Triple-S Salud, Inc.
San Juan, Puerto Rico

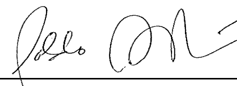
Independent Concessionaire of the Blue Cross/Blue Shield Association

GROUP CONTRACT RIDER

Petsmart

This rider is signed on behalf of Triple-S Salud by the President of the Board of Directors and the President of the Corporation.

Jesús R. Sánchez Colón, D.M.D.
President of the Board of Directors



Pablo Almodóvar Scalley
President and CEO

This rider is part of the policy to which it is attached and is issued considering the payment of premiums in advance. Also, is subject to the terms and conditions of the contract that are not in conflict with the terms and conditions of this rider.

This rider amends the following parts of the group policy: **Petsmart, effective November 01, 2012.**

Coverage Codes: FD-72, DA-20

CHANGES

The section has been modified:

- A child, under the definition of direct dependent of this policy, ceases to be eligible as direct dependent of the insured employee:

    a. The child attains age twenty-six (26). The birth date will be taken as date of the request for termination to end insurance coverage. The termination will be effective on the first day of the month following the day of birth.

    b. When any child joins the Armed forces of the United States of America, the date of entry will taken as the date of the request for termination of the health insurance plan. Termination of the health plan coverage will be effective on the first day of the following month in which the event took place.

COVERED SERVICES

This section has been added:

Under our plan, there is a maximum of disbursements that people pay for medical services and hospital covered according to their type of contract. The maximum amount of disbursement is $6,350 in an individual contract and $12,700 in contract couple or family. This is the maximum amount that the insured pay during the year policy by concept of deductibles, copayments and

coinsurance when you receive medical services and hospital care covered under the policy when you visit providers inside the network. Once the insured person reaches the amount that applies to you according to their type of contract, you don't have to do additional disbursements by the rest of the year insurance policy for their medical services and hospital care. The services provided through non- participating providers, **non-essential services,** payment for dental services, medications covered on an outpatient basis through the benefit of pharmacy and the services not covered under this policy as well as the monthly premium paid to Triple-S Salud by the plan, are not considered eligible expenditure for the accumulation of pocket maximum.

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

- Organ and Tissues Transplant
- Hearing Aids
- Sport Medicine
- Services of non-participants in and outside of PR

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

AMBULATORY MEDICAL-SURGICAL AND DIAGNOSTIC SERVICES IN AMBULATORY FORM

Treatment and Diagnostic Services

This section has been added:

Other services for the treatment of disorders within the continuum of Autism	
This policy covers the services targeted for the diagnosis and treatment of persons with disorders within the Continuum of Autism without limits such as: • Neurological tests • Immunology • Genetic testing • Laboratory tests for autism • Services of Gastroenterology • Nutrition services • Occupational therapy and speech • Visits to a psychiatrist, psychologist, with master's or doctoral degree and valid license issued by the Board of Examiners of Psychologists of Puerto Rico) or social worker (by reimbursement).	• Copay and coinsurance applies according to the rendered service.

EXTENDED COVERAGE IN THE UNITED STATES OF AMERICA

The following incise has been eliminated:

- The maximum benefit established is of $1 million per life, per insured.

MAJOR MEDICAL COVERAGE

The following incises has been eliminated:

- **Maximum Benefit** – The maximum benefit for this coverage is $1,000,000per life, per insured person. (Except for the organ and tissue transplant services, which has an independent maximum benefit of $1,000,000 per life, per type of transplant.)

- All benefits are subject to the maximum benefits established in the Limitations section.

The following incise has been modified:

- 80% of the covered medical expenses incurred during a policy year, by the insured or his/her dependent while insured, when they exceed the total of benefits of the basic coverage. The insureds must first cover the cash deductible and the services will be subject to the limitations established in this coverage.

TISSUE AND ORGAN TRANSPLANT

The following incise has been eliminated:

MAXIMUM BENEFIT

The Maximum Benefit is $1,000,000 per life, per type of transplant, per insured person. This amount includes all expenses related to the benefits covered in this policy, including but without limiting to, pre and post transplant expenses, administration of Immunosuppressive and any claim related to said benefits.

The following incise has been modified:

- **Re-transplant**

The following incise has been eliminated:

- **Benefit period**- until reaching the maximum benefit of $1,000,000

RIGHT TO APPEAL IN CASES OF ADVERSE DETERMINATIONS

This section has been modified:

- **Adverse Determination** - is a determination that includes a denial, reduction or termination of your coverage or a failure to make a payment for a particular benefit when the adverse determination has been based on:
    - Eligibility to the plan
    - A service not covered by the plan

- Exclusion for a preexisting condition; on an exclusion based on how the injury or illness occurred; or an exclusion from a provider in the provider's network or other limitations on covered services.
- An experimental, investigative, or not medically necessary or appropriate service.

The aforementioned determinations refer to claims of pre and post-service benefits.

A Rescission of Coverage is also considered an adverse determination, as defined below.

- **Rescission of Coverage -** the plan's decision to cancel your contract retroactive to the effective date or another date prior to the cancellation notice, provided that the reason for the determination of termination of coverage is not non-payment of premiums, fraud or false representation that is prohibited by the plan and has been committed intentionally. Cancellations notified in writing thirty (30) days prior to the date of effectiveness.

RIGHT TO APPEAL AN ADVERSE DETERMINATION OF COVERAGE

If you disagree with an adverse determination made by Triple-S Salud regarding a reimbursement application, a request for precertification, the rescission of coverage, or any denial of benefits as described in this policy, you may appeal Triple-S Salud's determination of coverage under the following procedure:

APPEALS PROCEDURE

1. First Internal Level of Appeal

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

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

You must also submit any other written evidence or information regarding your appeal. You must send your appeal request to Triple-S Salud, Customer Service Division, PO BOX 363628, San Juan, PR 00936-3628.

If your case is considered to be Urgent, Triple-S Salud will notify its decision within a period that does not exceed 72 hours, from the date the completed application for appeal was received.

Incomplete applications will not be considered, until they meet the requirements thereof. Urgent appeals means those appeal requests that correspond to services or medical treatment in which the timeframe to complete the regular appeal process (a) may jeopardize the life or the health of the plan member or the ability of a vital organ of the body to function at its maximum capacity,

(b) or by physician's opinion the insured may be under severe pain that can't be handled without medical care or treatment subject to the appeal.

In case of appeals to precertifications, Triple-S Salud must inform their decision within 15 days from the receipt of your appeal request. In other instances, Triple-S Salud must give an answer within 30 days from the receipt of your appeal request. If Triple-S Salud requests additional information, you must provide it within 45 days from the date of the notification. If you do not submit the information requested within this period, Triple-S Salud will make its decision based on the documents that were first submitted. Triple-S Salud may also notify you that your appeal is being considered, but that additional time is needed. In this case, Triple-S Salud will have 15 additional days to give you its determination on your appeal. Once Triple-S Salud notifies you its decision, you have the right to request Triple-S Salud to disclose the names and positions of the officers or consultants that participated in the evaluation of your appeal, as well as an explanation of the criteria on which they based their decision.

2. Second Internal Level of Appeal:

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

With this second request for appeal, you must include a copy of all the documents related to your first appeal, a statement explaining why you believe Triple-S Salud's decision on your first appeal was incorrect and additional evidence to support your allegations.

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

In case of urgent appeals (as defined earlier), Triple-S Salud must respond to your request within 72 hours. In cases of precertification appeals, Triple-S Salud must respond to your second appeal within 15 days from the date it received your appeal. In other cases, Triple-S Salud must respond within 30 days from the date it received your appeal.

3. External Appeal Process:

If you do not agree with the determination made in the second internal level of appeal, you have the right to request an evaluation to the Office of Personnel Management (OPM), within four months from the date you received the notice on adverse determination. You or your authorized representative may submit the request for external evaluation if:

1) Your case determination involves medical judgment (for example: medical need, effectiveness of the treatment received or to be received, level of care, among others). Determinations based on coverage exclusions will not be evaluated by OPM, or

2) Rescission of Coverage, as previously defined.

For your appeal to be considered for evaluation it must include the following: Name and contact information (including address, telephone number and e-mail address, if applicable); Copy of the adverse determination notice; An explanation of why you do not agree with Triple-S' decision; and, must specify if you are requesting an expedite evaluation. You must also include any other document, evidence or additional information to support your claim (for example, letters from the attending physician, invoices, and medical records, among others). If you appoint a representative to act on your behalf (refer to the requirements detailed later in this document) you must include a signed authorization. It is important that you keep copies of all the documents regarding your claim.

You may submit your claim in writing and mail it to the Office of Personnel Management (OPM) at PO Box 791 Washington DC, 20044; by fax to (202) 606-0036 or via e-mail to Disputedclaim@opm.gov. Should you have any questions during the external evaluation process you may call at the toll-free number (877) 549-8152.

Once you submit your request for external evaluation, OPM will assign an examiner to evaluate your case and notify the final determination within 45 days from the date OPM received your request. The external evaluation will be carried out by an Independent Third Party with legal and clinical experts that do not have conflicts of interest with Triple-S Salud. As part of the preliminary evaluation, the examiner will notify Triple-S Salud of your request, will send a copy of the documents submitted and may request additional information if he deems necessary. If the examiner determines that the claim is not eligible for the external appeal process, he will notify you or your authorized representative and Triple-S Salud.

The external evaluation process is not subject to Triple-S Salud's prior determinations. As part of the process, Triple-S Salud has the option to evaluate the request submitted to the external evaluator and reconsider its adverse determination decision. We will send you and OPM a written notice informing our decision to cover or pay the claim in case of a reconsideration favorable to you, and in this way, to terminate the process.

OPM will keep your case file for a period of 6 years and it will be available for evaluation, should you or we request it.

If your case is considered to be urgent, you may submit your request an expedite external evaluation either orally or in writing, when you (a) receive a benefit adverse determination on a medical condition in which the timeframe to complete an expedite internal appeal may jeopardize your life, your health or the ability of your body to function at its maximum, (b) an adverse benefit determination regarding a hospital admission, availability of care, a service or item for which you received services while you are still confined in the facility and you requested an expedite internal appeal.

In urgent care cases, you may begin a request for expedite external evaluation by calling toll-free at (877) 549-8152. In these cases the examiner must provide the final determination as soon as your medical conditions require and never later than 72 hour from the date it received the request. If you have an urgent care situation and you are being treated for this condition, the final determination must be notified within 24 hours. In these cases the examiner can provide the notification orally, but must issue the written notice within 48 hours.
If your case does not comply with the criteria specified in the first paragraph of this section, you have the right to request an investigation of the case to the Federal District Court for Puerto Rico District, under §502(a) of the Employee Retirement Income Security Act (ERISA) or to the

Puerto Rico Insurance Commissioner Office.

It is required that you make use of all the internal appeals procedures previously described before submitting you claim to the Office of Personnel Management (OPM), the Federal District Court or to the Insurance Commissioner Office.

RIGHT TO BE ASSISTED

You have the right to be assisted by the Health Advocate in the appeals processes previously described. The Office of the Health Advocate is located at 1215 Ponce de León, Stop 18, Santurce, PR and you may contact them at (787) 977-0909 (Metro Area) or 1-800-981-0031 (Outside Metro Area).

RIGHT TO APPOINT A REPRESENTATIVE

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

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

The insured or beneficiary is responsible of notifying Triple-S Salud, in writing, if the designation has been revoked before the expiration date.

The insured member will be entitled to the benefits determined, as they are determined as a result of the appeal process.

PRIVACY PRACTICES NOTICE

This section has been modified:

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

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

Our Legal Duties

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

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

We reserve the right to change our privacy practices and the terms of this notice. Before we make a significant change in our privacy practices, we will change this notice and send an updated notice to our active subscribers. **This privacy notice is effective from September 23, 2013 on**.

Organizations Covered by this Notice

TRIPLE-S SALUD, INC.

INTERACTIVE SYSTEMS, INC.

Summary of Privacy Practices

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

- applications and other documents you have provided to obtain a product or insurance service;
- transactions you make with us or our affiliates;
- consumer credit reporting agencies;
- healthcare providers;
- Government health programs

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

Uses and Disclosures of Information

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

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

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

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

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

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

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

Disaster relief or emergency situations

Government Sponsored Benefits Programs

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

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

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

Your Authorization: You may give us a written authorization to disclose your medical information to anyone for any purpose. Activities such as marketing of non-health related products or services or the sale of health information must be authorized by you. The authorization must be signed and dated, mention the entity authorized to provide/receive the information, a brief description of the data to be disclosed and the expiration date, which will not exceed 2 years from the date of signage. You may revoke the authorization in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice.

Family and Friends Involved in Your Care or Payment for Care: To a family member or friend you involve in your health care or payment for your health care, unless you request a restriction. We will disclose only the medical information that is relevant to the person's involvement.
Before we make such a disclosure, we will provide you with an opportunity to object. If you are not present or disabled or in case of emergency we will use our professional judgment to determine whether disclosing your medical information is in your best interest.

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

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

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

Individual Rights

Access: You have the right to examine and receive a copy of your protected health information on enrollment and claims within the limits and exceptions provided by law. You must make a written request.

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

Disclosure Accounting: You have the right to a list of instances after April 14, 2003, in which we disclose your protected health information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

The report will provide the name of the entity to which we disclosed your information, the date and purpose of the disclosure and a brief description of the data disclosed. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to your additional requests. The report only covers the last six (6) years.

Amendment: You have the right to request that we amend your medical information. Your request must be in writing, and it must explain and justify the amendment requested.

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

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

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by alternative means or to alternative locations. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request.

We will accommodate your request if it is reasonable, specifies the alternative means or location for confidential communication, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the subscriber.

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

Notice of security breaches in which your health information may be at risk: You are entitled to be notified by any means if the security breach is the result of not having your

information secured by technologies or methodologies approved by the Department of Health and Human Services.

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

Questions and Complaints

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

If you are concerned that we or any of our business associates may have violated your privacy rights, or you disagree with a decision we made about access to your health information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your medical information, you may complain to us using the contact information at the end of this notice.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services (DHHS) at: Region II, Office of Civil Rights, US Department of Health and Human Services, Jacob Javitz Federal Building, 26 Federal Plaza – Suite 3312, New York, New York, 10278; voice phone: (212) 264-3313; fax (212) 264-3039; TDD (212) 264-2355.

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

Contact Office: **COMPLIANCE AND PRIVACY OFFICE TRIPLE-S SALUD**
Telephone: (787) 277-6686
Fax: (787) 706-4004
E-mail: privacidad@ssspr.com
Address: PO Box 363628, San Juan, PR 00936-3628

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

GENERAL DISPOSITIONS

The following incise has been modified:

- **INDIVIDUAL CANCELLATION:** Triple-S Salud may cancel the insurance of any plan member at any time if the insured commits fraud or makes material misrepresentation, has submitted or caused someone to submit a fraudulent claim or false information supporting said fraudulent claim in order to obtain payment of such claim, according to the terms of any Triple-S Salud policy; regardless of the date in which the act was committed or the date and the manner in which the action was discovered or, when the insured began to show signs of a fraudulent utilization pattern of the benefits provided under the policy. The retroactive cancellation or termination of the policy will be notified to the plan member through a written notice delivered in person or mailed to the person's last known address in Triple-S Salud files. The cancellation or termination of the policy will be effective within 30 days following the date of the cancellation or termination notice.

Triple-S Salud will provide the insured with a certification of coverage as required by HIPAA. If the insured does not receive a certification of coverage he/she may obtain one by calling our Customer Services Department at 787-774-6060.

- **CONVERSION CLAUSE**

  The following incises have been modified or added:

  - The Direct Payment Policy should also cover the insured employee's spouse or direct dependent if they were covered on the date of termination of the group insurance. At Triple-S Salud option, a separate Direct Payment Policy may be issued to cover the spouse or direct dependent.
  - the spouse or direct dependent of the insured whose coverage under the group policy ceases because of the death of that person.
  - the spouse or direct dependent of the person whose coverage ceases because they do not qualify as family members under the group policy even though the insured continues to be covered under the group policy.
  - If a person insured under the group policy loses coverage under the Direct Payment Policy described in clause 1 of this section, while he/she qualifies for the Direct Payment Policy issued, but before the Direct Payment Policy is in effect, the benefits for which he/she would be eligible under such policy, will be payable by claim against the group policy although a Direct Payment Policy has not been requested nor payment of the first premium been effected.
  - If the person whose group insurance terminates is interested in another individual coverage not specified in this clause, he or she may fill out the enrollment form for the policy, but the eligibility to this coverage will be subject to evidence of insurability.

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

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

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

  c. If the mother and newborn are discharged in a shorter period of time to the provisions of paragraph (a) of this article but in accordance with subsection (b), the cover will provide for a follow-up visit within forty-eight (48) hours following. Services will include, but are not limited, to the assistance and physical care for the benefit of the minor, education on care of the child for both parents, assistance and training on lactation, guidance on in-home support and the realization of any treatment and medical tests for both the infant and mother.

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

e. In addition, the law does not allow the requirement of Precertification for those hospital stays within the scope of the law provisions. Nevertheless, the law permits the requirement of a Precertification to use some providers or to reduce payments in which the insured might need to incur. Triple-S Salud will not request this Precertification.

DEFINITIONS

BASIC COVERAGE

The following definitions has been incorporated or modified:

- **FAMILY CONTRACT:**

  a. It means the insurance that provides benefits to any eligible employees and his/her direct dependents, as defined in clause 18 of this Section. The corresponding premium for family contracts will apply in these cases.

  b. If there is not an eligible spouse, as defined in clause 18, the insured employee's contract with 1 or more eligible direct dependents may, at his/her option, be considered a Family Contract or an Individual Contract with 1 or more direct dependents, as defined in clause 18 of this section. The insured employee may choose among both alternatives the one with the lower total premium.

  Dependents may only be included at the moment the policy is acquired or on the policy renewal date, except as provided in the Changes or Special Enrollment Sections of this policy, or if otherwise provided in any other provision of the Law.

- **INDIVIDUAL CONTRACT:** Means the insurance that provides the benefits to any single or married eligible employee, which does not include the spouse as an insured, as defined in clause 18, Direct Dependent. The corresponding premium for individual contracts will apply in these cases. This employee will have the option of including under his/her insurance plan any direct dependent as defined in clause 18 of this section, by paying the corresponding additional premium.

  Dependents may only be included at the moment the policy is acquired or on the policy renewal date, except as provided in the Changes or Special Enrollment Sections of this policy, or if otherwise provided in any other provision of the Law.

- **DIRECT DEPENDENTS:** The following are considered direct dependents:

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

  b. Natural or adopted children of the insured employee or his/her spouse, as defined in clause 17a, until they reach 26 years of age, except those who are working and are eligible to their employer's health plan. The insured employee's children-in-law, grandchildren or the children of the spouses of the policyholder's children are not eligible dependents under this plan.

c. Minors placed in the insured employee's house during the adoption process. The insured employee must include the adoption papers with the corresponding documentation requested by Triple-S Salud.

d. A non-emancipated minor that is a grandchild or blood relative of the insured employee, will be eligible as a direct dependent, if the permanent custody of the child was granted to the insured employee by court order through a firm and final decision; said direct dependent may remain in the plan until he/she reaches 26 years of age. A grandchild or blood relative of the insured employee that is of legal age, will also be eligible as a direct dependent, if such person is declared handicapped by a court with jurisdiction through a firm and final decision and the custody of this person was granted to the insured employee. In both cases, the main policyholder that would want to subscribe a grandchild or blood relative as a direct dependent under this clause, must evidence his/her custodial rights by presenting a Final Decree from Court adjudicating the custody.

e. Foster Children of the insured employee (as defined under Law No. 251 of August 31, 2000) will be considered direct dependents as long as they are totally dependent on the insured employee for their well-being and until they reach 26 years of age. The foster child status must be evidenced with the documentation requested by Triple-S Salud.

- **SPECIAL ENROLLMENT:** Instance in which the employee and his eligible dependents can subscribe to the health plan at any moment during the policy year as the result of a specific qualified event such as marriage, birth, or death, among others.

MAJOR MEDICAL COVERAGE

The following definition has been eliminated:

- **MAXIMUM BENEFIT:** Maximum benefit amount payable during the insured person's lifetime.

CONTACTS

Services Center

The following incise has been modified:

Plaza Carolina Shopping Mall
Second Level
M-F 9am-7pm
Sat. 9am-6pm
Sun 11am-5pm