

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

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

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

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

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

The transition care period is subject to the payment of the corresponding premium and may be denied or terminated if the plan member and/or provider incurs in fraud against the insurance. The member can choose to enroll in a direct payment policy or choose the transition period for the plan termination. Once the termination transition period ends, the provisions set forth in the Conversion clause will apply.

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

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

32. **TOTAL COVERED SERVICE PAYMENT IF THERE IS NOT A PROVIDER:** In cases where a member needs a medically necessary service covered by the plan for which there is no contracted provider and it is not provided in your coverage that the service will be provided by reimbursement to the member, Triple-S Salud will coordinate and establish a special agreement with a non-participating provider for the provision of such services to the member. This will be subject to the terms and conditions of the policy of the member and the payment to the provider based on the fee established by Triple-S Salud for the services to be rendered.

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

    The new plan should at least offer the member its group conversion policy. This is

a type of policy usually offered to insured members who leave a group and request coverage as individuals. The conversion policy offers coverage without requiring a medical examination or health certificate.

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

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

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

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

34. **UNIQUE CONTRACT-CHANGES:** This policy, riders, and attached documents, if any, constitute the entire text of the insurance contract. No change to this policy will be valid until approved by the executive officer designated by the Board of Directors of Triple-S Salud and the Office of the Commissioner of Insurance of Puerto Rico before its use, and unless said approval is endorsed in the present document, or is attached to it. No agent has authority to change this policy or waive any of its provisions.

35. **WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA):** This policy provides coverage to the insured member for reconstructive surgery following a mastectomy, as well as the reconstruction of the other breast to maintain a symmetrical appearance, prostheses and any physical complications that may arise during all the stages of a mastectomy. These benefits will be provided based upon a consultation between the insured member and her physician, and are subject to the copayments and coinsurances set forth in her policy.

DEFINITIONS

BASIC COVERAGE

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

2. **ABUSE**: One or more of the following acts executed by a family member or former family member of the victim, anyone residing in the victim's house, a romantic partner, or any person in charge of their care:

    a. Attempting to cause or intentionally or recklessly causing another person bodily injury, physical harm, severe emotional distress, psychological trauma, rape, sexual assault, or involuntary sexual intercourse;

    b. knowingly engaging in an unwanted pursuit behavior towards the victim, including following the person without proper authority, under circumstances that place the victim in reasonable fear of harm to his/her bodily integrity;

    c. subjecting another person to false imprisonment, or

    d. cause knowingly or recklessly damage to property so as to intimidate or control the behavior of the victim

3. **ABUSE VICTIM**: A person against whom an act of abuse has been committed; who has currently or previously suffered injuries, illnesses, or disorders as a result from the abuse; or who seeks, may have sought, or had reason to seek medical or psychological treatment for abuse; or court-ordered protection or shelter from abuse.

4. **ABUSE VICTIM STATUS:** The fact or impression that a person is or has been a victim of abuse, regardless of whether the person has suffered any abuse-related health conditions.

5. **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.

6. **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.

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

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

    1. 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

    2. 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.

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

10. **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.

11. **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.

12. ***BLUE CROSS AND BLUE SHIELD*** **PLAN**: Independent insurer under contract with the Association of Plans Blue Cross/Blue Shield) acquires the license to belong to the association of independent plans and allows the use of its marks.

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 member will pay

when purchasing a prescription drug or receiving a covered services from a participating physician or provider or any other provider, as his or her contribution to the cost of the services received, as set forth in the policy and notified to the participating physician or provider. This amount is not reimbursable by Triple-S Salud.

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. **CONCURRENT REVIEW:** Utilization review carried out during the stay of the member in a facility or during the treatment of the member at the office of a health professional or another place where health care services are provided to members admitted or on an outpatient basis.

17. **CONDITION OF HIGH RISK**: A condition of long or short duration that entails or that has the probability of entailing a poor prognosis.

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

19. **CLINICAL REVIEW CRITERIA**: The written proceedings for the growth, summaries of decisions, clinicals protocols, and practice guidelines used by the insurer or health insurance company to determine the medical need and suitability of health care services.

20. **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.

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

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

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

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

22. **CHRONIC CONDITION:** A condition of long or permanent duration.

23. **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.

24. **CUSTOMARY CHARGE**: A charge is customary when it is within the set of usual charges billed by a service determined by most physicians or service providers with similar training and experience within a given area.and service providers with similar training and experience within a specific field.

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

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

    2. Biological or adopted children of the insured member or the spouse of the member as defined in this clause 25 (a) until they attain age 26. The children or the spouses of the member's dependents will not be eligible for coverage under this plan, except those included in paragraph 25(d) below, or the children of the spouse of the insured employee's child.

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

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

    5. Foster children will also be considered direct dependents until they attain age 26. The policyholder may demonstrate the status of the foster children providing to Triple-S Salud a sworn statement where he/she specifies when the relationship with the minor began, legal custody or the certification of the income tax returns of the last two years, among other evidences. It will be understood that foster children are those minors, who, without being biological or adopted children of the insured employee, have lived from their infancy under the same roof with the member in a parent-child relationship and that receive feeding as this term is defined by Article 142 of the Civil Code of Puerto Rico.

26. **DURABLE MEDICAL EQUIPMENT:** Equipment whose main purpose is of a medical nature and whose medical necessity must be certified. This equipment includes, but is not limited to, hospital-type beds, wheelchairs, oxygen equipment, and walkers, among others.

27. **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.

28. **ELIGIBILITY WAITING PERIOD:** Period of time which must pass before the member is entitled to receive certain benefits, under the health plan terms. The waiting period will not exceed ninety (90) days.

29. **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 an 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.

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

31. **EQUIPMENT, TREATMENT AND NON-AVAILABLE FACILITIES IN PUERTO RICO:** Treatment in facilities or with medical-hospital equipment not available in Puerto Rico, in the case of an insured member who, due to their health condition, requires these services.

32. **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.

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

34. **EXPERIMENTAL OR INVESTIGATIVE SERVICES:** Medical treatment:

    a. That is considered experimental or investigative 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 investigative phase.

35. **FAMILY CONTRACT:**

1. The insurance that provides benefits to any insured employee, his/her spouse and his/her direct dependents as defined in clause 25 of this section. The premium for family contracts will apply in these cases.

2. Should there be no eligible spouse as a direct dependent, as defined in clause 25, the insured member's contract with one (1) or more as direct dependents may, at his/her option, be considered a Family Contract or an Individual Contract with one (1) or more direct dependents, as defined in clause 25 of this section. In both alternatives, the premium will be the same.

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

36. **FEES**: The fixed amount used by Triple-S Salud to pay its participating physicians or providers for the covered services rendered to members when these are not paid by any other method.

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

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

- The availability, rendering or quality of health care, including grievances related to adverse determinations that may result from a utilization review;
- The payment or handling of claims or indemnification for health care services; or
- Issues related to the contractual relationship between the covered person or member and the insurer.

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

40. **HEALTH INFORMATION**: Means whether oral or recorded information or data in any form or medium:

a. That is created or received by the insurer or the health services organization, related to physical, mental, or behavioral health, or past, present or future conditions of the person, or dependent, the provision of health care to an individual, or past, present, or future payments for the provisions of health care to an individual.

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

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

41. **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.

42. **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.

43. **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.

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

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

    2. 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

    3. 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.

45. **HOSPICE:** Special care for persons with terminal diseases whose life expectancy is 6 months or less.

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

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

48. **HOST BLUE:** Blue Cross or Blue Shield Plan of the area where the service is received under the Blue Card Program. The Host Blues determine a negotiated price, which is indicated in the conditions of each of the contracts with the Host Blue. The negotiated price made available to Triple-S Salud by Host Blue may be represented by one of the following:

    a. The real price. The actual price is the current payment rate at the time the claim is processed without any further increase or reduction, or

    b. Estimated price or approximate price. The approximate price is a negotiated payment rate, in force at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the supplier and other transactions that are related and not related to the claims. Such transactions may include, but are not limited to, recovery from fraud and abuse, reimbursements for suppliers not applied to a specific claim, retrospective arrangements and payments related to performance or

    c. Average rate or average price. The average price is a percentage of the charges billed for covered services in effect at the time a claim is processed representing the total payments negotiated by Host Blue with all of its health care providers or a similar classification with its providers and other transactions that are related and not related to claims. Such transactions may include the same as those indicated above for an approximate price.

49. **INDIVIDUAL CONTRACT**: The insurance that provides benefits to any eligible single or married employee without including the spouse, as defined in clause 25, Direct Dependent, as an insured member. Said employee has the option to include in his insurance any eligible direct dependent, as defined in clause 25 of this section, by paying the corresponding additional premium.

    The inclusion of dependents may only be done at the time of acquiring this policy or on the date of renewal of this policy, except as provided in the sections on Subscription and Special Subscription Changes of this policy or any other provision of law.

50. **ILLNESS:**

    d. Any non-occupational illness contracted by the insured member.

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

        1) That services are rendered to the female member regardless of her marital status
        2) Any service rendered for a therapeutic abortion.

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

52. **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.

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

54. **IRO**: The Independent Review Organization (IRO) is an organization that is accredited to conduct independent medical reviews. These reviews will be carried out by an independent physician.

55. **MEDICAL EMERGENCY:** A medical or behavioral condition that manifests itself with acute symptoms of sufficient severity, including severe pain, so that a wise, prudent person with an average knowledge of medicine and health can deduce that the lack of Immediate medical attention can seriously endanger the health condition of the person affected by such condition or it would result in a dysfunction of any member or organ of the body or, with respect to a person insured during their pregnancy, the health of the insured member or the fetus, or in the case of a behavioral disorder, may put the health condition of said person or other persons in serious danger; cause problems in the bodily functions of said person; cause serious dysfunction of any organ or part of the body of said person or serious disfigurement.

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

    1. Severe chest pain
    2. Serious or multiple injuries
    3. Severe respiratory distress
    4. A sudden change in mental state (for example, disorientation)
    5. Severe bleeding
    6. Pain or conditions that require immediate attention, such as heart attack or suspected acute appendicitis
    7. Poisoning
    8. Seizures

56. **MEDICAL NEED**: Means everything that a licensed physician prudent and reasonable understands that it is medically necessary above all that service or health procedure that is provided to a patient for the purpose of preventing, diagnosing or treating a disease, injury, disease, disease or its symptoms in a way that:

        1. Agree with the generally accepted standards of medical practice, considering the modern means of communication and teaching

2. Be clinically appropriate in terms of type, frequency, grade, location and duration of health services or procedures;

3. The determination of medical necessity is not made merely for the convenience of the patient or physician or for the economic benefit of the insurer, health service organization or other health plan provider, of the medical treatment itself or of another provider of medical care. medical care;

4. Be within the scope of the practice and / or medical specialty of the or the licensed medical professional who determined the medical necessity;

5. That said determination of medical necessity is based on clinical evidence that supports the determination and is duly documented by the physician who treated the patient.

57. **MEDICAL OR SCIENTIFIC EVIDENCE:** Means evidence produced by any of the following sources:

- Peer-reviewed studies, published or accepted for publication by specialized medical journals that comply with nationally-recognized standards for scientific texts;
- Peer-reviewed medical publications, including those related to therapies that have been evaluated and approved by institutional review boards, the biomedical compendia, and other medical journals that comply with the indexing criteria of the National Institutes of Health Medical Library, in the Medicus Index (Medline), and those of Elsevier Science Ltd. In Excerpta Medicus (EMBASE);
- Medical journals recognized by the Secretary of Health and Human Resources of the United States Government, pursuant to the federal Social Security Act;
- The following regulations:
    - The American Hospital Formulary Service-Drug Information;
    - Drug Facts and Comparisons®;
    - The American Dental Association Accepted Dental Therapeutics; and
    - The United States Pharmacopoeia-Drug Information;
- The findings, studies, or investigations conducted by or under the sponsorship of federal government agencies and by federal research institutes recognized in the United States of America, which include:
    - The federal Agency for Health Care Research and Quality;
    - National Institutes of Health;
    - National Cancer Institute;
    - The National Academy of Sciences;
    - Centers for Medicare and Medicaid Services (CMS); and
    - Any national board recognized by National Institutes of Health whose purpose is to evaluate the efficiency of healthcare services;
- Any additional medical or scientific evidence comparable to the provisions in Subsections (A) to (E) cited above.
- Categorical exclusion - means the specific provision established by Triple-S to not cover a prescribed drug, identifying it by its scientific or commercial name.

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

59. **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.

60. **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.

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

62. **MAXIMUM OUT-OF-POCKET AMOUNT:** It is the maximum amount stated in the policy that a person must pay during the policy year. Before the person reaches the out-of-pocket amount stated in this policy, the person will pay the deductibles, copayments, or coinsurances for essential medical-hospital care and prescription drugs, as described in the table of benefits, received from the plan participating providers. Once the insured member reaches the maximum out-of-pocket amount stated in the policy, the plan will pay 100% of the medical expenses covered under this policy. Services rendered by non-participating providers, payment for medical expenses not covered under this policy and the premium paid to Triple-S Salud for the plan, are not considered eligible expenses for the accumulation of the out-of-pocket maximum.

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

64. **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.

65. **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).

66. **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.

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

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

    b. are an integral part of a covered service;

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

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

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

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

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

70. **OPTIONAL DEPENDENTS:** In addition, under a family contract, an optional dependent will be a person who for some reason does not qualify as a direct dependent, but is handicapped, and the insured member has a final judgment granting custody or guardianship.

71. **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.

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

73. **PERSONAL REPRESENTATIVE**:

    (1) A person expressly authorized in writing by the member to represent him or her, for purposes of the Puerto Rico Health Insurance Code;
    (2) a person authorized by law to consent in the member's absence;
    (3) an immediate relative of the member, or the member's attending health care professional when the member is unable to provide consent;
    (4) a healthcare professional when the member's health insurance requires that a healthcare professional request the benefit; or
    (5) in case of an urgent care request, a healthcare professional that has knowledge about the member's medical condition.

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

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

76. **PREAUTHORIZATION**: It means the process of obtaining prior approval of the health insurance organization or insurer, which is required under the terms of the coverage of the health plan, for the dispensing of a prescription medication.

77. **PRECERTIFICATION:** Advanced authorization from Triple-S Salud for the payment of any of the benefits covered under this policy and its riders, in cases Triple-S Salud deems necessary. Some of the objectives of the precertification are: evaluate if the service is medically necessary, evaluate the adequacy of the service location, verify the eligibility of the member for the requested service, and its availability in Puerto Rico. Precertification's will be evaluated based on the precertification's 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.

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

79. **PREMIUM:** Means the specific money amount paid to the insurance company, in this case Triple-S Salud, as the condition to receive the benefits of a health plan for the

eligible employees of an employer. The premium collected from an member cannot be changed during the contract year, unless there is a change in the affiliation of the employer, the family group of the eligible employee or the benefits of the health plan requested by the employer.

80. **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

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

81. **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.

82. **PSYCHOANALYSIS**: Psychoanalysis is based on a set of theories related to the conscious and unconscious mental processes and the interaction between them. It is a therapy modality used to treat people with chronic life problems on a mild to moderate scale. Psychoanalysis should not be used as a synonym for psychotherapy, since they do not pursue the same goal. This service is not covered in this policy, as expressed in the Exclusions Section.

83. **PSYCHOLOGICAL EVALUATION:** Initial interview to obtain personal and clinical history of the member, as well as his/her 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.

84. **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.

85. **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.

86. **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.

87. **REASONABLE CHARGE:** A charge is reasonable when it satisfies the usual and customary criteria or it may be reasonable if, in the opinion of an appropriate Review Committee, it deserves special consideration according to the complexity of the management of the particular case.

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

89. **RESCISSION OF COVERAGE:** Triple-S Salud may decide to terminate its contract with retroactive effect on the basis of fraud or intentional misrepresentation of substantial data as prohibited by this plan. The termination shall be notified in writing thirty (30) days in advance and the participant or member has the right to request review of this termination.

90. **RESIDENTIAL TREATMENT:** High-intensity and restrictive care services for patients with mental health conditions, including drug addiction and alcoholism, and co-morbid conditions that are difficult to handle at home and in the community, which have not responded to other less restrictive treatment levels. This treatment integrates clinical and therapeutic services that are coordinated and supervised by an interdisciplinary team in a structured environment, 24 hours a day, 7 days a week. The facility must be a hospital institution accredited by Medicare, the *Joint Commission*, and the Department of Education, and clinical teachers must be accredited under Act No. 30. They must also have the ASSMCA license for drug administration and storage, as well as an interdisciplinary staff (clinical personnel, psychiatrist, psychologist, and registered nurses).

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

92. **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.

93. **REQUEST FOR URGENT CARE:**

    1. A request for a health care service or treatment for which the established time period for non-urgent care determinations:

        a) Could endanger the member's life, health, or full recovery; or

        b) In the opinion of a physician with knowledge of the member's health condition, would expose the person to pain that cannot be adequately managed without the healthcare service or treatment requested.

    2. When determining if the request will be treated as urgent, the person representing the health insurance company or insurer will exercise the prudent judgment of a layperson with average healthcare and medicine knowledge. If a physician with knowledge of the member's health condition decides to submit an urgent care request under subsection (1), the health insurance company or insurer will treat said request as one for urgent care.

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

95. **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.

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

97. **SPECIAL CONDITIONS**: A condition of low prevalence or rare occurrence.

98. **SPECIAL ENROLLMENT:** Instance in which it is allowed to subscribe dependents at any time in the health plan, as a result of a qualified event such as loss of eligibility under another group plan, marriage and births, among others.

99. **STANDARD REFERENCE COMPENDS ("STANDARD REFERENCE COMPENDIA"):** MEANS:

    - The American Hospital Formulary Service-Drug Information;
    - The American Medical Association Drug Evaluation or
    - The United States Pharmacopoeia- Drug Information

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

101. **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.

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

103. **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

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

the facilities. The telephone number to call Teleconsulta is located on the back of the Triple-S Salud's identification card.

105. **TELECONSULTA MD®: ®:** Interactive virtual service by smartphone or computer, where the member may conduct a medical consultation with a generalist, internist, primary care physician, or pediatrician who has been certified to practice telemedicine, pursuant to Act No. 168 of March 13, 2018. Its main objective is to offer access to a physician and provide relief for acute medical conditions. Conditions that can be addressed through this service include allergies, bronchitis, nasal infections, stomachache, hypertension, sore throat, migraine, cold, nausea, earache, asthma, and muscle pain.

106. **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

107. **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.

108. **URGENCY:** Means a medical condition caused, that does not expose the risk of imminent death or the integrity of the person, and that can be treated in medical offices or offices of extended hours, not necessarily in emergency rooms, but which, If not treated at the right time and in the right way, it could become an emergency.

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

110. **UTILIZATION REVIEW ORGANIZATION**: Entity hired by a health insurance company or insurer to perform utilization reviews, if it is not the health insurance organization or insurer itself conducting the review of its own health insurance plan. It will not be considered as a requirement for the health insurance company or insurer to subcontract an independent entity to carry out the utilization review processes.

MAJOR MEDICAL COVERAGE

1. **IMPLANT:** A device, object or material that is placed inside the body with the purpose of preserve configuration, offer stability, or offer temporary or permanent stimulus to a body part. They are covered as it is established in the policy.

2. **MEDICAL MATERIALS OR SUPPLIES:** Those, which, for their diagnostic or therapeutic characteristics, are essential for the effectiveness of the care plan, ordered by the physician for the treatment or diagnosis of the patient's illness or injury.

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

4. **ORTHOTIC DEVICES:** External accessories that restrict, eliminate or redirect the movement of a weak or ill part of the body, as, for example: claps, bracers, corsets, splints, casts for injured ligaments, etc.

5. **PROSTHESIS:** External replacement for a dysfunctional body part, that is fabricated and adapts to the measures and individual necessity of the person who is receiving it, with the purpose of providing function or mobility. It may substitute a part of the body that does not work properly or is missing. These are covered as it is established in the policy.

6. **SURGICAL ASSISTANCE:** When a licensed physician actively assists the lead surgeon in performing a covered surgical procedure, which because of its complexity justifies the necessity of assistance.

7. **SCALE OF MEDICAL BENEFITS:** Scale based on which services covered and received by the insured member will be paid, when such services cannot be paid under the concept of usual, customary and reasonable

charge. The Scale of Medical Benefits will apply in Puerto Rico.

ORGAN AND TISSUES TRANSPLANT

1. **PRE-EXISTING CONDITIONS:** Physical or mental conditions suffered by a member which were initially manifested prior to the issuance of the policy; or that existed prior to the issuance and for which the member received treatment.

2. **ORGAN TRANSPLANT INSURANCE:** An insurance independent from the health plan that the eligible member may have with Triple-S Salud. Said provides coverage for the organ transplant only, as defined in the Benefits Section of this policy. The covered benefits will be payable by indemnization or assignation of benefits. To be eligible for this benefit, you will have to be subscribed in the basic coverage.

3. **PRE-TRANSPLANT**: Evaluation and preparation of a member to receive a tissue or organ transplant.

4. **PROCUREMENT:** Those expenses incurred in connection with locating, removing, preserving and transporting an organ or tissue including also the evaluation before the surgery and surgical removal of the donor organ or tissue. Benefits will be provided only for procurement of a donor organ or tissue that is used for a transplant for which benefits are provided under this rider, unless the scheduled transplant is canceled because of the member's medical condition or death and the organ or tissue cannot be transplanted to another person. These expenses will only be covered only if the recipient is covered by the Plan. For bone marrow transplant, the term donation is used instead of procurement.

5. **SECOND MEDICAL OPINION**: Requirement that Triple-S Salud or his authorized representative makes an opinion from a physician other than the physician in charge of the case and selected by Triple-S Salud, in cases in which Triple-S Salud determines that there was a need for such an opinion, before the insured member receive the service. Triple-S Salud may require a second medical opinion, by doctors appointed by this, for those procedures in which in the opinion of Triple-S Salud or his authorized representative may need to obtain such an opinion.

6. **TRANSPLANT:** Means a procedure or a series of procedures by which an organ or tissue is either:

   a. Removed from the body of one person called a donor and implanted in the body of another person called a recipient; or

   b. Removed from and replaced in the same person's body.

PHARMACY COVERAGE

1. **ACUTE DRUGS:** Medications prescribed to treat non-recurrent diseases, such as antibiotics. These drugs have no refills.

2. **ANNUAL PHARMACY DEDUCTIBLE:** The annual cash amount that must be accumulated before becoming entitled to the benefits of this policy. All members insured under individual or family contracts shall be responsible for the payment of covered services until they accumulate the annual coverage deductible. Afterwards, they may pay the plan's copayments and/or coinsurance, as established in this policy.

3. **COINSURANCE:** Percentage of fees to be paid by the member at the moment services are rendered, as his/her contribution to the cost of the services received, as established in the policy and notified to the participating pharmacy. This amount is not reimbursable by Triple-S Salud.

4. **COPAYMENT:** The fixed preauthorized amount to be paid by the insured member to at the moment services are rendered, as his/her contribution to the cost of the received services, as established in the policy and notified to the participating pharmacy. This amount is nor reimbursable by Triple-S Salud.

5. **EFFECTIVE DATE:** The plan's first day of coverage.

6. **FDA**: United States Food and Drug Administration. Federal Drug Administration or FDA.

7. **MAIL ORDER PHARMACY PROGRAM:** Voluntary program that allows members to receive certain maintenance medications through the United States Postal Service.

8. **MAINTENANCE PRESCRIPTION DRUGS:** Medications that require prolonged therapy and have a low probability of changes in dosage or therapy due to side effects. Also, medications whose most common use is to treat a chronic illness when a therapeutic end cannot be determined.

9. **MEDICAL OR SCIENTIFIC EVIDENCE:** Means evidence produced by any of the following sources:

    - Peer-reviewed studies, published or accepted for publication by specialized medical journals that comply with nationally-recognized standards for scientific texts;
    - Peer-reviewed medical publications, including those related to therapies that have been evaluated and approved by institutional review boards, the biomedical compendia, and other medical journals that comply with the indexing criteria of the National Institutes of Health Medical Library, in the Medicus Index (Medline), and those of Elsevier Science Ltd. In Excerpta Medicus (EMBASE);

    - Medical journals recognized by the Secretary of Health and Human Resources of the United States Government, pursuant to the federal Social Security Act;

    - The following regulations:
        - The American Hospital Formulary Service-Drug Information;
        - Drug Facts and Comparisons®;
        - The American Dental Association Accepted Dental Therapeutics; and
        - The United States Pharmacopoeia-Drug Information;
    - The findings, studies, or investigations conducted by or under the sponsorship of federal government agencies and by federal research institutes recognized in the United States of America, which include:
        - The federal Agency for Health Care Research and Quality;
        - National Institutes of Health;
        - National Cancer Institute;
        - The National Academy of Sciences;
        - Centers for Medicare and Medicaid Services (CMS); and
        - Any national board recognized by National Institutes of Health whose purpose is to evaluate the efficiency of healthcare services;
    - Any additional medical or scientific evidence comparable to the provisions in Subsections (A) to (E) cited above.
    - Categorical exclusion - means the specific provision established by Triple-S to not cover a prescribed drug, identifying it by its scientific or commercial name.

10. **NEW PRESCRIPTION DRUGS:** 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.

11. **NON-PARTICIPATING PHARMACY:** Any pharmacy that has not subscribed a contract with Triple-S Salud to provide services to members.

12. **NON-PREFERRED GENERIC PRESCRIPTION DRUGS (Tier 2):** This tier includes generic prescription drugs with a higher cost than the drugs in Tier 1. These are classified as non-preferred because there are alternatives in the previous tier that are more cost-effective or have fewer side effects.

13. **NON-PREFERRED BRAND NAME PRESCRIPTION DRUGS (Tier 4):** A drug is classified as non-preferred because there are alternatives in the previous tiers that are more cost-effective or have fewer side effects. If the member obtains a non-preferred brand-name prescription drug, he/she will have to pay a higher cost for the medication.

14. **NON-PREFERRED SPECIALTY PRODUCTS (Tier 6):** Denomination used for the drugs or products in the Drug List or Formulary offered under the Special Condition Medication Program. Medications in this tier cost more than Tier 5 preferred specialty drugs. These are used to treat chronic and high-risk conditions that require special administration and management.

15. **OVER-THE-COUNTER (OTC) DRUGS:** These are medications without a federal script that can be sold to clients without a physician's prescription.

16. **PARTICIPATING PHARMACY:** Any pharmacy that has signed a contract with Triple-S Salud to provide services to members.

17. **PARTICIPATING PHYSICIAN OR PROVIDER:** All physicians, hospitals, primary service centers, diagnosis and treatment centers, dentists, laboratories, pharmacies, pre-hospital emergency medical services, or any other person or entity authorized to provide health care services in Puerto Rico, that under direct contract with Triple-S Salud, or through a third-party, provides health care services to Triple-S Salud members.

18. **PHARMACIST**: A person who is licensed to prepare, mix, and administer drugs, and practices within the scope of such license.

19. **PHARMACY**: Any legally approved establishment to dispense drugs.

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

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

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

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

21. **PREFERRED BRAND-NAME PRESCRIPTION DRUGS (Tier 3):** There are certain medications that have been selected by the Pharmacy and Therapeutics Committee as preferred agents after evaluating their safety, efficacy, and cost. They are identified as Tier 3. For therapeutic classes where there are no generic equivalents available, we urge members to use medications identified as preferred as their first choice.

22. **PREFERRED GENERIC PRESCRIPTION DRUGS (Tier 1):** This tier includes generic drugs that have been selected by the Pharmacy and Therapeutics Committee as preferred agents after evaluating their safety, efficacy, and cost.

23. **PREFERRED SPECIALTY PRODUCTS (Tier 5):** Denomination used for the drugs or products in the Drug List or Formulary offered under the Special Condition Medication Program. Medications in this include generic, biosimilar (generics of biological products), and brand-name drugs. These are used to treat chronic and high-risk conditions that require special administration and handling.

24. **PRESCRIPTION DRUG:** Medications that have been approved or regulated for marketing and distribution by the Food and

Drug Administration (FDA), and which are required by Puerto Rico or United States laws to be provided with a prescription.

25. **PRESCRIPTION DRUGS WITH REFILLS:** Prescription containing written indications from the physician authorizing the pharmacy to dispense a drug on more than one occasion.

26. **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.

27. **THERAPEUTIC CLASSIFICATION:** Categories used to classify and group drugs in the Drug List or Formulary according to the conditions they treat or the effects they produce in the human body.

28. **PREAUTHORIZATION**: drugs that require prior authorization are usually those that must meet the clinical criteria as they may present a potential for toxicity, are candidates for the improper use or are related to a high cost.

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

    The adequate manner, from a clinical perspective, of prescribing, administering, and overseeing the use of prescription drugs for outpatients; and
    Reviewing and assessing the use of these drugs, as well as intervening with such usage.

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

30. **SPECIALIZED PHARMACIES:** Pharmacies providing services for chronic and high-risk conditions requiring specialty drugs for plan members.

31. **STANDARD REFERENCE COMPENDIA** means:
    - The American Hospital Formulary Service-Drug Information;
    - The American Medical Association Drug Evaluation; or
    - The United States Pharmacopoeia-Drug Information.

32. **STEP THERAPY (*ST,*):** Protocol that specifies the sequence in which prescription drugs must be administered for certain medical conditions. In some cases, we require that the member use a medication first as therapy for his/her condition before we cover other medications for the same condition (first step medications). For instance, if Drug A and Drug B are both used to treat your health condition, we require that the member first use Drug A. If Drug A does not work for the member, then we will cover Drug B (second step medication).

33. **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.

34. **WAITING PERIOD:** The period of time a member must wait before becoming eligible for certain benefits under the terms of the health plan. The waiting period under no circumstances may exceed ninety (90) days. However, emergency room services will not have a waiting period and the waiting period for preventive services may not exceed thirty (30) days.

35. **90-DAY PRESCRIPTION DRUG DISPENSING PROGRAM:** Voluntary program that allows members to obtain a ninety-day (90) supply of certain maintenance medications through participating pharmacies in this program.

DENTAL COVERAGE

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

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

3. **EMERGENCY SERVICES**: Services provided due to a sudden and unexpected condition requiring dental care. Such assistance should be received immediately after the onset of the condition or as soon as possible.

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

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

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

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

8. **PARTICIPATING DENTIST**: A dentist with a regular license issued by the governmental entity assigned for such purposes, and member of the Dental Surgeons College of Puerto Rico; who has signed a contract with Triple-S Salud to render dental services.

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

10. **TREATMENT PLAN**: Means a detailed report of the procedures recommended by the doctor or surgeon-dentist for the treatment of medical or dental needs of the patient, found in the physical examination done by the same physician or surgeon-dentist.

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

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