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

Triple-S Óptimo Reserve Policy
Group Plans

Employer
Policyholder: Petsmart
Sponsor number: SP0003239 (ORV1)
Effective Date: January 1, 2025

Triple-S Salud, Inc., (hereinafter referred to as Triple-S Salud) insures the active employees of the employer named in the group insurance contract and the eligible dependents of such employees, in conformity with the provisions of this policy/certificate, the medical policies and payment policies established by Triple-S Salud, against expenses for medically necessary medical-surgical and hospitalization services rendered while the policy is in force, due to injuries or diseases suffered by the member. This policy is not subject to a risk evaluation: it is issued in consideration of the statements in the group insurance contract and the employer's advance payment of the corresponding premiums, according to the date the employer enrolls in the group health insurance.

This policy is issued to *bona fide* residents of Puerto Rico, whose permanent residence is located within the Area of Service, as defined in this policy, for one (1) year from the date that appears in the group insurance contract. This insurance may be continued in additional, consecutive and equal periods of time through the payment of the corresponding premiums, which will be the responsibility of the employer first, as policyholder, as well as the employee as the health plan member and user, as provided henceforth. All the terms of coverage begin and end at 12:01 a.m., Puerto Rico time.

Triple-S Salud shall not deny, exclude, or limit the benefits of a member because of a preexisting condition, regardless of the age of the member. This policy is not a supplemental policy or contract for the Federal Health Insurance Program for the Elderly (Medicare). Please review the Health Insurance Guide for People with Medicare available through the insurance company.

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

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

Thurman Justice
President of Triple-S Salud

Please keep this document in a safe place. It includes the benefits to which you are entitled as a Triple-S Salud member. For additional coverage contracted by your employer, please refer to any endorsements issued along with this policy for the full information of 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 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 787-792-1370 or** **1-866-215-1999 (toll free)**
Call Center **Business 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)
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 **Clinical Management Programs: asthma, diabetes, heart failure, hypertension, COPD (Chronic Obstructive Pulmonary Disease), prenatal and Smoking Cessation**	**787-706-2552** **TTY users call 787-792-1370 or 1-866-215-1999** Monday to Saturday from 8:00am to 4:30pm (AST) **Fax: 787-774-4824** commercialclinicalmanagement@ssspr.com

Service Centers	
Plaza Las Américas (2nd level entrance - North Parking Lot) Monday to Saturday: 9:00 a.m.-6:00 p.m. (AST)	**Plaza Carolina** (Second level, next to the Post Office) Monday to 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 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** Road 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, incluyendo la evidencia de cubierta y la tarjeta del plan en Braille. Usuarios TTY pueden llamar al 787-792-1370 o 1-866-215-1999 (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. Written materials may be available in other formats, including evidence of coverage and ID Card in Braille. TTY users can call our Customer Service Department at 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. On our website, 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. With the Triple-S Salud app, you will be able to: • View your plan ID card and email it to your doctors so you can receive your services even if you do not have your card with you. • See your health plan coverage and benefits. • See the health care services you have received. This way, you can keep a log of the health services you and your family have received. • Find a health care provider near you for your needs. • Have quick access to Triple-S Salud's contact information, such as phone numbers, office locations, and email addresses. Go to: https://salud.grupotriples.com/mi-triple-s/ IMPORTANT: The Mi Triple-S application is only available to insured members of Triple-S Salud's health plans and dependents over 18 years old.
Telexpreso	Automated phone line to help with health plan issues at any time. By calling (787) 774-6060 or 1-800-981-3241 (toll free), you can: • Check their eligibility and that of their dependents • Check a reimbursement status • Obtain guidance for some processes, such as submitting a reimbursement claim, requesting card duplicates, and certifications, among others
Teleconsulta MD®	Virtual interactive consultation with a physician from any place within the Puerto Rico region. Visit our website to access the service through a mobile device or computer. You can consult licensed general practitioners, family physicians, internists, pediatricians, or psychologists during the following hours: Monday to Sunday, from 6:00 a.m. to 10:00 p.m. (AST)

AST- Atlantic Standard Time

IMPORTANT NOTICE FOR PEOPLE WITH MEDICARE
THIS INSURANCE IS NOT MEDICARE SUPPLEMENT INSURANCE

Some of the health care services covered under Medicare may be covered under this policy.

This insurance provides limited benefits if you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance, and it is not a substitute for Medicare Supplement Insurance.

Medicare usually covers most of these expenses.

Medicare pays extended benefits for medically necessary services, regardless of why you need them. These include:

- Hospitalization
- Medical services
- Hospice
- Prescription drugs for outpatients if they are enrolled in Medicare Part D
- Other approved items and services

This policy must pay benefits regardless of any other health benefit coverage you may be entitled to under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** the health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement Insurance, review the Health Insurance Guide for People with Medicare available through the insurance company.
- ✓ To get help understanding your health insurance, please contact the Office of the Insurance Commissioner or the State Health Insurance Assistance Program (SHIP) of Puerto Rico.

ERISA NOTICE FOR PRIVATE SECTOR EMPLOYEES

ERISA Coverage

The federal *Employee Retirement Income Security Act (ERISA*) governs benefits such as pension, health, and disability plans; death benefits; compensation schemes; prepaid plans to obtain legal services; funds for education and training programs; as well as day care centers operated by private employers. The United States Department of Labor oversees compliance with this act.

This act does not require private employers to provide specific benefits to employees, such as health plans. However, ERISA requires that, once the private employer opts to offer such benefits, they should operate according to certain standards designed to protect the interests of the (participating) employees and their dependents.

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

Scope of *ERISA*

ERISA does not cover plans offered by churches or health plans granted by the agencies, corporations, and entities of the Commonwealth of Puerto Rico and its municipalities. It does not cover the plans required and managed by local laws, such as employee compensation under the State Insurance Fund and unemployment benefits.

ERISA Requirements

ERISA generally establishes that benefit plans should be implemented in a fair and financially reasonable manner. The private employers and entities that manage and control the employment benefit plans are required to:

- Manage such funds for the "exclusive benefit" of the plan's participants and members;
- Avoid conflicts of interest when investments and decisions are made regarding the benefits;
- Notify both the government and the participants of certain information regarding the plans; and
- Comply with the specific guidelines that regulate how and when the plan funds should be invested.

Triple-S Salud, as an insurer, does not manage or make decisions, administer, control, invest, or distribute the plan funds used to finance the health plan. Please ask your employer for the SPD for more information.

Each plan should notify its participants about the due procedures to apply for benefits, and the established standards that should be followed to be able to enjoy such benefits. Such standards may, for example, include criteria to determine if someone is disabled and entitled to receive disability benefits, how soon may an employee retire and be entitled to pension benefits, how soon after paying the plan can an employee receive its benefits, and how soon can a participant file a claim for the health plan's benefits to obtain coverage for an illness or injury. Employers or administrators (such as a disability insurance company or a retirement investment firms) may not make any significant changes to the plan without notifying the participants. Please ask your employer for the SPD for more information on whether these benefits are available.

Benefit Claims

Under ERISA, claims should be addressed within certain regulatory terms. If the health or disability plan denies a benefit, such denial must be done in writing and include the reasons to justify this decision. It should also provide guidance to resubmit the case for a fair revision. We urge you to read the Appeals for Adverse Benefit Determinations section in this policy issued by Triple-S Salud, regarding health plan claims.

For more information about ERISA, you may visit the page of the US Department of Labor at www.dol.gov.

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DEFINITION

1. **9-1-1 SYSTEM:** Response system for public safety emergency calls, through the 9-1-1 number created by virtue of Act No. 144 of December 22, 1994, as amended, known as the “Act for Speedy Attention of Public Safety 9-1-1 Emergency Calls” or “9-1-1 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 harassment towards the victim, which includes following the person with no proper authorization, under circumstances where the victim could reasonably understand that their physical safety is at risk;

    c. Restricting the victim's freedom; or

    d. Knowingly or recklessly causing damage to property with the intent to intimidate or control the victim's behavior.

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:** It means 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**: An employee that renders services to an employer in exchange for wages, salaries, compensation, commissions, bonuses, or any other form of payment, or who is on paid leave of absence, such as vacation, sick leave, or military training, among others, regardless of whether his/her work duties are carried out in or outside the employer’s facilities and whether the employee is considered permanent, full-time, or part-time. Active employees are also those who are temporarily absent from their workplace due to their own health conditions or those of their relatives. An employee will cease to be active when he/she resigns, abandons his/her employment, goes on unpaid leave of absence (save for exceptional circumstances established by law, such as those provided in the benefits offered by the State Insurance Fund Corporation and the *Family Medical Leave Act*), is fired, retires, dies, or when the position is declared vacant by the employer.

6. **ADMISSION:** If a plan member is discharged and needs to be hospitalized again within three (3) days after the date of discharge due to the same diagnosis for which they were initially hospitalized, this will be considered a readmission, and the plan will merge it with the previous hospitalization.

7. **AFFORDABLE COVERAGE:** Coverage whose total premium or contribution amount to the premium does not exceed 9.5% of the employee’s or member’s household income.

8. **AMBULANCE SERVICES**: Transportation services rendered in a vehicle that has been duly certified for such purposes by the Public Service Commission of Puerto Rico and the Puerto Rico Department of Health.

9. **ANNUAL OUT-OF-POCKET MAXIMUM**: Maximum amount determined that the member will pay per policy year. Before reaching the annual maximum out-of-pocket set forth in this policy, the member must pay the deductibles, copayments, or coinsurances for essential medical-hospital care, drugs and dental, if enrolled for coverages, as established in the Table of Copayments and Coinsurance received via plan participating providers. After the member reaches the maximum out-of-pocket established in this policy, the plan will pay 100% of the medical expenses covered by the policy. Services rendered by non-participating providers, payments made by the member for services not covered under this policy, alternative therapy services (Triple-S Natural), eyeglasses or contact lenses (if applicable) and the monthly plan premium paid to Triple-S Salud are not considered eligible expenses to be accumulated towards the maximum out-of-pocket.

10. **ASSIGNMENT OF BENEFITS:** Process through which non-participating physicians, hospitals, and facilities agree to provide the necessary covered services (in Puerto Rico and United States) for insured members, while billing Triple-S Salud for said services based on participating provider rates.

11. **BARIATRIC SURGERY**: A surgical procedure for obesity control, which can be performed via four techniques: gastric bypass, adjustable band, intra-gastric balloon, or sleeve gastrectomy. Triple-S Salud will only cover, as required by law, the gastric bypass, subject to precertification. Adjustable bands, intragastric balloons, and sleeve gastrectomies will not be covered.

12. **BENEFICIARY**: Is the person(s) designated by the insured employee to get the benefit when the insured employee dies.

13. **BLUECARD® *PROGRAM***: The program that offers claims processing for covered services outside the geographic area of Puerto Rico, to be paid based on the fees negotiated by the *Blue Cross* or *Blue Shield* plan in the area.

14. **BLUE CROSS *BLUE SHIELD PLAN***: Independent insurer that, by contract with the Blue Plans Association (*Blue Cross/Blue Shield Association*), obtains the license to belong to the independent plan association and to use its trademarks.

15. **CHRONIC CONDITION:** A long-lasting or permanent condition.

16. **CLINICAL REVIEW CRITERIA:** The documented screening procedures, summaries of decisions, clinical protocols, and practice guidelines used by the health insurance company or insurer to determine the medical necessity and adequacy of the health care service.

17. **COBRA LAW**: Public Law 99-272, Title X, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA*), which requires all employers with twenty (20) or more employees to sponsor group health insurance plans, and to provide their employees and their relatives, in certain situations, with a temporary coverage (referred to as Continued Coverage) when the plan coverage ends.

18. **COINSURANCE**: The percentage of the fee the member has to pay, upon receiving covered services, to participating providers or physicians, or to any other providers, as their contribution for the cost of the services received, as established in this policy and as notified to the participating physician or provider. This amount is not refundable by Triple-S Salud.

19. **COLLATERAL VISITS:** Interviews at the office of a psychiatrist or psychologist (with a Master's or Doctorate degree and current license issued by the Puerto Rico Board of Psychologist Examiners) with the member's immediate family.

20. **COMPENSATION:** Amount of money a member receives for a claim submitted to the health plan for a received covered service.

21. **CONCURRENT REVIEW:** Utilization review conducted during the member's stay at a facility or during the member's treatment at the office of a health care professional or any other place where health care services are provided to members on an inpatient or outpatient basis.

22. **COPAYMENT**: The predetermined fixed amount the member has to pay, upon receiving covered services, to participating providers or physicians or to any other providers, as their contribution to the cost of the services received, as established in the policy and as notified to the participating physician or provider. This amount is not refundable by Triple-S Salud.

23. **COSMETIC SURGERY**: Surgery with the sole purpose of improving the individual appearance, not to restore functionality or to correct deformities. Purely cosmetic surgery does not become reconstructive surgery for psychiatric or psychological reasons.

24. **COVERAGE RESCISSION:** Triple-S Salud may decide to retroactively cancel your contract due to fraud or intentional misrepresentation of a material fact, as prohibited in this plan. This rescission will be notified in writing thirty (30) days in advance, and the member has the right to request a review of this determination.

25. **CREDITABLE COVERAGE:** The health coverage the policyholder has before enrolling in this plan under a group plan, provided that the person has not had substantial coverage interruption. The certification of creditable coverage will be provided:

    a. When the person ceases to be covered by the health plan or acquires coverage according to a provision of the *Consolidated Omnibus Budget Reconciliation Act* of 1986 (COBRA) about continuation;

    b. In the case of members under COBRA, according to a COBRA provision about continuation, when the person ceases to be covered in accordance to said provision; and

    c. When the request is done on behalf of a person, if the request is made up to twenty-four (24) months after the date the coverage ceased, as described in subsections (1) or (2), whichever date is last.

26. **CUSTODIAL CARE**: Personal attention or assistance provided on a permanent basis to someone in his/her daily activities, such as bathing, dressing, eating, getting in and out of bed or chairs, move around, use the bathroom, or prepare meals, and to supervise their nutrition and medications. Custodial care does not require continued oversight from medical personnel.

27. **CUSTOMARY CHARGES**: A charge is customary when it is within the range of charges usually billed for a determined service by most physicians or service providers with similar training and experience within a given area.

28. **DEDUCTIBLE**: The annual cash amount that must be accumulated before becoming entitled to the benefits under this policy.

29. **DENTIST:** An odontologist who is legally authorized to practice the profession of dentist.

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

    a. The spouse (person with whom one is married after complying with the ceremonies and formalities required by law) of the insured employee, included in a Family contract while this policy is in force, provided that the member lives with said spouse.

b. Biological or adopted children of the insured employee or his/her spouse, as previously defined in subsection 30a, until they reach twenty-six (26) years of age. However, eligibility will not be extended to the spouse of the insured employee's child; the children of the insured employee's child, except those included in subsection 30d below; or the children of the insured employee's child's spouse.

c. Minors placed in the primary policyholder's home who are in the process of being adopted by the policyholder. The primary policyholder must provide proof of the placement for adoption along with the documents requested by Triple-S Salud.

d. Non-emancipated minors who are the primary policyholder's grandchild or blood relative will be eligible as direct dependents, as long as the member holds permanent custody of such minor as awarded by a final and firm court judgment; this direct dependent may remain in the plan until he/she reaches twenty-six (26) years of age. Grandchildren and blood relatives of the insured employee, regardless of age, may also be eligible as direct dependents if said person is declared disabled by a firm and final court judgment, and the primary policyholder is awarded guardianship of the disabled person by court. In either case, primary policyholders interested in enrolling a grandchild or relative as a direct dependent under this clause must prove their status as custodians or guardians by submitting the final court judgment awarding them permanent custody or guardianship.

e. The primary policyholder's foster children will be eligible as direct dependents until they reach twenty-six (26) years of age. The primary policyholder may prove the status of foster children by sending Triple-S Salud an affidavit showing the date the relationship with the minor began, a school certificate, or income tax return certificates for the last two years, among other documentary evidence. Foster children will be understood to be minors who, without being the primary policyholder's biological or adoptive children, have lived since childhood under the same roof with the policyholder in a normal father/mother and son/daughter relationship, and are fed by them, as defined in Article 142 of the Civil Code of Puerto Rico.

31. **DISABILITY:** Injury or illness that prevents an employee from performing the regular duties.

32. **DISMEMBERMENT:** Loss of an appendage or loss of vision due to an accident.

33. **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.

34. **EFFECTIVE DATE:** The plan's first day of coverage.

35. **ELIGIBILITY WAITING PERIOD:** The time period a member must wait before becoming eligible for certain benefits under the terms of the health plan. The waiting period should never exceed ninety (90) days.

36. **ELIGIBLE EMPLOYEE**: An employee that works full-time for the minimum amount of hours required by the employer (regular work week of 30 hours or more), or part-time (at least 17.5 hours per regular work week) for an employer, within a goodwill employer-employee relationship not established with the objective of purchasing a health plan. These calculations should include any employees who are absent from work due to a license or lawfully acknowledged right, such as the benefits offered by the State Insurance Fund Corporation or the Family and Medical Leave Act of 1993. The term "eligible employee" does not include temporary employees or independent contractors.

37. **ENROLLMENT PERIOD:** Established period of time for the eligible employee to enroll in an employer-sponsored health plan.

38. **EQUIPMENT, TREATMENT, AND FACILITIES NOT AVAILABLE IN PUERTO RICO**: Treatment in facilities or with medical-hospital equipment not available in Puerto Rico, in the case of members who require these services due to their conditions.

39. **EVIDENCE OF INSURABILITY:** Proof of health condition or occupation of the person eligible for the insurance offered by this policy.

40. **EXPERIMENTAL OR RESEARCH SERVICES**: Medical treatments that:

    a. are considered experimental or investigative under the criteria of the *Technology Evaluation Center (TEC)* of the *Blue Cross Blue Shield Association* for the specific indications and methods ordered; or

    b. do not have final approval from the corresponding regulatory agencies, such as the Food and Drug Administration (FDA), the Department of Health and Human Services (DHHS), and the Puerto Rico Department of Health; or

    c. have insufficient scientific evidence, according to the available scientific evidence, to arrive at a conclusion about the effect of the treatment or technology on the medical results obtained; or
    d. have insufficient reported positive results to acceptably counterbalance the treatment's negative outcomes; or

    e. are no more beneficial than other already recognized alternative treatments; or

    f. show improvement that cannot be obtained outside the research phase.

41. **FAMILY CONTRACT:**

    a. The insurance that provides benefits for any insured employee, his/her spouse, and his/her direct dependents, as defined in subsection 30 of this section. In these cases, the premium corresponding to the family composition will apply.

    b. If an eligible spouse does not exist as defined in subsection 30, the contract of the insured employee with one (1) or more eligible 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 subsection 30 of this section.

    c. The insured employee may also include optional dependents in his/her Family contract, if applicable and as defined in subsection 80 of this section, provided that he/she pays the corresponding additional premium.

    Dependents may only be included when the policy is acquired or renewed, except as provided in the Changes in Enrollment and Special Enrollment sections of this policy, or as provided by law.

42. **FEES**: The fixed amount Triple-S Salud pays its participating physicians or providers for covered services rendered to members when these are not compensated in any other way.

43. **GENETIC COUNSELING**: Counseling offered by a health care provider who specializes in genetics, regarding genetic disorders that affect or may affect an individual or family. It considers family history, medical history, including diagnosis, probable course of the condition, and available treatment.

44. **GENETIC INFORMATION:** Information about genes, genetic products, and inherited characteristics that could be derived from the person or a family member. This includes information about the carrier's

status and information gleaned from laboratory tests identifying mutations in specific genes or chromosomes, physical examinations, family history, and direct gene or chromosome analyses.

45. **GRIEVANCE:** A written or verbal complaint, if it entails a request for urgent care submitted by a member or on his/her behalf, regarding:

    - The availability, delivery, or quality of health care services, including grievances related to an adverse determination resulting from a utilization review;

    - The payment or handling of claims or reimbursements for health care services; or

    - Issues related to the contractual relationship between the member and the insurer.

46. **GROUP MEDICAL PLAN:** A policy, insurance contract, or certificate, issued by Triple-S Salud, Inc. or an insurer on behalf of an employer or group of employers, to provide health care services to eligible employees and their dependents.

47. **HEALTH INFORMATION**: Information or data, either in oral form or in any other way or means in which:

    a. it is created or received by the insurer or health service organization,

    b. regarding the physical, mental or behavioral health, or the past, present, or future health conditions of the person or his/her dependent; the provision of health services to the person, or the past, present, or future payment for health services provided to a person.

    c. The payment for health care services provided to a person.

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

48. **HEALTH PROFESSIONAL:** A physician or any other professional health care practitioner who is licensed in Puerto Rico and is accredited or certified by the corresponding entities to provide certain health care and medical services in accordance with the corresponding state laws and regulations. These are, but are not limited to, physicians, surgeons, podiatrists, naturopathic doctors, chiropractors, optometrists, audiologists, psychologists, dentists, pharmacists, nurses and medical technologists.

49. **HIGH-RISK CONDITION**: A long-term or short-term condition that leads or may lead to a poor prognosis.

50. **HIPAA (Health Insurance Portability and Accountability Act of 1996):** Federal Public Act No. 104-191 of August 21, 1996): It regulates everything related to portability and continuity of coverage in the group and individual markets, contains provisions to combat fraud and abuse in health coverages and in the provision of health services, as well as the administrative simplification of health plans. This law is applicable in our jurisdiction and supersedes the Puerto Rico Insurance Code.

51. **HOME CARE:** Home assistance or care provided to an individual by a licensed heath care professional or caregiver to help in daily activities, such as bathing, dressing, eating, getting in and out of bed or chairs, move around, use the bathroom, or prepare meals, and to supervise drug use.

52. **HOME HEALTH CARE AGENCY:** An agency or organization that offers a home health care program and:

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

b. Is established and operates in accordance with the applicable laws in the jurisdiction where it is located, and, if a license is required, has been approved by the regulatory authority that is legally responsible for granting such a license, or

c. Meets all of the following requirements:

1. It is an agency that is introduced to the public with the primary objective of providing a system that offers medical assistance and support services at home.
2. It has a full-time administrator.
3. It keeps written records of the services provided to patients.
4. Its staff includes at least one graduate registered nurse (RN).
5. Its employees are bonded, and it provides professional misconduct and malpractice liability insurance.

53. **HOSPICE:** Special care for people who are terminally ill with a life expectancy of 6 months or less.

54. **HOSPITALIZATION PERIOD:** The period of time the member remained hospitalized. This period of time corresponds to the number of days elapsed between the date of admission to the hospital and the date of discharge.

55. **HOSPITALIZATION SERVICES**: Services covered by this policy and received by the member while he/she is admitted as a hospital patient.

56. **HOST BLUE:** Blue Cross Blue Shield Plan in the area where the service is received under the Blue Card program. Host Blues determine a negotiated fee, which is stated in the conditions of each Host Blue contract. The negotiated fee made available to Triple-S Salud by the Host Blue can be represented by one of the following:

a. The real price. The real price is the payment rate in effect at the time the claim is processed, with no other increases or reductions; or

b. Estimated fee or approximate price. The approximate price is the payment fee negotiated and effective at the time a claim is processed, which is then reduced or increased by a percentage to take into account certain payments negotiated with the provider, and other transactions that are related and not related to the claims. Such transactions may include, but are not limited to, fraud and abuse recovery, reimbursements for providers not applied to specific claims, retroactive arrangements, and payments related to performance or incentives, or

c. The average fee or average price: The average price is a percentage of the charges billed for covered services valid at the time a claim is processed, representing the total payments negotiated by the *Host Blue* with all their health care providers, or a similar classification with their providers, and other transactions that are related and unrelated to the claims. Such transactions may include the same as previously stated for an approximate price.

57. **HYPERBARIC OXYGENATION OR HYPERBARIC CHAMBER**: It is the method or treatment where a patient is subjected to an environment containing higher levels of oxygen than the atmosphere or 100% pure oxygen or increased oxygenation. It is the process of compression, high pressure, or over-pressure achieved by increasing the pressure of the breathing air to higher than normal.

58. **ILLNESS**:

a. Any non-occupational disease contracted by any member.

b. Maternity and secondary, pregnancy-related conditions will be considered as diseases for purposes of the coverage offered by this policy, subject to the following conditions:

1) The services are provided to the member regardless of her marital status.

2) Any service provided to induce an abortion for therapeutic purposes.

59. **IMPLANT:** Object, material, or device that is placed within the body to preserve the configuration or provide stability or a temporary or permanent stimulus to a part of the body.

60. **INCURRED EXPENSE:** Amount the member pays for the total cost of a service that was received and not billed to the plan or handled by assignment of benefits.

61. **INDIVIDUAL CONTRACT**: The insurance that provides benefits to any eligible employee, single or married, without including the spouse, as defined in subsection 30, Direct Dependent, as a member. This employee will have the option to include any eligible direct dependent in his/her insurance, as defined in subsection 30 of this section, by paying the corresponding additional premium. He/she may also include optional dependents, if applicable, and as defined in subsection 80 of this section, provided that he/she pays the corresponding additional premium.
Dependents may only be included when the policy is acquired or renewed, except as provided in the Changes in Enrollment and Special Enrollment sections of this policy, or as provided by law.

62. **INJURIES**: Any accidental injury suffered by the member that is not a car- or work-related accident and requires medical treatment and hospital services.

63. **INSURANCE AMOUNT:** Amount of money for which the insured person is covered.

64. **INTENSIVE CARE UNIT**: A separate and clearly designated service area that is reserved for patients who are seriously ill or in critical condition and require constant audiovisual observation, as prescribed by the attending physician. It also provides rooms and nursing care services by nurses whose responsibilities are focused on the care of intensive care patients, as well as special equipment or supplies, which are immediately available at any time, for the patients admitted in this area.

65. **IRO**: *The Independent Review Organization* is an organization authorized to perform independent medical reviews. These reviews will be carried out by an independent physician.

66. **LICENSED PHYSICIAN:** Someone who requests and is granted authorization to practice medicine and surgery in Puerto Rico by previously obtaining a license from the Puerto Rico Board of Medical Licensure and Discipline, in accordance with the provisions of the Law and these Regulations.

67. **MEDICAL EMERGENCY:** A medical or behavioral condition that shows acute symptoms, including intense pain, that are so severe that a prudent layperson of average medical and health knowledge may deduce that a lack of immediate medical attention may seriously threat the health condition of the afflicted person, or would result in a serious impairment of any organ or body member, or regarding members during pregnancy, the health of the member or of the fetus, or in case of a behavioral disorder, would put the health condition of said person or others at serious risk; cause problems in the bodily functions of said person; cause serious impairment of any organ or body part of said person, or serious disfigurement.

For example, an emergency condition may include, but is not limited to, the following conditions:

a. Severe chest pain

b. Serious or multiple injuries

c. Severe respiratory difficulty

d. A sudden change in mental state (e.g., disorientation)

e. Severe bleeding

f. Pain or conditions that require immediate attention, such as a heart attack or suspected acute appendicitis

g. Poisoning

h. Seizures

Emergency services are those that are solely and exclusively provided in an Emergency Room.

68. **MEDICAL NECESSITY:** Anything a prudent and reasonable licensed physician understands as medically necessary regarding any health service and procedure rendered to a patient in order to prevent, diagnose, or treat an illness, injury, condition, disease, or associated symptoms, in a manner:

    a. Consistent with generally accepted standards of medical practice, taking into account the modern communication and educational media;

    b. Clinically adequate in terms of type, frequency, degree, place, and duration of the health services or procedures;

    c. So that the determination of medical necessity is not made merely for the patient's or physician's convenience, or to boost financial profits for the insurance company, the health service organization, other health insurance and health care providers, or the medical treatment providers themselves;

    d. Within the scope of the medical practice and/or specialty of the licensed health professional who determined the medical necessity; and

    e. That such determination for "medical necessity" is based on supporting clinical evidence and is duly documented by the physician who treated the patient.

69. **MEDICALLY NECESSARY SERVICES**: Services that are provided by a participating physician, physician group, or provider to maintain or restore the member's health, and which are determined and provided according to good medical practice standards.

70. ***MEDICARE***: Health Insurance for the Aged and Disabled, Title XVIII of the 1965 amendments to the federal Social Security Act, as established or subsequently amended.

71. **MEMBER:** Anyone who is eligible and enrolled, be it the main policyholder or a dependent (direct or optional), who is entitled to receive the services and benefits covered under this policy.

72. **METABOLIC SYNDROME:** A group of various diseases or risk factors, in a single person, that increases their chance of developing heart disease or diabetes mellitus. Metabolic syndrome patients have at least three of the following risk factors: excessive abdominal fat, high blood pressure (hypertension), abnormal blood fat levels (lipids), cholesterol and triglycerides, and hyperglycemia (high blood sugar levels).

73. **MORBID OBESITY:** Excess of body fat, as determined by a Body Mass Index (BMI) greater than or equal to 35. This condition is part of the metabolic syndrome and is a risk factor for the development of other conditions, such as hypertension, cardiac disease, orthopedic problems, sleep apnea, skin

problems, circulation problems, diabetes mellitus, acidity, psychological problems, anxiety, infertility, and pulmonary embolism, among others. Studies show that it is a condition that may arise from multiple factors, such as genetics, the environment, and psychological causes, among others. This means that it can be caused by excessive nutrition, metabolic disorders, or hereditary factors.

74. **NEW MEDICAL TECHNOLOGY:** New diagnostic and treatment procedures for different diseases which have been approved by the FDA and widely recognized in the medical community and are available in the service area.

75. **NON-COVERED SERVICES**: Services that:

    a. are explicitly excluded in the member's policy;

    b. are an integral part of a covered service;

    c. are provided by a medical specialization that has not been recognized for payment;

    d. are considered experimental or investigative 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.

76. **NON-PARTICIPATING PHYSICIAN OR PROVIDER**: Doctor, hospital, medical group, or provider not actively contracted with Triple-S Salud.

77. **NURSING HOME:** A private residential institution that is equipped to care for people who cannot take care of themselves, such as the elderly or people with chronic illnesses.

78. **NUTRITION SPECIALISTS**: Health professional certified by the governmental entity designated for such purposes, who specializes in food and nutrition.

79. **OPTIONAL DEPENDENTS**: Immediate relatives of the insured employee, or his/her spouse, who do not qualify as direct dependents, are substantially dependent on said employee for their sustenance, and have not reached sixty-five (65) years of age. The insured employee shall be responsible for demonstrating the eligibility of such dependents. If it is allowed to enroll these dependents, anyone who does not qualify as a direct dependent within a family contract may qualify as an optional dependent if he/she is disabled and the insured employee submits or holds final award of custody, parental authority, or guardianship.

80. **ORTHOPEDIC DEVICES**: Devices used after a surgical or mechanical correction of general deviations, malformations, or fractures.

81. **ORTHOTIC DEVICES**: External attachments that restrict, impede, or redirect the movement of a weak or diseased body part, such as clamps, *corsets*, splints, casts for ligament injuries, etc.

82. **OUTPATIENT SERVICES**: Services covered by this policy and received by the member while he/she is not admitted as a hospital patient.

83. **OUTPATIENT SURGERY CENTER**: a specialized establishment:

    a. That is regulated by law and has been licensed by the regulatory authority in charge of issuing such licenses as per the law in the jurisdiction where it is located; or

    b. That is not regulated by law, but meets the following requirements:

1) It is established, equipped, and managed, according to the applicable laws in the jurisdiction where it is located, mainly for the purpose of carrying out surgical procedures.

2) It operates under the supervision of a licensed medical doctor (*MD*) who works full-time in such oversight tasks and allows surgical procedures to be carried out only by qualified physicians who, at the time of the procedure, also carry out such procedures in at least one other hospital in the area.

3) It always requires, except in cases where only local anesthesia is needed, a licensed anesthesiologist to administer anesthesia and remain throughout the surgical procedure.

4) It provides at least two (2) operating rooms and at least one post-anesthesia recovery room; it is equipped to conduct diagnostic radiography and laboratory tests; and it has the necessary trained personnel and equipment to address foreseeable emergencies, including, but not limited to, a defibrillator, a tracheotomy kit, and a blood bank or blood supplies.

5) It provides the full-time services of one or more graduate registered nurses (*RN)* to assist patients in the operating and recovery rooms.

6) It keeps a written contract with at least one hospital in the area for the immediate admission of patients with complications or who require post-operative hospitalization.

7) It keeps adequate medical records for every patient, which should include an admission diagnosis—comprising a preoperative examination report, medical history, laboratory and/or radiography tests, an operative report, and a discharge summary—for all patients, except those who submit to procedures under local anesthesia.

84. **PARTIAL HOSPITALIZATION**: Services that have been coordinated for the care of patients with mental conditions that require hospital care through daytime or nighttime programs, covering daily periods of less than twenty-four (24) hours.

85. **PARTICIPATING PHYSICIAN OR PROVIDER**: Any physician, hospital, primary care center, diagnostic and treatment center, dentist, laboratory, pharmacy, pre-hospital emergency medical service, or any other individual or entity authorized to provide health care services in Puerto Rico, that provides health care services to Triple-S Salud members under direct contract with Triple-S Salud, or through a third party.

86. **PERSON WITH AUTISM SPECTRUM DISORDER:** Someone who exhibits all or some of the symptoms associated with this disorder and who has been diagnosed by a medical practitioner or health care professional.

87. **PERSONAL REPRESENTATIVE:** It means**:**

a. A person authorized in writing by the covered or insured person to represented them;

b. a person authorized by law to consent in the member's absence;

c. an immediate relative of the member, or the member's attending health care professional, if the member is unable to provide consent;

d. a healthcare professional, if the member's health insurance requires that a healthcare professional request the benefit; or

e. in case of an urgent care request, a healthcare professional that has knowledge about the member's medical condition.

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

89. **POLICYHOLDER:** This is the person who holds the insurance contract or policy with Triple-S Salud, who in the case of this policy is the employer.

90. **PREAUTHORIZATION:** Process to obtain the insurer's or health insurance company's prior approval, as required by the health plan terms of coverage, to dispense a prescription drug.

91. **PRECERTIFICATION**: The prior authorization issued by Triple-S Salud to pay for any of the benefits and coverage under this policy and its endorsements. Some of the objectives of the precertification are: to assess if the service is medically necessary, to evaluate the suitability of the place of service, and to verify the member's eligibility for the requested service and whether the service is available in Puerto Rico. Precertifications are evaluated based on the precertification policies established by Triple-S Salud from time to time.

    Triple-S Salud will not be responsible for the payment of such services if they are provided or received without such authorization by Triple-S Salud.

92. **PREEXISTING CONDITION:** A condition, regardless of the cause, for which treatment was recommended or a diagnosis, care or treatment was received for six (6) months immediately prior to the date of enrollment in the health plan. This policy does not exclude or discriminate against members for preexisting conditions, regardless of the age of the member.

93. **PREMIUM:** The specific amount of money paid to an insurer, in this case Triple-S Salud, as a condition for eligible employees to receive health plan benefits.

94. **PREVIOUS OR CURRENT QUALIFYING COVERAGE**: 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 government-funded program.

    b. A group health plan issued by a health insurance company or insurer, a prepaid hospitalization plan, or a medical service or health plan from the Auxilio Mutuo association, that provides benefits that are similar or exceed the ones offered by the basic health plan, provided that the coverage has been valid for at least one year.

    c. A health plan paid by the employer through a self-insurance arrangement that provides benefits that are similar or exceed the ones offered by the basic health plan, provided that the coverage has been valid for at least the last twelve (12) consecutive months, if:
        - The employer opted for a participating health plan in the Health Plan Insurers Association; and
        - The employer met the requirements to participate in the Health Plan Insurers Association operational plan.

    d. An individual or bona fide association health plan that includes coverage provided by a health insurance company or insurer, or from the Auxilio Mutuo association, that provides benefits that are similar or exceed the ones offered by the basic health plan with silver-level coverage, provided that the coverage has been valid for at least the last twelve (12) consecutive months; or

    e. The state coverage provided by a Health Plan for the Uninsurable, if the coverage has been valid for at least one year.

95. **PRIMARY CARE PHYSICIAN:** Doctor who meets the state requirements to practice medicine and is prepared to provide routine and preventive care, as well as basic medical services to treat an illness or injury. Provides health care to the insured member. The primary care physician may be a generalist, a family physician, a pediatrician, an internist, or a gynecologist. According to Law No. 79-2020, Triple-S Salud may allow cancer patients to consider an oncologist as their primary care physician, provided that the oncologist provides their consent. This plan does not require to choose a primary care physician.

96. **PRIMARY POLICYHOLDER:** Person who maintains an insurance contract with Triple-S Salud, which entitles him/her to the benefits established in the policy issued to his/her name, and assumes the responsibilities established in the policy.

97. **PROSPECTIVE REVIEW:** Utilization review before the health care service or treatment is provided to the patient, according to the insurer's requirements to approve such service or treatment, in part or in its entirety, before it is rendered.

98. **PROSTHESIS**: Artificial replacement for a dysfunctional body part, manufactured and adapted to the individual measurements and needs of the recipient in order to provide functionality and/or mobility. It may substitute a non-functioning or absent body part.

99. **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 mode of therapy used to treat people who have chronic life problems, on a scale from mild to moderate. Psychoanalysis should not be used as synonym for psychotherapy, as they do not pursue the same end. This service is not covered in this policy, as established in the Basic Coverage Exclusions Section.

100. **PSYCHOLOGICAL ASSESSMENT**: An initial interview to obtain the member's personal and clinical history, as well as a description of his/her symptoms and problems. The psychological evaluation must be performed by a Psychologist with a Master's or Doctoral Degree in Psychology, graduated from a duly accredited graduate program, and with a valid license issued by the Puerto Rico Board of Psychologist Examiners.

101. **PSYCHOLOGICAL TESTS**: The use of tools designed to measure an individual's intellectual skills or ability to master particular areas. The psychological tests to be used in each case will be subject to the professional judgment of a psychologist with a Master's or Doctorate degree, with the knowledge to administer, correct, and interpret them, graduated from a duly accredited graduate program, and with a current license issued by the Puerto Rico Board of Psychologist Examiners.

102. **PSYCHOLOGIST**: Professional with a masters or doctorate degree from an accredited university, college, or center, who has been authorized by the Puerto Rico Board of Psychologist Examiners to practice psychology in the Commonwealth of Puerto Rico.

103. **PSYCHOTHERAPY**: Methods used to treat mental and emotional disorders through psychological techniques rather than physical methods. Some of the goals in psychotherapy are to change maladaptive behavioral models, improve interpersonal relationships, resolve internal conflicts that cause personal suffering, modify inaccurate ideas about the self and the environment, and promote a defined sense of self identity that encourages individual development to achieve a pure and meaningful existence.

104. **REASONABLE CHARGES:** 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 management for this particular case.

105. **RECONSTRUCTIVE SURGERY:** Surgery that is performed on abnormal bodily structures with the intention of improving deficiencies in functionality or appearance arising from congenital defects, diseases, or trauma.

106. **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, coordinated and supervised by an interdisciplinary team within 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).

107. **RETROSPECTIVE REVIEW:** Review of a benefit request that is conducted after the health care service has been provided. It does not include claim reviews that are only meant to evaluate documentation accuracy or correct code usage.

108. **SECONDARY CONDITIONS:** A medical condition that is directly caused by an existing medical condition, and not on its own.

109. **SERVICE AREA**: The area within which the member is expected to receive most medical-hospital services. In this policy, service area means Puerto Rico, because the benefits provided in this policy are available only to those who permanently reside in Puerto Rico.

110. **SESSIONS:** Two or more types of physical or respiratory therapy treatment.

111. **SKILLED NURSING FACILITY (SNF)**:

    a. A Skilled Nursing Facility, as defined by *Medicare*, that it is qualified to participate and is eligible to receive payments in accordance with *Medicare* provisions; or

    b. An institution that meets the following conditions:

        1) It is directed in accordance with the applicable laws of the jurisdiction where it is located.

        2) It is supervised by a licensed physician or registered nurse (*RN*) who is dedicated full-time to such supervision.

        3) It regularly provides rooms, meals, and continuous skilled nursing services, 24 hours a day, to sick and injured people during the convalescence phase for an injury or illness.

        4) Keeps medical records for every patient under the assistance of a duly qualified physician.

        5) It is authorized to administer medications and treatment to patients as per the instructions of a duly qualified physician.

        6) It is not, other than incidentally, a site for the elderly, blind, or deaf, a hotel, a house for home care, a maternity home, or an institution for alcoholics, drug addicts, or the mentally ill.

        7) It is not a hospital.

112. **SPECIAL CONDITIONS:** A low-prevalence or rare condition.

113. **SPECIAL ENROLLMENT:** Cases when the employee and his/her eligible dependents may enroll in the health plan at any moment due to a specific qualified event, such as loss of eligibility under another group plan, marriage, and birth, among others.

114. **SPECIALIZED NURSES:** Nurses dedicated to the specialized care of a specific population of patients (i.e. nurse anesthetists).

115. **SPORTS MEDICINE**: Branch of medicine that deals with the conditions and injuries arising from sports activities, including any preventive and preparatory care needed to stay in good physical and mental shape.

116. **SPOUSE**: Person of the same or a different gender to whom the primary policyholder is legally married.

117. **SUBMITTED CHARGE:** Amount billed by a physician or provider for a service rendered to the insured person.

118. **SUBSTANTIAL INTERRUPTION OF COVERAGE**: A period of sixty-three (63) consecutive days during which the person has had no creditable coverage. The waiting and enrollment periods are not taken into account to calculate this term.

119. **SURGICAL ASSISTANCE:** When a licensed physician actively assists a primary surgeon in the performance of a covered surgical procedure, which, due to its complexity, requires such assistance.

120. **TELECONSULTA**: Triple-S Salud service where the member, at his/her option, may receive guidance about their health-related concerns. This telephone line is staffed by nursing professionals, seven (7) days a week, twenty-four (24) hours a day. If a member calls and is advised to go to the emergency room, he/she will be assigned a registration number that must be presented in order to receive the service. In case of illness, upon presenting this number at the emergency room, the member may obtain a lower copayment for the use of the facilities. The phone number to call Teleconsulta is located on the back of the member's Triple-S Salud identification card.

121. **TELECONSULTA MD ®:** Interactive virtual service rendered via smartphone or computer, where the member can hold a medical consultation with a generalist, internist, family physician, pediatrician, or psychologist certified to practice telemedicine, pursuant to Act No. 168 of March 13, 2018.

122. **TELEMEDICINE:** It is a long-distance practice of medicine that integrates diagnosis, treatment, and medical education through the use of technological resources to optimize health care services. These include, but are not limited to, services that are complementary and expedited to the care of a general practitioner or specialist; immediate diagnosis by a specialist physician in a given area or region; digital record services for X-rays, ultrasounds, medical emergencies, and others; in accordance with Law No. 168 of 2018 and Law No. 68 of July 16, 2020.

123. **TRANSPLANT**: A procedure or series of procedures where an organ or tissue is:

    a. removed from the body of one person, the donor, and implanted in the body of another person, the recipient; or

    b. removed from and implanted in the same individual's body.

124. **TREATMENT PLAN**: A detailed report of the procedures recommended by the physician to treat the patient's medical needs, which are detected during the physical examination done by the same physician.

125. **URGENT:** A sudden illness that does not threaten the life or the integrity of a person and may be treated in a physician's office or extended hours clinic, and not necessarily in an emergency room, but if it is not properly treated at the appropriate time, may become an emergency.

126. **URGENT CARE:** Care services for an illness, injury, or condition that is serious enough so that a person may reasonably seek immediate medical care, but not so serious to warrant a visit to the emergency room. Urgent care is usually available during extended hours, including weekends and evenings.

127. **URGENT CARE REQUEST:**

    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 requested healthcare service or treatment.

    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 lay person with average knowledge of healthcare and medicine. If a physician with knowledge about the member's health condition decides to submit an urgent care request under subsection (1), the health insurance company or insurer will treat such request as an urgent care case.

128. **USUAL CHARGES:** The usual charge is the most frequent charge physicians or service providers make to patients for a determined service.

129. **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.

ELEGIBILITY

WHO IS ELIGIBLE?

All active employees and their dependents are eligible for the insurance offered by this policy. Triple-S Salud may verify the member's eligibility to meet the necessary requirements to obtain the benefits this policy provides. All active employees and their spouses who are over sixty-five (65) years old and enrolled in both Parts of the Medicare Program may obtain insurance through the benefits of this policy.

EFFECTIVE DATE

Employees and their eligible dependents will be insured as of the policy's effective date if the employee's individual insurance application including said eligible dependents, if any, also includes any other document related to the contract, which should be provided by Triple-S Salud via the employer's personnel officer or Benefits Administrator. After this date, the employee may not enroll in the insurance until the next renewal date for this policy or if a special enrollment event comes up.

Any new employees whose date of eligibility for this insurance is later than the date of this policy will have an eligibility waiting period of no more than 90 days after the date they begin working for the employer. The insurance application should include the corresponding document that confirms the employees date of eligibility. The insurance in such cases will be effective immediately on the day after the waiting period. If there is no insurance application, the employee may enroll in the insurance on the next renewal date for this policy or if a special enrollment event comes up.

CHANGES IN ENROLLMENT

After the end of the enrollment period, the employee cannot cancel at any time during the policy period, except in case of termination of employment unless they believe the existing coverage under the eligible employer group plan is not affordable or if they are notified that their coverage does not provide a minimum actuarial value (60%) for the next renewal. Additionally, changes may not be made to their insurance, and the employer may not request them, unless such changes are necessary for any of the following reasons:

1. Death of any plan member: 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. The insured employee gets divorced: If the insured employee gets divorced 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 divorce, which must be proved with the Divorce Decree and its corresponding Notification. The change will be effective the first day of the month after the month when the Divorce Decree was notified by the Court.

3. A son/daughter, grandson/granddaughter, blood relative, or foster child, as per the definition for direct dependent in this policy, is no longer eligible as a direct dependent of the insured employee:
    a. If the direct dependents mentioned in this subsection reach the age of twenty-six (26) years, the birthday date shall be considered the date of change for the cancellation of coverage, except in the case of disabled dependents, as established in the definition for direct dependent. The change shall be effective on the first day of the month after the event.

    b. If a direct dependent enlists in the Armed Forces of the United States, the date of enlistment shall be considered the date the insurance cessation was requested. This change shall be effective on the first day of the month after the event.

4. If an optional dependent stop being eligible, as explained in the definition for optional dependent in this policy, if applicable:
    a. If an insured optional dependent reaches the age of sixty-five (65) years, the birthday date shall be considered the insurance date of cessation. The change shall be effective on the first day of the month after the event.

    b. If an optional dependent enlists in the Armed Forces of the United States, the date of enlistment shall be considered the date the insurance cessation was requested. The change shall be effective on the first day of the month after the event.

All insured employees must fill an enrollment application in its entirety and send it through the employer's personnel officer or Benefits Administrator. The same norm will apply to any change request for the insurance, except changes due to age, which may be done automatically by Triple-S Salud. The employer's personnel officer or Benefits Administrator shall be responsible for promptly forwarding or submitting to Triple-S Salud all received insurance applications or change requests, health plan cards from the members who cancel their insurance, and a certified summary of all new applications and pending changes. Triple-S Salud may verify the member's eligibility to meet the necessary requirements to obtain the benefits this policy provides.

SPECIAL ENROLLMENT

Active employees and their eligible dependents may enroll in this policy at any time if any of the following conditions, terms, and limitations occur:

1. The insured employee gets married: If the insured employee gets married during the term of this policy, he/she may include his/her spouse in his/her insurance, as well as any dependents who become eligible through such marriage, if the change request is submitted to Triple-S Salud within thirty (30) days after the date of the marriage, and it is proved with the Marriage Certificate and evidence that proves the dependents are eligible, as the case may be. In such cases, the insurance shall be effective on the first day of the month after Triple S-Salud receives the request.

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

    a. If the insured employee procreates a biological child, legally adopts a minor, has a minor placed in his/her home to be adopted by the insured employee, or is awarded legal custody or guardianship of a minor, the insured employee may include him/her under this policy. The event must be evidenced with an original Birth Certificate, Court sentence or resolution, or the official document issued by the corresponding agency or governmental authority, as the case may be.

    b. In the case of newborns who are biological children of the insured employee, the plan will cover the newborn as of the moment of birth. If Triple-S Salud does not receive the application to include the dependent in these cases, Triple-S Salud shall cover the newborn under the primary policyholder's health plan, if it is an individual contract, or in the health plan of the insured employee or the insured employee's spouse, if it is a family contract, during the first thirty (30) days after birth, while the enrollment process for the minor is completed.

    c. For minors who have been recently adopted by members, starting from the first of the following dates:

        1. The date the child is placed in the insured employee's home with the purpose of being adopted, and remains in the home under the same conditions as the rest of the dependents, unless the placement is interrupted before legal adoption takes place and the minor is removed from the home where he/she had been placed;

        2. The date an order is issued providing custody of the minor to the insured employee who intends to adopt him/her; or

        3. The effective date of adoption.

    d. Coverage for newborns, newly adopted minors, or minors put up 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 exclusions based on preexistent conditions.

e. In the case of newborns:

    1. If the payment of a premium or specific subscription charge is required to provide coverage for a newborn, the plan may require the insured employee to notify the birth of the minor, including a request to include the dependent and the original Birth Certificate, and that he/she provide payment for the required fees or premium no later than thirty (30) days from the date of birth.

    2. If the insured employee fails to provide notification or pay the premium, the plan may opt not to continue providing coverage for the dependent minor beyond the 30-day period. However, if the insured employee issued all payments owed no later than four (4) months from the child's date of birth, the child's coverage will be reinstated.

    3. If on the other hand, the plan does not require a premium payment, it may request a notification of birth, but it may not deny or refuse continued coverage if the insured employee does not provide such notice.

f. For newly adopted minors or minors placed for adoption, the insurer or health insurance company shall be required to provide reasonable notification to the insured employee about the following:

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

    2. If the insured employee does not provide the notification or payment described in the previous subsection within thirty (30) days, the plan may not treat the adopted minor or minor placed for adoption in a less favorable way than the other dependents, except for newborns, for whom coverage is requested at a later date from the date the dependent became eligible for coverage.

g. If the insured employee has a family contract and the event of adoption or placement for adoption does not involve the payment of additional premium, the insured employee must notify the plan about the event within thirty (30) days from the date of adoption or placement for adoption, and submit the corresponding evidence to prove the eligibility of the minor, the compliance of the submitted documents with all legal requirements, and the consequent issuance of the health plan card for the minor.

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

3. Special enrollment due to loss of eligibility under another group plan, or due to the termination of employer contributions to cover the premium of another health group plan

    Active employees and their direct dependents may enroll in this policy during special enrollment periods if any of the following events occur:

    a. In cases where, during the time open enrollment periods, the active employee did not enroll in the health plan of his/her current employer or failed to enroll an eligible dependent, because at that time he/she was a participant in another health plan or extended coverage under COBRA from his/her former employer.

b. Because the former employer used to contribute to the premiums of the health plan the employee had up until then, and completely ceased to contribute as an employer to such health plan.

c. The other health plan the active employee used to have finished according to the health plan's eligibility requirements, which include separation, divorce, death, employment termination, or reduction in working hours.

d. In the case of birth, adoption, or awarded custody or guardianship of a minor, the dependent may be enrolled in the health plan. Please refer to subsection 2 of this Section to see the applicable rules and effective dates for these cases.

e. In the case of marriage, if the employee and his/her dependent were not initially enrolled in the health plan, they may enroll during this special enrollment period.

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

g. The previous policy has not been canceled by lack of payment or fraud by the member.

h. If the person lost eligibility to the Puerto Rico Government Health Plan.

In all of these cases, both the active employee and his/her eligible dependent are entitled to special enrollment to this policy as of 30 days from the date the event happened. To be able to use this special enrollment benefit, the loss of eligibility under another plan should not have happened due to a default on the premiums or a unilateral decision from the other plan to terminate due to fraud.

This special enrollment period benefits both the active employee and his/her eligible dependents, who will have to meet the eligibility requirements contained in the terms of this policy when applying for enrollment. In such cases, the employee shall be responsible for submitting, along with the enrollment application, the letter of cancellation or insurability issued by the other plan or insurance, as provided by law.

4. If an insured employee or one of their eligible dependents fails to enroll in the employer's health plan during the enrollment period because they were participating in Medicaid or the *Children's Health Insurance Program* (CHIP) and have subsequently lost their eligibility for either of these programs or becomes eligible for a premium subsidy under either of these programs. In such cases, the insured employee and his/her eligible dependents shall be entitled to special enrollment and may apply for the employer's health plan within 60 days after any of the aforementioned events.

If a (non-custodial) primary policyholder with minor children listed as dependents in the policy or a member of legal age but listed as eligible dependent in the policy requests that compensation be paid directly to them because they paid for the covered medical services being claimed, Triple-S Salud may issue direct payment to the non-custodial parent or member.

HOW YOUR PLAN WORKS

Your coverage under this policy / certificate

Your employer (the "Policyholder") has acquired a policy from Triple-S Salud and holds a contract with Triple-S Salud. You, as an employee, and your dependents are entitled to the benefits described in this Policy/Certificate.

The benefits provided by this policy are included within the general classifications below. 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 provided by this basic policy do not have a cumulative effect and are not subject to waiting periods.

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

Free Choice Plan

You, as a Triple-S Salud member, are enrolled in a Free Choice plan. This means you may freely access your medical care within the Triple-S Salud Participants and Providers Network, without the need for a referral from a primary care physician or any other physician.

However, we recommend that you always select a primary care physician to coordinate your services with other providers. Your physician will help you identify the medical care you need to coordinate with other medical specialists and providers of the Triple-S Salud Participants and Providers Network who are part of the Directory.

The Triple-S Salud plan also has certain rules you should follow to ensure your services are covered, such as: visiting certain providers to receive specific services, obtaining a precertification for services before receiving them, using the Drug List, if applicable, among other rules.

Medically Necessary Services

Triple-S Salud covers the benefits described in this policy, provided they are medically necessary. Medically necessary services are services that are provided by a participating physician, group of physicians, or provider to maintain or restore the member's health, and that are determined and provided according to good medical practice standards.

Please refer to the section Appeals for Adverse Benefit Determinations to learn more about your right to appeal an adverse benefit determination for a service deemed not medically necessary.

Medical-Surgical Services During Hospitalization

Triple-S Salud promises to pay, based on the fees established for such purposes, for the services covered in this policy, that are provided to the member during periods of hospitalization. We will only cover the services of physicians that are normally available at the hospital where the member is hospitalized during any period of hospitalization.

Members under this policy who are hospitalized in semi-private or private hospital rooms will not be required to pay any amount to a participating physician for the services rendered by the physician and covered by this policy. In these cases, Triple-S Salud will pay the medical fees directly to the participating physicians, based on the fees established for such purposes.

Hospitalization Services

If your plan includes the hospital preferred network, participating hospitals in the Triple-S Salud network have been grouped in two classifications based on the level of quality of their hospital facilities. The first classification is the **Preferred Hospitals** network, where you pay a lower admission copayment. The second classification is the **Non-Preferred Hospitals** network, which includes the rest of the contracted hospitals and where you pay a higher admission copayment. To verify which hospitals are preferred and non-preferred, please read the section on Preferred Networks in the Triple-S Salud Participants and Providers Directory. To find out if your plan includes the preferred hospital network, please see the Table of Copayments and Coinsurance at the end of the policy.

If a member insured under this plan needs to be hospitalized due to an injury or illness, they will be required to pay the hospital, upon admission, the copayment or coinsurance established for admission. The member will also be responsible for paying any other services provided during hospitalization that require copayments or coinsurance, as defined in this policy. Copayments and coinsurance are non-refundable.

To calculate a hospitalization period, the admission day is counted, but the day the patient is discharged by the attending physician does not count. Triple-S Salud is not responsible for services received by any member if he/she stays in the hospital after being discharged by the attending physician. Triple-S Salud is not responsible for any day(s) in which the patient is authorized to leave the hospital during the same hospitalization period.

Our Participating Provider Network

We hold contracts with physicians, facilities and providers all over the Island to provide services to our members. It is essential that you know and are able to access our Provider and Participant Directory at all times.

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

- Check the available Provider and Participant Directory for your Triple-S Salud Network.
- Visit our website at: www.ssspr.com.
- Access our Triple-S Salud **mobile application** for smartphones (Android and Apple). You may access the Provider Directory after completing the registration process.
- If you have any questions about a specific provider, please call Customer Service at the number listed on the back of the member identification card.

Preferred Networks for Outpatient Facilities

Your policy may include Preferred Networks for medical visits, clinical laboratories, X-rays, radiology and imaging outpatient services. This means that if you visit participating providers from these Preferred Networks, as follows:

- SALUS Clinics: The Salus Clinics network offers lower copayments and/or coinsurance than any other contracted provider. Some of the services you may access at a reduced cost are medical visits and X-rays. You may visit other physicians within the Triple-S Salud participating provider network for a higher copayment.

- Selective Networks: Networks of clinical, radiology, and imaging laboratories.

It is important to check the Triple-S Salud Participants and Providers Directory before you receive services to become familiar with our participating network providers. Please refer to the Table of Copayments and Coinsurance to confirm if the plan you are enrolled in includes Preferred Networks as part of its coverage.

Special Management Contracts

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

Compensation to Participating Providers

The services provided by participating providers are paid based on the established fee for each service, in accordance with the contract between the participant and Triple-S Salud. When requesting a service, the member is obligated to show the plan identification card that certifies him/her as eligible to receive services from the provider. The card will show the coverage the member is entitled to.

If you need additional information about the fees or rates paid to participating physicians or providers for a specific service, please call Customer Service at the number listed on the back of the member identification card.

Hired Benefits Administrators

Triple-S Salud contracts with other organizations (providers or entities) to provide certain health care services, such as: Pharmacy Benefit Manager for prescription drugs, developing and updating the drug formulary, contracting with pharmacies, processing and paying prescription drug claims; Mental Health Benefits Manager for use, case management; Vision Benefits Manager; and Teleconsulta (health guidance hotline), available 24 hours a day, 7 days a week, 365 days a year, where every medical consultation is handled by highly trained nursing professionals supported by the most advanced technology and you will get answers to your questions about health issues that concern or interest you. To learn more about these organizations and their impact on you, you may contact Customer Service.

You should refer to this policy to check your health plan coverage and whether there are any benefit limits. If you have any questions about your benefits, you may contact Customer Service through any of the service channels listed in the Contacts Section.

Services outside the Contracted Provider Network in Puerto Rico

Any services covered in this policy and provided by non-Triple-S Salud doctors or providers in Puerto Rico will be reimbursed at 100% of the fees contracted with participating providers, minus the corresponding copayment or coinsurance. If the insured member decides to visit or obtain services from a non-participating provider, additional fees may apply as established by the provider. The insured member will be responsible

for the difference between the amount billed by the non-participating provider and the fee established by Triple-S Salud for its participating providers.

Notice and consent to be treated by a non-participating provider in a participating facility

In compliance with the Consolidated Appropriations Act of 2021, when the insured member is seen or receives services from a non-participating provider in a participating facility, the participating facility will be responsible for notifying the member, either via an official written document, printed, or in electronic format (including electronic notifications), based on the options selected by the insured member, that the provider that will render the service is not a participant provider. This notification must also include the costs of providing the service, a list of participating providers that offer the service in the participating facility, and that the insured member may opt to seek service from a participating provider in the facility or at another participating facility with participating providers, in regard to the service. The insured member must give their consent in writing and receive a signed copy of said consent. If the insured member agrees to proceed with the service, they will be responsible for the full cost of the services received from the non-participating provider. If the insured member was not notified in writing, the facility will be liable for the full cost of the services received by the member from the non-participating provider, minus the copayment or coinsurance for the service had it been rendered by a participating provider.

Transition

When a provider abandons the Triple-S Salud Network

If a provider cancels (voluntarily or involuntarily) or the health plan is terminated, the member shall be notified of such cancellation at least 30 days before the effective date of cancellation. If we authorize a provider to offer a covered service, and their status changes to non-participating before the insured member obtains the service, and the member failed to receive the notification at least 30 days prior to the date of the authorized service, the financial liability will be limited to the amount that would have been incurred if the provider had been a participant.

In the case of a cancellation, and subject to the 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.

New members with ongoing treatment

If the member is receiving an ongoing treatment with a non-participating provider when this policy coverage becomes effective, the member may receive covered services for the ongoing treatment with the non-participating provider for a maximum of 60 days, from the effective date of Triple-S Salud coverage.

This course of treatment must be for a life-threatening disease or condition, or a degenerative and debilitating condition or disease. Members may also continue receiving care from a non-participating provider if the member is in her second or third trimester of pregnancy when the coverage of this policy becomes effective. Members may continue receiving health care up until the date of delivery and for any post-partum services directly related to it.

To continue receiving services from a non-participating provider under the aforementioned circumstances, the provider must accept our fees as payment for such services. The provider must also agree to provide the necessary medical information about the member's health care and accept our policies and procedures, including those to ensure the quality of health care, to obtain a precertification and a plan of treatment approved by the Plan. If the provider agrees with these conditions, the member will receive the covered services as if they were provided by a participating provider. The member shall be liable only for copayments and coinsurance applicable to his/her coverage.

After the established period of time, the services received from non-participating providers will be reimbursed based on 100% of the contracted fees with participating providers, minus the corresponding copayment or coinsurance.

Emergency Services

Triple-S Salud covers emergency services to treat an emergency condition at a hospital or an independent emergency room.

Coverage of emergency services to treat an emergency condition will be provided to the member regardless of whether the provider is a participating provider. The plan will only cover medically necessary emergency services and supplies used to treat or stabilize a member's emergency condition at a hospital.

Urgent Care

Urgent care services are covered by the Plan. Our provider network includes urgent care centers where your copay may be lower than it would be at the emergency room. Urgent care centers include the contracted Sanitas Urgent Care Centers in Florida.

The Sanitas Medical Centers are part of our Preferred Provider Network and provide advanced urgent care, including the treatment of illnesses, infections, fever, cold or flu, cuts and wounds, minor sprains or tears, and fractures. These clinics are also equipped to monitor and treat conditions such as asthma, abdominal pain, migraines, and dehydration. The Sanitas Medical Centers' services in Florida are part of our extended coverage in the United States. A $50 copayment applies.

Maximize Your Plan Benefits

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

- Avoid using the emergency room for urgent or routine services instead of emergencies. Visiting the emergency room in such cases could result in higher costs for the health plan and higher disbursements for you, compared to a medical visit. Observe the following examples:

Non-emergency services **You must call your doctor or visit a SALUS Clinic or an urgent care center**	**Emergency** **Visit the closest emergency room or call the 9-1-1 System**
Mild throat pain Earache Mild cuts or scrapes Mild sprains or tears Fever under 103 F° Cold or flu	Broken bones or serious tears / Deep cuts or uncontrolled bleeding / Poisoning / Severe burns / Chest pain or intense and sudden pain / Fever over 103 F° / Coughing or vomiting blood / Sudden dizziness, weakness, loss of coordination or balance, or loss of consciousness / Numbness in the face, arms, or legs / Seizures / Difficulty to breathe / Sudden blurred vision or sudden or unusual headache

Remember: if you feel **ill**, are **injured**, or **need health advice, call Teleconsulta.** Nursing professionals in this volunteer-based service will offer you guidance to help you decide whether you should:

- Make a medical appointment,
- visit an emergency room,
- or follow their instructions to relieve your symptoms in a safe and reliable manner in the comfort of your home.

Visit a general practitioner or primary care physician instead of visiting multiple medical specialists to properly diagnose and treat a condition. A primary care physician may be a generalist, a family physician, a pediatrician, an internist, or a gynecologist. According to Law No. 79-2020, cancer patients may consider an oncologist as their primary care physician, provided that the oncologist provides their consent. Your primary care physician will coordinate the necessary and preventive services according to your age and health condition, as well as any necessary health care services with other medical specialists and providers from the Triple-S Salud network.

Your general practitioner or primary care physician will know all about your health and keep a record of your health condition. Remember that you do not need a referral to receive covered services from any provider in the Triple-S Salud network.

- Use generic medications as your first choice to treat your condition whenever they are available, if you are enrolled in this coverage.
    - A generic medication is a copy of a brand medication whose patent has expired. A patent gives pharmaceutical companies the sole right to sell a medication while it is effective. When a patent expires, companies may sell generic versions of the available brand medication.
    - A generic medication has the same use and works in the same way in the body as brand-name drugs. It has the same active ingredient and it is equal in dosage, safety, and quality, as required by the Food and Drug Administration (FDA).
    - Generic medications can also mean savings for you, since they cost much less than the brand name. In addition, copayments and/or coinsurance for generic medications are usually lower. Please note that, if you are using a brand-name medication for which there is a generic available, you could receive the same benefits at a lower cost.
- Use Over the Counter (OTC) medications with a $0 copayment under the Triple-S Salud program, if you are enrolled in this coverage. The list includes medications for stomach conditions, allergies, and eye drops that have demonstrated to be safe and effective, and also represent lower costs for the health plan. Please remember you need to submit a physician's prescription for the OTC medication.

- Talk with your physician to evaluate the medications that are part of your treatment and are included in our Drug List, if you are enrolled in this coverage. Use preferred drugs, which are cost-effective and already proven to treat conditions. They have also been selected by the Pharmacy and Therapeutics Committee for their effectiveness. Your out-of-pocket expenses will be higher if you use non-preferred medications. Check your coverage description and the Table of Copayments and Coinsurance to see how much is your out-of-pocket copayments and coinsurance.

- Use your preventive service coverage to detect conditions in time.

  Our plan offers all the preventive services required by law at no cost to you. This means you pay nothing out-of-pocket for services such as annual physical exams and preventive gynecological appointments, preventive mammograms, and other tests, vaccinations, and much more. These

are important steps to stay healthy, so you should maximize this benefit to promptly detect any health issues.

- Significantly reduce your out-of-pocket expenses by always using network providers. Triple-S Salud provides a comprehensive provider network in and outside Puerto Rico.
- If you have additional health insurance, notify Triple-S Salud and your other plan to coordinate benefits between both plans. Please refer to the Coordination of Benefits Section for more information on the rules to determine which plan will be primary.

Teleconsulta[1]

Teleconsulta is a voluntary service offering telephone health care guidance, 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 staffed by qualified clinical personnel to offer you help and guidance about your condition. These professionals assess the member's symptoms to determine the most appropriate treatment.

If you feel **ill**, are **injured**, or **need health care advice**, our professional nurses will offer you advice to help you decide whether you should:

- Make a medical appointment,
- visit an emergency room,
- or follow their instructions to relieve your symptoms in a safe and reliable manner in the comfort of your home.

As an added benefit from Teleconsulta, if the nursing professional recommends you "visit an Emergency Room", you will be given a number that will waive or reduce your copayment / coinsurance at the Emergency Room (available only in Puerto Rico.) This does not apply in case of an accident. If a non-participating provider cannot process the number in their system to waive or reduce your copayment/coinsurance, the member will have to pay and then request a reimbursement from Triple-S Salud for the amount that would have been waived or reduced.

Calls to Teleconsulta are **free of charge** through **1-800-255-4375**. Look for the phone number on the back of your Triple-S Salud health insurance card. Remember, when you call ***Teleconsulta,*** have your health insurance card with you.

Service Precertification

There are certain services that require prior approval from Triple-S Salud before the member can receive them. Either the member or the provider is responsible for requesting a service precertification. Please refer to the Sections on Precertifications and Procedures for Precertification to obtain a detailed list of the services that require precertification and the steps the member or provider should follow to obtain precertification from the plan.

Clinical Management

The benefits offered by this Policy are subject to precertifications and concurrent and retrospective reviews to determine when those services should be covered by the plan. The objective of these reviews is to

[1] Teleconsulta is an exclusive Triple-S Salud service for its members.

promote the provision of medical care in a cost-effective way by revising the usage of medical procedures and, as the case may be, the level or provider rendering the service. Covered services must be deemed medically necessary to be covered by the plan.

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 Programs:

• Diabetes
• Hypertension and congestive heart failure
• Asthma
• Obstructive pulmonary disease
• Prenatal - high-risk pregnancies
• Chronic kidney disease

Complex case management:

• Immunological disorders (for example, HIV or AIDS)
• Cerebrovascular diseases
• Cystic fibrosis
• Degenerative diseases (for example, multiple sclerosis, ALS)
• High users
• Organ and tissue transplant, including bone marrow, liver, kidney, heart, lung, and pancreas
• Skin lesions (stage 3 and 4 ulcers)
• Mental illness and substance abuse
• Strokes
• Pulmonary hypertension
• Cancer being treated by continuous chemotherapy (head/neck, gastrointestinal, lung, ovary/uterus, brain, metastasized or terminal)

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 the services and follow-up through phone calls and personal visits.

If you need additional information, please contact us at the phone numbers or emails listed in the Contacts section at the beginning of this policy.

Clinical Management Program

The Clinical Management Program is designed to reach the entire population, as it focuses on identified needs based on the predominance of health conditions in our community. The pertinent interventions are provided to individuals within a given population to reduce health risks and improve the quality of the provided services.
This program is intended to provide comprehensive care in order to improve coordination and cover the healthcare needs of our (adult and pediatric) insured members and their families, and, in turn offer preventive education and service coordination.

The insured can benefit from the Programs through provider referral, self-referral, employer referral, or by being identified through a claims-based chronic condition registry.

This program serves as a specialized support unit whose personnel works in collaboration with the providers to ensure optimal health care.

The Program consists of three levels of interventions with the population, provided by nurses, nutritionists, health educators, clinical clerks, and social workers. Every insured member participating in our clinical programs will have an individualized care plan, and follow-up will be provided until they reach their healthcare goals.

- **Diabetes Program:** This program provides insured members with personalized guidance, through a healthcare professional (nurse) who will identify the member's specific risk factors and needs by conducting a comprehensive condition-related risk assessment. They will educate the member on the use and administration of medications, on the prevention of future complications, reinforcing nutritional habits (if necessary, the member will be referred to a nutrition specialist), physical activity, and the use of a glucometer, among others. This program also helps coordinate services, depending on the member's needs.

- **Asthma Program:** This program is designed to provide guidance to our insured members, motivating them to develop the necessary skills to identify risks and take care of their asthma condition. Members will receive information and guidance regarding their condition through a nurse specializing in respiratory conditions. With the help of clinical management staff, educators, and therapists, members who have asthma can receive information about their condition and the factors that may cause asthma attacks, symptoms, warning signs, and medications, to help establish control strategies. Members will receive guidance on the correct use of inhalers, both for maintenance and emergencies. Assistance is provided in scheduling appointments.

- **Hypertension Program:** Designed for insured members over the age of 18 who suffer from hypertension (high or uncontrolled blood pressure) and may benefit from the educational activities offered by this program. They can learn what hypertension is, its signs or symptoms, lifestyle modification, and how to control blood pressure. The provision of a blood pressure monitor is coordinated, as the benefit may apply, and the member is educated on possible lifestyle changes that may have an effect on their hypertension condition. Assistance is provided in scheduling appointments.

- **Heart Failure Program:** Members who suffer from heart failure (disease that causes the heart to function abnormally when pumping blood to the body). If the condition is severe, they will receive educational materials at home, and our nurse practitioners from the Heart Failure Program will provide guidance for self-care, so they may start feeling better. Members whose condition is not severe will be invited by health educators to attend educational activities. This will help them manage their condition, prevent complications, and improve their quality of life.

- **COPD Program:** Insured members over 40 years of age who have COPD (chronic obstructive pulmonary disease) will receive a guide and an individualized care plan to manage their condition, a medication review, and orientation on their proper use and on how to identify symptoms and signs of complications. The healthcare professional (nurse) will reinforce the importance of medical follow-up. Members will also receive assistance with requests for the necessary equipment to manage their condition. Our professionals will help participants learn about their condition and adopt healthy lifestyles to avoid future complications and enjoy a better quality of life.

- **Contigo Mamá Program:** This program educates members on the importance of early prenatal care and the risk factors to watch out for. During their pregnancy, members will receive educational brochures on how to take care of their pregnancy and their baby. They will also receive orientation phone calls from a clinical manager specialized in prenatal care and additional education at workshops offered by health educators.

- **Smoking Cessation Program:** This is an educational program that offers general information and education about the effects of smoking on your health and the benefits of modifying or eliminating this addiction. It is aimed at people who suffer from chronic conditions and those who want to stop this addiction. The program is free of cost for members, and it is offered by phone. The member will coordinate with the education specialist offering the program to establish a convenient date and time. This program helps participating members in the process of reducing or ceasing their habit, thus helping reduce their health risks. For more information, you can email servpreven@ssspr.com.

- **Contigo Mujer Program:** Educational program focused on comprehensive women's health through activities that promote prevention and wellbeing. Different campaigns and initiatives will be available on a quarterly basis. The campaign themes will be: Women & Health, Beautiful and Healthy, Finances and Health, and Healthy for the Holidays.

If you need additional information or would like to enroll in the program, please contact us at the phone numbers or emails listed in the Contacts section at the beginning of this policy.

Your coverage when you participate in a *Clinical Trial*

Below, we explain what the plan does and does not cover when you participate in a clinical trial.

Please remember this applies if you enroll in a trial or study to treat a life-threatening disease for which there is no effective treatment and obtain your physician's approval to participate in the trial because it offers potential benefits.

Our plan covers:

- The patient's routine medical expenses, according to covered service categories, limits, and other conditions established by the policy. These are expenses for which there is usually available coverage, regardless of whether the patient is participating in a clinical trial. This includes services to diagnose and treat any complications resulting from the trial.

Our plan does not cover:

- Expenses for research studies or clinical trial treatments
- Experimental or research devices or medications administered to be used as part of these trials
- Services or products provided to obtain data and analyses, and not for the direct management of the member
- Items or services free of cost to the member, usually offered by the research sponsor.

Preventive Centers Program

In order to extend the access to preventive services, Triple-S Salud has Preventive Care Centers available to all members insured under the commercial line. The Preventive Care Program provides services to adults over 21 years old. These centers integrate a comprehensive medical evaluation with preventive tests, following the clinical guidelines of the US Preventive Services Task Force. They allow you to perform your annual preventive check-ups in a single place, as well as receive medical advice and the results of your lab tests and screenings at your follow-up visit. Medical check-ups and preventive tests ordered in accordance with the federal reform guidelines and performed at the Preventive Care Centers are free of copayment for insured members. To get a list of our participating Preventive Care Centers, please see the Triple-S Salud Provider and Participant Directory.

If you need more information, you may contact the Department of Clinical Quality Preventive Services Unit at 787-277-6571 or email servpreven@ssspr.com.

Triple-S Natural

Triple-S Natural is a program that lets you receive medical services using a new model of integrative medicine, which incorporates complementary techniques and treatments certified by the United States National Institutes of Health and other renowned international organizations. The member will be responsible for the copayment established for the service, which is shown in the Table of Copayments and Coinsurance at the end of the policy.

The Triple-S Natural Program comprises the various disciplines from conventional and complementary medicine, such as:

- **Conventional primary medicine:** Conventional health care offered by specialists in Family Medicine, Chinese Medicine, and Acupuncture.

- **Integrative and complementary health care:** It is the use of conventional medicine along with therapies, treatments, and therapeutic procedures and approaches based on the scientific method, which are conducive to a person's optimal state of health, even within the limitations posed by a health condition. Its objective is preventing diseases and, if they occur, a coordinated intervention with all of these therapies to reestablish the patient's physical, mental, and spiritual health.

- **Medical acupuncture:** Acupuncture is based on the body's ability to regenerate and heal through stimuli produced by the insertion and manipulation of needles or other instruments at certain points on the skin. These points have been clinically defined for therapeutic purposes.

- **Therapeutic massage:** This type of massage is based on the concept of human beings as a whole, and it sees disease as a rupture in the constant flow of energy, nutrients, and well-being, which ensures a person's optimal state of health. Hands, elbows, and auxiliary instruments are used in a combination of specialized techniques to help activate the flow of blood and energy needed for the patient's recovery.

- **Naturopathic Medicine:** It is the system of care practiced by a Doctor of Naturopathy to prevent, diagnose, and treat health conditions through the use of natural medicine, therapies, and patient education, in order to maintain and stimulate each individual's intrinsic self-healing system.

- **Bioenergetic Medicine *(Pranic Healing):*** Treatment of different health conditions by balancing the vital energy that permeates or inhabits our body. This therapeutic method is based on the principle that the body has a life-giving energy, 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.

- **Traditional Chinese Medicine:** Group of healing techniques and methods that follow the traditional Chinese medicine principles of healing. This healing system has different procedures, like stimulating acupuncture points through different techniques, such as: needles, laser, electricity, heat (moxibustion), massages (acupressure), magnets, bleeding techniques, injections, auriculotherapy, cranial acupuncture, Chinese herbs, Oriental nutrition and food, 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 the feet and hands. This technique is based on using body maps with the traditional Chinese medicine acupuncture points.

- **Clinical Nutrition:** It is the oral or injected administration of food supplements, such as vitamins and minerals, to treat various diseases.

- **Botanical Medicine:** It is the use of plants with medicinal properties, or their derivatives, to treat diseases. These are administered in various ways, such as tea, infusions, capsules, injections, tinctures, 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, such as inhalation, diffusers, compresses, aromatherapy massage, and mud poultices (on specific areas), to improve health and obtain balance between body, mind, and spirit.

- **Music Therapy:** It uses music for therapeutic purposes. Specialization focused on opening communication channels through sound, rhythm, gestures, movement, and silence, at a psychological, physical, and cognitive level. Music therapy has various applications for mental conditions, addictions, depression, and hyper or hypoactivity, among others.

- **Chiropractic care:** It is based on the concept that a human being's vital energy flows through the spinal column, and that any alteration in this energy flow causes pathologies that devolve into disease. The chiropractor uses spinal adjustment techniques to restore the normal flow of energy, up to a total or partial disappearance of the patient's symptoms.

The program is only available through participating facilities in the Program. For a list of the participating providers in the program, please refer to the Triple-S Salud Participants and Providers Directory, visit our website www.ssspr.com, search our mobile application, or call Customer Service.

Tool for Health Risk Assessment (HRA)

The HRA (Health Risk Assessment) tool helps evaluate lifestyles, risk factors, and existing conditions. This tool helps us obtain a clear profile of the insured member population and determine where to direct our health education efforts and prevention strategies. It also helps members perform a self-assessment to know where they are in terms of compliance with their preventive tests and the changes they need to do, while encouraging them to discuss these changes with their primary care physician and thus improve their awareness to prevent future health problems. **Register today on our website www.ssspr.com and complete your questionnaire. Stay active, stay healthy!**

Educational Materials on Our Website

Search for **Our Blog** section on our website, www.ssspr.com, to obtain health and wellness information for our members.

Satisfaction Surveys

The opinion of our members matters.

Triple-S Salud periodically surveys its members to measure their overall satisfaction with the plan and the care provided by our network providers. These studies are conducted with organizations independent from Triple-S Salud. The survey results are used by Triple-S Salud in its continuous efforts to improve the members' overall experience with the health plan, including service experience and quality of care.

For more information and the most recent customer satisfaction survey results, please call Customer Service.

Benefits Not Covered by the Plan

Your physician could recommend medical services, treatments, or medications not covered by your Triple-S Salud policy. If you receive non-emergency services not covered by your Triple-S Salud policy, you will be responsible for paying the provided services or dispensed medications in full.

We recommend that you verify the Exclusions Sections in your policy before receiving the medical service, treatment, or medication, as well as any added endorsement, to verify if it is covered or not. We also recommend you talk with your physician or service provider about the treatment alternatives covered under the plan to reduce your disbursements, or about coverage options under programs with other organizations that may provide you additional help.

Advance Instructions or Directives

Advance directives or statements of intent regarding medical treatment are legal documents that allow any person of legal age (21 years or older) and in full use of their mental faculties to express their decisions in writing about the medical care and treatment they wish to receive in case of a health condition that would not allow them to express themselves during treatment. This document offers you greater control over crucial matters regarding your quality of life, offering family members, friends, and doctors the basic information they need to care for you. Physicians and other health care professionals are legally obliged to follow patient directives. In accordance with the provisions of law, you cannot be denied care or be discriminated based on whether you have signed or not an advance directive.

If a disease disables you from communicating, the decisions regarding your health will be taken by another person, and not always in accordance to what you would have wished.
As per Puerto Rico law, the closest relative of legal age—first of which is the patient's spouse—shall be the one to make the decisions about accepting or rejecting medical treatment. Therefore, it is important to take a few moments to write your advance directives.

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

Informed Decisions About Your Health Care

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

- What is my diagnosis?
- What caused this problem?
- What is the adequate treatment? What are the estimated costs?
- When will I begin my treatment, and how long will it last?
- What are the benefits of this treatment, and how much success does it usually have?
- What are the risks and side effects associated with this treatment?
- Are there any foods, medications, or activities that I should avoid while I am following the treatment plan?
- What medications will I take before, during, and after treatment?

Ask for a cost estimate. After your physician gives you all the details about your condition and treatment alternatives, call Triple-S Salud to confirm how much your disbursement will be to treat 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.

Coverage of Services by Local or Federal Law

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

Preventive screening services, in accordance with the minor's preschool age, required by Act No. 296 of September 1, 2000 are covered by this policy. In accordance with letter No. N-AV-7-8-2001, the Department of Education is responsible for ensuring that every child has received an annual medical evaluation before the beginning of each school year. Said medical evaluation will include physical, mental, and oral health evaluations, ocular and hearing screenings, and other periodical screenings recommended by the American Academy of Pediatrics.

In compliance with Act 97 of May 15, 2018 (Bill of Rights of Persons with Down Syndrome), we cover the required services for members with Down Syndrome, including genetic testing, neurology, immunology, gastroenterology and nutrition, medical visits and tests referred by physicians, as well as therapeutic services with a remedial approach to independent or assisted living for adults over 21 years old; subject to the limitations, copayments, and coinsurances established in the policy.

Vaccines. This policy also covers the vaccines established by the Centers for Medicare & Medicaid Services (CMS), 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 Puerto Rico Department of Health. For specific information about the coverage, please refer to the section on Standard Vaccine Coverage for Minors, Adolescents, and Adults.

In order to comply with Law No. 43 of April 16, 2020 (Law to fight COVID-19), Triple-S Salud will not require any copayment, coinsurance, deductible, precertification, or referral from the member to provide health care, tests, analyses, diagnostics, and treatment related to COVID-19, including hospitalization, as long as these services are provided in Puerto Rico.

Hereditary Angioedema: The diagnosis and treatment of Hereditary Angioedema (HAE) is covered, in accordance with Act No. 62 of April 16, 2024. As provided by law, medications, treatments, therapies, and tests that are not experimental or of genetic modification and scientifically validated as effective and recommended to diagnose and treat this condition, according to the specific needs of the patient without the need for a referral, are covered. The member can also count on the plan's support if they have access problems by calling Triple-S's Customer Service call center for support in coordinating access if no provider can be found.

Protections for Insured Members under Law No. 134 of September 1, 2020

In compliance with Law No. 134 of September 1, 2020, the rights established by this regulation for the insured member, as well as the benefits that are covered under this policy when rendered by non-participating providers are the following:

The services rendered by non-participating physicians and providers in Puerto Rico will be covered through reimbursement, based on 100% of the fees contracted with participants minus the corresponding copayment or coinsurance. If you visit a provider not under contract with us, you will be responsible for the difference between the fee established for participating providers and the amount billed by the provider. Triple-S Natural and the executive exam (if applicable) are only offered through participating providers.

Services rendered by non-participating providers in Puerto Rico in case of an emergency will be paid directly to the provider, after deducting the applicable copayment and/or coinsurance. If you receive emergency services in Puerto Rico, the facility will not bill you in excess of any deductible, copayment, or coinsurance applicable to the services within the participating provider network. Please review the sections Emergency Room/Urgent Care Services, Outpatient Medical-Surgical and Diagnostic Services and How your Plan Works to learn more about the management of the services rendered by non-participating providers in Puerto Rico in case of an emergency.

Triple-S Salud has different relationships with other Blue Cross Blue Shield (BCBS) plans in the United States. If you agree to receive health care services outside the geographical area served by Triple-S Salud, you will receive the service from either of two types of providers: participating providers contracted by another BCBS plan in said geographical area and non-participating providers. Providers that are not BCBS participants may only be covered in case of emergency, and you may be responsible for the difference between the amount billed by the non-participating provider and the payment Triple-S Salud issues for the services. Please review the section Extended Coverage in the Unites States, or the major medical expense coverage, if enrolled for coverage, to learn more about how these services are covered.

Please refer to the Table of Copayments and Coinsurance section to learn more about your payment responsibility when obtaining services covered under this policy.

Before obtaining a service, it is important that you review the Triple-S Salud Provider and Participant Directory by visiting www.ssspr.com, registering in our smartphone mobile app, or by calling 787-774-6060 (toll-free: 1-800-981-3241), Monday through Sunday, from 6:00 a.m. to 10:00 p.m. AST (Atlantic Standard Time), to make sure that the provider is a participant. To learn whether a provider is a Blue Cross Blue Shield participant, visit www.bcbs.com or call 1-800-810-2583. Significantly reduce your out-of-pocket expenses by always using network providers.

You are entitled to:

- Obtain a clear description of the health benefits outside the contracted provider network, including the method used by Triple-S Salud to determine the amount allowed for out-of-network services. Please review Services Outside the Contracted Provider Network in Puerto Rico in the section "How Your Plan Works".

- Obtain information about the amount allowed to be reimbursed by Triple-S Salud and about the insured member's liability to pay the difference between the allowed amount and the charges billed by a provider outside the contracted provider network. Please review Services Outside the Contracted Provider Network in Puerto Rico in the section "How Does Your Plan Work".

- Obtain examples of anticipated costs for frequently billed services outside the contracted provider network. For example, you may get billed more than $140 for a computerized tomography interpretation performed by a radiologist, or you may receive a bill of more than $2,500 for a robot-assisted surgery. These examples are for illustrative purposes, and the amount billed may differ from the amounts presented since the non-participating provider is who determines the cost for the service.

- Obtain information on whether a health or medical care provider is a member of the contracted provider network.

- Access a hotline that will operate at least sixteen (16) hours per day, seven (7) days a week, in order to learn about the status of the participating provider network and the costs.

- Only pay the deductible, copayment, or coinsurance established in your policy for the services rendered by Triple-S Salud's participating providers.

If we authorize a provider to offer a covered service, and their status changes to non-participating before the insured member obtains the service, you will receive a notification as soon as possible. If you failed to receive the notification at least 30 days prior to the date of the authorized service, the financial liability will be limited to the amount that would have been incurred if the provider had been a participant.

Inadvertent and unintended out-of-network charges by a provider that are in a contracted facility are not subject to collection or billing beyond the financial liability incurred under the terms of the in-network service agreement (does not apply if you were notified of the cost and knowingly and voluntarily determined to obtain the service). Any attempt to collect or bill on behalf of the provider must be immediately reported to the Customer Service Department at 787-774-6060. You have the right to contact the Office of the Commissioner of Insurance to report or dispute a charge for a service rendered by a non-participating provider:

Office of the Commissioner of Insurance
Investigations Division
361 Calle Calaf
World Plaza Building
268 Muñoz Rivera Ave.
San Juan, PR 00918
Phone: 787-304-8686
www.ocs.pr.gov

If you decide to visit or receive a service from a non-participating provider, additional charges may apply as established by the provider. You will be responsible for the difference between the fee established for participating providers and the amount billed by the provider as well as any copayment or coinsurance applicable to the service.

You may request the following additional information to understand your plan better and learn more about the company.

- The cost of a specific medical service, treatment, or medication, if you are enrolled in this coverage
- The policies about the specific coverage, treatment, or medication, if you are enrolled in this coverage

- The reason why a medication was not approved in the Drug List, if you are enrolled in this coverage
- Results from the satisfaction surveys conducted by Triple-S Salud
- Coverage for specific benefits, and an explanation of how we determine what will be covered
- A report of how much you have accrued towards your maximum out-of-pocket in the coverage
- A written description of how we pay our network providers, including descriptions and justifications for the provider's compensation
- Programs, including incentives or sanctions to providers in order to control referrals to other specialists or providers
- Financial information about the company
- Copy of adverse benefit determinations and the clinical guidelines used for such determinations
- Status of our accreditations

Acts of Wrongful Discrimination

Wrongful discrimination is:

- Denying, refusing to issue, renew or reissue, cancelling or otherwise terminating a health plan, increasing its premium, or adding a surcharge based on the member's status as abuse victim; or

- Excluding, limiting coverage, or denying a claim based on the member's status as abuse victim;

Discriminatory acts include requesting information about acts of abuse or a current or potential member's status as abuse victim, or using this information, however obtained, except for the limited purposes of complying with legal obligations or verifying a person's claim to be a victim of abuse.

Discriminatory acts also include terminating group coverage for an abuse victim because coverage was originally issued in the name of the abuser and the abuser has divorced, separated from, or lost custody of the abuse victim, or the abuser's coverage was otherwise terminated voluntarily or involuntarily. Nothing in this subsection prohibits Triple-S Salud from requiring the abuse victim to pay the full premium for the health plan coverage, or from requiring, as a condition for coverage, that the abuse victim reside or work within the health plan service area, if these requirements apply equally to all existing or potential members. If conversion to an equivalent individual plan is offered, Triple-S Salud may terminate the group coverage after the required continued coverage is in effect for eighteen (18) months. The required continued coverage may be met with the coverage provided by virtue of the "Consolidated Omnibus Budget Reconciliation Act of 1985" (COBRA) and will not be additional to the coverage provided under COBRA.

How Does Your Coverage Work?

This plan helps you pay for some of the costs incurred when you are sick or injured. It also pays for certain health care services, to help them remain in optimal health conditions and detect any conditions through preventive services.

Aside from the monthly payment you make for your plan (called the "premium"), you also pay part of the costs when you receive the health care services covered by the plan. There are different types of costs you must pay out-of-pocket: deductibles, copayments, and coinsurances; until you reach the coverage maximum out-of-pocket. For details about your plan copayments, coinsurance, and deductibles, please refer to the Table of Copayments and Coinsurance at the end of this policy.

COORDINATION OF BENEFITS (COB)

If a member is covered by two or more plans, the rules to determine the order in which plans must pay the 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 is 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 if the member receives services from a provider outside the panel, except for emergency services or authorized referrals provided by the primary plan.

3) If there are multiple contracts providing coordinated coverages and these are treated as the same plan for the purposes of this rule, this section shall apply only to the plan as a whole, and the coordination between contract components shall be governed by their own terms. If more than one contractor pays or provides benefits under the plan, the contractor designated as the primary payer in 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 shall pay their benefits between one another. Each secondary plan takes into account 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 paragraph (2), if a plan has not provided a priority order for the coordination of benefits in accordance with this section, it shall be deemed a primary plan, unless the provisions for both plans, regardless of what is stated in this paragraph, state that the plan establishing the order for the coordination of benefits is the primary plan.

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

c. A plan may only take into account the benefits paid by another plan if, under these rules, it is a secondary payer in relation 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, a plan covering someone as non-dependent (for example, a plan covering someone as an employee, member, policyholder, or retiree) is the primary plan, and the plan that covers that person as a dependent is the secondary plan.

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

(I) Secondary to the plan covering the person as a dependent; and
(II) Primary to the plan covering the person as a non-dependent

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

2) Dependent Child Covered Under More than One Plan

Unless there is a court order stating 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 living together although they 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 time will be the primary plan.

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

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

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

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

(iv) If there is no court order assigning responsibility to either one of the parents for the dependent child's medical expenses or for providing a health plan, then the order of benefits will be determined as follows:

I. The plan covering the custodial parent;
II. The plan covering the spouse of the custodial parent;
III. The plan covering the non-custodial parent; and finally
IV. The plan covering the spouse of the non-custodial parent.

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

d)

i. For dependent children who are covered under the plan of one or both parents and who also have their own coverage as dependents under the plan of a spouse, the rule in paragraph (5) applies.

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

3) Active Employee or Retired or Former Employee

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

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

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

4) COBRA or Extensions of Coverage Under State Law

a) If a person with extended coverage under COBRA or other similar federal or state law also has coverage under another plan, the plan covering this person as an employee, member, or retiree, or as a dependent of an employee, member, subscriber, or retiree, will be the primary plan. The plan covering that person under COBRA or other similar federal or state law shall be the secondary plan.

b) If the other plan does not have this rule and the plans do not agree about 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 benefits.

5) Longer or Shorter Coverage Time

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

b) To determine the time period a person has been covered under a plan, two successive plans shall be treated as one if the person was eligible to participate in the second plan within 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 plan benefits;
ii. A change in the entity that pays, provides, or administers the plan benefits; or
iii. A change in the type of plan, like for example, from a single employer plan to a multiple employer plan.

d) The period of time that a person has been covered under a plan is measured from the date that person's coverage began under the plan. If we cannot determine such date in

the case of a group plan, the date when the person became an insured employee for the first time will be used to determine the period of time the person has been covered under the group plan.

6) If none of the previous rules determines the order of benefits, expenses shall be shared by all plans in equal parts.

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

GENERAL PROVISIONS

1. **ACTIONS FROM THIRD PARTIES:** If by fault or negligence from a third party, the member or any of their 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 through which an insurer assumes the member's rights before a third party that has caused them damages. If the member suffers an accident caused by a third party's fault or negligence (for example, a school, a grocery store, or any other private or public 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 automobile accidents, which are addressed by the Automobile Accident Compensation Administration (ACAA, by its Spanish acronym), or to work-related accidents, for which the insurer is the State Insurance Fund.

   The member recognizes Triple-S Salud's subrogation rights and will be responsible for notifying Triple-S of Salud any actions initiated against said third party; and the member shall be responsible for paying Triple-S Salud for such expenses, should they act otherwise.

2. **BENEFIT CERTIFICATE/POLICY:** Document issued by Triple-S Salud to the holder of the policy / certificate of benefits.

3. **BLUECARD® PROGRAM AND OUT-OF-AREA SERVICES**: Triple-S Salud has a wide variety of relationships with other Blue Cross and/or Blue Shield licensees. These relationships are usually known as "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on the rules and procedures established by the Blue Cross Blue Shield Association (the "Association"). Whenever you access health care services outside the geographic area served by Triple-S Salud, claims for these services may be processed through one of such Inter-Plan Arrangements. Inter-Plan Arrangements are described in general terms below.

   Whenever you receive medical care outside Triple-S Salud's service area, you will get it from two provider types. Most participating providers are contracted by the Blue Cross or Blue Shield licensee in that other geographical area ("Host Blue"). Some providers ("non-participating providers") are not contracted by Host Blue. We will explain below how Triple-S Salud pays both provider types.

   Types of claims

   All claim types fulfill the requirements to be processed through *Inter-Plan Arrangements*, as described above, except for any dental care, prescription drugs, or vision care benefits that may be managed by Triple-S Salud to provide services.

   A. BlueCard® Program

   Under the BlueCard® Program, if you receive covered services in a Host Blue service area, Triple-S Salud will continue being responsible for fulfilling our part in the contract. However, the Host Blue is responsible for hiring and coordinating all your interactions with their participating health care providers.

If you obtain covered services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for the covered services is calculated based on the lowest cost between:

- Covered charges that have been billed for covered services, or
- the negotiated price between Triple-S Salud and the Host Blue.

This "negotiated price" will often consist of a simple discount that states the real price paid by the Host Blue to your health care provider. Sometimes, it is an estimated price that takes into account the special arrangements made with your specific provider or provider group, which may include arrangements, incentives, and other credits or charges. It may occasionally be an average price based on a discount that yields average anticipated savings for health care providers, compared to the same type of transactions occurring at an estimated price.

The estimated price and the average price also take into account previously noted adjustments to correct overstated or understated changes to old prices to correct the prices of past claims. However, said adjustments will not affect the price we have used for your claims, as these will not be applied retroactively to claims that have been paid.

Host Blues decide if they will use a real price, an estimate, or an average. Host Blues using either estimates or average prices may prospectively increase or reduce such prices to correct previously understated or overstated prices (in other words, prospective adjustments may mean that the current price reflects an additional amount or credit for paid claims or those that providers are to pay or receive). However, the BlueCard Program requires the sum paid by the insured member to be the final price. No future price adjustment will result in increases or reductions in the price determined for prior claims. Triple-S Salud takes into account the method Host Blues use for claim payments in order to determine their premiums.

B. Federal and State Taxes/Late Fees/Charges

In some cases, federal or state laws or regulations could levy a late fee, tax, or any other applicable fee to member accounts. If applicable, Triple-S Salud will include any of these late fees, taxes, or charges to determine the premium.

C. Non-Participating Providers Outside Triple-S Salud's Service Area

If covered services are rendered outside Triple-S Salud's service area by non-participating providers, the amount you pay for such services will usually be based on either the local rate payable to providers not participating as Host Blues or the payment agreements required by the applicable state law. In any of these cases, the member may be responsible for paying the difference between the amount billed by the non-participating provider and the payment made by Triple-S Salud for the covered services, as set out in this paragraph. Payments for emergency services outside the network are regulated by the applicable federal and state laws.

D. Blue Cross Blue Shield Global® Core Program

General Information

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (the "BlueCard Service Area"), you may benefit from the Blue Cross Blue Shield Global Core Program when accessing covered services. The Blue Cross Blue Shield Global Core Program is somewhat different from the BlueCard Program available within the BlueCard Service Area. For example, even though the Blue Cross Blue Shield Global Core Program helps members access a professional provider network for hospitalized patients and on an outpatient basis, this program does not operate within the Host Blue's service area. Therefore, when insured members receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit a claim to receive a reimbursement for those services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard Service Area, you must call the Blue Cross Blue Shield Global Core Service Center at 1-800-810-BLUE (2583) or make a collect call to 1-804-673-1177, available 24 hours a day, every day of the week. A care coordinator, working jointly with a medical professional, can schedule a physician appointment or hospitalization, as needed.

Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center to get help, hospitals will not require that you pay for covered patient hospitalization services, except for your copayment/deductible/coinsurance. In such cases, the hospital will submit its claims to the Blue Cross Blue Shield Global Core Service Center to initiate the claims process. However, if you make a full payment upon receiving the service, you need to submit a claim to receive a reimbursement for the covered services. You must contact Triple-S Salud to get a hospitalization service precertification for non-emergencies.

Outpatient Services

Doctors, urgent care centers and other outpatient providers located outside the BlueCard Service Area will usually require that you pay in full upon receiving the service. You must submit a claim to obtain a reimbursement for the covered services.

How to Submit a Claim to Blue Cross Blue Shield Global Core

When you pay for covered services outside the BlueCard Service Area, you must submit a claim to get a reimbursement. For institutional and professional claims, you must fill a Blue Cross Blue Shield Global Core claim form and send it, along with an itemized statement from the provider, to the Blue Cross Blue Shield Global Core Service Center address (this address is listed in the form) to initiate the claims process. Follow the instructions on the claim form to ensure your claim is processed promptly. You can get the claims form by calling Triple-S Salud, from the Blue Cross Blue Shield Global Core Service Center, or online at www.bcbsglobalcore.com. If you need help filing your claim, you must call Blue Cross Blue Shield Global Core Service Center at 1-800-810-BLUE (2583) or make a collect call to 1-804-673-1177, available 24 hours a day, every day of the week.

Non-emergency services are covered based on the fee of the participating provider in Puerto Rico, as established in the section Member Compensation.

4. **BLUE CROSS BLUE SHIELD ASSOCIATION INDEPENDENT LICENSEE:** The member and their dependents hereby expressly acknowledge and understand that this policy constitutes a contract solely between the member and Triple-S Salud, Inc. is an independent corporation operating under a license of the Blue Cross and Blue Shield Association, an association of Independent Plans affiliated to Blue Cross and Blue Shield (the Association), thus allowing Triple-S Salud, Inc. to use the service brand Blue Cross and Blue Shield in Puerto Rico. Triple-S Salud, Inc. is not contracted as an agent of the Association.

   The member and their dependents agree and accept that they have not acquired this policy based on representations from any person other than Triple-S Salud, Inc., and that no person, entity, or organization other than Triple-S Salud, Inc. may be held liable for any of Triple-S Salud Inc.'s obligations with the member created under this policy.

   The aforementioned statements shall not create any additional obligations by Triple-S Salud, Inc. other than the obligations created under the provisions of this agreement.

5. **CIVIL ACTIONS:** No civil action shall be initiated to claim any of the member's rights under this policy before sixty (60) days have elapsed after submitting written proof of service, in accordance with the requirements of this policy. No action shall be initiated after three (3) years have elapsed from the date written proof of the service is required to be submitted.

6. **CIVIL RIGHTS FOR INDIVIDUALS UNDER SECTION 1557:** Triple-S Salud, Inc. follows all applicable federal civil rights laws and does not discriminate on the basis of race, color, nationality, age, disability, or sex.

   Triple-S Salud, Inc. It does not exclude persons nor treats them differently because of their ethnic origin, color, nationality, age, disability, or sex.

   We offer free assistance and services to people with disabilities so they may communicate with us effectively. We also offer free language services to people whose first language is not English.

   For more information, please refer to our website: http://www.ssspr.com/SSSPortal/GeneralInfo/politica-privacidad.html, or call the following numbers: (787) 774-6060, or toll free to 1-800-981-3241, for telephone services for the hearing impaired (TTY/TDD) at (787) 792-1370, or toll free to 1-866-215-1999.

7. **CLAIM NOTICE:** The member or employer should issue a written claim notice to Triple-S Salud within twenty (20) days after the service occurs, or, after such term, as soon as reasonably possible. A written notice delivered by the member, in their name, to Triple-S Salud, at the main office in San Juan, Puerto Rico, or at any of its Service Centers throughout the Island, or to any authorized Triple-S Salud representative, with sufficient identifying information, shall be deemed as a notice issued to Triple-S Salud.

8. **CLAIM PAYMENTS**: As a general rule, the benefits provided under this policy are payable directly to participating providers, except in cases of emergency, where they will be paid as provided by law. If the member uses non-participating providers in case of emergency, the services rendered will be paid directly to the provider.

   If the member receives health care services after receiving post-stabilization or emergency services, which would be covered under the health plan except for the fact that it is a non-participating provider, Triple-S Salud will reimburse the member based on the lesser amount 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. This policy also contains benefits that are paid based on compensation or reimbursement to the member even if the provider is a participating provider.

   In order for Triple-S Salud to pay or issue reimbursement to the member in these cases, the member must give written notice of the claim to Triple-S Salud within twenty (20) days after receiving the service or as soon as reasonably possible, but no later than one (1) year from the date the service was rendered, unless evidence is submitted that it was impossible to submit the claim within the stated period of time.

9. **COBRA (Consolidated Omnibus Budget Reconciliation Act) applicable to employers with 20 or more employees**: Provides, in some situations, continued (extended) coverage to covered employees and eligible direct dependents if the group health plan coverage ends for reasons (qualifying events) established in said act. The insured employee or member should check with their employer whether they are eligible for this coverage. The employer, not Triple-S Salud, shall be the COBRA administrator.

   In case of employment termination, be it due to dismissal (provided that it was not caused by misconduct) or resignation, or a reduction of hours, COBRA states that the member of the group health plan is entitled to extended coverage for 18 months. This coverage shall also be available for the member's direct dependents. If the member under COBRA becomes disabled, and such disability is certified by the Social Security Administration within 60 days after the qualifying event, then the member under COBRA shall be entitled to an 11-month extension under COBRA. Lastly, in the case of an employee's divorce or death, the spouse and children shall be entitled to extended coverage for a period of 36 months. Direct dependents (children) shall have 36 months if they lose eligibility under the plan. If the employee receives

Medicare benefits, the spouse and dependents shall be entitled to extended coverage for 36 months. Extended coverage under COBRA may end for the following reasons:

a. The COBRA period ends;
b. Default on payments;
c. The employer terminates the group health plan;
d. The member enrolls in Medicare;
e. The member enrolls in another health plan with no waiting period;
f. The member engages in an offense that, according to the plan, is just cause to be removed from the plan (for example, submitting fraudulent claims).

Transition cases are included as COBRA cases for purposes of group experience.

10. **CONFIDENTIALITY**: Triple-S Salud shall keep the confidentiality of the member's medical information and claims, in accordance with the policies and practices set forth in the Notice of Privacy Practices contained in this policy.

11. **CONVERSION CLAUSE**:

a. If a member's insurance policy ceases due to separation from employment or from a class eligible for coverage under the policy, such person shall have the right for Triple-S Salud to issue, without need for proof of insurability, a basic individual policy at one of the various metallic levels available in the market, in exchange for the payment of the premium for such individual health plan. The written application for enrollment in an individual policy and the first premium payment should be submitted to Triple-S Salud no later than thirty (30) days after the aforementioned termination; while also stipulating that:

1) If the member had prior qualifying coverage with benefits that are not comparable or do not exceed those offered in the coverage of the individual basic Plata health plan, Triple-S Salud shall offer the individual basic Bronce health plan to that person, thus converting the plan between enrollment periods, until the next enrollment period. During the enrollment period, the member may select the basic individual health plan they prefer.

2) The premium of the individual policy shall be the current applicable Triple-S Salud rate for the form and benefits corresponding to the policy selected by the member. Health conditions shall not be an acceptable basis for risk classification.

3) The individual policy should also cover the insured employee's or member's spouse and/or direct dependents if they were covered on the date the group insurance ended. Triple-S Salud may issue a separate individual policy to cover the enrolled spouse and/or direct dependents. Any optional dependent of the insured employee or member covered on the date the insurance ended shall be eligible for an individual policy.

4) The individual policy shall be effective as of the termination of insurance under the group policy.

5) Triple-S Salud shall not be required to issue an individual policy to someone who:

a) Fails to apply for a basic individual health plan within thirty (30) days after the qualifying event, or no later than thirty (30) days after losing eligibility for the existing qualifying coverage.

b) Is covered or is eligible for coverage, according to another medical benefit contract, be it public or private, which includes Medicare supplemental or Medicare program policies, as established in Title XVIII of the Social Security Law, as amended, or in any other federal or state law, except in case of someone who is eligible for Medicare for reasons other than age.

c) Is covered or is eligible for coverage under a health plan, as offered by the employer of the recently covered person.

d) Is covered or eligible for coverage under a health plan with health care coverage in which the spouse, parent, or guardian is enrolled or eligible for enrollment, except if such health plan is the Puerto Rico Government Health Plan or any other government health plan managed by the Health Insurance Administration.

e) For the time period they are covered according to the previous individual health plan, which ends after the effective date of the new coverage.

f) Is covered or is eligible for coverage for an extended group health plan, in tune with Section 4980b of the US 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 in subsection (a) of this section, the privilege of conversion shall be granted:

1) to the member's spouse or direct dependents whose coverage under the group policy has ceased due to the death of the member.

2) to the spouse or direct dependents of the person whose coverage has ceased because they did not qualify as a dependent under a group policy, even if the member remains covered under the group policy.

3) Optional dependents, if applicable

c. If a member insured under a group policy loses coverage under an individual policy as described under subsection (a) of this section, during the time period they would have qualified to have such individual policy issued, and before such policy becomes effective, the benefits to which they are entitled under said policy shall be payable as a claim under the group policy, even if they did not apply to the individual policy or have not yet made the first premium payment.

d. If a member insured under this group policy becomes entitled to obtaining an individual policy under the group policy terms, subject to application and first premium payment within the time specified in the policy, and if such person is not notified of the existence of this right at least fifteen (15) days before the expiration date of such time period, then the that person shall have an additional time period during which they may exercise this right, but this does not imply the continuation of a policy beyond the time provided by said policy.

The additional period will end 15 days after notice is provided, but under no circumstance will it extend for more than 60 days after the policy expiration date. A written notice handed to the person or sent by mail by the policyholder to that last known address of the individual, as written by the policyholder, will be considered sufficient warning to these ends. If an additional period is granted to exercise the right to conversion, as provided here, and if the written application for said individual policy is sent along with the first premium payment during the additional period, the individual policy will be effective on the date the group insurance policy ends.

12. **COVERAGE TRANSFER**: If the member moves to an area covered by another Blue Cross Blue Shield Association affiliate plan, and if the member so requests it, Triple-S Salud will process the transfer to the plan servicing the member's new area of residence.

The new plan should offer the member at least its group conversion policy. This is a type of policy usually offered to members who abandon a group and request individual coverage. The conversion policy offers coverage without need for a medical exam or health certificate.

If the member accepts the conversion policy, the new plan shall credit the time they were insured under Triple-S Salud against any waiting time period. Any physical or mental condition covered by Triple-S Salud shall be covered under the new plan without need for a waiting period, if the new plan offers such a feature to others who have the same type of coverage.

The available fees and benefits under the new plan may vary significantly from those offered by Triple-S Salud. The new plan may provide the member with other types of coverage outside the Transfer Program. These policies may require a medical exam or health certificate to exclude coverage for preexisting conditions; or they may not apply the time insured under Triple-S Salud to the waiting time periods.

Members may obtain additional information about the Transfer Program by contacting our Customer Service Department.

13. **GRACE PERIOD:** A grace period of 31 calendar days will be granted for each premium payment due after the first premium, during which the policy will continue in force.

14. **IDENTIFICATION**: Triple-S Salud will issue a card to each member, which will be required to be presented to any participating Triple-S Salud provider whose services are requested, to have them covered by this policy. The member must also present a second photo identification.

15. **INDIVIDUAL CANCELLATION**: Triple-S Salud may cancel the insurance of any member at any time, if the member commits fraudulent acts, misrepresents material facts, has submitted or made someone else submit a fraudulent claim or evidence to support such claim, to obtain payment for a claim pursuant to any Triple-S Salud policy, regardless of the date when such act was committed or the date and manner it was discovered; or if the member displays patterns of fraud in the utilization of the benefits provided by the policy. The cancellation will be notified to the member via written notice, which will be delivered or mailed to the latest address shown in Triple-S Salud's records, stating when the cancellation will be effective, which shall not be less than thirty (30) days after the notice.

    Triple-S Salud issues a certification of coverage, as required by HIPAA, to the insured employee or member. If the employee does not receive the certification of coverage, they may obtain it by calling our Customer Service Department at 787-774-6060.

16. **INDIVIDUAL TERMINATION:** Any insured employee or member who retires or ceases to be employed shall be required to return the Triple-S Salud plan ID cards. Triple-S Salud shall not cover any services used after the insurance is terminated. The employee shall be responsible for the payment of such services.

17. **LIABILITY WAIVER FOR MEMBERS**: Members will not be responsible for paying any services where the participating provider failed to comply with the eligibility procedures, payment policies, or service protocols established by Triple-S Salud.

18. **MANDATORY COVERAGES:** This policy is subject to federal and local laws and regulations that may require, during its effectiveness, coverage for additional hospital or medical-surgical services that were not part of the covered services when the policy was made effective. These mandatory coverages, which become effective on a date subsequent to the issuance of this policy, may have an impact on costs and premiums.

19. **MODEL FOR CLAIMS:** Upon receipt of a claim notice, Triple-S Salud will provide the claimant with the models that it regularly provides to submit proofs of service. If these models are not provided within fifteen

days after said notice was given, it will be understood that the claimant has complied with the requirements of this policy in terms of proof of service, if they submit, within the time established in this policy to submit proof of service, written proof covering what happened and the nature and scope of the service for which the claim is being filed.

20. **PATIENTS' BILL OF RIGHTS AND RESPONSIBILITIES:** Triple-S Salud require its members, or in the case of persons with disabilities or minors, to their parents, guardians, custodians, or persons in charge, to read and become familiar with the "Patients' Bill of Rights and Responsibilities" or a proper and reasonable summary thereof, as prepared or authorized by the Department of Health.

21. **PERSONAL RIGHTS**: The rights and benefits of this policy are not transferable, and no member may assign, transfer, or alienate any of the rights or benefits that they could claim under the policy in favor of third parties. Triple-S Salud reserves the right to recover all expenses incurred if the member, with their express or implied consent, allows uninsured persons to use the member card issued in their name by Triple-S Salud. In addition, the recovery of such expenses will not prevent Triple-S Salud from being able to cancel the insurance contract when it discovers the illegal use of the card, nor will it prevent the filing of a grievance so that the member or the person using such card illegally is prosecuted criminally.

22. **PHYSICAL EXAMS**: Triple-S Salud has the right and opportunity to examine, on its own account, the member when and as frequently as it is reasonably required for the purposes of auditing or investigating fraud.

23. **PREMIUM PAYMENT:** Both the employer and the insured employee or member shall be jointly responsible for paying the policy premium; providing that such responsibility covers the entire premium due until the policy's date of termination, according to the clause of Termination.

    Triple-S Salud is entitled to collecting the premium due from the insured employee or member, or, at its option, it may recover the costs incurred in the payment of claims for services provided to the member after the cancellation of that person's health plan; stipulating that the insured employee or member shall be responsible for paying any of the two amounts as claimed by Triple-S Salud. Triple-S Salud may use collection agency services to demand the payment of any existing debt with Triple-S Salud. Besides, the debtor shall be required to pay the costs, expenses, and attorney fees, as well as any other additional amount or expense, unless the Court orders otherwise.

    Triple-S Salud reserves the right to alert any credit agency, institution, or entity, in detailed form, about the breach of payment incurred by the employer or the insured employee or member.

24. **QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)**: The Employee Retirement Income Security Act (ERISA) requires employment-based group health plans to extend health care coverage to the children of employees who are divorced, separated, or who never married, when ordered to do so by state authorities. This provision states that the plan may be required to offer health care coverage for an employee's underage dependents. The State or Court may require the ERISA-covered employer to extend the coverage to an employee's underage dependents through an order for health care coverage support.

25. **RECOUPMENT OR RECOVERY OF EXCESS OR ERRONEOUS PAYMENTS:** 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 a payment in error or excess.

26. **REINSTATEMENT:** If an overdue premium is not paid before the end of the grace period granted to the group, subsequent acceptance of premium payment by Triple-S Salud or an authorized representative, without need for a reinstatement request, shall be sufficient to reinstate the policy. If Triple-S Salud or the

authorized representative asks for a request, a conditional receipt for the premium will be given. If the request is approved, this policy shall be reinstated as of the date of approval. In the absence of such approval, the policy shall be reinstated on the forty-fifth (45th) day after the date of the conditional receipt, unless the denial has been notified in writing.

The reinstated policy only covers losses resulting from an injury occurring after the date of reinstatement, or from an illness beginning after ten (10) days have elapsed from such reinstatement.

In all other cases, your rights and those of Triple-S Salud remain the same, subject to any provisions stipulated or attached to the reinstated policy. Any premium accepted for reinstatement shall be applied to a period for which the premium has not been paid; but no premium shall be applied to a period greater than sixty (60) days prior to the reinstatement date.

27. **RIGHT OF TRIPLE-S SALUD TO PERFORM AUDITS:** By subscribing to this policy, the members accept, acknowledge, and understand that Triple-S Salud, as payer of the health services obtained by the primary policyholder and their dependents, is authorized to access their medical records to perform audits on any or all health service claims paid by Triple-S Salud.

28. **RIGHT TO A GUARANTEED RENEWAL OF THE PLAN:** The employer has the right to demand the guaranteed renewal of the health plan for all eligible employees and their dependents, except in the following cases:

    a. Due to a default in the premium payments, taking into account the grace period;

    b. If the employer, the eligible employee, or any of their dependents commits a fraudulent act. In such cases, Triple-S Salud may choose not to renew the health plan for the employer, the eligible employee, or the member for one (1) year after the date of termination of the coverage;

    c. If the employer, the eligible employee or member has intentionally misrepresented an important and material fact under the health plan terms. In such cases, Triple-S Salud may choose not to renew the health plan for the employer, the eligible employee, or the member for one (1) year after the date of termination of the coverage;

    d. For failing to meet the minimum requirements of participation;

    e. For failing to meet the employer contribution requirements;

    f. If Triple-S Salud decides to stop offering all the health plans it has executed with employers in Puerto Rico: In such cases, Triple-S Salud shall send written notice of its determination not to renew to the Office of the Commissioner of Insurance of Puerto Rico, the employers, and all covered members, at least 180 days before the health plan's date of renewal.

    g. If the Commissioner of Insurance determines that continuing the health plan would not respond to the best interests of the policyholders or would affect the insurer's ability to meet its contractual obligations.

    h. In the case of health plans made available in the small group market through a preferred network plan, if the employer has no more employees who live, work, or reside within the geographical are established by the insurer.

29. **RIGHTS UNDER LAW NO. 248 OF AUGUST 15, 1999, ACT TO GUARANTEE ADEQUATE CARE FOR MOTHERS AND THEIR NEWBORNS DURING THE POST-PARTUM PERIOD**: The applicable laws provide, among other things, the following:

    a. The stays of the mother or the newborn as a result of childbirth will not be limited to less than 48 hours in the event of natural childbirth, or less than 96 hours in the case of deliveries by caesarean section.

b. However, insurers and group plans may cover stays shorter than these periods, if the physician, after consulting with the mother, orders the discharge of the mother or the newborn prior to meeting the aforementioned terms.

c. If the mother and the newborn are discharged within a shorter time period than what was established in subsection (a) of this item, but, as per subsection (b), the coverage provides for a follow-up visit within the next forty-eight (48) hours. Services include but are not limited to: assistance and physical care for the minor, education on childcare for both parents, breastfeeding assistance and training, guidance about home support, and medical treatments and tests for both.

d. Insurers and group plans shall not design benefits or include copayments or coinsurances that imply an unfavorable treatment during some portion of the hospital stay.

30. **RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT**: Any member insured under a group health plan for at least eighteen (18) months is entitled to enroll in an individual health insurance policy without the need for a waiting period or a preexisting condition clause.

    To be able to enroll, the application for the individual plan should not be submitted more than sixty-three (63) days after losing the previous group plan or employer's contribution, and the plan's termination must have happened for one of the following reasons:

    a. Loss of eligibility (for example, resignation or dismissal),

    b. Loss of employer's contribution, or

    c. Termination of COBRA coverage

31. **SINGLE CONTRACT - CHANGES**: This policy, including its endorsements and added documents, if any, constitutes the full text of the insurance contract. No change to this policy shall be valid until it is 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 prior to its use, unless such approval is herein endorsed or attached. No authorized representative has the authority to change this policy or waive any of its provisions.

32. **TERMINATION:** Triple-S Salud reserves the right to terminate this policy on its expiration date due to a default on the premium, after the grace period, via written notification to the insured employee or member no less than thirty (30) days in advance. The termination shall not affect any claim for services rendered before the date of termination.

    Triple-S Salud also reserves the right to terminate this policy for non-payment of the premiums through written notification to the employer, no less than thirty (30) days in advance. If the employer decides to cancel this policy to continue providing its employees with health plan benefits through another organization, the employer may terminate the policy on the due date of any premium by sending written notification to Triple-S Salud at least thirty (30) days in advance. On the other hand, if the employer decides not to continue providing its employees with a health plan as part of their employee benefits, it should provide written notification to Triple-S Salud at least forty-five (45) days before the cancellation becomes effective, which should be on the last day of the month after the notification is delivered. The termination shall not affect any claim for services rendered before the date of termination.

    If a health care plan is terminated or canceled, or if a provider terminates or cancels, Triple-S Salud will notify you of such termination or cancellation thirty (30) calendar days prior to the date of termination or cancellation.

Subject to any premium payment, if a provider or health plan is terminated, the insured employee or member may continue receiving the same benefits during a transition period of ninety (90) days from the termination date of the plan or contract with the provider.

The transition period, in the circumstances described below, will occur in the following way:

a. If the member is hospitalized on the plan's termination date, and the date of discharge was scheduled before such termination date, the transition period shall be extended from this date up to ninety (90) days after the date of discharge.

b. If a member is in her second trimester of pregnancy by the termination date of this policy and the provider has been offering medical treatment related to the pregnancy before such termination date, the transition period for pregnancy-related services shall be extended until the member's date of discharge from hospitalization for delivery or the newborn's date of discharge, whichever of the two is latest.

c. If the patient is diagnosed with a terminal condition before the termination date of the policy and the provider has been offering medical treatment related to this condition before such date, the transition period shall be extended for the remainder of the patient's life.

   The transition care period is subject to payment of the premium and may be denied or terminated if the member and/or the provider commit fraud against the insurance. The member may choose to enroll in a Triple-S Directo policy or use the period of transition due to termination of the plan. Once this transition period ends, provisions under the Conversion clause shall apply.

33. **TOTAL PAYMENT FOR COVERED SERVICES IF THERE IS NO PROVIDER:** If a member has medical need for a service covered by the plan but for which there is no contracted provider, and the coverage does not state whether the service will be available 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 member's policy, and to the provider payment based on the fee established by Triple-S Salud for the services to be provided.

34. **WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA):** This policy provides coverage to the member for breast reconstruction in connection with a mastectomy, for the reconstruction of the other breast to produce a symmetrical appearance, and for prostheses and the treatment of any physical issues that arise at any stage of the mastectomy. These benefits are provided in consultation between the member and her physician and will be subject to the coinsurance and copayments established in this policy.

YOUR RIGHTS AND RESPONSIBILITIES AS A PATIENT

Law 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 plans and provider selection

Every individual has the right to:

- Select health care plans and providers that are appropriate and best fit their 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 the 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 number 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 must 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 they continue 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 to emergency services and facilities

- Free and unrestricted access to emergency services and facilities, whenever and wherever the need may arise, without the requirement of precertification or waiting periods, regardless of the patient's socioeconomic status and ability to pay. No health plan may deny payment or coverage for emergency medical-hospital health services, regardless of whether they are provided by a non-participating provider.

- 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.

- If the member receives health care services after receiving emergency or post-stabilization services from a non-participating provider, they will be reimbursed based on the fees that would have been paid to a participating provider, as long as there is a compelling medical reason why the patient cannot be transferred to a participating provider.

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.

- Right to coverage of routine medical expenses, in the case of members with life-threatening conditions for which there is no effective treatment and which makes them eligible to participate in an authorized clinical therapy trial, provided that their participation offers a potential benefit and that the physician who refers the covered person presents evidence that their participation in the study is appropriate, or that the member submits their own evidence supporting that their participation in the trial is appropriate. "The patient's routine medical expenses" are not those related to the trial, or the tests administered to be used as part of the trial, or the expenses that should reasonably be paid by the entity conducting the trial.

- 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 information and health record confidentiality

- 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, provider who rendered the service, and the amount paid for said service. The member may access the quarterly utilization report, which itemizes paid services for them and their dependents, by registering as a 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 settlement of any bills. Know the rules for coordination of benefits and comply with the health plan's administrative processes.
- 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.
- Know the coverage, options and benefits, and other details pertaining to the health plan, such as internal procedures for resolving differences, limitations, and exclusions.

- 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.

APPEALS FOR ADVERSE BENEFIT DETERMINATIONS

RIGHT TO APPEAL AN ADVERSE DETERMINATION

What is an Adverse Determination?

- A determination made by the insurer or a utilization review organization, to deny, reduce, or terminate a benefit, or to not pay the benefit in part or in full, since in applying the utilization review techniques, based on the information provided and according to the health plan, the requested benefit does not meet the requirements for medical necessity and appropriateness, the place where the service is provided, or the level or effectiveness of care, or it is determined that it is experimental or investigative in nature;

- The denial, reduction, termination, or absence of payment for a benefit, either partial or in full, by the insurer or utilization review organization, based on the determination of the member's eligibility to participate in the health plan; or

- The determination resulting from a prospective or retrospective review in which the benefit is denied, reduced, terminated, or not paid, in part or in full.

- Coverage rescission: the decision to terminate your contract with retroactive effect to the effective date or any other date prior to the termination notice, provided that the reason for such determination is not a default on premiums, fraud, or misrepresentation, as prohibited by the plan and made intentionally. Cancellations must be notified in writing thirty (30) days before their effective date.

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

RIGHT TO APPEAL AN ADVERSE DETERMINATION

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

APPEALS PROCEDURE

1. <u>First Level Review of Grievances Related to an Adverse Determination</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. Triple-S Salud will provide the member with the name, address, and phone number of the person or organization appointed to coordinate the first level review on behalf of Triple-S Salud. If the appeal arises as a result of an adverse determination related to a utilization review, Triple-S Salud will appoint one or several clinical peer reviewers belonging to the same or a similar specialty as the health care professionals who normally handle the case for which the adverse determination was made. These clinical peer reviewer(s) may have not participated in the initial adverse determination. If Triple-S Salud appoints more than one peer reviewer, it ensures the reviewers have the adequate expertise to evaluate the case.

When evaluating the case, the reviewers will consider all remarks, documents, and records, as well as any information related to the submitted request for appeals, regardless of whether the information was presented or considered when making the initial adverse determination.

The member or, if applicable, their personal representative is entitled to free access to and copies of all the documents and records, to be furnished by Triple-S Salud. As well as relevant information about the grievance. They have the right to:

- Submit written statements, documents, records, and other material related to the grievance under review; and
- Receive from Triple-S Salud, upon request and free of charge, access to and copies of all documents and records, as well as pertinent information about the grievance.

Documents, records, and any other information shall be deemed material for the purpose of filing the member's grievance if they:

- were used in the initial determination
- were 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;
- prove 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
- constitute 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.

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
OCI Mailing Address
PO Box 195415
San Juan, PR 00919-5415

361 Calle Calaf
World Plaza Building
268 Ave. Muñoz Rivera
San Juan, PR 00918
Phone: 787-304-8686
www.ocs.pr.gov

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 inform the member or, if applicable, their personal representative about the rights they are entitled to no later than three (3) business days after receipt of the grievance.

The periods for determination and notice will begin when Triple-S Salud receives the grievance, regardless of whether it includes all the information necessary to make a determination. If Triple-S Salud understands the grievance does not contain all the information necessary to make a determination, the member or their personal representative, if applicable, shall be informed in clear terms of the reasons why the grievance cannot be processed, including the documents or additional information to be submitted.

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

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

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

This determination will include:

- The qualifications and credentials of the individuals who participated in the first level review process (the reviewers).

- A statement of the interpretation made by the grievance reviewer(s).

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

- The evidence or documentation used as basis for the determination.

If after the first level review, the determination is adverse, 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 regarding the member's rights to access or obtain free copies of the documents, records, and other relevant information used in the appeals review.

- If Triple-S Salud used a rule, guideline or internal protocol, or other similar criteria, in order to arrive at the adverse determination, a copy of such rule, guideline, protocol, or any other similar criteria used as a basis for the adverse determination must be furnished, free of charge, at the request of the member or, if applicable, their personal representative;

- 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 their personal representative, free of charge, at their request.

- If applicable, it must include the instructions to request a copy of the rule, guideline, internal protocol, or any other similar criteria used as a basis for the determination, and an explanation of the scientific or clinical rationale followed to make the determination.

- It must include a statement describing the process used to obtain an additional voluntary review, as well as the deadlines for such review, 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>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 initiate proceedings before a qualified 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 notice of the member's right to contact the Commissioner's Office or the Office of the Advocate of Health to request guidance and help, including the phone 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 361 Calle Calaf, World Plaza Building, 268 Muñoz Rivera Ave, San Juan, PR 00918, or you may call (787) 304-8686.

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

RIGHT TO APPOINT A REPRESENTATIVE

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

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

Triple-S Salud may require additional information from the authorized representative to help authenticate them if they call by phone or visits our Offices.

The member or their 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.

3. Voluntary Level of Grievance Reviews

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 their 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 their 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 their request, they may submit a written request stating their interest in appearing in person before the review panel, within 15 business days from the receipt.

In terms of requests for additional voluntary review of an issued determination, Triple-S Salud appoints a review panel consisting of Triple-S Salud employees or representatives, in order to assess the request, and you or your authorized representative may attend in person or by phone to explain your request. A reviewer who participated in the First Internal Level of Appeal can be a panel member or appear before said panel to provide information or answer the panel's questions. Triple-S Salud will ensure the reviewers participating in the additional voluntary review are health professionals with adequate expertise, and that the personnel performing the voluntary review is not a provider of the covered member's health insurance and has no financial interest in the results of the review process.

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 their personal representative, who wishes to appear in person before the review panel shall submit a written request to Triple-S Salud no later than fifteen (15) business days after receiving the notification.

During the review, the appointed panel will perform its evaluation and take into account all remarks, documents, records, and any other information related to the request for additional voluntary review submitted by you or your authorized representative, regardless of whether the information was presented or considered to make a determination in previous reviews (first level).

When a member or their personal representative asks to appear in person before the panel, the procedures to conduct the additional voluntary review shall be governed by the following provisions:

The review panel will schedule and hold a meeting no later than thirty (30) calendar days after receiving the request for an additional voluntary review.

At least fifteen (15) calendar days in advance, the member or their personal representative, if applicable, will receive written notice of the date when the review panel meeting will be held.

Triple-S Salud shall not unreasonably deny a request from the member or their representative to defer the review.

The review meeting will be held during regular business hours at a place that is accessible to the member or, if applicable, their personal representative.

If an in-person meeting is not feasible due to geographic constraints, Triple-S Salud will offer the member or, if applicable, their personal representative the chance to contact the review panel by conference or video phone call, or any other appropriate technology, courtesy of Triple-S Salud.

Triple-S Salud intends to obtain assistance from its legal counsel, and shall notify this to the member or their personal representative, if applicable, at least fifteen (15) calendar days prior to the date of the review meeting. The member shall also obtain notice of this so they may seek their own assistance from a legal representative.

The review panel shall issue a written determination and notify the member or their personal representative, if applicable, no later than ten (10) calendar days after the review meeting is concluded.

If the member or their personal representative, if applicable, does not request the opportunity to appear in person before the review panel, said panel shall issue their determination and notify this in writing or electronically (if notifications have been authorized in this manner) no later than forty-five (45) calendar days after the first of the following dates:

- The date the member or their personal representative notifies Triple-S Salud that they will not request an in-person appearance before the review panel; or
- The deadline for the member or their personal representative to request to appear before the review panel.

Once the decision by Triple-S Salud is made, the written determination must include:

- 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 used by the review panel as a basis for the determination

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.

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 in this Section, under Right to Assistance.

4. Expedited Reviews of Grievances Related to Adverse Determinations

Triple-S Salud will provide written procedures for the expedited review of urgent care requests related to an adverse determination.

The procedures will allow the member, or their personal representative, to request an expedited oral or written review from Triple-S Salud.

For the expedited review, Triple-S Salud will appoint clinical peers of the same or a similar specialty as the person who would normally handle the case under review. These peers must not have participated in the initial adverse determination.

In an expedited review, all necessary information, including the determination from Triple-S Salud, will be conveyed between Triple-S Salud and the member or, if applicable, their personal representative, via telephone, fax, or the quickest means available.

If your case is evaluated in an expedited manner, Triple-S Salud will notify the decision to you or, if applicable, to your authorized representative via telephone, fax, or in the most expedited manner available, with the urgency required by your medical condition, but no later than 48 hours from the date the expedited review request was filed with Triple-S Salud, regardless of whether the filing included all the information required to make the 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 appeals.

This determination will include:

- The titles and credentials of the reviewers involved in the evaluation.
- A clear explanation of the determination made by the reviewers for the expedited review.
- The reviewers' determination with the medical justification or contractual basis to allow the member or their personal representative to respond to the claims;
- The 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 their personal representative, free of charge, at their 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 should also include a description of how to obtain an independent external review, if the member decides not to request a voluntary review.
- A statement that the member is entitled to file a lawsuit with a competent court.
- If applicable, it must also include a statement saying that Triple-S Salud and you may have other available options for voluntary dispute resolution, such as mediation or arbitration.
- A notice of the right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health to obtain guidance, available options, and to ask for help, as well as information about the numbers to call in these cases.
- You have the right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health to request assistance.
- Triple-S Salud may provide notice verbally, in writing, or electronically.
- If the adverse determination is notified verbally, Triple-S Salud shall provide written or electronic notice no later than three (3) days after the verbal notification.

- Nothing herein shall be construed to limit Triple-S Salud's ability to waive an adverse determination without following the procedure prescribed herein.

To request assistance, please contact:

Office of the Commissioner of Insurance
Investigations Division
OCI Mailing Address
PO Box 195415
San Juan, PR 00919-5415

361 Calle Calaf
World Plaza Building
268 Ave. Muñoz Rivera
San Juan, PR 00918
Phone: 787-304-8686
www.ocs.pr.gov

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.

5. Procedures for Utilization Review and Ordinary Determination of Benefits

Triple-S Salud shall have written procedures to perform utilization reviews and ordinary benefit determinations, for benefit claims made by members, and to notify its determinations.

- In the case of prospective review determinations, Triple-S Salud will make its determination and notify the member, regardless of whether the benefit is certified or not, within a reasonable period of time based on the member's health condition, but no later than fifteen (15) days from the date the request is received.

- In the event an adverse determination is made, Triple-S Salud shall notify such determination as provided in this article.

The period of fifteen (15) days to make the determination and notify the member may be extended or deferred once by Triple-S Salud, for an additional period of fifteen (15) days, provided Triple-S Salud meets the following requirements:

- Determines that the extension is necessary due to circumstances beyond Triple-S Salud's control; and

- Notify the member, before the initial fifteen (15) day period expires, of the circumstances warranting the extension and the date you expect to make the determination.

If the extension is caused by the member's failure to submit the information necessary for Triple-S Salud to make its determination, the extension notice will meet the following requirements:

It will describe exactly what additional information is required to complete the application; and

It will provide at least forty-five (45) days from the date of receipt of the extension notice for the member to provide the specified additional information.

When Triple-S Salud receives a prospective review request that does not meet the requirements for filing claims for Triple-S Salud benefits, Triple-S Salud will notify the member of this deficiency and provide a notice with information about the procedures to be followed to file the claim correctly.

- The notice of deficiency in filing the claim shall be provided as soon as possible, but no later than five (5) days from the date of the submission of the deficient claim.
- Triple-S Salud may give notice of a deficiency, verbally or in writing, if so requested by the member.

In the case of concurrent review determinations, Triple-S Salud has previously certified ongoing treatment for a specific period of time or number of treatments, the following rules will apply:

- Any reduction or termination of treatment made by Triple-S Salud before the end of the previously certified term or number of treatments will be considered an adverse determination, unless the reduction or termination is due to an amendment in the benefits of the medical plan or the termination of the medical plan; and

- Triple-S Salud will notify the adverse determination to the covered or insured member in advance of the reduction or termination so that the member may file an internal grievance and obtain a determination regarding such grievance before the benefit is reduced or terminated.

The health care service or treatment subject to the adverse determination will continue until Triple-S Salud notifies the member of the determination regarding the internal grievance.

- In the case of retrospective review determinations, Triple-S Salud will make its determination within a reasonable period of time, but no later than thirty (30) days from the receipt of the request.

- If an adverse determination is issued, Triple-S Salud will notify such determination.

The period to make the determination and notify the member may be extended or deferred once by Triple-S Salud, for an additional period of fifteen (15) days, provided Triple-S Salud meets the following requirements:

- Determines that the extension is necessary due to circumstances beyond Triple-S Salud's control; and

- Notifies the member, before the initial period of thirty (30) calendar days expires, of the circumstances warranting the extension and the date it expects to make the determination.

If the extension is caused by the member's failure to submit the information necessary for Triple-S Salud to make its determination, the extension notice will meet the following requirements:

- It will describe exactly what additional information is required to complete the application; and
- It will provide at least forty-five (45) days from the date of receipt of the extension notice for the member to provide the specified additional information.

The time period for Triple-S Salud to make its determination will begin on the date Triple-S Salud receives the application, regardless of whether the filing includes all of the information required to make the determination.

- If the deadline is extended because the member did not submit all of the information necessary to make the determination, the applicable timeline will be interrupted, starting on the date Triple-S Salud sends the extension notice to the member, until the earlier of the following happens:

    - The date the member responds to the specified request for additional information; or

    - The date by which the specified additional information should have been submitted.

- If the member fails to submit the specified additional information before the extension expires, Triple-S Salud may deny certification of the requested benefit.

If, as a result of the Triple-S Salud utilization review and determination processes, an adverse determination is issued, the notice of such adverse determination shall use simple language to explain the following to the member:

- Sufficient information to identify the benefit requested or the claim made, including applicable data such as date of service, provider, amount of claim, diagnostic code and its meaning, and treatment code and its meaning.

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

- A reference to the health plan’s specific provisions on which the determination is based.

- A description of any additional material or information needed for the member to complete the application, including an explanation of why such material or information is necessary;

- A description of Triple-S Salud's internal grievance procedures, including the deadlines applicable to those procedures.

- If the Triple-S Salud adverse determination was based on a rule, guideline, internal protocol, or other similar criteria, a copy of such rule, guideline, internal protocol, or similar criteria shall be provided, free of charge, to the member;

- If the adverse determination was based on a judgment about the medical necessity of the service or treatment, the experimental or investigative nature of the service or treatment, or a similar exclusion or limitation, the notification shall include an explanation of the scientific or clinical rationale followed in making the determination and applying the health plan terms to the member's circumstances; and

- An explanation of the member's right to contact, as appropriate, the Office of the Commissioner or the Patient Advocate Office for assistance at any time and regarding the right to file a lawsuit in a competent court after Triple-S Salud's internal grievance process is completed. The contact information for the Office of the Commissioner and the Advocate of Health shall be included.

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

6. Procedure for Expedited Utilization Review and Determination of Benefits

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.

The member shall promptly receive a verbal or written notice (if the member requests written notices) regarding the deficiency in filing the request for urgent care, but never later than within twenty-four (24) hours from the moment 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.

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 request for urgent care as soon as possible, but no later than forty-eight (48) hours from the earlier of the following: the date Triple-S Salud receives the specified additional information, or the deadline for the member to 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.

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 its meaning, and treatment code and its meaning.

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

- A reference to the policy's specific provisions on which the determination is based;

- 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 expedited 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, of a similar exclusion or limitation, the notice will 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 Insurance Commissioner's Office or the office of the Advocate of Health to request assistance at any time regarding their right to file a legal action in a court with jurisdiction when Triple-S Salud's internal grievance process concludes, including the contact information of the Insurance Commissioner's Office and the Advocate of Health's office.

Triple-S Salud shall provide notice in a culturally and linguistically appropriate manner, as required by federal law.

7. Emergency Services

When performing utilization reviews or making benefit determinations regarding emergency services, Triple-S Salud will follow the provisions of this Article.

Triple-S Salud will cover the emergency services required for the screening and stabilization of the covered or insured member, in accordance with the following standards:

- Triple-S Salud will not require prior authorization for emergency services, even if those emergency services were rendered by a provider who is not part of the Triple-S Salud provider network (non-participating providers);

- If emergency services were provided by a non-participating provider, no administrative requirements or coverage limitations will be imposed that would be more restrictive than the requirements or limitations applicable to participating providers when providing the same emergency services.

If emergency services are provided by a participating provider, such services will be subject to the applicable copayments, coinsurances, and deductibles.

If the emergency services were rendered by a non-participating provider, such services will be subject to the same copayments, coinsurances, and deductibles that would apply if rendered by a participating provider.

The member may not be required to pay any amount in excess of the applicable copayments, coinsurances, and deductibles pursuant to the preceding paragraph.

Triple-S Salud meets the aforementioned payment requirements, if paying for emergency services rendered by a non-participating provider, at a fee no lower than the greater of the following amounts:

- The fee negotiated with participating providers for such emergency services, excluding the copayments or coinsurances to be paid by the member;

- The fee for the emergency service provided, calculated using Triple-S Salud's method to determine payments for non-participating providers, using the copayments, coinsurances, and deductibles applicable to participating providers for the same services.

- The fee that would be paid under Medicare for the emergency service provided, excluding any copayment or coinsurance requirements applicable to participating providers.

Notice of Right to External Review

Triple-S Salud will provide written notice to the member of their right to request an external review. Such notice will be provided by Triple-S Salud once a written notice is sent of any of the following:

- An adverse determination, upon completion of the utilization review process.
- A final adverse determination.
- Cases of coverage termination.

The commissioner may determine the form and content of the required notice.

Triple-S Salud will include the following in the notice, as applicable:

- In the case of an adverse determination notice, a statement informing the member of the following, as applicable:

    - If the member has a health condition where the required time to conduct an expedited internal review of their grievance would endanger their life, health, or full recovery, they may request an expedited external review, as appropriate. In these cases, the independent review organization (IRO) appointed to conduct the expedited external review will determine whether the member will be required to complete the expedited internal review of their grievance prior to conducting the external review; and
    - The member may file a grievance in accordance with Triple-S Salud's internal grievance process. However, if Triple-S Salud has not issued a determination within thirty (30) days from the date the internal grievance was filed, the member may file a request for external review since they will be deemed to have exhausted the internal grievance process.

In the case of an adverse determination notice, a notification informing the member of the following, as applicable:

- If the member has a health condition where the required time to conduct an ordinary external review of their grievance would endanger their life, health, or full recovery, they may request an expedited external review; or
- If the final adverse determination pertains to:
    - Emergency services received in a health care facility from which the member has not yet been discharged, the member may request an expedited external review; or
    - A denial of coverage based on a determination that the recommended or requested service or treatment is of an experimental or investigative nature, the member may submit a request for an ordinary external review, or, if the member's physician certifies in writing that the recommended or requested health care service or treatment will be significantly less effective if it is not initiated promptly, the member may request an expedited external review.

In addition to the information to be provided, Triple-S Salud will include a description of the ordinary external review and expedited external review procedures, highlighting the provisions that offer the member the opportunity to submit additional information. It should also include, if any, the forms necessary to process the request for external review.

Triple-S Salud shall include an authorization form, or any other document approved by the Commissioner, whereby the member authorizes Triple-S Salud to disclose protected health information, including medical records, that are relevant to the external review.

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
OCI Mailing Address
PO Box 195415 San Juan, PR 00919-5415
361 Calle Calaf, World Plaza Building, 268 Muñoz Rivera Ave., San Juan, PR 00918
Phone: 787-304-8686
www.ocs.pr.gov

- **By email:** investigaciones@ocs.pr.gov

Request for External Review

All requests for external review will be addressed to the Commissioner. The Commissioner may determine the form and content of the request for external review.

The member may request an external review of an adverse determination or of a final adverse determination.

Requirement to Exhaust the Internal Grievance Process

No request for external review will be processed until the member has exhausted the internal Triple-S Salud grievance process.

Triple-S Salud's internal grievance process will be considered exhausted when the member:

- Has filed an internal grievance, and
- Has not received a written determination from Triple-S Salud within thirty (30) days from the date the grievance was filed, unless an extension has been requested or agreed to.

However, the Insured Person may not request an external review of an adverse determination regarding a completed retrospective review until the member has exhausted Triple-S Salud's internal grievance process.

Concurrent with the request for an expedited internal review of a grievance, the member may request an expedited external review under any one of the following options:

- If the member has a health condition where the time required for an expedited internal grievance review would endanger their life, health, or full recovery; or

- If the adverse determination entails a denial of coverage based on a determination that the recommended or requested service or treatment is experimental or investigative in nature and the member's physician certifies in writing that such service or treatment would be significantly less effective if not initiated promptly.

Upon receipt of a request for an expedited external review, the independent review organization (IRO) appointed to conduct the external review will determine whether the member will be required to complete the expedited internal review process first.

If the independent review organization (IRO) determines that the member must first complete the expedited internal review process, they will immediately notify the member and advise them that, based on this decision, the expedited external review will not be performed until the internal process is completed.

An external adverse determination review may be requested before the member has exhausted Triple-S Salud's internal grievance procedures, provided that Triple-S Salud agrees to waive the requirement that such procedures be exhausted.

If Triple-S Salud waives the requirement to exhaust internal grievance procedures, the member may submit a written request for ordinary external review.

Ordinary External Review

No later than one-hundred and twenty (120) days after receiving an adverse determination or final adverse determination notice, the member may submit a request for external review to the Commissioner.

Upon receipt of a request for external review, the Commissioner will have one (1) business day to send a copy of the request for external review to Triple-S Salud.

No later than five (5) business days after receiving a copy of the request for external review, Triple-S Salud will complete a preliminary review of the request to determine the following:

- If the requester was insured at the time the health care service was requested or, in the case of a retrospective review, was a Triple-S Salud member at the time the health care service was provided;
- If it could be reasonably understood that the health care service subject to adverse determination or final adverse determination is a covered service under Triple S-Salud, except if Triple-S Salud has determined it is not covered because it does not meet the criteria of medical necessity, appropriateness, location where the health care service is provided, level of care, or effectiveness of the service.
- If the member has exhausted the Triple-S Salud internal grievance process, except when the Triple-S Salud internal grievance process is not required to be exhausted; and
- If the member has provided all information and forms required by the Commissioner to process the requests for external review, including the authorization form for the disclosure of health information.

Not later than the next business day after completing the preliminary review, Triple-S Salud will notify the Commissioner and the member in writing whether:

- The request for external review has been completed, and
- The request is eligible for external review.

If the request:

- Has not been completed, Triple-S Salud will send an initial determination notice in writing to notify the member and the Commissioner of the information or documentation needed to complete the application, or
- Is not eligible for external review, Triple-S Salud will send an initial determination notice in writing to notify the member and the Commissioner about the reasons for ineligibility.

The Commissioner may determine the form and content of the initial determination notice.

- If Triple-S Salud determines, as a result of the preliminary review performed, that the request is not eligible for external review, the notice sent to the member for such purposes must advise that the determination of ineligibility made by Triple-S Salud may be appealed before the Commissioner.

The Commissioner may determine that a request is eligible for external review, even if Triple-S Salud initially determined otherwise.

- The Commissioner's determination that a request is eligible for external review, after the initial determination to the contrary by Triple-S Salud, shall be made in accordance with the health plan terms of coverage and shall be subject to all applicable provisions.

No later than the next business day after the Commissioner receives notice that a request is eligible for external review:

- An independent review organization will be appointed to conduct the external review and Triple-S Salud will be notified of which independent review organization was appointed.
- The member will be notified in writing that the request is eligible and was accepted for external review.

In making its determination, the designated independent review organization shall not be bound by any of the decisions or conclusions arising from the utilization review process or the Triple-S Salud internal grievance process.

The Commissioner must include, in the notice sent to the insured member informing them that their request for external review has been accepted, terms for the purposes of submitting, in writing, to the independent review organization, within five (5) business days from receipt of the notification of acceptance, any additional information deemed appropriate for consideration during the external review. The independent review organization is not required to but may accept and consider any additional information submitted after the term of five (5) business days provided herein.

Not later than five (5) days after receiving notification of the appointed independent review organization, Triple-S Salud shall furnish the documents and any information that was taken into account in making the adverse determination or final adverse determination subject to external review.

Triple-S Salud's failure to provide the required documents and information within five (5) days shall not delay the external review.

If Triple-S Salud does not provide the required documents and information within five (5) days, the independent review organization may terminate the external review and decide to revoke the adverse determination or final adverse determination subject to external review.

Not later than the next business day after deciding to revoke the adverse determination or final adverse determination under review, the independent review organization shall notify the member, Triple-S Salud and the Commissioner.

The independent review organization will review all the information and documents received from Triple-S Salud and any other information submitted in writing by the member.

If the independent review organization receives information from the member, they shall in turn forward such information to Triple-S Salud no later than the next business day after receiving the information.

Upon receiving the information, Triple-S Salud may reconsider its adverse determination or final adverse determination subject to external review.

Triple-S Salud's reconsideration of its adverse determination or final adverse determination will not cause the external review to be delayed or terminated.

The external review may only be terminated if, upon completing its reconsideration, Triple-S Salud decides it will revoke its adverse determination or final adverse determination and provide coverage or payment for the health care service subject to the adverse determination or final adverse determination.

- Within one (1) business day from the decision to revoke its adverse determination or final adverse determination, Triple-S Salud shall provide written notice of such determination to the member, the independent review organization, and the Commissioner.
- The independent review organization shall terminate the external review after receiving the aforementioned notice from Triple-S Salud.

Aside from documents and information, the independent review organization shall, in so far as it deems appropriate and the information or documents are available, take the following into account in making its determination:

- The member's relevant health records;
- The recommendation from the member's attending health care provider;
- Consultation reports filed by health care providers and other documents submitted by Triple-S Salud, the member, or the member's attending provider;
- The terms of coverage of the member's health plan;
- The most appropriate practice guidelines, which could include generally accepted standards of practice, evidence-based practice guidelines, or other guidelines developed by the federal government or by national medical and professional associations or boards.
- Any clinical review criteria created and used by Triple-S Salud or the utilization review organization in making the adverse determination or final adverse determination; and
- The opinion of the clinical reviewers from the independent review organization, after examining the documents.

Not later than forty-five (45) days after receiving a request for external review, the independent review organization shall notify its determination as to whether it confirms or reverses the adverse determination or final adverse determination under review. Written notice will be sent to:

- The member;
- Triple-S Salud;
- The Commissioner.

The independent review organization shall include the following in its written notice of determination:

- A general overview of the rationale for the external review request;
- The date when the independent review organization received the referral from the Commissioner to carry out the external review;
- The date the external review was performed;
- The date of determination;
- The main reason or reasons for the determination, including which standards, if any, supported the determination;
- The rationale for their determination; and
- References to the evidence or documentation, including practice guidelines, that were taken into account in making the determination.

If the independent review organization's determination revokes the adverse determination or final adverse determination under review, Triple-S Salud will immediately approve the coverage or payment for the service or benefit that was the subject of review.

The Commissioner's appointment of an independent review organization to conduct an external review shall be made by selecting at random from among the independent review organizations authorized and qualified to conduct the specific external review in question, taking into account the nature of the health care services subject to the adverse determination or final adverse determination under review, as well as any other relevant circumstances, including potential conflicts of interest.

Expedited External Review

The member may file a request for expedited external review before the Commissioner upon receiving any of the following:
An adverse determination, provided that:

- The adverse determination is related to a health condition of the member where the time provided for an expedited internal review would endanger their life, health, or full recovery; and
- The member has filed a request for an expedited internal grievance review for which an adverse determination was made; or

A final adverse determination, provided that:

- The member has a health condition where the time provided for an ordinary external review would endanger their life, health, or full recovery; or
- The final adverse determination concerns admission to a health care facility, the availability of a service, or the ongoing stay at a facility where the member received emergency services and from which they have not yet been discharged.

Upon receipt of a request for expedited external review, the Commissioner shall immediately send a copy of said request to Triple-S Salud.

After receiving a copy of the request for expedited external review, Triple-S Salud must immediately determine whether the request meets the criteria for review and notify the member and the Commissioner of its determination as to whether the application is eligible for external review.

The Commissioner may determine the form and content of the initial determination notice.

If Triple-S Salud determines, as a result of the preliminary review performed, that the request is not eligible for external review, the notice sent to the member for such purposes must advise that the determination of ineligibility made by Triple-S Salud may be appealed before the Commissioner.

- The Commissioner may determine that a request is eligible for external review, even if Triple-S Salud initially determined otherwise.
- The Commissioner's determination that a request is eligible for external review, after the initial determination to the contrary by Triple-S Salud, shall be made in accordance with the health plan terms of coverage and shall be subject to all applicable provisions.

Upon receiving notice from Triple-S Salud that a request meets the criteria for review, the Commissioner will immediately appoint an independent review organization to perform the expedited external review. In addition, Triple-S Salud will be notified of which independent review organization was appointed, and the member will be notified in writing that their request is eligible and was accepted for expedited external review.

In making its determination, the designated independent review organization shall not be bound by any of the decisions or conclusions arising from the utilization review process or the Triple-S Salud internal grievance process.

Upon receiving the Commissioner's notice regarding the appointed independent review organization, Triple-S Salud shall furnish, electronically or by any other expedited method, the documents and all the information that would be taken into account in making the adverse determination or final adverse determination subject to expedited external review.

Aside from documents and information, the independent review organization shall, in so far as it deems appropriate and the information or documents are available, take the following into account in making its determination:

- The member's relevant health records;
- The recommendation from the member's attending health care provider;
- Consultation reports filed by health care providers and other documents submitted by Triple-S Salud, the member, or the member's attending health care provider;
- The terms of coverage of the member's health plan;
- The most appropriate practice guidelines, which could include generally accepted standards of practice, evidence-based practice guidelines, or other guidelines developed by the federal government or by national medical and professional associations or boards.
- Any clinical review criteria created and used by Triple-S Salud or the utilization review organization in making the adverse determination or final adverse determination; and

- The opinion of the clinical reviewers from the independent review organization, after examining the documents.

The independent review organization will make its determination with the urgency required by the insured member's circumstances or health condition, but never later than seventy-two (72) hours after receiving the request for expedited external review. Within this period, the independent review organization must:

- Make its determination whether to confirm or revoke the adverse determination or final adverse determination under review; and
- Provide notice of its determination to the member, Triple-S Salud, and the Commissioner.

If the independent review organization does not initially furnish its determination notice in writing, within forty-eight (48) hours from making its determination, the independent review organization must:

- Send written confirmation of the determination to the member, Triple-S Salud, and the Commissioner; and
- Include the information in the written notice.

If the independent review organization's determination revokes the adverse determination or final adverse determination under review, Triple-S Salud will immediately approve the coverage or payment for the service or benefit that was the subject of expedited external review.

The recourse of expedited external review is not available if the adverse determination or final adverse determination was made for a retrospective review.

The Commissioner's appointment of an independent review organization to conduct an expedited external review shall be made by selecting at random from among the independent review organizations authorized and qualified to conduct the specific external review in question, taking into account the nature of the health care services subject to the adverse determination or final adverse determination under review, as well as any other relevant circumstances, including potential conflicts of interest.

External Review for Adverse Determinations Based on Experimental or Investigative Treatment

No later than one-hundred and twenty (120) days after receiving a notice of adverse determination or final adverse determination whereby a requested or recommended health care service or treatment is denied due to its experimental or investigative nature, the member may submit a request for external review before the Commissioner.

The member may verbally request an expedited external review of an adverse determination or final adverse determination denying a recommended or requested health care service or treatment due to its experimental or investigative nature, provided that their physician provides written certification that the denied health care service or treatment would be substantially less effective if not initiated promptly.

Upon receipt of a request for expedited external review, in accordance with the previous paragraph (a), the Commissioner will immediately notify Triple-S Salud of the submission of the aforementioned request.

After receiving a copy of the request, Triple-S Salud must immediately determine whether the request meets the criteria for review and notify the member and the Commissioner of its determination as to whether the application is eligible for external review.

The Commissioner may determine the form and content of the initial determination notice.

If Triple-S Salud determines, as a result of the preliminary review performed, that the request is not eligible for external review, the notice sent to the member for such purposes must advise that the determination of ineligibility made by Triple-S Salud may be appealed before the Commissioner.

The Commissioner may determine that a request is eligible for external review, even if Triple-S Salud initially determined otherwise.

The Commissioner's determination that a request is eligible for external review, after the initial determination to the contrary by Triple-S Salud, shall be made in accordance with the health plan terms of coverage and shall be subject to all applicable provisions.

Upon receipt of Triple-S Salud's notification that the request meets the criteria for review, the Commissioner will promptly appoint an independent review organization to perform an expedited external review; notify Triple-S Salud as to which independent review organization was appointed, and send written notice to the member that their request was eligible and approved for expedited external review.

Upon receiving the Commissioner's notice regarding the appointed independent review organization, Triple-S Salud shall furnish, electronically or by any other expedited method, the documents and all the information that would be taken into account in making the adverse determination or final adverse determination subject to review.

Except for requests for expedited external review, no later than the next business day after receiving a request for external review for a denial of a recommended or requested health care service or treatment due to its experimental or investigative nature, the Commissioner will send notice and a copy of the request to Triple-S Salud.

After receiving a copy of the request for expedited external review, Triple-S Salud will have five (5) business days to conduct a preliminary review of the request to determine if it meets the following criteria:

- The person is or was insured under the health plan when the health care service or treatment was requested or recommended, or in the case of a retrospective review, the person had been insured under a health plan when the health care service was rendered;
- The requested or recommended health care treatment or service subject to the adverse determination or final adverse determination:
    - Is a benefit covered under the member's health plan, but Triple-S Salud has determined that the treatment or service is of an experimental or investigative nature; and
    - It is not explicitly mentioned as an excluded benefit under the member's health plan;

The member's physician has provided written certification that one of the following circumstances applies:

- The usual and customary health care services or treatments have not been effective to improve the member's condition;
- The usual and customary health care services or treatments are not medically adequate for the member; or
- There is no health care treatment or service covered by the plan that would be more beneficial than the health care service or treatment recommended or requested.

The member's attending physician:

- Has recommended a health care service or treatment and certified, in writing, that it is their opinion that it will most likely benefit the member more than the usual and customary health care services or treatments; or
- The member's attending physician, who is qualified to practice medicine to treat the health condition in question, has provided written certification that there is valid scientific research, performed following the accepted protocols, showing that the health care service or treatment requested by the member is more likely to be beneficial than any other usual or customary health care service available;

The member has exhausted Triple-S Salud's internal grievance process, except if such process is not required to be exhausted; and

The member has provided all the information and forms required to process the external review, including the authorization form.

Not later than the next business day after completing the preliminary review, Triple-S Salud will provide written notice to the Commissioner and the member:

- If the request is complete, and
- If the request is eligible for external review.

If the request:

- Has not been completed, Triple-S Salud will notify the member and the Commissioner in writing of the information or documentation needed to complete the application; or
- Is not eligible for external review, Triple-S Salud will notify the member and the Commissioner in writing about the reasons for ineligibility.
- The Commissioner may determine the form and content of the initial determination notice.
- If Triple-S Salud determines, as a result of the preliminary review performed, that the request is not eligible for external review, the notice sent to the member for such purposes must advise that the determination of ineligibility made by Triple-S Salud may be appealed before the Commissioner.

The Commissioner may determine that a request is eligible for external review, even if Triple-S Salud initially determined otherwise.

The Commissioner's determination that a request is eligible for external review, after the initial determination to the contrary by Triple-S Salud, shall be made in accordance with the health plan terms of coverage and shall be subject to all applicable provisions.

If Triple-S Salud determines that the request for external review is eligible for such purposes, this should be notified to the member and the Commissioner.

No later than the next business day after receiving Triple-S Salud's notice stating that the request is eligible for external review, the Commissioner shall:

- Appoint an independent review organization to conduct the external review and notify Triple-S Salud of which independent review organization was appointed; and
- Notify the member in writing that the request is eligible and was accepted for external review.

The Commissioner must include, in the notice sent to the insured member informing them that their request for external review has been accepted, terms for the purposes of submitting, in writing, to the independent review organization, within five (5) business days from receipt of the notification of acceptance, any

additional information deemed appropriate for consideration during the external review. The independent review organization is not required to but may accept and consider any additional information submitted after the term of five (5) business days provided herein.

No later than the next business day after receiving the notice of appointment for external review, the independent review organization shall:

- Select, as deemed appropriate, one or more clinical reviewers to perform the external review.

When appointing clinical reviewers, the independent review organization shall select physicians or other health care professionals that meet the minimum requirements and who, based on their clinical experience over the last three (3) years, are experts in treating the member's condition, and who also possess extensive knowledge about the health care service or treatment that was recommended or requested.

Neither the member nor Triple-S Salud shall choose or control the way physicians or other health care providers are selected for the role of clinical reviewer.

Each clinical reviewer will provide the independent review organization with a written opinion as to whether the recommended or requested health care service or treatment should be covered.

When forming their opinion, clinical reviewers will not be obligated by any of the decisions or conclusions arising from Triple-S Salud's utilization review or internal grievance processes.

Not later than five (5) days after receiving notification of the appointed independent review organization, Triple-S Salud shall furnish the documents and any information that was taken into account in making the adverse determination or final adverse determination subject to review.

Triple-S Salud's failure to provide the required documents and information within the five (5) days provided shall not delay the external review.

If Triple-S Salud does not provide the required documents and information within the five (5) days provided in paragraph (E)(1) of this Article, the independent review organization may terminate the external review and decide to revoke the adverse determination or final adverse determination subject to review.

If the independent review organization decides to revoke the adverse determination or final adverse determination for any reason, the independent review organization shall immediately notify the member, Triple-S Salud, and the Commissioner.

Each clinical reviewer shall analyze all of the information and documents received from Triple-S Salud and any other information submitted in writing by the member.
If the independent review organization receives information from the insured member, they shall in turn forward such information to Triple-S Salud no later than the next business day after receiving the information.

Upon receiving the information, Triple-S Salud may reconsider its adverse determination or final adverse determination subject to external review.

Triple-S Salud's reconsideration of its adverse determination or final adverse determination will not cause the external review to be delayed or terminated.

The external review may only be terminated if, upon completing its reconsideration, Triple-S Salud decides it will revoke its adverse determination or final adverse determination and provide coverage or payment for the health care service subject to the adverse determination or final adverse determination.

If Triple-S Salud makes the decision to revoke its adverse determination or final adverse determination, written notice will be immediately furnished to the member, the independent review organization, and the Commissioner.

The independent review organization shall terminate the external review after receiving this notice from Triple-S Salud.

No later than twenty (20) days after being selected to perform the external review, the clinical reviewer(s) shall provide the independent review organization with their opinion as to whether the recommended or requested health care service or treatment should be covered.

Each clinical reviewer's opinion must be delivered in writing and include the following information:

- A description of the member's health condition;
- A description of the relevant factors taken into account to determine whether there is sufficient evidence to show the recommended or requested health care service or treatment is more likely to be beneficial to the member than the usual and customary health care service or treatment, and that the adverse risks related to the recommended or requested health care service or treatment would not be significantly higher than those of the usual and customary health care services or treatments available;
- A description and analysis of the medical or scientific evidence considered to formulate the opinion.
- A description and analysis of any evidence-based standard considered to formulate the opinion; and
- Information as to whether the rationale behind the reviewer's opinion
- In the case of expedited external reviews, each clinical reviewer shall express their opinion, either verbally or in writing, to the independent review organization as soon as the member's condition or health problems require, but no later than five (5) days after being selected to perform the external review.
- If the clinical reviewer's opinion was initially formulated verbally, no later than two (2) days after providing their opinion, the clinical reviewer shall provide a written confirmation to the independent review organization, including the required information.

Each clinical reviewer, inasmuch as they deem appropriate and the information or documents are available, shall take the following into account when formulating their opinion:

- The member's relevant health records;
- The recommendation from the member's attending health care provider;
- Consultation reports filed by health care providers and other documents submitted by Triple-S Salud, the member, or the member's attending provider;
- The terms of coverage of the member's health plan;

Whichever of the following alternatives that is applicable, if any:

- The recommended or requested health care service or treatment has been approved by the Food and Drug Administration (FDA) for the member's condition; or

- There is medical or scientific evidence, or evidence-based standards, showing that the recommended or requested health care service or treatment is more likely to benefit the member than the usual and customary health care service or treatment available, and that the adverse risks of the recommended or requested health care service or treatment would not be significantly higher than those of the usual and customary health care services or treatments available.

No later than twenty (20) days after receiving the opinion of the clinical reviewers, the independent review organization shall make its determination and notify the following people in writing:

- The member;
- Triple-S Salud; and
- The Commissioner.

In the case of an expedited external review, no later than forty-eight (48) hours after receiving the opinion of the clinical reviewers, the independent review organization will make its determination and provide either verbal or written notification to the insured member, Triple-S Salud, and the Commissioner.

If the determination was initially notified verbally, no later than two (2) days after providing such verbal notice, the independent review organization will provide written confirmation to the insured member, Triple-S Salud, and the Commissioner, including the required information.

If most clinical reviewers agree that the recommended or requested health care service or treatment should be covered, the independent review organization will determine that the adverse determination or final adverse determination under review shall be revoked.

If most clinical reviewers agree that the recommended or requested health care service or treatment should not be covered, the independent review organization will determine that the adverse determination or final adverse determination under review shall be confirmed.

If there is a tie among clinical reviewers as to whether the recommended or requested health care service or treatment should be covered or not, the independent review organization will obtain the opinion of an additional clinical reviewer so that a decision may be made based on majority opinion.

If there is a need to select an additional clinical reviewer, in accordance with the paragraph above, such additional clinical reviewer shall peruse the same information the other clinical reviewers had available when formulating their opinion.

The selection of an additional clinical reviewer will not delay the deadline for the independent review organization to make its determination based on the opinions of the selected clinical reviewers.

The independent review organization shall include the following in its written notice of determination:

- A general description of the reason why an external review has been requested;
- The opinion of each clinical reviewer, including each one's advice as to whether the recommended or requested health care service or treatment should be covered or not, and the rationale for the reviewer's recommendation;
- The date when the independent review organization was appointed by the Commissioner to carry out the external review;

- The date the external review was performed;
- The date of determination;
- The primary reason(s) for its determination; and
- The reason or rationale for their determination.

If the independent review organization's determination revokes the adverse determination or final adverse determination under review, Triple-S Salud will immediately approve the coverage or payment for the health care service or treatment that was the subject of review.

The Commissioner's appointment of an independent review organization to conduct an external review in accordance with this Article shall be made by selecting at random from among the independent review organizations authorized and qualified to conduct the specific external review in question, taking into account the nature of the health care services subject to the adverse determination or final adverse determination under review, as well as any other relevant circumstances, including potential conflicts of interest.

Binding Nature of the External Review Determination

The external review determination binds Triple-S Salud, except when Triple-S Salud has any other recourse based on the applicable law in Puerto Rico.

The external review determination binds the member, except when the member has any other recourse based on the applicable Puerto Rico or federal law.

The member may not submit further requests for external review in regard to an adverse determination or final adverse determination for which there was already an external review in accordance with this Chapter.

Paying for the Costs of External Review

If Triple-S Salud receives a request for ordinary or expedited external review, they will be obligated to pay the independent review organization for the external review.

The Office of the Commissioner of Insurance shall notify Triple-S Salud about the costs entailed of the process or any modification therein at least 120 days in advance.

The member shall pay a nominal fee no greater than $25.00 per review. Furthermore, the fees for a single member may not exceed seventy-five dollars ($75.00) per policy year. The amount paid by the member will be reimbursed if the opinion is determined in their favor.

The external review processes at the Office of the Commissioner of Insurance regarding final adverse determinations will be conducted by the independent review organization “Federal Hearings & Appeals Services, Inc” The health insurance company or insurer subject of the request for external review will be required to cover the cost of the external review requests, which will be based on a fee of $625 for each ordinary review request or $700 for an expedited review request.

PROCEDURE FOR REIMBURSEMENTS

1. Reimbursement requests should be sent:

   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, to the following email: reembolso@ssspr.com. For dental services, please send your documents to: reemdental@ssspr.com.

   c. By mail: Triple-S Salud, Inc. 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
      - Diagnosis Code *(ICD-10)* and/or diagnosis description
      - Procedure code (effective as of the date of service) and/or service description
      - *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 distance traveled, evidence of medical necessity, and the carrier's Incident Report
      - If the services required 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
      - State the cost for each medication

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

      - Service code, number of restored teeth and surfaces (if applicable).

      - Amount paid for each service

      - If the member pays more than one visit under a single a receipt, they must send the exact dates of service **(MONTH, DAY, YEAR)** for which they paid.

      - When requesting a reimbursement for the initial visit and down payment for orthodontic services, if enrolled for coverage, you should include the detailed treatment plan, including visit

records, down payment, monthly payments, and the total cost and duration of the medical treatment.

- If you receive dental prostheses and periodontology services, if enrolled for coverage, you must bring the radiographies.

If you are requesting a reimbursement for Coordination of Benefits, you should include:

- Contract number of your primary plan if it is with Triple-S Salud

- If you are requesting reimbursement for the amount not paid by your primary health insurance plan, you must include the Explanation of Benefits of the other plan

2. You must notify Triple-S Salud in writing about the claim within twenty (20) days after receiving the service or as soon as reasonably possible for the member or the employer, but no later than one (1) year after the date the service was rendered, unless evidence is submitted that it was impossible to file the claim within the established time.

3. Triple-S Salud has up to 15 days to deliver an acknowledgement of receipt after receiving the claim notice by mail. Notices delivered to a member's appointee shall be considered notices delivered to the member, provided that the authorization is in force and has not been revoked. If the person is not authorized and receives a notice addressed to the member, they must report it to the claimant 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.

4. Triple-S Salud will investigate, adjust, and resolve all claims in the shortest reasonable period, within 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 resolution 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 or 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, Monday through Friday, from 8:00 a.m. – 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 72 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)
- Orthognathic surgery
- 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
- Injectable medications covered in the medical coverage not related to cancer
- Genetic tests
- Durable Medical Equipment
- Skilled nursing facility
- Home health services
- Residential treatment
- Hospice
- Non-emergency services obtained in the United States
- General anesthesia and hospitalization services for covered dental procedures on minors and physically or mentally disabled people who require them.
- 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

Fax: 787-774-4824

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

PROCEDURE FOR PRECERTIFICATIONS

Once the precertification request is received, Triple-S Salud will evaluate it and notify its determination to the member, regardless of whether the benefit is authorized or not, within a period not exceeding fifteen (15) days after the date the request is received.

If Triple-S Salud cannot make its determination within that time frame for reasons beyond its control, said term may be extended for fifteen (15) additional days. In these cases, Triple-S Salud will send a justification to the member, before the end of the initial fifteen-day (15) term from the receipt of the precertification request, stating the date when the determination is expected to be made.

If your request is incomplete and fails to fulfill the minimum evaluation requirements, Triple-S Salud will notify you verbally or in writing, no later than five (5) days from the date the request was received, and confirm the information you must provide to complete the evaluation process. Should you request the confirmation in writing, Triple-S Salud will send you the notice within the established period. In such case, you will have up to 45 days from the notice to provide the information requested, starting from the date of notice.

PRECERTIFICATION FOR URGENT CASES

You may need Triple-S Salud to consider your precertification request urgently. This could be due to a health condition that, according to your attending physician, could put your life, health, or ability to regain maximum function at serious risk, or because submitting you to the regular terms to respond to the precertification request would expose you to suffering severe pain that cannot be handled properly without the treatment for which the precertification is being requested. In such cases, your attending physician must state the nature of the urgency. Once stated by the physician, Triple-S Salud will process the request urgently. Requests for these cases may be made orally or in writing. Triple-S Salud must notify you of its decision verbally or in writing, unless you request that it be done in writing, within 24 hours from receiving your request.

If Triple-S Salud needs additional information to furnish its determination, it must notify you verbally or in writing, unless you request it to be in writing within 24 hours after the request was received. You or your representative will have at least 48 hours from the notification to submit any additional information requested. After receiving the additional information, Triple-S Salud must answer the request within no more than 48 hours after whichever comes first between: the date of receipt of the additional information,

or the established deadline to receive it. If Triple-S Salud does not receive the information requested by the aforementioned deadline, Triple-S Salud may deny the requested service certification.

The notification of the adverse determination shall state the following:

- Date of service, provider, claim amount, 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 plan's specific provisions on which the determination is based;
- Description of all additional material or information needed to complete the request, including an explanation of why it is necessary;
- Description of the plan's internal procedures for grievances and expedited grievance reviews, including the applicable time limits for such procedures;
- If a rule, guideline, internal protocol, or other similar criteria was considered for the adverse determination, a copy will be provided free of charge to the member;
- If the adverse determination considered judgment of medical necessity, experimental or investigative nature, or similar exclusions or limits, we shall include an explanation of the scientific or clinical rationale that was considered for the determination when applying the health plan terms to the member's circumstances.

You have the right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health to request assistance at any time, and you have the right to sue before a competent court after concluding Triple-S Salud's internal grievance process. The Office of the Commissioner of Insurance is located at 361 Calle Calaf, World Plaza Building, 268 Muñoz Rivera Ave., San Juan, PR 00918, or you may call (787) 304-8686.

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

Some of the services in this Section are subject to applicable copayments or coinsurance. For details about your copayments and coinsurances, please refer to the Table of Copayments and Coinsurance at the end of this policy.

MAXIMUM ANNUAL OUT-OF-POCKET

The maximum annual out-of-pocket for this coverage is $6,350 for individual contracts and $12,700 for couple or family contracts. Once the member reaches the applicable amount for his/her type of contract, he/she will not need to make any additional disbursements for the remaining policy year for essential benefits; Triple-S Salud will pay 100% of the remaining health care expenses covered under this policy.

Services provided by non-participating providers in and outside Puerto Rico, payments made by the member for non-covered services under this policy, alternative therapy services (Triple-S Natural), eyeglasses or contact lenses (if benefit is covered), essential dental services (if enrolled for coverage) and the monthly premium paid to Triple-S Salud for the plan are not considered eligible expenses for the accrual of the maximum out-of-pocket.

The selected maximum out-of-pocket is in accordance with the amount allowed by the Office of the Commissioner of Insurance of Puerto Rico.

Teleconsulta MD®

Telemedicine services through virtual medical consultations. **Teleconsulta MD®** lets you receive medical attention from 6:00 AM to 10:00 PM from anywhere within Puerto Rico, 365 days a year. You will be able to access medical consultations with licensed general practitioners, family physicians, internists, pediatricians, or psychologists, be it for minor medical conditions or less urgent cases.

You decide if you would rather set up a time for the medical consultation or choose your preferred physician. The provider must send the prescriptions to the participating pharmacy. If you need to carry out laboratories or radiological studies, you can receive the medical orders through the platform. You may also share test results with the physician.

Visit our website, at www.ssspr.com to download the app and connect from your mobile device or your computer. Telemedicine services do not substitute the care provided by your doctor. In the event of a medical emergency, call 911 or go to your nearest emergency room. This benefit requires a $10 copayment per consultation.

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 during the year, in accordance with HCERA and USPSTF updates. 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 physicians and providers in Puerto Rico. For an updated list, as well as additional information about these services, please visit the following website: https://www.healthcare.gov/coverage/preventive-care-benefits/.

Preventive Care for Adults

Preventive Service	Indication
Abdominal Aortic Aneurysm	One (1) service per ultrasonogram for abdominal aortic aneurysm (AAA) screening, for members 65 to 75 years of age who currently are or were smokers at some point
Screening for Anxiety Disorders	The USPSTF recommends screening for anxiety disorders in adults (64 years of age or younger), including pregnant or postpartum individuals.
Colorectal cancer	According to administrative order #334 of the Department of Health, one annual occult blood test for colorectal cancer screening is covered for adults 40 years of age and older. If the person has a family history of colorectal cancer, the annual screening is performed via colonoscopy instead of the occult blood test. The USPSTF recommends performing the colorectal cancer screening via occult blood test, sigmoidoscopy, colonoscopy, or serological test in adults 45 to 75 years old. The risks and benefits of these screening methods vary. The USPSTF also recommends performing a follow-up colonoscopy after a positive result on a non-invasive test. This is a screening test, and patients will not incur any out-of-pocket expenses.
Depression and Suicide Risk Screening for Adults	The USPSTF recommends screening for depression in the adult population, including individuals during pregnancy or postpartum, as well as older adults (65 years of age or older).
Fall prevention in senior citizens: exercise or physical therapy	Exercises and physical therapy to prevent falls in adults over 65 years old who are at risk of falling.
Healthy diet and physical activity as a form of prevention for cardiovascular disease in adults at cardiovascular risk	Offering and referring adults who are overweight or obese and who have additional risk factors for cardiovascular disease to intensive behavioral counseling interventions, to promote a healthy diet and physical activity to prevent cardiovascular diseases.
Hepatitis B virus screening	The USPSTF recommends screening for the Hepatitis B virus in adults at high risk for infection.
Hepatitis C virus screening: teenagers and adults	Screening for hepatitis C (HCV) infections in adults from 18 to 79 years old.
Hypertension screening for members who have not been diagnosed with the condition	Hypertension screening for adults 18 years of age and older. Readings should be obtained outside the clinical setting to confirm the diagnosis before starting treatment.
Prevention of HIV Acquisition: Pre-exposure Prophylaxis: adolescents and adults at increased risk for HIV	The USPSTF recommends that physicians prescribe pre-exposure prophylaxis using antiretroviral therapy to individuals who are at increased risk of contracting HIV in order to decrease the risk of acquiring HIV. See the USPSTF Practice Considerations section for more information on identifying persons at increased risk and effective antiretroviral therapy.

Human Immunodeficiency Virus (HIV) screening test: teenagers and adults that are not currently pregnant	Human Immunodeficiency Virus (HIV) screening for adults 13 to 65 years old, as well as younger teenagers and older adults with high risk. As required by Act No. 45-2016, this includes one HIV test per year as part of the routine medical evaluation, except for pregnant members to whom USPSTF requirements apply.
Immunization	Vaccines. The recommended dosages, ages, and population vary: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza, MMR, Meningococcus, Pneumococcus, Tetanus, Diphtheria, Whooping Cough, and Chickenpox, Haemophilus influenza type B. Catch-up vaccines are covered. COVID-19 vaccine for persons 19 years of age and older adults, as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) and in accordance with section 2.050 (c) of the Puerto Rico Health Insurance Code. *The Mpox vaccine is recommended for anyone at risk of Mpox infection.* The vaccine against respiratory syncytial virus (RSV) is recommended using seasonal administration for pregnant individuals and older adults over 60 years of age. See CDC recommendations.
Detection of latent tuberculosis infection	The USPSTF recommends screening tests for latent tuberculosis infection in high-risk populations. See the USPSTF "Risk Assessment" section for additional information on adults at increased risk.
Lung cancer screening	Annual lung cancer screening through computerized tomography for adults from 50 to 80 years old with a history of smoking twenty (20) packs per year, who are currently smoking or stopped smoking within the last 15 years. The screening will be discontinued once the person has stopped smoking for 15 consecutive years or develops a health problem that substantially limits their life expectancy or the likelihood of undergoing lung surgery to cure the disease.
Obesity screening and counseling for adults	Physicians may offer or refer patients with a Body Mass Index (BMI) of 30 kg/m2 or more to intensive multi-component behavioral interventions.
Screening for prediabetes and type 2 diabetes in asymptomatic adults aged 35 to 70 years old and who are overweight or obese	The USPSTF recommends screenings for prediabetes and type 2 diabetes in adults aged 35 to 70 years old who are overweight or obese. Physicians must offer or refer patients with prediabetes to effective preventive interventions.
Sexually transmitted diseases	Intensive behavioral counseling for sexually active teenagers and adults at high risk of contracting sexually transmitted diseases.
Statins to prevent cardiovascular events in adults: Preventive Medications	The USPSTF recommends prescribing a statin for the primary prevention of cardiovascular disease (CVD) for adults aged 40 to 75 years who have one (1) or more CVD risk factors (for example, dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year cardiovascular event risk of 10% or greater.
Syphilis screening tests in teenagers and adults who are not currently pregnant	The USPSTF recommends screening for syphilis infection in asymptomatic and nonpregnant teenagers and adults who are at increased risk for infection.
Tobacco use and drug use cessation: Adults who are not currently pregnant	The USPSTF recommends that physicians ask all adults about their tobacco use, discourage this habit, and offer behavioral interventions and smoking cessation drugs approved by the Food and Drug Administration (FDA). For those using products to cease tobacco use, this plan covers the supply of FDA-approved smoking cessation

	medications for ninety (90) consecutive days in a single attempt and for up to two (2) attempts per year.
TB Screening Test: adults	Screening for tuberculosis infection in high-risk populations.
Harmful alcohol use: adults	Screening for harmful alcohol use at primary care facilities in adults over 18 years old, including pregnant members, by providing brief behavioral counseling interventions to reduce harmful alcohol consumption for people who engage in dangerous or risky consumption.
Harmful drug use in adults	Screening for harmful drug use in adults 18 years of age or older by providing brief behavioral counseling interventions. The screening should be performed when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.

Preventive Services for Adults, including Pregnancies

Preventive Service	Indication
Screening for bacteria in pregnant individuals	The USPSTF recommends performing urine culture screening for asymptomatic bacteriuria in pregnant individuals.
BRCA: Risk Assessment	Primary care providers must screen people who have had relatives with breast, ovarian, fallopian, or peritoneal cancer, using tools designed to identify family history that could be associated with an increased risk for potentially harmful mutations in the breast cancer susceptibility genes (BRCA1 or BRCA2). Members whose tests suggest they might be at risk must receive genetic counseling and, if prescribed as a result, the BRCA test.
Breast cancer: preventive drugs to reduce risk	The USPSTF recommends that physicians offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, to women who are at increased risk for breast cancer who are 35 years of age or older and at low risk of having adverse reactions to the medications.
Breast Cancer Screening	Pursuant to Act No. 10 of January 3, 2020, “Law on the Right to Effective Breast Cancer Screening,” establishes that the following must be included among the preventive care benefits: • One mammography, for members who are thirty-five (35) to thirty-nine (39) years old. • One (1) annual mammography for members who are forty (40) years or age or older. • One (1) annual mammography, follow-up treatment, or supplementary diagnostic tests (MRI/sonomammograms), for members who are forty (40) years of age or older whose breast tissue is considered to be heterogeneously dense or extremely dense. • One (1) annual mammography, follow-up treatment, or supplementary diagnostic tests, for women who are at high risk of developing breast cancer due to their family history, their own history as a cancer patient, the presence of high-risk markers in their genetic profile, or any other factor determined by their physician.

Breastfeeding	Comprehensive breastfeeding support services (including consultation, counseling, education by physicians and peer support services, and breastfeeding equipment and supplies) during the prenatal, perinatal, and postpartum periods to optimize successful breastfeeding initiation and maintenance. Breastfeeding equipment and supplies include, but are not limited to, double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies. Access to double electric breast pumps must be prioritized in order to optimize breastfeeding and will not be based on a previous problem with manual breast pumps. The breastfeeding team may also include equipment and supplies as clinically indicated to support dyads with breastfeeding difficulties and those in need of additional services. No monetary limits apply. Breastfeeding equipment and supplies cannot be provided through reimbursement or optional major medical coverage.
Cervical cancer screening	Cervical cancer screening for members who are 21 to 29 years old, with the Papanicolaou test every three (3) years. For members from 30 to 65 years old, one test every three (3) years with cervical cytology, every five (5) years with the high-risk human papillomavirus (hrHPV) test, or every five (5) years with the hrHPV test in combination with cytology.
Chlamydia screening	Screening for chlamydia for all members who are pregnant and for members who are sexually active and under 24 years old, or older if at a high risk for infection.
Contraceptive Methods	FDA-approved contraceptive methods, sterilization procedures, screening, counseling, and education for all members of reproductive age, as prescribed. The insertion and removal of any device are covered. Follow-up visits are also considered part of contraceptive care.
Healthy weight and weight gain counseling for pregnant individuals	Behavioral counseling interventions for teenagers and adults to promote a healthy increase in weight and prevent excessive weight gain during pregnancy.
Intimate partner violence, elder abuse, and abuse of vulnerable adults: Screening: women of reproductive age	Screening for violence, such as domestic violence, in the intimate relationships of members of reproductive age, and offering and referring individuals who tested positive to the screening to intervention services.
Folic acid supplementation to prevent neural tube defects: preventive medicine	For all people who are planning or who may become pregnant, they must take a daily folic acid supplement of 0.4 to 0.8 mg (400 to 800 ug).
Gestational Diabetes Mellitus	The Women's Preventive Services Initiative (WPSI) recommends screening pregnant women for gestational diabetes mellitus (GDM) after 24 weeks of gestation (preferably between 24 and 28 weeks of gestation) to prevent adverse birth outcomes. The WPSI suggests that pregnant women with risk factors for type 2 diabetes or GDM be screened before 24 weeks of gestation —ideally at the first prenatal visit.
Gonorrhea screening	Screening for gonorrhea in individuals who are sexually active and no more than 24 years old, or older if at a high risk for infection.

Hepatitis B screening: pregnant members	For pregnant members, screening for Hepatitis B virus infection during the first prenatal visit.
Screening test for human immunodeficiency virus (HIV): Pregnant members	Physicians must screen all pregnant members for HIV, including those who come in for delivery and have not been tested and whose HIV status is unknown. The following tests are covered at no copayment for pregnant individuals: a. First HIV test during the first trimester of gestation or on the first prenatal visit, and b. Second test during the third trimester of gestation (between 28 and 34 weeks of gestation).
Human Immunodeficiency Virus (HIV) screening test	• All adolescents and adult women (15 years and older) should be tested for HIV at least once in their lifetime. • Earlier or additional screening tests should be based on risk, and annual or more frequent retesting may be appropriate starting at age 13 for adolescents and adult women at increased risk of HIV infection. • Risk assessment and HIV prevention education beginning at age 13 and continuing as determined by risk. • An HIV screening test is recommended for all pregnant women at the start of prenatal care, with retesting during the pregnancy based on risk factors. • Rapid HIV testing is recommended for pregnant women who have gone into active labor and whose HIV status is unknown. Screening during pregnancy can help prevent vertical transmission.
Prevention of obesity in middle-aged women.	Counseling middle-aged women (40 to 60 years old) who have a normal or overweight body mass index (BMI) (18.5 – 29.9 kg/m2) to help them maintain their weight or limit their weight gain in order to prevent obesity. These counseling services may include a one-on-one discussion on healthy nutrition and physical activity.
Counseling and Screening for Human Immunodeficiency Virus	Annual counseling and screening for human immunodeficiency virus infection for all sexually active women.
Osteoporosis screening: postmenopausal members under 65 years old at a higher risk for osteoporosis	Screening for osteoporosis with a bone densitometry test to prevent osteoporosis fractures in postmenopausal 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	Screening for osteoporosis with a 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 or postpartum members who are at a risk for perinatal depression.
Preeclampsia prevention: aspirin	Use of low-dose aspirin (81mg/d) as preventive medication after the 12th week of gestation in members at high risk for preeclampsia.

Hypertensive disorders of pregnancy: asymptomatic pregnant individuals	Screening for preeclampsia in people using blood pressure monitoring throughout the entire pregnancy.

Rh(D) Incompatibility Screening	Rh(D) blood type and antibody tests for all pregnant members during their pregnancy at the first prenatal visit. Includes repeating the antibody test for pregnant members who have Rh-negative blood but aren't Rh-sensitized, sometime between 24 and 28 weeks of gestation, unless the biological father is also Rh-negative.
Anxiety screening tests	The Women's Preventive Services Initiative recommends anxiety screening tests for teenage and adult women, including those who are pregnant or postpartum. The optimal intervals for screening are unknown, and clinical judgment should be used to determine the frequency for these assessments. Given the high prevalence of anxiety disorders, the lack of recognition in clinical practice, and the multiple problems associated with untreated anxiety, physicians should consider screening women who have not been recently screened.
Screening for diabetes mellitus after pregnancy	The Women's Preventive Services Initiative (WPSI) recommends screening for type 2 diabetes 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. Ideally, initial tests must be performed within the first year postpartum and may be performed as soon as 4 to 6 weeks after delivery. For women who were not screened in the first year postpartum or whose initial result was negative, the postpartum screening test should be performed at least every 3 years for a minimum of 10 years after pregnancy. For those who test positive for diabetes in the early postpartum period, the test should be repeated at least 6 months postpartum to confirm the diabetes diagnosis regardless of the initial test type (for example, fasting plasma glucose, hemoglobin A1C, glucose tolerance test). Repeat testing is also indicated for women tested with hemoglobin A1C in the first 6 months postpartum, regardless of whether the test results were positive or negative, because hemoglobin A1C testing is less accurate during the first 6 months postpartum. For women who were not screened in the first year postpartum or whose initial result was negative, the postpartum screening test should be performed at least every 3 years for a minimum of 10 years after pregnancy. For those who test positive for diabetes in the early postpartum period, the test should be repeated at least 6 months postpartum to confirm the diabetes diagnosis regardless of the initial test type (for example, fasting plasma glucose, hemoglobin A1C, glucose tolerance test). Repeat testing is also indicated for women tested with hemoglobin A1C in the first 6 months postpartum, regardless of whether the test results were positive or negative, because hemoglobin A1C testing is less accurate during the first 6 months postpartum.
Syphilis screening during pregnancy	Screening for syphilis in all members during pregnancy.
Urinary incontinence screening tests in women	The Women's Preventive Services Initiative recommends screening women to detect urinary incontinence as a preventive service. Factors associated with a higher risk for urinary incontinence include a higher parity, advancing age, and obesity; however, these factors should not be used to limit screening. Several screening tools have demonstrated moderate to high accuracy in identifying urinary incontinence in women. Although the minimum screening intervals are unknown, given the prevalence of urinary

	incontinence, it is advisable to perform the test annually since many women do not exhibit symptoms, and the multiple risk factors associated with incontinence change frequently.
Tobacco use and smoking cessation for pregnant members	Physicians must ask all pregnant members about their tobacco use, advise them to stop, and provide behavioral interventions to help smoking members cease their tobacco consumption.
Preventive visits for members	Annual preventive visit (depending on the member's health needs and other risk factors) so that adult members can access the recommended preventive services adequate for their age, including essential prenatal care and services. Whenever appropriate, this annual preventive visit must include other listed preventive services. Should the physician determine that the patient requires additional visits, these will be covered without copayment.

Preventive Services for Minors

A preventive health care visit for minors normally includes the following services: medical history, measurements, sensory screening, developmental/behavioral assessment, physical examination, anticipatory guidance (such as nutritional counseling), and dental referrals, among others. The following services are available to the minor, based on age and other established guidelines as indicated below:

Preventive Service	**Indication**
Anemia / Iron Deficiency	Perform risk assessments or screenings, as appropriate, per the recommendations in the current edition of AAP's Pediatric Nutrition: Policy of the American Academy of Pediatrics (chapter on Iron). Iron supplement for children from 4 months to 21 years of age who are at risk for anemia.
Anxiety in children and teenagers: Screening: children and teenagers between 8 and 18 years old	The USPSTF recommends screening for anxiety in children and teenagers from 8 to 18 years old.
Autism Screening	For minors between 18 and 24 months of age.
Behavioral, social, and emotional screening	The American Academy of Pediatrics (AAP) recommends performing an annual assessment from birth to 21 years of age.
Bilirubin screening	Screening for newborns.
Blood pressure	Screening for minors: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years.
Blood test	Screening for newborns.
Cervical displacement	Screening for sexually active members.
Screening for depression and suicide risk in children and teenagers	The American Academy of Pediatrics (AAP) and the USPSTF recommend screening for major depressive disorder (MDD) in teenagers from 12 to 21 years old.
Developmental screening and monitoring	Screening for children under 3 years of age and monitoring throughout childhood.
Dyslipidemia	Screening for minors, once between 9 to 11 years of age, and once again between 17 to 21 years of age. Screening for minors at risk for lipid disorders. Ages: 1-4 years, 5-10 years, 11-14 years, 15-17 years.
Eye prophylaxis for gonorrhea: preventive medication	Topical eye medication to prevent gonorrhea in newborns.
Hearing	Hearing screening for all newborns and for minors, once between 11 to 14 years old, once between 15 to 17 years old, and once between 18 to 21 years old.

Growth in terms of 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.
Hematocrit or hemoglobin screening	Screening for all minors when there is a risk factor.
Sickle cell disease (hemoglobinopathy)	Screening for sickle cell disease in newborns.
Hepatitis B screening	The USPSTF and the American Academy of Pediatrics (AAP) recommend screening for hepatitis B virus (HBV) infection in newborns up to early adulthood (21 years old) who are at high risk for infection.
Hypothyroidism	Screening for congenital hypothyroidism in newborns.
Vaccines	Recommended vaccines from birth to 21 years old. The recommended dosages, ages, and population 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. Catch-up vaccines are covered. HPV screening starts at the age of 9 for minors and teenagers with a history of sexual abuse or assault who have not started or completed all 3 doses (recommended by the Advisory Committee on Immunization Practices ACIP) COVID-19 vaccine as part of preventive immunization for infants and children aged 6 months through 12 years and adolescents 13 to 18 years in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) and in accordance with section 2.050 (c) of the Puerto Rico Health Insurance Code. Dengue vaccine for children aged 9-16 years who live in dengue endemic areas and have laboratory confirmation of previous dengue infection: 3-dose series administered at 0, 6, and 12 months according to the recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC). Mpox vaccine recommended for persons 18 years of age at risk of Mpox infection. Respiratory syncytial virus vaccine for young pregnant individuals aged 11 to 12 years up to 18 years. One (1) dose of the maternal RSV vaccine during 32 to 36 weeks of pregnancy, administered between September and January. Abrysvo is the only RSV vaccine recommended during pregnancy. See CDC recommendations. Vaccination against respiratory syncytial virus is recommended: One (1) dose of nirsevimab for all infants 8 months and younger born during or entering their first respiratory syncytial virus season. One (1) dose of nirsevimab for infants and children 8 to 19 months who are at increased risk for severe respiratory syncytial virus disease and entering their second RSV season. See CDC recommendations.

Preventive Service	Indication
Lead	Screening for minors from 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.
Postpartum depression	Screening for mothers of newborns during their visits at 1, 2, 4 and 6 months.
Medical history	For any minor during development, from 0 to 21 years old.
Screening for obesity in minors and teenagers	For minors and teenagers (6 years old and up), intensive comprehensive behavioral interventions to promote an improvement in the child's weight.
Oral health	Risk assessment for minors from 0 to 11 months old, 1 to 4 years old, and 5 to 10 years old.
Phenylketonuria (PKU) screening for newborns	Screening for phenylketonuria (PKU) in newborns.
Prevention of tooth decay in children under 5 years of age: Screening and interventions: children under 5 years of age	The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. The American Academy of Pediatrics (AAP) also recommends considering adding an oral fluoride supplement if the main water source is fluoride-deficient. The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. Once the tooth is in place, apply fluoride varnish to all children between 3 to 6 months of age via primary care or at the dental office, based on risk for cavities.
Skin cancer: Counseling	Counseling for minors, teenagers, 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.
Sudden cardiac arrest and sudden cardiac death	The American Academy of Pediatrics (AAP) recommends counseling on the risks of sudden cardiac arrest and sudden cardiac death, and this has been added for those 11 to 21 years of age (to account for the range in which risk counseling may take place) to be consistent with AAP's policy (“Sudden Death in the Young: Information for the Primary Care Provider”). Perform an assessment, as appropriate.
Tobacco use in minors and teenagers	Interventions, including education and counseling, for 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 test, at least once (1) for all minors between 3 and 5 years old to detect amblyopia or risk factors.

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.sspr.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 - 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)* • *Dengue*** • *Prevnar 20 (90677)* • *COVID*
Covered vaccines with coinsurance. The member will be responsible for paying the coinsurance established in the Table of Copayments and Coinsurance at the end of this policy.
Immunoprophylaxis for respiratory syncytial virus (Synagis, Palivizumab 90378) – Requires precertification following the protocol established by Triple-S Salud.

*For members between 9 and up to 27 years old. It also covers, as of the age of 9, for minors and adolescents with history of sexual abuse or assault, who have not started or completed the series of three (3) doses.

** For members between 9 and 16 years old with laboratory-confirmed previous dengue virus infection and living in dengue endemic areas. After six months of the confirmation of infection, a 3-dose series will be administrated with six-month intervals between each dose, as recommended by the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC).

Note: The vaccine codes included are shown as published in the latest revision 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.

OUTPATIENT MEDICAL-SURGICAL AND DIAGNOSTIC SERVICES

(Services available when the member is not admitted to the hospital)

The member will be responsible for paying the plan's copayment or coinsurance directly to the participating provider. Please refer to the section Table of Copayments and Coinsurance.

Diagnostic and Treatment Services

- Visits to the general practitioner's office
- Visits to specialists
- Visits to subspecialists
- Visits to audiologists
- Visits to optometrists
- Visits to podiatrists, including routine foot care
- Annual preventive visits
- Medical services provided in the member's home by physicians who provide this service
- Intra-articular injections, up to two (2) daily injections and up to a maximum of twelve (12) injections per member, per policy year
- Cryosurgery of the uterine cervix
- Vasectomy

Note: the supplies used at a gynecologist's medical office for covered diagnostic tests are included in the visit copayment.

Allergy Care

- Allergy tests, up to 50 tests per member, policy year

Laboratories, X-rays, and other diagnostic and specialized tests

- Clinical laboratory, genetic tests **require precertification**
- X-Rays
- PET Scan and PET CT, r**equires precertification**
- Non-invasive cardiovascular tests
- Non-invasive vascular tests
- Electrocardiograms and echocardiograms
- Nuclear medicine tests
- Computerized tomography (CT)
- *Single Photon Emission Computerized Tomography* (SPECT)
- Sonograms
- Mammograms, digital mammograms, or sonomammograms, if they are not rendered as preventive tests as provided by federal law, but as a follow-up to a condition diagnosis or treatment
- Magnetic resonance angiography (MRA) study
- Magnetic resonance imaging (MRI) study
- Electromyograms
- Color Doppler Flow
- Nerve Conduction Velocity Test
- Gastrointestinal endoscopies
- Electroencephalograms
- Polysomnography diagnostic test (study of sleep disorders), up to four (4) tests, per lifetime, per member
- Bone densitometry, for people under 65 years of age, or if it is not conducted as a preventive test as provided by federal law, but as a follow-up to a condition diagnosis or treatment
- Neurological tests and procedures
- Audiological and vestibular function tests, and special diagnostic procedures

- Tympanometry, one (1) test per member, per policy year
- Blood pressure monitoring up to four (4) services per member, per policy year

Surgeries

- Surgeries provided on an outpatient basis. **Requires precertification** if it is medically necessary to change the level of service (hospitalization or outpatient surgery center)

Treatment Therapies

- Dialysis and Hemodialysis: Services related to any type of dialysis or hemodialysis, as well as any complications that may arise and the hospital or medical-surgical services that may be needed to treat these complications, will be covered during the first 90 days from:
    a. the date the member first becomes eligible to this policy; or
    b. the date the first dialysis or hemodialysis is performed.

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

Respiratory Therapy (administered in the physician's office)

- Respiratory therapy (provided by physicians specialized in allergy, pediatric allergy, anesthesia, pneumology and pediatric pneumology), up to 2 therapy sessions per day, and up to a maximum of 20 sessions per member, per policy year.

Durable Medical Equipment

- **Requires precertification**
- Purchase or rental of oxygen and the necessary equipment for its administration
- Purchase or rental of wheelchairs or adjustable beds
- Purchase or rental of respirators, and other equipment to treat respiratory paralysis
- The following services are covered for members diagnosed with type 1 diabetes mellitus by an endocrinologist or pediatric endocrinologist, as required by Law No. 19 of January 12, 2020, to amend the Title and Articles 1, 2, and 4 of Law No. 177 of 2016:
    - FDA-approved glucometers, up to one (1) per policy year. If the endocrinologist orders a specific glucometer as required in the member's treatment, the endocrinologist shall submit a justification. In this case, the glucometer brand ordered by the endocrinologist will be covered, along with its accessories, for patients exhibiting a clinical pattern of susceptibility or a greater number of risk factors for developing type 1 diabetes mellitus.
    - Lancets, up to 150 for 30 days
    - Strips, up to 150 for 30 days
    - Insulin infusion pumps and supplies ordered by an endocrinologist for insured members diagnosed with type 1 diabetes mellitus. The endocrinologist will determine the brand of insulin infusion pumps based on age, level of physical activity and the knowledge of the condition of the member or caregiver. **Requires precertification.**
    - The provision of a Glucagon injection and replacement of said injection in case it is used or expires.

Mechanical ventilator

- Coverage comprises the necessary medical services, tests, and equipment for underage members who, even after turning 21 years old, require the use of technological equipment to stay alive, a minimum of one (1) daily session of eight (8) hours per patient, of services provided by skilled nurses specialized in respiratory therapy or respiratory therapist specialists with nursing skills, or of emergency medical technician - paramedics (EMT-P) duly licensed with approved and validated courses/certifications and training or with the skills and knowledge requirements established via regulation by their respective examining boards regarding the care and management of such patients and their medical equipment, as authorized in Law No. 69 of December 27, 2021. It also includes coverage for the supplies involved in the management of the technological equipment and physical and occupational therapy required for the motor development of these patients, as well as prescription drugs, which must be dispensed by a participating pharmacy that has been freely selected by the member and authorized by the laws of Puerto Rico (under the pharmacy benefit). The coverage provides for each member to have annual access to the appropriate laboratory tests and immunizations based on their age and physical condition.

- These services will be covered, provided that the member or his/her representative submits proof of the medical justification and the member's inscription in the registry designed by the Health Department for such purposes. It also includes the necessary supplies to manage the Mechanical Ventilator technological equipment.

- The mechanical ventilator services and the services provided by skilled nurses with knowledge in respiratory therapy or respiratory therapy specialists with knowledge in nursing, supplies needed to manage the technological equipment and physical and occupational therapy shall be covered 100%. For the copayments and coinsurance for medical services, treatments, diagnostic tests, and medications, please refer to the Table of Copayments and Coinsurance at the end of this policy.

Nutrition services

- Triple-S Salud will pay for nutritional services rendered by licensed nutritionists or physicians specialized in nutrition or metabolic diseases. Visits are covered up to six (6) visits per member, per policy year.

Chiropractors

- Visits to the chiropractor
- Up to fifteen (15) chiropractor manipulations per member, per policy year

Physical Therapy

- Physical therapies provided by physiatrists (or under their supervision and billed by such professionals) or chiropractors, up to one (1) daily session and up to 15 therapies per member, per policy year

Visual care

- Ophthalmology diagnostics tests
- Refraction examination, one (1) exam per member, per policy year

Alternative therapies (Triple-S Natural)

The program is only available through participating facilities in the Program. Please refer to the Participants and Providers Directory for a list of participating facilities. Up to 6 visits per policy year, per member, including the following types of therapy:

- Comprehensive and Complementary Health Care
- Medical Acupuncture

- Therapeutic Massage
- Naturopathic Medicine
- Bioenergetic Medicine
- Traditional Chinese Medicine
- Reflexology
- Clinical nutrition
- Botanical Medicine
- Aromatherapy
- Music therapy

Other Services to Treat Disorders within the Autism Continuum

This policy covers services aimed at diagnosing and treating people with Disorders within the Autism Continuum, without limits, such as:

- Neurological exams
- Immunology
- Gastroenterology services
- Genetic tests, subject to precertification
- Laboratory tests for autism
- Nutrition services
- Physical, occupational, and speech/language therapy
- Visits to the psychiatrist, psychologist (with a Masters or Doctorate degree and a current license issued by the Puerto Rico Board of Psychologist Examiners), or social worker.

In compliance with "Ley para el Tratamiento de Oxigenación Hiperbárica para las Personas con Trastorno de Espectro de Autismo" (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.

Phenylalanine-free Amino Acid Formula

This policy covers the phenylalanine-free amino acid formula for patients who have been diagnosed with the genetic disorder known as phenylketonuria (PKU), with no exceptions as to the member’s age.

MEDICAL-SURGICAL SERVICES DURING HOSPITALIZATION

During hospitalization periods, the member shall be entitled to receive medical-surgical services, including:

Medical-Surgical Services

- Surgeries
- Orthognatic surgery, **requires precertification**
- Corneal transplants, skin and bone grafts, including care before and after the procedure
- Bariatric surgery: initial treatment must be diet and lifestyle changes. The physician must document the failed attempts at supervised weight loss. This policy only covers gastric bypass surgery to treat morbid obesity, up to one surgery per lifetime, per member, provided the services are available in Puerto Rico. The health facility where the surgery will be performed must be accredited by the Joint Commission and one of the following two entities: the American College of Surgeons or the American Society for Metabolic and Bariatric Surgery. Surgeries to remove excess skin will be covered if the physician certifies it is necessary to remove the excess skin because it affects the functions of any body part. These surgical procedures **require precertification** from Triple-S Salud.
- Diagnostic services
- Treatments
- Anesthesia administration
- Consultation with specialists
- Gastrointestinal endoscopies
- Sterilization services
- Audiological evaluations, including the Neonatal Hearing Screening Test
- Invasive cardiovascular tests
- Lithotripsy (*ESWL*); **requires precertification**

AMBULANCE SERVICES AND SERVICES PROVIDED BY HOSPITALS AND OTHER FACILITIES

- Triple-S Salud promises to pay for the services contracted with the corresponding hospital institution during the member's hospitalization, during the eligible person's term of insurance, provided that such hospitalization is ordered in writing by the attending physician and that it is medically necessary.

Hospitalizations

- Semi-private or isolation room, up to a maximum of three hundred and sixty-five (365) days for regular admissions
- When a member uses a private room at a participating hospital, Triple-S Salud will cover what it would have paid for a semi-private room. The hospital may charge the patient for the difference between the normal cost of the private room and the fee established by Triple-S Salud for a semi-private room, except in cases where it is medically necessary and with prior notification to Triple-S Salud. The member's other hospitalization costs covered by this policy are included in the contract between the participating hospital and Triple-S Salud, hence no other difference may be charged to the member. Please check the Table of Copayments and Coinsurance for any copayment or coinsurance amounts additional to the hospital admission.
- Meals and special diets
- Use of telemetry service
- Use of recovery room
- Use of *Step-Down Unit* (intermediate care unit for infants)
- Use of Intensive Care, Coronary Care, Pediatric Intensive Care, and Neonatal Intensive Care Units
- General nursing service
- Administration of anesthesia by non-medical personnel
- Clinical laboratory services
- Medications, biological products, healing supplies, hyperalimentation products, and anesthesia supplies
- Production of electrocardiograms
- Production of radiological studies
- Physical therapy services
- Use of services provided by physicians in training, interns, and hospital residents authorized to provide medical services to patients
- Respiratory therapy services
- Use of emergency room if the member is admitted to the hospital
- Use of other facilities, services, equipment, and supplies, as ordered by the primary physician, that the hospital usually provides and that have not been expressly excluded from the contract with the hospital
- Blood for transfusions

Note: These services are included in the copayment you pay for hospital admission

- Chemotherapy in all its methods of administration (injectable, oral, intravenous, or intrathecal), and radiotherapy
- Hemodialysis Facilities: Services related to any type of dialysis or hemodialysis, as well as any complications that may arise and the hospital or medical-surgical services that may be needed to treat these complications, are covered for the first 90 days from:
    a. the date the member first becomes eligible to this policy; or
    b. the date the first dialysis or hemodialysis is performed.

  This will apply if the subsequent dialysis or hemodialysis are related to the same clinical condition.
- Lithotripsy (ESWL); **requires precertification**.
- Outpatient Surgery Center

POST-HOSPITALIZATION SERVICES THROUGH A HOME HEALTH CARE AGENCY

Triple-S Salud covers these services if they begin within 14 days after the member's date of discharge after a hospitalization of at least three (3) days, and if they are provided due to or in relation to the same condition for which he/she was hospitalized. It covers the following services rendered and supplies delivered at the patient's home by a Home Health Care Agency certified by the Puerto Rico Department of Health. **Requires precertification.**

- **Nursing Services** – partial or intermittent services provided by or under the supervision of a graduate nurse.
- **Home Health Services Assistant** – partial or intermittent services provided primarily for the care of the patient.
- **Physical, Occupational and Speech/Language Therapies:** up to forty (40) visits, combined, per member, per policy year.

Note: These services should be supervised by a licensed physician, and its **medical necessity should be certified in writing.**

SKILLED NURSING SERVICES

The Plan covers these services if they begin within 14 days after the date the member was discharged after a hospitalization of at least three (3) days, and if they are provided due to or in relation to the same condition for which he/she was hospitalized. **Requires precertification.**

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

Note: These services must be supervised by a licensed physician or graduate registered nurse (RN) dedicated full-time to such supervision, and its **medical necessity must be certified in writing. Requires precertification.**

EMERGENCY ROOM / URGENT CARE SERVICES

Emergency room/urgent care services: supplies and medicines included in the suture tray contracted with Triple-S Salud. In addition to those included in the suture tray, it also covers any medications and supplies provided in the emergency/urgent care room due to an accident or illness. Copayment or coinsurance for illnesses and accidents applies, as per the Table of Copayments and Coinsurance.

If a member requires urgent care for a condition, Triple-S Salud applies a lower copayment if the patient visits an urgent care center from our provider network instead of an emergency room.

If the member requires emergency treatment for a condition, please seek immediate attention at the emergency room of the nearest hospital or health facility or call the 9-1-1 System. Emergency services require no precertification and are not subject to wait periods. However, we only cover emergency services in an emergency room to treat an emergency condition, and these are covered regardless of whether they were rendered by a participating provider.

If the member receives emergency services from a non-participating provider, these services will be paid directly to the provider based on the contracted rates that would have been paid to a participating provider, after deducting the applicable copayment and/or coinsurance, as established in the policy. The non-participating provider is obligated to accept the payment for an amount no less than the contracted fee for participating providers for the same services. The patient will not be responsible for paying for the services more than what the applicable amount would have been if they had received the services from a provider contracted by Triple-S Salud.

If the member receives health care services after receiving post-stabilization or emergency services, which would be covered under this policy, except for the fact that the services were rendered by a non-participating provider, Triple-S Salud will reimburse the member the lesser between the cost incurred and the fee that would have been paid to a participating provider, after deducting the applicable copayment and/or coinsurance, as provided in this policy.

If the member calling Teleconsulta is advised to go to the emergency room with a registration number, a lower copayment/coinsurance may apply for the use of such facilities.

Psychiatric emergencies are covered, in accordance with Act No. 183 of August 6, 2008, as well as transportation between healthcare service providers, including ambulances, that are certified by the Public Service Commission and the Department of Health, as established in the last paragraph of section 4.20 (b) of Act No. 183 of August 6, 2008, and as stated in the Ambulance Benefit under the Section of Ambulance Services and Services Provided by Hospitals and Other Facilities.

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

Hospital admissions: If a member was admitted to the hospital as part of an emergency, they do not have to notify the plan about the admission, except if it happened outside Puerto Rico. In these cases, the member or anyone else must notify the plan at the telephone number that appears on the back of the identification card, within forty-eight (48) hours after the admission or as soon as reasonably possible.

Urgent care/emergency services in the United States

Members are entitled to urgent care/emergency service coverage if they are in the United States.

Triple-S Salud will cover urgent care/emergency services based on the contracted fees by *Blue Cross Blue Shield* plan in the area, as long as the provider rendering the services is a participant of the *Blue Cross Blue Shield* Plan network.

The member will be responsible for paying the coinsurance established for these services.

AMBULANCE SERVICES

- In accordance with Act No. 129 of August 1, 2019, if the service is used through the 9-1-1 System in emergency cases, Triple-S Salud shall pay the provider directly based on the established fees.

  This benefit is covered if the patient was transported:

  - from the residence or place of the emergency to the hospital or Skilled Nursing Facilities;
  - from a hospital to another hospital or *Skilled Nursing Facility* – in cases where the institution doing the transfer or authorizing the discharge is not adequate for the covered service
  - from the hospital to the residence, if the discharged patient's condition requires it
  - Between health care institutions, in case of psychiatric emergencies, by ambulances certified by the Public Service Commission and the Health Department.

In non-emergency cases, this benefit is covered by reimbursement. The member shall pay the total cost and send the claim to Triple-S Salud with the medical report including the diagnosis. Triple-S Salud will reimburse up to a maximum of $80.00 per case.

- Air ambulance service in Puerto Rico, subject to medical necessity.

CANCER SERVICES

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

This policy covers pelvic exams and all types of Pap smear tests that may be required to detect, diagnose, and treat the early stages of abnormalities that could lead to cervical cancer. Outpatient services for cancer treatment, such as radiotherapy and cobalt are also covered.

In accordance with Act No. 275 of September 27, 2012, Triple-S Salud does not reject or deny any accorded treatment and/or within the terms and conditions of the health insurance contract subscribed by the parties, to any patient diagnosed with cancer or cancer survivor, when medical orders have been issued to such ends. It also covers all preventive services and benefits mentioned under the federal ACA Act for the early detection of breast cancer, and also breast cancer monitoring studies and tests, such as visits to specialists, breast clinical exams, mammographies, digital mammographies, magnetic resonance mammographies, sonomammograms, and treatments like, but not restricted to, mastectomies, post-mastectomy reconstructive surgeries, the reconstruction of the other breast to achieve a symmetrical appearance, breast implants, treatment for physical complications during all stages of the mastectomy, including lymphedema (inflammation that occurs sometimes after breast cancer treatment), as well as any other post-mastectomy surgery necessary for the patient's physical and emotional recovery.

In compliance with Law 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,” “Milliman Care Guidelines,” and the internal guidelines of the PRHIA will also be used.

  The rights established in this Law will be in addition to those provided by Law No. 275-2012, as amended, known as the "Bill of Rights of Cancer Patients and Survivors," and will have the scope and be governed in accordance with the requirements and procedures established by Public Law No. 111-148, known as the "Patient Protection and Affordable Care Act," Public Law No. 111-152, known as the "Health Care and Education Reconciliation Act," as well as any federal and local regulations adopted under it and any other successive or applicable law or regulation.

  All insured members are entitled to receive the most effective and advanced treatment available in the market, recommended by their physician, in accordance with the coverage and the protocols established in the guidelines listed in the previous subsection and established by the Advisory Board on the Care and Treatment of Cancer Patients and Survivors.

  This policy will not establish that the final interpretation of the contract terms will be subject to the insurer's discretion; neither will it contain rules for their review or interpretation in contravention of the provisions of this Law.

  If a primary care physician is selected, in the case of cancer patients, they are allowed to select a physician specialized in oncology as their primary care physician, as long as the health care

professional consents to such designation. This policy does not require to select a primary care physician.

Triple-S Salud shall send its approval or denial for 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. If a determination is not issued within such terms, the medications, treatments, and/or diagnostic tests will be deemed to be approved.

MATERNITY SERVICES

(Applies to members, spouses, and direct dependents)

Outpatient Maternity Care

- Medical Visits
- Obstetric sonograms; according to clinical protocol
- Biophysical profile
- Preventive *Well-Baby Care* visits according to age and coverage recommended by the *United States Preventive Services Task Force (USPSTF)*

Maternity Hospital Care

Hospitalization services will be extended in case of maternity or secondary, pregnancy-related conditions, only if the member is entitled to maternity benefits. As provided by Act No. 248 of August 15, 1999, Act to Guarantee Adequate Care for Mothers and their Newborns during the Post-Partum Period, hospital admissions in the event of delivery will be covered for a minimum of 48 hours in the event of natural childbirth, and 96 hours for cesarean deliveries, unless the physician, after consulting with the mother, authorizes the hospital discharge for the mother and/or newborn. If the mother and the newborn are discharged after a period shorter than the time established, Triple-S Salud will cover a follow-up visit within the next 48 hours. Services will include, but will not be limited to: assistance and physical care for the minor, education on childcare for both parents, breastfeeding assistance and training, guidance about home support, and medical treatments and tests for both the mother and the infant.

- Semi-private or isolation room, assistance and physical care for the minor, education on child care for both parents, breastfeeding assistance or training, counseling about home support, and medical treatments and tests for both the infant and the mother.
- Obstetric services
- Use of Delivery Room
- Fetal Monitoring production and interpretation
- Use of Well-Baby Nursery (newborns' room)

Note: These services are included in the copayment you pay for hospital admission.

HOSPICE

Services provided through hospice for members who have been diagnosed with a life expectancy of six (6) months or less as a result of a terminal health condition.

Note: These services **require precertification** from Triple-S Salud and will be evaluated by your Individual Case Management Program to coordinate through network participating providers.

MENTAL HEALTH AND SUBSTANCE ABUSE

This policy covers mental health and controlled substance abuse services, as provided under state and federal laws, Act No. 183 of August 6, 2008, and the *Mental Health Parity and Addiction Equity Act of 2008*, which promotes equity in the care of mental health and substance abuse disorders. This policy does not have any major restrictions in terms of limits to medical-surgical benefits, such as limited days or visits, limits to mental health benefits/substance abuse applied to medical-surgical benefits. Copayments have no major restrictions on the medical-surgical benefits.

If your plan includes the hospital preferred network, participating hospitals in the Triple-S Salud network have been grouped as preferred and non-preferred hospitals, according to the cost and quality of the hospital facilities. You will benefit from using preferred hospitals as your first option, since their copayments/coinsurance is lower than those of non-preferred hospitals.

General Mental Health Conditions

Hospitalizations for mental conditions

- Regular hospitalizations
- Partial hospitalizations
- Electro-convulsive therapy for mental conditions, covered according to justified medical necessity and the standards of the American Psychiatric Association (*APA*).

Outpatient Services

- Patient visits to the office of the psychiatrist or psychologist (with a Masters or Doctorate degree and a current license issued by the Puerto Rico Board of Psychologist Examiners)
- Collateral visits (immediate family), including marriage counseling provided by a psychiatrist or psychologist (with master's or doctorate degree and a current license issued by the Puerto Rico Board of Psychologist Examiners)
- Group therapy visits

Other Psychological Evaluations

- Psychological evaluation
- Psychological tests: Psychological tests required by Act No. 296 of September 1, 2000, known as the Children and Adolescents Health Conservation Act of Puerto Rico.

Substance Abuse (Drug Addiction and Alcoholism)

- Regular hospitalizations, including detoxification services
- Partial hospitalizations
- Visits to the office of the psychiatrist or psychologist (with masters or doctorate degree and a current license issued by the Puerto Rico Board of Psychologist Examiners).
- Collateral visits (immediate family), including marriage counseling provided by a psychiatrist or psychologist (with master's or doctorate degree and a current license issued by the Puerto Rico Board of Psychologist Examiners)
- Group therapy visits

Residential treatment

- This policy covers residential treatment, as long as there is medical justification, and the facilities have the required accreditations and personnel to offer the service. **Requires precertification**.

MEMBER COMPENSATION

If any person entitled to benefits, as per this policy, receives covered services from non-participating professionals or facilities outside Puerto Rico, except if otherwise provided in this policy or for services paid based on compensation, Triple-S Salud will issue direct payment to the member for the expenses incurred, up to the amount that it would have paid to a participating professional or facility, or up to the corresponding amount according to what is specified in the benefit. If the service is provided in the United States and it is not an emergency or it is available in Puerto Rico, Triple-S Salud will pay the amount equivalent to the fee established in Puerto Rico, less the copayment or coinsurance established in the policy for the service. The member must provide Triple-S Salud with all the reports and evidence of payments required by law in such cases.

BASIC COVERAGE EXCLUSIONS

This policy does not cover the following expenses or services:

1. Services provided while the patient's insurance is not in force.
2. Services that can be received according to workers' compensation laws, the employer's responsibility, private workers' compensation plans, automobile accidents (ACAA), and services available as per state or federal law, which the member is not legally required to pay. Also, such services shall be excluded if they are denied by the corresponding governmental agencies, due to breach or infringement on the requirements or provisions of the aforementioned laws, even if said breach or infringement does not constitute a crime.
3. Treatment services that may arise as a result of the member committing a crime or not complying with the laws of the Commonwealth of Puerto Rico or any other country, except for injuries resulting from an act of domestic violence or a medical condition.
4. Services that are received free of charge or paid through donations.
5. Expenses or services for personal convenience, such as telephone, television, custodial care services, rest house, convalescence home, or home care, except for post-hospitalization services provided through a Home Health Care Agency.
6. Services provided by health care professionals who are not doctors of medicine or dentistry, except for audiologists, optometrists, podiatrists, psychologists, social workers (only in cases of autism), chiropractors, and others specified in this policy.
7. Expenses for physical exams, tests, studies, vaccines, or any other procedure required by the insured employee's employer.
8. Reimbursement of the expenses incurred in payments issued by the member to any participating physician or provider, without being required by this policy to do so.
9. Expenses for services provided by non-participating physicians for Triple-S Natural.
10. Expenses for covered services received without a precertification from Triple-S Salud, if it were required, except in case of emergency, as established in the policy.
11. Services that are not medically necessary, services deemed to be experimental or investigative, according to the criteria of the *Food and Drug Administration (FDA), the Department of Human and Health Services (DHHS),* the Puerto Rico Department of Health, or the *Technology Evaluation Center (TEC)* of the *Blue Cross Blue Shield Association,* for the specific indications and methods ordered.
12. Expenses or services for new medical procedures, equipment, or medications not considered as experimental or trial-related, except as required by state or federal law. Also not covered are the expenses for clinical trials and treatments, devices, experimental or investigative medications administered to be used as part of these studies, services, or products provided to obtain data and analysis, and not for the direct management of the patient, and items or services at no cost to the member that are usually offered by the research sponsor. This restriction 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.
13. Expenses for cosmetic or aesthetic surgery, treatments to correct defects in physical appearance, except for the care and treatment of congenital anomalies and defects in newborns, recently adopted children, or children placed for adoption, mammoplasty or plastic surgery to reconstruct the breast for a

size reduction or increase (except breast surgery and reconstruction after a breast cancer mastectomy), septoplasty, rhinoseptoplasty, blepharoplasty, surgical interventions and medical treatments for obesity control, except treatment for morbid obesity or metabolic syndrome, including bariatric surgery, as defined by Act No. 212 of August 9, 2008 in Puerto Rico and in the Definitions Section of this policy; or treatments for liposuction, abdominoplasty, abdominal rhytidectomy, and injection sclerotherapy for varicose veins in the legs. Hospital and medical-surgical services, and any related complications, are also excluded, regardless of whether there is medical justification for the procedure.

14. Expenses for the member's contraceptive methods; except those listed as covered under this policy.
15. Treatment services for infertility, artificial conception, and to restore the ability to procreate (for example, in vitro fertilization, intracytoplasmic sperm injections, embryo transfers, donor fertilization). Additionally, hospital and medical-surgical services, and their associated complications, as well as drugs and hormones, are excluded. Lab tests ordered for infertility treatments will be covered, as long as they are a laboratory covered under this policy.
16. Expenses for scalenotomy services - division of the anterior scalene muscle (*anticus*) without resection of the cervical rib.
17. Expenses for alternative therapy treatments, except those specified as covered in the Triple-S Natural Program and rendered by participating providers in this Program.
18. Expenses for sports medicine services, psychoanalysis, and cardiac rehabilitation.
19. Intravenous or inhalational analgesia services provided at the oral surgeon or dentist office.
20. Necessary services to treat temporomandibular joint (jaw joint) dysfunction, either through the application of prosthetic devices or any other method.
21. Expenses for excision services for granulomas or radicular (periapical) cysts caused by infection in the pulp of the tooth; necessary services to correct vertical dimension or occlusion, or to remove exostosis (torus mandibularis, maxillary tori, etc.)
22. Expenses for materials related to orthognathic surgery (mandibular or maxillary osteotomy - Le Fort).
23. Expenses for allergy immunotherapy.
24. Services rendered for an induced abortion.
25. Surgical assistance services, regardless of whether they are medically justified.
26. Expenses in excess of the first 30 days for newborns of the primary policyholder’s direct dependents after delivery, except if they meet 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 conducted in an outpatient setting.
29. Expenses related to the management of the employer’s drug screening program, such as coordination, sampling, administration of screening tests (even if provided by a participating provider), and coordination of employee services to be provided by the employer or the entity responsible for managing the program, among others. We also exclude expenses for care, supplies, treatment and/or services that the member obtains from the employer at no cost, and the services provided by the employer’s Employee Assistance Program as part of the employer’s drug screening program. We will cover mental health and substance abuse services after the member completes the employer’s Drug Screening Program, regardless of whether the condition was detected through this program.
30. Expenses caused by war, civil insurrection, or international armed conflict; except in cases where the services received are related to an injury suffered while the member was active in the army *(service-connected)*, in which case Triple-S Salud will be reimbursed by the Veterans Administration.
31. Laboratory tests that are not coded in the Laboratory Manual, as well as those considered experimental or investigative, shall not be recognized for payment by Triple-S Salud.
32. Immunizations for travel purposes or against occupational hazards and risks.
33. Expenses for services rendered by water ambulance.

34. Expenses for air ambulance services, except when the transportation is within Puerto Rico.
35. Services provided by residential treatment facilities outside Puerto Rico, with no medical justification or precertification for the treatment.
36. Expenses related to organ and tissue transplants (except for cornea, skin and bone grafts), as well as hospitalizations, complications, chemotherapies, and immunosuppressant medications related to the transplant.
37. Expenses for ptosis repair and injections in tendons/trigger points.
38. Expenses for heavy metals laboratory tests, *doping*, *HLA Typing*, and paternity tests.
39. Expenses for orthopedic or orthotics devices, prostheses, or implants (except for prosthesis after mastectomy), and other artificial devices. We cover any hospital and medical/surgical services necessary for their implementation.
40. Expenses for Dental Services. Hospital and medical-surgical services, and their associated complications, are excluded. Only the preventive services required by law are covered.
41. Expenses for services rendered to optional dependents of the insured employee.
42. Preventive services rendered by providers outside Puerto Rico.
43. Growth hormones and all related treatments.
44. New diagnostic or therapeutic services or procedures approved by the FDA, and equipment and devices that become available after the effective date of this policy, unless they are required by federal or local law.
45. Genetic tests performed in order to provide genetic counseling (offspring or family planning).
46. Expenses or services performed with new medical technologies available in the market during the policy year and not covered by Triple-S Salud, except for cases of cancer, in accordance with Law No. 79 of August 1, 2020, or when required by federal or local law or ordered by the Office of the Commissioner of Insurance of Puerto Rico.
47. Complications related to body piercings or tattoos and any other related procedures.
48. Occupational and speech/language therapy, except those offered under post-hospital services, mechanical ventilators, and autism (BIDA Act).
49. 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.
50. New benefits required by the local law that have been enacted during the calendar year the policy is in effect or after the approval of the rates for said coverage, unless explicitly required by the Commissioner of Insurance or the local law itself.
51. Any service related to anti-aging or aesthetic treatment.
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.
53. Charges for drugs or medications provided during medical appointments not covered under this policy.
54. Charges for exceeding the limits established in this policy.

NOTICE OF PRIVACY PRACTICES

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

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

OUR LEGAL RESPONSIBILITY

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

This notice provides examples for illustrative purposes and shall not be construed as a complete listing of such uses and disclosures.

This notice contains some examples of the types of information we collect and describe the types of uses and disclosures we execute, and your rights.

Triple-S is required to abide by the terms of this Notice. However, we reserve the right to amend our privacy practices and the terms of this notice. Before we make a significant change in our privacy practices, we will amend this notice and send an updated notice to our active subscribers.

SUMMARY OF PRIVACY PRACTICES

Our commitment 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 made with us or our affiliates;
- Consumer credit reporting agencies;
- Healthcare providers;
- Government health programs

Protected Health Information (PHI) is information that can identify you (name, last name, social security number); including demographic information (such as address, zip code), obtained from you through a request or other document in order to obtain a service, created and received by a health care provider, a medical plan, intermediaries who submit claims for medical services, business associates, and that is related to (1) your health and physical or mental condition, past, present, or future; (2) the provision of medical care to you, or (3) past, present, or future payments for the provision of such medical care. For purposes of this Notice, this information will be called PHI. This Notice of Privacy Practices has been written and amended, so that it will comply with the HIPAA Privacy Regulation. Any term not defined in this Notice will hold the same meaning as in the HIPAA Privacy Regulation. We have also implemented policies and procedures for the handling of PHI, which you may examine, at your request. You can submit your request via email hipaacompliance@sssadvantage.com or in writing to the address included below.

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

LAWS AND REGULATIONS

HIPAA: Health Insurance Portability and Accountability Act of 1996 implements rules relating to the use, storage, transmission, and disclosure of protected health information pertaining to members in order to standardize communications and protect the privacy and security of personal, financial and health information.

HITECH: The Health Information Technology for Economic and Clinical Health Act of 2009. This Rule promotes the adoption and meaningful use of health information technology. It also addresses privacy and security concerns associated with the electronic transmissions of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

Privacy and Security Rule: Standards for Privacy of Individually Identifiable Health, as well as Security Standards for the Protection of Electronic Protected Health Information are guided through 45 C.F.R. Part 160 and Part 164.

USES AND DISCLOSURES OF INFORMATION

Triple-S will not disclose or use your information for any other purpose other than those mentioned in this notice unless you provide written authorization. You may revoke the authorization in writing at any time, but your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Triple-S will not disclose information for fundraising activities.

Triple- S may use and disclose PHI for the following:

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

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 you medical services including treatment, services coordination, monitoring of your health and other services related. For example, the plan may disclose your medical information to your provider to coordinate your treatment.

Payment: To pay for the health services provided to you, to determine your eligibility for benefits, to coordinate your benefits with other payers, or to collect premiums, and other related activities. For example, the plan may use or disclose information to pay claims related to health services received by you or to provide eligibility information to your health care provider when you receive treatment.

Health Care Operations: For audits, legal services, including fraud and abuse detection, compliance, business planning, general administration, and patient safety activities, credentialing, disease management, training of medical and pharmacy students. For example, the plan may use or disclose your health information to communicate with you to provide reminders of meetings, appointments or treatment information.

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

Affiliated Covered Entities: In order to perform our duties as insurance or benefit administrator, we may use or disclose PHI with the following entity: Triple-S Salud, Inc.

Business Associate: Triple-S may use and disclose your personal information to our business associates, who provide services on our behalf of .and Triple-S Salud, Inc. and contribute in the administration or coordination of your services.

Your Employer or other employee organization that provide you the group health plan: Triple-S may disclose your health information to your employer or organization that provide you the group health plan, with the purpose of facilitating its management such as the discharges from the health plan. Also, we may disclose a summary of health information. This summary of health information may include aggregated

claims history, claims or coverage expenses or types of claims experienced by the members in your group health plan.

For research purposes: We may use or disclose your PHI to researchers, if an Institutional Review Board or an Ethics Committee, has reviewed the research proposal and has established protocols to protect your information's confidentiality, and has approved the research as part of a limited data set.

Required by Law: We may use or disclose your PHI whenever Federal, State, or Local Laws require its use or disclosure. In this Notice, the term "as required by Law" is defined as in the HIPAA Privacy regulation. For these purposes your authorization or opportunity to agree or object will not be required. The information will be disclosed in compliance with the safeguards established and required by law.

Legal proceedings: We may use or disclose your PHI during the course of any judicial or administrative proceedings to comply with any order (disclosure as expressly permitted); or in response to a citation, subpoena, discovery request, or other procedure as authorized by law.

Forensic Pathologists, Funeral directors, and organ donation cases: We may use or disclose your PHI to a medical examiner (Pathologist) for identifying a deceased person, determine a cause of death, or other duties authorized by law. We may also disclose your information to a funeral director, as necessary to carry out its duties with respect to corpses and to other entities engaged in the procurement, banking, or transplantation of bodies organs, eyes, or tissues.

Worker's compensation: We may use or disclose your PHI to comply with laws relating to workers' compensation or other similar programs as established by law, that provide benefits for work-related injuries or illness without regard to fault.

Disaster relief or emergency situations, Government Sponsored Benefits Programs: We may disclose your PHI to a public or private entity authorized by law or its acts that helps in case of a disaster. In this way, your family can be notified about your health condition and location in case of a disaster or an emergency.

Monitoring activities of regulatory agencies: We may disclose health information to a regulatory agency such as the Department of Health (DHHS) for audit purposes, monitoring of regulatory compliance, investigations, inspections or license. These disclosures may be necessary for certain state and federal agencies to monitor the health care system agencies, government programs and the compliance with civil rights laws.

Public Health and Safety Activities: We may use and disclose your health information when required or permitted by law for the following activities, for these purposes your authorization or opportunity to agree or refute will not be required:

- Public health, including to report disease and vital statistics, for specialized government functions, among others;
- Healthcare oversight, fraud prevention and compliance;
- To report child and/or adult abuse or domestic violence;
- Regulators Agency activities;
- In response to court and administrative orders;
- To law enforcement officials or matters of national security;
- To prevent an imminent threat to public health or safety;
- For storage or organ, eye or tissue transplant purposes;
- For statistical investigations and research purposes;
- For descendant purposes;
- As otherwise required by applicable laws and regulations

Military activity, national security, protective services: We may disclose your PHI to appropriate military command authorities if you are a member of the Armed Forces, or a veteran. Also, to authorized federal

officials to conduct national security activities, lawful intelligence, counterintelligence, or other national security and intelligence activities for the protection of the President, and other authorities, or heads of state.

Health-Related Products and Services: We may use your health 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 use your information to call or send you reminders of your medical appointments or the preventive services that you need according to your age or health condition.

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

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

- To support a request for benefits under a life insurance policy, its reinstallation or modifications to such policy, in which case the authorization will be valid for 30 months or until the application is denied, the earlier of the two events; or
- To support or facilitate the communication of an ongoing treatment of a chronic disease or rehabilitation of an injury.

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

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

Before we disclose your health information to any person related to your medical care or payment for health services, we will provide you with the opportunity to refute such disclosure. If you are not present, disabled or for an emergency, we will use our professional judgment in the disclosure of information that we understand will be 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.

YOU HAVE THE FOLLOWING RIGHTS REGARDING YOUR PHI

Access: You have the right to review and receive an electronic or paper copy of your personal, financial, health or insurance information, related to the enrollment or medical claims within the limits and exceptions provided by law. You must submit a written request. Upon receipt of your request, we will have 30 days to do any of the following activities:

- Request for additional time
- Provide the requested information or allow you to examine your information during working hours
- Inform you that we do not have the requested information, in which case, we will guide you where to find it if we know the source
- Deny the request, partially or in its entirety, because the information was created from a confidential source or was compiled in anticipation of a legal proceeding, investigations by law enforcement agencies or the anti-fraud unit or quality assurance programs which disclosures are prohibited by

law. We will notify you in writing the reasons for the denial, except in the event there's an ongoing investigation or in anticipation of a legal proceeding.

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

Disclosure report: You have the right to receive a list of examples in which we disclose your protected health information for purposes other than treatment, payment, health care operations, or as authorized by you. 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 the costs of processing the additional request (s). The report only covers the last six years.

Restriction: You have the right to request us to implement additional restrictions in the management of your health 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. Your request and our agreement to implement additional restrictions must be in writing.

Confidential communication: You have the right to request that our communications about your health information are made by alternative means or at an alternative location. You must make your request in writing. We will accept your request if it is reasonable, specify the alternative means or the alternative location.

Amendment: You have the right to request corrections to your health information. Your request must be in writing, and it must include an explanation or evidence that justify the amendment request. We will respond to your request within 60 days. If additional time is needed, we will notify you in written before the expiration of the original term.

We may deny your request if we do not originate the information you request to be amended and the originator is available to receive your request, or for other reasons. If we deny your request, we will provide you with a written explanation. You have the right to send a statement of disagreement to be included with our determination for any future disclosures. If we accept your request, we will make the reasonable efforts to inform others, including our business associates, and we will include the amendment in any future disclosure of such information.

Notice of privacy and security breaches in which your health information may be at risk: We will let you know promptly if a breach occurs that may have compromised the privacy, security or confidentiality of your information.

Electronic notice: If you receive this notice through our web site www.salud.grupotriples.com for Triple-S Salud, or by e-mail, you are entitled to receive this notice in paper form.

QUESTION 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.salud.grupotriples.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 have the right to file a complaint with us to the following address:

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

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

U.S. Department of Health and Human Services
Mailing Address: 200 Independence Avenue, S.W. Room 509F HHH Bldg. Washington, D.C. 20201.
Email: 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 retaliate in any way if you choose to file a complaint with us or with the OCR.

Si interesa recibir copia de este aviso en español envíe su solicitud a la dirección arriba indicada o visite nuestra página; o www.salud.grupotriples.com para Triple-S Salud.

TABLE OF COPAYMENTS AND COINSURANCE

	Copayments / Coinsurance
Outpatient Medical-Surgical and Diagnostic Services	
Benefit Description	
Diagnostic and Treatment Services	
Services available at SALUS Clinics, including visits, diagnostic tests, laboratories, radiology, and imaging	$0.00
Visits to the general practitioner's office	$10.00
Visits to specialists	$15.00
Visits to subspecialists	$15.00
Visits to audiologists	$15.00
Visits to optometrists	$15.00
Visits to podiatrists, including routine care	$15.00
Teleconsulta MD® (virtual consultation)	$10.00
Preventive services covered by local or federal law, including annual preventive visits, bone densitometry, mammograms, digital mammograms, and sonomammograms. You may access these services through participating Preventive Centers or the participating providers included in the Directory.	$0.00
Medical services provided in the member's home by physicians who provide this service	$15.00
Intra-articular injections	$0.00
Emergency room • illness • Accident • Teleconsulta	 $75.00 $75.00 $35.00
Urgent care • Illness • Accident	 $15.00 $15.00
Sanitas Urgent Care Centers in the state of Florida	$50.00
Cervical cryosurgery Vasectomy	$0.00
Allergy tests	$0.00
Laboratories	25%
X-Rays	25%
Diagnostic tests	25%
Diagnostic specialized tests	25%
Color doppler flow	25%
Blood Pressure Monitoring	25%
Pelvic exams and all types of Pap smear that may be required to detect, diagnose, and treat early stages of abnormalities that could lead to cervical cancer	$0.00
Surgeries provided on an outpatient basis	$0.00
Chemotherapy in its various methods of administration (injectable, oral, intravenous, or intrathecal), radiotherapy, and cobalt	0%
Dialysis and hemodialysis	$0.00
Biophysical profile	50%
Well-Baby Care preventive visits	$0.00

	Copayments / Coinsurance
Respiratory Therapy (administered in the physician's office)	$5.00
Durable Medical Equipment	25% 20% for insulin infusion pump, strips and lancets 0% for insulin pump supplies
Mechanical ventilator, supplies, and therapies (respiratory, physical, and occupational)	$0.00
Post-hospitalization services through a home health care agency	25%
Hospice	$0.00
Nutrition services	$0.00
Visits to the chiropractor	$7.00
Chiropractic manipulations	$7.00
Physical Therapy	$7.00
Visual care	
• Ophthalmology diagnostics tests	25%
• Refraction test	25%
Alternative therapies (Triple-S Natural)	$15.00
Medical screenings and screening tests to detect the condition of autism, as part of preventive services	$0.00
Other Services to Treat Disorders within the Autism Continuum a) Neurological exams b) Immunology c) Genetic tests d) Laboratory tests for autism e) Gastroenterology services f) Nutrition services g) Physical, occupational, and speech/language therapy h) Visits to psychiatrist i) Visits to social workers (by reimbursement) j) Visits to psychologists	a) 25% coinsurance b) 25% coinsurance c) 25% coinsurance d) 25% coinsurance e) 25% coinsurance f) $0.00 copayment g) $7.00 copayment h) $15.00 copayment i) $15.00 copayment j) $15.00 copayment
Preventive vaccines	$0.00
Palivizumab (Synagis)	20%
MEDICAL-SURGICAL SERVICES DURING HOSPITALIZATION PERIODS	
Medical-Surgical Services	
• Surgeries, including orthognathic surgery • Corneal transplants; skin and bone grafts • Post-mastectomy reconstructive surgery • Bariatric surgery	$0.00
• Diagnostic services • Treatments • Anesthesia administration • Consultation with specialists • Gastrointestinal endoscopies • Audiological evaluations, including the Neonatal Hearing Screening Test	$0.00

	Copayments / Coinsurance
Chemotherapy in all its methods of administration (injectable, oral, intravenous, or intrathecal), and radiotherapy	0%
Invasive cardiovascular tests	25%
Lithotripsy (ESWL)	25%
AMBULANCE SERVICES AND SERVICES PROVIDED BY HOSPITALS AND OTHER FACILITIES	
Hospitalizations	
Semi-private or isolation room for maternity and regular hospitalizations	$25.00 preferred hospital $50.00 non-preferred hospital
• Meals and special diets • Use of telemetry service • Use of recovery room • Use of *Step-Down Unit* (intermediate care unit for infants) • Use of Intensive Care, Coronary Care, Pediatric Intensive Care, and Neonatal Intensive Care Units • General nursing service • Administration of anesthesia by non-medical personnel • Clinical laboratory services • Medications, biological products, healing supplies, hyperalimentation products, and anesthesia supplies • Production of electrocardiograms • Production of radiological studies • Physical therapy services • Use of services provided by physicians in training, interns, and hospital residents authorized to provide medical services to patients • Respiratory therapy services • Use of emergency room if the member is admitted to the hospital • Use of other facilities, services, equipment, and supplies • Blood for transfusions	$0.00
Dialysis and hemodialysis	$0.00
Chemotherapy in all its methods of administration (injectable, oral, intravenous, or intrathecal), and radiotherapy	0%
Lithotripsy (ESWL)	25%
Outpatient Surgery Center	$25.00
Post-hospitalization services through a Skilled Nursing Facility	$0.00
Ambulance	
Ground ambulance service	$0 in emergency cases In non-emergency cases, members pay the total cost and Triple-S Salud will reimburse up to a maximum of $80 per case.
Air ambulance service in Puerto Rico	$0.00

MENTAL HEALTH AND SUBSTANCE ABUSE	
General Mental Health Conditions	
Hospitalizations for mental conditions Regular hospitalizations	$25.00 preferred hospital $50.00 non-preferred hospital
Partial hospitalizations	$25.00 preferred hospital $50.00 non-preferred hospital
Electroconvulsive therapies for mental health conditions	$0.00
Outpatient Services	
Visits to the psychiatrist office	$15.00
Visits to the psychologist office	$15.00
Visits for immediate family (collaterals)	$15.00
Group therapy visits	$15.00
Other Psychological Evaluation	
Psychological evaluation	$10.00
Psychological tests	$10.00
Substance Abuse (Drug Addiction and Alcoholism)	
Regular hospitalizations, including detoxification services	$25.00 preferred hospital $50.00 non-preferred hospital
Partial hospitalizations	$25.00 preferred hospital $50.00 non-preferred hospital
Visits to the psychiatrist office	$15.00
Visits to the psychologist office	$15.00
Visits for immediate family (collaterals)	$15.00
Group therapy visits	$15.00
Residential treatment	$0.00

Triple-S Salud, Inc. cumple con las leyes federales aplicables de derechos civiles y no discrimina a base de raza, color, origen de nacionalidad, edad, discapacidad o sexo. Triple-S Salud, Inc. complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 787-774-6060, (TTY/TDD), 787-792-1370 or 1-866-215-1919. Free of charge 1-800-981-3241. If you are a federal employee or retiree, call 787-774-6081, Toll free 1-800-716-6081; (TTY/TDD) 787-792-1370; Toll free 1-866-215-1999. ATENCIÓN: si hablas español, tienes a tu disposición servicios gratuitos de asistencia lingüística. Llama al 787-774-6060, Libre de costo 1-800-981-3241. (TTY/TDD) al 787-792-1370 o 1-866-215-1919. Si es empleado o retirado federal llame al 787-774-6081, libre de costo 1-800-716-6081; (TTY/TDD) 787-792-1370; libre de costo 1-866-215-1999. Concesionario independiente de BlueCross BlueShield Association.

LIFE INSURANCE COVERAGE

This term Life Insurance is up to 95 years of age, renewable annually and will be effective the same day as the policy is in effect, following the same enrollment requirements. The life insurance coverage is only for the insured employee.

Insurance Amount

The benefit for natural death is $10,000. If it is an accidental death, the benefit is $10,000. For dismemberment, the benefit is up to $10,000.

Beneficiary

The beneficiary is the person(s) designated by the insured employee to get the benefit when the insured employee dies. If two or more beneficiaries outlive the insured employee, Triple-S Salud will pay out the benefit in equal parts, unless the employee choose a different distribution. If no beneficiary outlives the insured employee, will be paid to their heirs. If the insured employee dies and no beneficiary has been designated, Triple-S Salud will pay out said benefits in a lump sum, in the order established, to one of the following persons or groups: 1) spouse; 2) surviving children; 3) surviving parents; 4) surviving siblings; 5) executors or administrators.

Changes

To change the owner or beneficiary, the insured employee must submit a written request while the Insured is still alive. The change will not take effect until it is registered at our office. Once registered, it will be effective on the date the employee signed it. This change will not apply to any payment made by Triple-S Salud before the request was registered. If the insured employee had designated an irrevocable beneficiary, the employee must obtain that beneficiary's consent for the change to be effective.

Elegibility

An employee is eligible to this coverage:

1. On the effective date of the policy; or

2. After the period established in the group enrollment application, for employees hired after the effective date of this policy.

Benefit

If the insured employee dies while this policy is in force and before the expiration date, we will pay the benefit to the beneficiary. The benefit is the sum of:

(a). Insurance Amount: PLUS

(b). any insurance on the life of the insured employee provided by additional endorsements

(c). portion of any paid premium applicable to a period after the month when the employee dies, MINUS

(d). any uncovered premium if death happens during the grace period.

We will pay the benefit to the beneficiary after we receive proof of death and the corresponding written claim.

Grace Period

If the insured employee dies during the grace period (31 days from the premium due date to pay the premiums after the first), we will pay the Death Benefit but will deduct the premium required to cover the period from the beginning of the grace period to the end of the policy month when the insured employee's death occurred.

Limitations

If the insured commits suicide or self-inflicted injuries, while either in their right mind or not, whether intended or not, within a period of two years from the policy date, the benefit will not be paid out. Instead, the beneficiary will receive a sum equal to the premiums paid.

PROVISION FOR CONVERSION

You may convert the amount of the term life insurance issued in this policy into a new policy with a different insurance plan. The date of conversion will be the first day of any policy month, provided that:

(a) this policy is in effect;
(b) all premiums due before this date have been paid; and
(c) the age of the Insured is 75 years or younger.

To convert this policy, you must submit a written application and pay the first premium due under the new policy. We will not require you to submit proof of insurability in order to convert the term life insurance provided under this policy.

The New Policy

The insurance amount provided under the new policy will be equal to the amount of the term life insurance under this policy. The policy date will be the date of conversion. The issue age will be the employee's age as of the date of conversion. The fee schedule will be that of the new individual policy. The insurance individual plan may be any life insurance designated by the Company, provided that:

(a) the plan is available for individuals of the Insured's age as of that date;
(b) the insurance amount offered is available under the plan as of that date; and
(c) our risk, excluding any attachments, does not increase as a result of the conversion.

There will always be at least one policy available for issuance under this section.

The fees applicable to the premium for the new policy will be those in effect on the policy date of the new policy, based on the issue age for the new policy.

The provisions of Incontestability and Suicide will be effective on the policy date of this policy.

Accidental Death or Dismemberment

Triple-S Salud will pay the benefits provided herein as soon as we receive satisfactory proof that the covered employee suffered a loss caused directly, and independently of any other cause, by external and violent bodily injuries occurred by accident, and in accordance with the following:

LIST OF BENEFITS

When a covered employee sustains injuries resulting in one of the following losses within ninety (90) days of the accident, we will pay the amount specified below, as applicable to the loss.

The benefit of this coverage is $10,000.

Loss	Amount
Life	Principal Amount
Both hands, both feet, or loss of vision in both eyes	Principal Amount
One hand and one foot, one hand and one eye or one foot and one eye	Principal Amount
One hand, one foot, or one eye	Half of Principal Amount

Loss of hand(s) or foot/feet means loss due to detachment at or above the wrist or ankle joint, respectively. Loss of one or both eyes mean total and irreversible loss of vision. If a covered insured employee suffers more than one of the aforementioned losses as a result of the same accident, only one of the specified amounts (whichever is the greater amount applicable) will be paid for all losses. The amount specified for the loss of: a) two limbs; b) both eyes; and c) one limb and one eye is payable only if such double loss occurs as a result of the same accident. Otherwise, we will pay the benefits for the actual loss, provided that in any case we will pay benefits in excess of the principal amount shown in the definition of insurance amount in this policy.

Limitations

The benefits provided herein will not be payable if the losses arise because of or are caused by any of the following events:

1. Suicide or self-inflicted injuries, whether in your right mind or not;

2. War or any act of war, whether declared or not;

3. Injuries sustained while serving in the armed forces of any country or international authority;

4. Injuries sustained while driving in any organized motor race or participating in any aviation or speed tournament;

5. Injuries sustained while serving as a pilot or crew member of an aircraft;

6. Poisoning or inhalation of fumes or smoke, unless satisfactory proof is provided that such event occurred unintentionally and accidentally;

7. Injuries sustained under the influence of alcoholic or intoxicating beverages, use or abuse of drugs, narcotics or hallucinogens, except those taken by prescription (although the voluntary consumption of medications prescribed by a doctor and intentionally not taking them as prescribed is not covered under the terms of this policy);

8. Mental or physical disease or treatment of a mental or physical disease; AND

9. Injuries sustained while committing or attempting to commit an assault or participating in a criminal act, or as a consequence thereof.

Termination

This coverage will end on the termination date of the policy. This coverage will be effective on the date of the policy and can be renewed under the terms and conditions of the policy

Term Life Insurance up to 95 years of age

The benefit will be paid if the employee dies while the policy is in force. Premiums shall be paid while the employee is alive, up until the expiration date. This policy does not partake of the Company's surplus.

MAJOR MEDICAL EXPENSES COVERAGE

This Major Medical Expense endorsement provides benefits for certain services that have been limited or excluded in the basic coverage, as specified in the Benefits section, provided that they meet the conditions established in this coverage for such services.

Medical expenses covered under this coverage will be paid directly to the member or through an assignment of benefits, as per the rates established for such purposes and the applicable amounts for the primary policyholder and each one of his/her insured eligible dependents.

To be entitled to the reimbursement of covered medical expenses, the person must be insured by the basic policy for hospitalizations and medical-surgical and outpatient services, under the coverage that corresponds or is analogous to that of the requested service. These benefits are subject to the terms and conditions specifically established for them and are only offered for members who permanently live in the Service Area.

Expenses for services received in or outside a hospital, anywhere in the world, will be paid if they are related to a disease, accident, pregnancy, delivery, or health condition, in the following manner:

- If the service is provided in Puerto Rico, the reimbursement will be based on the health care benefit level established by Triple-S Salud for such purposes;

- If the service is provided outside Puerto Rico, payment will be based on the rates established by the *Blue Cross Blue Shield Association (BCBSA)* plans for participating BCBSA providers, except as otherwise stated in this coverage.

- Services rendered by non-participating providers outside Puerto Rico will not be covered, except in case of emergency. In these cases, Triple-S Salud will pay the fee percentage for non-participating providers established by the local Blue Cross Blue Shield Association plan, or the highest of the following three amounts (adjusted to the shared costs of the participating provider network):

    - fee negotiated with participating providers,
    - the usual, customary, and reasonable (UCR) charge; or
    - the amount Medicare would pay.

The member will be responsible for paying the deductible and/or co-insurance established in this coverage, as well as any difference charged by the non-participating provider.

Pre-Certification

All services rendered outside of Puerto Rico are paid exclusively through this coverage, subject to a precertification from Triple-S Salud, except in case of emergency.

Expenses incurred for covered services as a result of a medical emergency while the affected member is outside Puerto Rico shall not require precertification, but they will be subject to Triple-S Salud's verification of their reasonableness and medical necessity.

Services that require a precertification in the Basic Coverage are still subject to the same requirement in this Major Medical Expenses coverage.

Coinsurance

a. Each member is responsible for 20% of the covered medical expenses.

b. Each insured family is responsible for 20% of the covered medical expenses.

c. The applicable amounts for the coinsurance of covered medical expenses shall be determined based on the rates established for covered medical expenses.

Reimbursement

Covered medical expenses for medical services shall be reimbursed under the following conditions:

- 80% of the covered medical expenses incurred during a policy year by the policyholder or his/her insured dependent, after meeting the deductible, if applicable.
- Each insured person or family member shall be responsible for the difference between incurred expenses and the rates established by Triple-S Salud for the reimbursement of covered medical expenses.

BENEFITS

COVERED MEDICAL EXPENSES: We will cover all medically necessary expenses for treating injuries or illnesses suffered by the member and as recommended and authorized by the attending physician, if these services are rendered outside Puerto Rico, or in Puerto Rico as an extension of the basic coverage benefits if they are limited or excluded. This endorsement for Major Medical Expenses does not cover services in excess of the limitations in the Basic Coverage, except for the services explicitly stated in this section.

1. **Anesthesia and Its Administration**

2. **Outpatient services for mental health conditions and substance and alcohol abuse:** covered medical expenses for outpatient services to address mental health conditions and substance and alcohol abuse will be reimbursed based on the provisions established for any other illness.

3. **Durable medical equipment (these benefits are covered only if they are rendered outside Puerto Rico, subject to precertification from Triple-S Salud):**

    a. Oxygen purchase or rental and the necessary equipment for its administration.
    b. The purchase or rental of wheelchairs or adjustable beds, subject to the criteria established by Triple-S Salud.
    c. The purchase or rental of respirators, ventilators, and other equipment to treat respiratory paralysis, subject to the criteria established by Triple-S Salud.

4. **Medical Supplies and Equipment:**

    a. Covered medications that have been prescribed by a physician during hospitalization.
    b. Surgical supplies and equipment, such as bandages and gauze.

5. **Ground Ambulance Services:** To and from any medical facility. These services are covered if they are rendered by a vehicle that has been duly authorized by the governmental entity appointed for such purposes.

6. **Nursing Services:** If certified as medically necessary and rendered by someone who has been duly certified for such purposes and is not an immediate family member of the patient or part of his/her household.

7. **Hospital Services:** Semi-private room and food, as well as other hospital services and supplies for regular admissions, mental health conditions, and substance and alcohol abuse.

8. **Laboratory and X-Ray Services:** For diagnostic and treatment purposes.

9. **Physician Services**

10. **Physical Therapy and Rehabilitation Services (these benefits are covered only if they are rendered outside Puerto Rico):** For the form and duration of treatment prescribed by the attending physician, under the supervision of a surgeon-physician specialized in physical medicine. In such cases, supervision will not entail a direct (face-to-face) involvement from the physician, albeit he/she will need to be available on site to evaluate or recommend a change in the treatment plan, if necessary.

11. **Outpatient Surgery Center Services**

12. **Other Services:** The following services are covered, provided that they are considered medically necessary. The concept “medically necessary” excludes services that are: not necessary, rendered outside Puerto Rico, or in Puerto Rico if the benefit is excluded or limited in the basic coverage, experimental or investigative, *clinical trials* for treatment or research, or provided in excess of those

usually required to diagnose, prevent, or treat an illness, injury, failure in bodily systems, or pregnancy.

a. Hearing devices, up to $250.00 per policy year, per member
b. Prosthetic devices or implants to substitute part of or an entire physical organ, or to maintain its functionality, such as pacemakers, prostheses, valves, etc. Replacements are excluded.
c. Orthotic devices
d. Orthopedic devices
e. Surgical assistance
f. Mammoplasty, subject to precertification by Triple-S Salud.
g. Sports Medicine, up to 20 therapies per member, per policy year.
h. Cardiac Rehabilitation Services are covered if they are rendered by a physical medicine physician with expertise in rehabilitation and exercise physiology. Its purpose is to minimize the physical and psychological disabilities that may arise as a result of a cardiovascular disease. These services will be reimbursed based on the rates and medical necessity provisions established by Triple-S Salud.
i. Intravenous or inhalational analgesia services rendered at the oral surgeon or dentist's office, provided the member has Triple-S dental coverage.
j. Prenatal and postnatal services
k. Tuboplasty
l. Vasovasostomy
m. Allergy immunotherapy
n. Covered services rendered by non-participating providers and facilities in Puerto Rico, based on participating provider rates.

MAJOR MEDICAL EXPENSES EXCLUSIONS

The basic coverage exclusions for hospitalization, medical/surgical, and outpatient services apply to this coverage, except for services specifically listed as covered services.

This coverage excludes the following expenses:

1. Services in excess of the limitations in the Basic Coverage, except for the services explicitly stated in the major medical coverage.

2. Those caused by war or international armed conflict.

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

4. Eyeglasses and contact lenses

5. Services rendered while admitted in an institution that is mainly a school or any other training institution, a resting place, a nursing home, or a sanatorium.

6. Services provided by a social worker, including psychologist and psychiatrist social workers, except in cases of autism.

7. Services rendered by air or water ambulance.

8. Services related to all types of dialysis or hemodialysis, as well as any associated complications, and its respective hospital or medical-surgical services, regardless of whether the health condition requires them.

9. Expenses for the applicable copayments or coinsurance in the basic policy for hospitalization, medical-surgical, and outpatient services, and their endorsements.

10. Expenses for post-hospitalization services rendered at a Skilled Nursing Facility or Home Health Care Agency.

11. Expenses for immunizations (excluding allergy immunotherapy), radioactive treatment, and tympanometry

12. Chiropractic manipulations

13. Expenses related to organ and tissue transplants.

14. Services provided by non-participating professionals and facilities outside Puerto Rico, except in emergency cases.

15. Expenses for services rendered to optional dependents, regardless of whether they are enrolled in the Basic Coverage for hospitalization, outpatient, and medical-surgical services.

ORGAN AND TISSUE TRANSPLANTS

The following terms shall be defined as stated below:

1. **MAXIMUM BENEFIT**: Maximum amount of benefits to be paid per lifetime or per policy year.

2. **NON-COVERED SERVICES**: Services that

   a. are explicitly excluded in this coverage;
   b. are an integral part of a covered service;
   c. are provided by a medical specialization that has not been recognized for payment;
   d. are considered experimental or investigative 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.

3. **ORGAN TRANSPLANT INSURANCE:** It is an independent insurance, separate from the Triple-S Salud Health Plan held by the eligible member. It only provides coverage for the Organ Transplant benefit, as defined in the Benefits section of this coverage. Payments for covered benefits are made through compensation or assignment of benefits. To be eligible for this insurance, you must be enrolled in the basic coverage.

4. **PRECERTIFICATION**: A prior authorization issued by Triple-S Salud to pay for any of the covered benefits, when deemed necessary by Triple-S Salud. Some of the objectives of the precertification process are: to assess if the service is medically necessary, to evaluate the suitability of the place of service, to confirm the member's eligibility for the service requested, and to check if the service is available in Puerto Rico. Precertifications will be assessed based on the precertification policies established by Triple-S Salud from time to time.

   Medications requiring preauthorization are usually those required to meet certain clinical criteria because they have a potential for toxicity, are commonly abused, or are related to high costs.

   Triple-S Salud will not be responsible for the payment of such services if they were provided or received without said authorization by Triple-S Salud.

5. **PRE-EXISTING CONDITIONS**: A member's physical or mental condition which first became apparent before the policy was issued, or which existed before the policy was issued and for which the member received treatment.

6. **PRE-TRANSPLANT**: Evaluation and preparation of the member to receive the organ or tissue transplant.

7. **PROCUREMENT**: It refers to expenses incurred during the identification, removal, preservation, and transport of an organ or tissue. It also includes the preoperative evaluation and the surgery required to remove the donor’s organ or tissue. Benefits will only apply for the procurement of an organ or tissue covered, provided that the transplant process is not canceled due to the member’s death or health condition and that the organ or tissue cannot be transplanted into someone else. These expenses will be covered insofar as the recipient is a Triple-S Salud beneficiary. When referring to bone marrow transplants, the term “donation” is used instead of procurement.

8. **SECOND MEDICAL OPINION:** Request made by Triple-S Salud, or its authorized representative, for the opinion of a physician selected by Triple-S Salud, different from the case attending physician, when Triple-S Salud has deemed such an opinion necessary before the member receives the service. Triple-S Salud may require a second medical opinion from a selected physician for those procedures where, as determined by Triple-S Salud or its authorized representative, it is necessary to obtain said opinion.

9. **TRANSPLANT**: A procedure or series of procedures where an organ or tissue is:

    a. Removed from the body of one person, the donor, and implanted in the body of another person, the recipient; or
    b. Removed from and implanted in the same individual's body.

ORGAN AND TISSUE TRANSPLANT BENEFITS

All benefits of this coverage are subject to their specifically established terms and conditions. They will only be available to members who permanently reside in the Service Area.

Triple-S Salud is responsible for the payment of the services offered to the member, subject to this coverage's provisions and the following conditions:

1. Benefits are covered per policy year and per member, unless when stated otherwise.

2. It only covers human organ and tissue transplants, up to the limits established by the coverage, and **requires precertification** from Triple-S Salud or its authorized representative for each transplant phase.

3. Triple-S Salud or its authorized representative may require a second medical opinion from a selected physician when deemed necessary to confirm that the member is receiving the most effective treatment possible and to maximize your coverage benefits.

4. The member, the physician, the hospital, and the Transplant Network facility will obtain guidance on the precertification process. If Triple-S Salud requires a precertification or preauthorization before the services are rendered, it will not be responsible for the payment of such services if they have been rendered without precertification of preauthorization from Triple-S Salud or its authorized representative.

These benefits will be covered by compensation (reimbursement) to the member or by an assignment of benefits to issue direct payment to the designated Transplant Network facilities in and outside Puerto Rico.

Once the services are precertified, the member may request an Assignment of Benefits. By accepting the Assignment of Benefits, the physician, hospital, or facility agrees to bill Triple-S Salud directly for the covered services provided to the member.

ORGAN AND TISSUE TRANSPLANT BENEFITS	
Maximum Benefit	$2,000,000 per lifetime
The member pays	0%
Transplant of Covered Organs	heart, heart/lung, lung (unilateral or bilateral), liver, pancreas/kidney, kidney, and small intestine.
Covered Medical Expenses	Recipient: Covers expenses that are directly related to the procedure. This includes the evaluation, pre- and post-operative care, transplant, and immunosuppressive drugs. Organs (procurement): Covers expenses and services provided for or related to the procurement, conservation, and transportation of organs to be used for the covered transplant. Transportation, food, and accommodations: This plan covers up to $10,000 per transplant type for transportation, food, and accommodation expenses. • Transportation: to and from the place of surgery for the patient and a companion. If the patient is under the age of nineteen (19), transportation will be allowed for two companions (parents or legal guardians). • Food and accommodations: up to $150.00 per day per person, or $200.00 per day for two people (parents or legal guardians of patients under the age of nineteen (19). **Retransplantation** **Immunosuppressants:** covers immunosuppressive drugs duly approved by the *Food and Drug Administration* (*FDA*) and drugs used in immunosuppressive therapy. This benefit will be covered up to the established maximum benefit. **Pre-transplant Expenses:** This coverage covers medical expenses related to the evaluation and preparation of a member eligible for an organ or bone marrow transplant, for thirty (30) days prior to the transplant procedure, in accordance with Triple-S Salud's established health care policy. Triple-S Salud will also cover one pre-transplant evaluation to determine whether the patient is an eligible candidate for transplant, regardless of the date of the procedure. This evaluation will strictly follow the protocol approved by Triple-S Salud.
Bone Marrow Transplant	Covers allogenic, autologous, syngeneic, and hematopoietic stem cell transplants, as long as they are suitable for the following illnesses and conditions: breast cancer, nonmalignant hematological disorders such as aplastic anemia, acute lymphocytic leukemia, acute nonlymphocytic leukemia, acute myeloid leukemia, acute and chronic myeloid leukemia in remission, malignant infantile osteopetrosis, Wiskott-Aldrich syndrome, Hodgkin's disease, non-Hodgkin's lymphoma, advanced neuroblastomas, and severe combined immunodeficiency. The policy covers the following expenses for the aforementioned transplants:

	1. Recipient: Covers expenses directly related to the procedure, including evaluation, pre- and post-operative care, transplant, and immunosuppressive drugs. 2. Bone marrow donation and storage: covers expenses and services related to the procurement, conservation, and transportation of tissue to be used for the covered transplant. 3. Pre-transplant chemotherapy or radiation treatments. 4. Postoperative outpatient care directly related to the transplant procedure. 5. Transportation, food, and accommodations: This plan covers up to $10,000 for transportation, food, and accommodation expenses. a. Transportation: to and from the place of surgery for the patient and a companion. If the patient is under the age of nineteen (19), transportation will be allowed for two companions (parents or legal guardians). b. Food and accommodations: up to $150.00 per day per person, or $200.00 per day for two people (parents or legal guardians of patients under the age of nineteen (19). 6. Retransplantation
Precertifications	Procedure for Organ and Tissue Transplant Cases: 1. The referral for transplant services will be made by phone, fax, or in person at the Triple-S Salud information desk. 2. Your eligibility and coverage will be verified. 3. Once coverage is verified, the specialty of the referring physician will be confirmed and whether the referral meets the previously established medical criteria. This refers to limitations or contraindications for the different types of transplant. 4. Triple-S Salud's transplant case specialist will offer initial guidance regarding transplant coverage benefits and alternatives. A precertification for the referral will be issued to one of the *Blue Cross and Blue Shield Association* Transplant Network Participating Institutions. 5. Triple-S Salud will coordinate the referral for Transplant services with the institution selected by the member and the physician. 6. The Transplant Program at the chosen institution will coordinate a clinical evaluation of the transplant candidate, based on their patient selection criteria, and will remain in direct contact with Triple-S Salud. 7. The member will request a precertification from Triple-S Salud for the Transplant services and at each of its stages. The coordination of claims for transplant services rendered at the selected institution will be handled between said institution and Triple-S Salud, Inc.

ORGAN AND TISSUE TRANSPLANT COVERAGE EXCLUSIONS

The following expenses or services are excluded from this coverage:

1. Expenses caused by war or international armed conflict.
2. Services provided while the patient's insurance is not in force.
3. Services that are available as per state or federal legislation, for which the member is not legally required to pay. Also, such services shall be excluded if they are denied by the corresponding governmental agencies due to breach or infringement of the requirements or provisions in the aforementioned laws, even if said breach or infringement does not constitute a crime.
4. Treatment services required arising from the member's perpetration of a crime or breach of the laws of the Commonwealth of Puerto Rico or of any other country, except for injuries resulting from an act of domestic violence or a medical condition.
5. Services received free of charge or paid through donations.
6. Expenses or services for personal convenience, such as telephone, television, custodial care services, rest house, convalescence home, or home care.
7. Reimbursement of expenses incurred in payments issued by the member to any physician or provider for services not covered under this coverage.
8. Services that are not medically necessary, services deemed to be experimental or investigative, as defined by the *Food and Drug Administration* (*FDA*), the *Department of Human and Health Services* (*HHS*), and the Puerto Rico Department of Health, or which are not in compliance with the health care policy established in the *Technology Evaluation & Coverage Manual* (*TEC*) of the *Blue Cross Blue Shield Association*, for the specific indications and methods ordered.
9. Expenses or services for new medical procedures not considered experimental or investigative, until Triple-S Salud determines their inclusion in this coverage.
10. Expenses and services related to organ and tissue transplants that were donated or received without a precertification from Triple-S Salud or an authorized representative.
11. Expenses related to special nursing services and home care.
12. Services rendered by air or water ambulance.
13. Expenses for services rendered to optional dependents.
14. Expenses for services rendered by facilities or providers not participating in the established Organ Transplant Network.

TRIPLE-S SALUD, INC.

(hereinafter referred to as Triple-S Salud)

1441 Ave. Roosevelt, San Juan, Puerto Rico

Independent licensee of *Blue Cross Blue Shield Association*

Pharmacy Endorsement

Group Name: Petsmart

Group Number: SP0003239 (ORV1) **Effective Date: January 1, 2025**

This endorsement is part of the policy to which it is attached, and it is issued in consideration of the additional corresponding premium payment in advance.

All the terms used in this Endorsement have the same meaning as in the policy, unless otherwise specified in this Endorsement. The remaining terms, provisions, limitations, and exclusions in the policy will apply as long as they are not in conflict with the benefits and conditions described in this Endorsement, in which case, the provisions of the pharmacy coverage will prevail.

Any expense you incur under the provisions of this Endorsement will be applied towards your pharmacy maximum out-of-pocket (MOOP).

This document will help you get acquainted with the pharmacy coverage benefits provided in this endorsement for you and your eligible dependents.

We invite you to carefully read this document and keep it close by for future reference.

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

Thurman Justice
President of Triple-S Salud

Please keep this document in a safe place so you may refer to the benefits described in this endorsement as part of your Health Care Plan.

DEFINITIONS

1. **ACUTE DRUGS:** Medications prescribed to treat non-recurrent diseases, such as antibiotics. These medications have no refills.

2. **ANNUAL PHARMACY DEDUCTIBLE:** The annual cash amount that must be accrued before being entitled to the benefits under this endorsement. Each member insured under an individual or family contract shall be responsible for paying the covered services until they reach the annual coverage deductible. Afterwards, they may pay the plan's copayments and/or coinsurance, as established in the Table of Deductibles, Copayments, and Coinsurance of this endorsement.

3. **BLUE CROSS BLUE SHIELD PLAN:** Independent insurer that, through a contract with the Blue Cross/Blue Shield Association, acquires the license to belong to the association of independent plans and to use its trademarks.

4. **CATEGORICAL EXCLUSION:** Means the specific provision established by Triple-S Salud to not cover a prescribed drug, identifying it by its scientific or commercial name.

5. **COINSURANCE**: The percentage of the fee the member has to pay when receiving covered services, to participating providers or physicians, or to any other providers, as their contribution to the cost of the services received, as established in this endorsement and as notified to the participating physician or provider. This amount is not refundable by Triple-S Salud.

6. **COPAYMENT**: The predetermined fixed amount that the member has to pay when receiving covered services, to participating providers or physicians or to any other providers, as their contribution to the cost of the services received, as established in this endorsement and as notified to the participating physician or provider. This amount is not refundable by Triple-S Salud.

7. **DRUG FORMULARY:** Guide of the drugs selected by the Triple-S Salud Pharmacy and Therapeutics Committee, which contains the therapies necessary for a high-quality treatment. Pharmacy coverage benefits are determined based on the medications included in the Drug Formulary. This selection is made based on the safety, effectiveness, and cost of the medications that ensure the quality of therapy, minimizing misuse that could affect the patient's health.

8. **EFFECTIVE DATE:** The plan's first day of coverage.

9. **FDA:** United States Food and Drug Administration.

10. **GENERIC DRUGS (Tier 1):** A generic drug is formulated with the same active ingredient as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are approved by the U.S. Food and Drug Administration (FDA).

11. **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.

12. **MEDICAL OR SCIENTIFIC EVIDENCE:** Means evidence produced by any of the following sources:

    a. Expert peer-reviewed papers, published or approved for publication in specialized medical journals that meet nationally recognized criteria for scientific texts;

    b. 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);

c. Medical journals recognized by the Secretary of Health and Human Resources of the United States Government, pursuant to the federal Social Security Act;

d. 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.

e. 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);
   - Food and Drug Administration (FDA), and
   - Any national board recognized by National Institutes of Health whose purpose is to evaluate the efficiency of healthcare services.

f. Any additional medical or scientific evidence comparable to those described in the preceding paragraphs.

13. **MEMBER:** Any eligible and enrolled person, be it the main policyholder or a (direct) dependent, who is entitled to receive the services and benefits covered under this endorsement.

14. **NEW DRUGS:** Drugs that have been recently introduced in the market.

15. **NON-PARTICIPATING PHARMACIES:** Any pharmacy that has not signed a contract with Triple-S Salud to provide services to the members.

16. **NON-PREFERRED BRAND-NAME DRUG (Tier 3):** 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.

17. **NON-PREFERRED SPECIALTY PRODUCTS (Tier 5):** Identifies the drugs or products in the Drug Formulary that are offered under the Specialty Drug Program. Drugs in this tier have a higher cost than the preferred specialty products in Tier 4. These are used to treat chronic and high-risk conditions that require special administration and management.

18. **OVER-THE-COUNTER DRUGS (OTC):** These are medications without a federal legend that can be sold to clients without a physician's prescription.

19. **PARTICIPATING PHARMACIES:** Any pharmacy that has signed a contract with Triple-S Salud to provide services to members.

20. **PARTICIPATING PROVIDER:** Healthcare services professional or facility that has a contract with Triple-S Salud to provide the benefits covered by this endorsement.

21. **PHARMACIST:** A person who is licensed to prepare, mix, and administer drugs and who practices within the scope of such license.

22. **PHARMACY:** A health care services facility that is licensed and registered under the provisions of federal and state laws to engage in the provision of pharmaceutical services, which includes dispensing prescription drugs, over-the-counter drugs, supplies, and other products related to health and the delivery of pharmaceutical care.

23. **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:

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

    b. 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 health insurance company, these members may only contribute with operational or logistical concerns, but they will not have a vote in any decisions regarding the inclusion or exclusion of prescription drugs in the Drug Formulary.

24. **PREFERRED BRAND-NAME PRESCRIPTION DRUGS (Tier 2):** There are certain drugs that have been selected by the Pharmacy and Therapeutics Committee as preferred agents after evaluating their safety, efficacy, and cost. These drugs are identified in Tier 2. For therapeutic classes where there are no generic equivalents available, we urge members to use medications identified as preferred as their first choice.

25. **PREFERRED SPECIALTY PRODUCTS (Tier 4):** Identifies the drugs or products in the Drug Formulary that are offered under the Special Care Pharmacy Program. Drugs in this tier include generic drugs, biosimilar drugs (generic versions of biological products), and brand-name drugs. These are used to treat chronic and high-risk conditions that require special administration and handling.

26. **PREMIUM**: The specific amount of money paid to an insurer, in this case Triple-S Salud, as a condition for eligible employees to receive health plan benefits. The premium charged by a health insurance plan may not be adjusted per contract year, except if due to changes in the employer's enrollment, the eligible employee's household composition, or the benefits of the health plan requested by the employer.

27. **PRESCRIPTION**: An order issued by a person who is licensed, certified, or legally authorized to prescribe drugs, addressed to a pharmacist to dispense a prescription drug.

28. **PRESCRIPTION DRUG:** A drug that has been approved or regulated for marketing and distribution by the Food and Drug Administration (FDA), and which is required by Puerto Rico or United States law to be provided with a prescription.

29. **PRESCRIPTION DRUGS WITH REPETITIONS (REFILLS):** Prescription containing written indications from the physician authorizing the pharmacy to dispense a drug on more than one occasion.

30. **SPECIALTY PHARMACIES:** These pharmacies provide specialty drugs for the treatment and management of chronic and complex health conditions. Specialty pharmacies handle specialty medications and provide fully integrated clinical management of the condition.

31. **STANDARD REFERENCE COMPENDIA:** Means The American Hospital Formulary Service-Drug Information; Drug Facts and Comparisons®; "The American Medical Association Drug Evaluations" 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:** Categories used to classify and group drugs in the Drug Formulary by the conditions they treat or the effects they produce in the human body.

PHARMACY BENEFIT (FB-23)

- The pharmacy coverage shall be subject to the terms and conditions of the coverage for hospitalization, medical-surgical, and outpatient services that are not in conflict with the benefits and conditions described in this section, and in such a case, what is established in the pharmacy coverage provisions shall prevail.

- Generic medications are dispensed as a first choice, except for brand-name medications included in the Supreme Drug Formulary for which there is no generic version. If the member chooses or the physician prescribes a brand-name drug when there is a generic version in the market, the member will pay the copayment for the brand-name drug and the difference in cost between the brand-name 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 drugs, regardless of the ailment, injury, condition, or disease for which they are prescribed, as long as the drug is approved by the FDA for at least one indication and the drug 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 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. When presented with a Triple-S Salud member card and a prescription, the participating pharmacy will provide the covered Supreme Drug Formulary medications specified in the prescription and 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 in 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 included in 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 Supreme Drug Formulary" in 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 period has elapsed from the date of the last refill or after one year from the original date the prescription was dispensed, unless otherwise provided by the law governing the dispatch of controlled substances.

This pharmacy coverage has the following characteristics:

- This pharmacy benefit uses a Supreme Drug 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 Supreme Drug Formulary and approves changes when:

a. any new drug introduced into the market during the term of this endorsement will be evaluated within no more than ninety (90) days after been approved by the FDA to determine if it is included in the Drug Formulary.

b. medications are changed from a higher copayment/coinsurance level to a lower copayment/coinsurance level.

c. changes are made for security reasons, if the manufacturer of the prescription drug cannot supply it or it has been pulled from the market, or if the change entails including new prescription drugs in the Supreme Drug Formulary.

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

- A doctor's prescription is required to dispense drugs.

- We will cover the generic drugs, preferred brand-name drugs, non-preferred brand-name drugs, preferred specialty products and non-preferred specialty products included in the Supreme Drug Formulary whose label contains the phrase «Caution: Federal law prohibits dispensing without prescription», as well as insulin and medications included in the Triple-S Salud over the counter (OTC) Program.

- Preventive services are covered, pursuant the federal acts: 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). We only cover the preventive drugs included in the Supreme Drug Formulary. Medications classified as preventive, as listed below, are covered with a $0 copayment if they are medically prescribed and dispatched by participating pharmacies in the Triple-S Salud network:
    - Contraceptive methods - We will only cover the drugs included in the contraceptive list of the Supreme Drug Formulary, which includes at least one medication for each of the categories defined in the Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA). Generic drugs will be covered as the only option except in categories where there is no generic version in the market.
    - 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.
- For those using tobacco cessation products, this plan covers 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. This does not apply to OTC (over-the-counter) products.
- Preventive drugs for patients at high risk of developing breast cancer, the generic version of tamoxifen or raloxifene tablets, for patients who are at high risk of developing the disease and at low risk for adverse reactions to the drugs.
- Certain oral iron supplements for minors ages 4 months to 21 years old who are at risk of anemia.
- 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 versions of Simvastatin 5, 10, 20, and 40 mg; Atorvastatin 10 and 20 mg, 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 from gastroenterologists for intestinal slides for colonoscopy procedures in adults over 50 years old, only the following prescription drugs with Federal legend will be covered: Sodium Sulfate/Potassium Sulfate/Magnesium Sulfate and PEG (polyethylene Glycol).
- The drugs for Human Immunodeficiency Virus Pre-Exposure Prophylaxis (HIV PrEP), Emtricitabine/Tenofovir Disoproxil Fumarate 200mg/300mg, require preauthorization to validate the diagnosis. Only the bioequivalent generic tablet will be covered.
- 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 with federal legend to comply with 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 15-day supply for acute drugs and a 30-day supply for maintenance drugs.

- The amount of maintenance drugs is provided based on the original prescription and up to five (5) refills, each with a 30-day supply, within one year from the date of the original prescription. The physician must state the amount of refills in the prescription.

- Ninety (90)-day supplies apply to certain maintenance drugs, such as medications for hypertension, diabetes (insulin and oral tablets), thyroid, cholesterol, epilepsy (anticonvulsants), estrogen, Alzheimer's (not applicable to patches), Parkinson's, osteoporosis, prostate, aromatase inhibitors, antiestrogens, asthma (tablets and liquid, excluding inhalers and nebulizers), and anticoagulants (excludes warfarin); released through the Mail-Order Pharmacy Program or the 90-Day Medication Dispensing Program in Pharmacies (except insulins that cannot be sent by mail). This does not apply to Tier 4 and 5 Specialized Products.

- This pharmacy benefit may be subject to an annual deductible. Please refer to the Table of Deductibles, Copayments, and Coinsurance in this endorsement. The "annual deductible" is the amount that the member must pay for the drugs before our plan starts to pay its share. When the member receives the

first medication in the policy year, they will pay the total cost of their drugs until the amount established is reached. Pharmacy coverages may have a first tier of coverage. This means that:

a. If the pharmacy coverage has an annual deductible, the first-tier level of coverage begins when the member has reached the deductible and until the plan pays the established amount.

b. If the pharmacy coverage does not have an annual deductible, the first-tier level of coverage begins when the member receives his/her first dispensed medication in the policy year, up until the plan pays the established amount.

c. In both cases, whenever the member begins the first-tier level of coverage, he/she will be responsible for the copayments and coinsurance, depending on the level of medications, up until the plan pays the established amount.

d. Once accumulated the amount established in the first-tier coverage, the member must pay coinsurance for all the medications covered for the rest of the policy year, as established in the Table of Deductibles, Copayments, and Coinsurance that appears in this endorsement.

e. These deductibles, copayments, and coinsurance do not apply to Preventive Services with $0 copayment, as required by the federal laws Patient Protection and Affordable Care Act and the Healthcare and Education Reconciliation Act, and as established by the United States Preventive Services Task Force. Please refer to the Table of Deductibles, Copayments, and Coinsurance in this endorsement.

MAXIMUM OUT-OF-POCKET

- Every health insurance organization or insurer that provides prescription drug benefits, manager or administrator of pharmacy benefits or any entity to which the administration or management of pharmacy services or benefits has been delegated, will include, in the calculation or in the contribution or cost sharing requirement (“cost sharing, out-of-pocket maximum”), any payment, discount, or item that is part of a financial assistance program, discount plan, coupons, or any contribution offered to the member by the manufacturer. These items will be considered for the exclusive benefit of the patient in the calculation of their contribution, out-of-pocket expenses, copays, coinsurance, deductibles, or in compliance with shared contribution requirements. These contributions, discounts, and manufacturer coupons will be available and may be used with all health providers, according to the requirements of the program, regardless of the place of acquisition of the discount or coupon. The use of benefit accumulators, maximizers, or any other similar program that has the effect of implementing a restriction on the liability established in this section is prohibited.

MANAGEMENT PROCEDURES

- Some prescription medications are subject to management procedures. Triple-S Salud provides its members, as part of the information provided in this endorsement, with the Supreme Drug 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):** In some cases, we require that the member start by using a first-step drug for their condition before we cover another second-step drug for the same condition. This program requires the use of drugs without prescription (OTC) or other generic or brand-name drugs as a first step before using other second-step drugs for certain medical conditions. These are known as first-step drugs in the step therapy program. The member may thus be able to access medications with 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. Classifications that require a generic drug 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 Supreme Drug 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. **Drugs requiring preauthorization (PA):** Certain drugs need a preauthorization for the patient to be able to obtain them. These are identified in the Supreme Drug Formulary as PA (requires Pre-Authorization), 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.

   Drugs 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 drugs 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 that is not associated with adverse effects and is effective to treat a condition.

d. **Medical specialization limits (SL):** Some drugs have a specialization limit based on the specialized physician who is treating the condition. For example, for a liver condition, only a gastroenterologist or infectious disease specialist may prescribe the medication. These specialization limits are established based on current medical literature.

e. **Age limits (AL)**: The Supreme Drug Formulary includes medications associated to the initials AL. AL means these medications have an age limit.

f. **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 specialty drugs, to receive fully integrated clinical management services for the condition. Some of the medical conditions or drugs 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 Specialty Pharmacy Network, please refer to the Triple-S Salud Provider 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 drugs. Please refer to the Supreme Pharmacy Benefit Exclusions section or the Supreme Drug Formulary for more information.

g. **Triple S en Casa:** Triple-S en Casa is a non-specialized prescription drug delivery service offered exclusively to Triple-S Salud members with a pharmacy benefit. This service is designed to improve the patient's experience while simplifying the dispensing of your prescriptions and medication management. You will have access to the Program by registering for the service, through the Triple-S en Casa mobile application. We accept electronic prescriptions sent by your doctor or paper prescriptions sent through the Triple-S mobile application at home. You can also choose to have medications delivered directly to your home, office, or another address of preference. Deliveries are made in all municipalities of Puerto Rico except Vieques and Culebra. The Triple-S en Casa Program does not have an additional cost; your copayment and coinsurance for the medications will correspond to your pharmacy benefit.

Structure of Pharmacy Benefit and Drug Dispensation

Please refer to the Table of Deductibles, Copayments, and Coinsurance in this endorsement to see the copayments and coinsurance corresponding to your plan.

30-day Supply

- Tier 1- Generic Drugs
- Tier 2- Preferred Brand-Name Drugs
- Tier 3-Non-Preferred Brand-Name Drugs
- Tier 4-Preferred Specialty Products
- Tier 5-Non-Preferred Specialty Products
- Oral chemotherapy
- Triple-S Salud Over-The-Counter Drug Program
- Medications required by federal law, including FDA-approved contraceptives as prescribed by a physician, limited to the drugs included in the Formulary.

TABLE OF DEDUCTIBLES, COPAYMENTS, AND COINSURANCE

You are responsible for the following:

Tier Structures Applicable to the Pharmacy Benefit	
30-day Supply	**Copayments/ Coinsurance**
Tier 1 – Generic Drugs	$5.00
Tier 2 – Preferred Brand-Name Drugs	$10.00
Tier 3 – Non-Preferred Brand-Name Drugs	20% minimum $20.00
Tier 4 – Preferred Specialty Products	20% maximum $100.00
Tier 5 – Non-Preferred Specialty Products	20% maximum $100.00
Oral chemotherapy	0%
Over-the-Counter Drug Program	$0.00
Drugs required by federal law, including prescription contraceptives, according to the Preventive Drug List.	$0.00

Note: In some cases, a copay or coinsurance may apply up to the maximum established per medication, or a coinsurance may apply after the member spends a specific amount.

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 (insulin and oral tablets), thyroids, cholesterol, epilepsy (anticonvulsants), estrogen, Alzheimer's (patches not included), Parkinson's, osteoporosis, prostate, Aromatase Inhibitors, Antiestrogens, Asthma (tablets and liquid, exclude inhalers and nebulizer) and Anticoagulants (exclude warfarin). Does not apply to specialty products. Triple-S Salud members will be able to select their preferred option to receive certain maintenance medications, either through participating pharmacies or from the comfort of their own home, by registering in the Triple-S Salud Pharmacy Program by Mail Order (except insulins that cannot be sent by mail) or Triple-S en Casa.

90-day Supply

- Tier 1 – Generic Drugs
- Tier 2 – Preferred Brand-Name Drugs
- Tier 3 – Non-Preferred Brand-Name Drugs
- Drugs required by federal law, including FDA-approved contraceptives, as prescribed by a physician.

90-Day Prescription Drug Dispensing Program: This extended supply program allows members to obtain a 90-day supply of certain maintenance drugs through participating pharmacies. The Program has a network of pharmacies located throughout the island, including chain pharmacies and independent community pharmacies.

Triple-S en Casa: Under this program the person, through an application on their smartphone, can manage a 90-day supply of their maintenance medications at home or another place of preference, with a delivery the next day. **For information call 1-888-525-4842.**

Tier Structures Applicable to the Pharmacy Benefit	
90-day Supply	**Copayments/ Coinsurance**
Tier 1 – Generic Drugs	$10.00
Tier 2 – Preferred Brand-Name Drugs	$20.00
Tier 3 – Non-Preferred Brand-Name Drugs	20% minimum $60.00
Drugs required by federal law, including prescription contraceptives, according to the Preventive Drug List.	$0.00

Mail-Order Pharmacy Program: Under this program, members receive 90-day supplies of their maintenance drugs at home or any other place of preference and may order their drug refills by mail or phone. The shipment for medications is free of charge, and members will save on their copayments. Does not apply to insulins as they cannot be mailed. For information and to register in the Mail-Order Pharmacy Program, call 1-866-560-5881.

Tier Structures Applicable to the Pharmacy Benefit	
90-day Supply	**Copayments/ Coinsurance**
Tier 1 – Generic Drugs	$10.00
Tier 2 – Preferred Brand-Name Drugs	$20.00
Tier 3 – Non-Preferred Brand-Name Drugs	20% minimum $60.00
Drugs required by federal law, including prescription contraceptives, according to the Preventive Drug List.	$0.00

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 Supreme Drug 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 DRUG PREAUTHORIZATIONS

Triple-S Salud has a term not to exceed 72 hours (3 days) after receiving all the required drug documentation to:

1) Evaluate the documentation received
2) If the required clinical information is not received, it will be requested from the physician, member, or pharmacy
3) Notify you of our determination

Triple-S Salud evaluates all the information received for a preauthorization of a drug from the pharmacy, physician or member. If any clinical information is required from the member, pharmacy or physician, Triple-S Salud will send a notice to the member, pharmacy or physician stating that they have five (5) calendar days to submit the missing clinical information.

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 consuming 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 SUPREME DRUG 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 your medication even if it is not in our Supreme Drug Formulary and is not an exclusion.
- To cover your medication that has been or will be discontinued from the Supreme Drug Formulary for reasons not related to health care, or because the manufacturer cannot provide it or has withdrawn it from the market.
- 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 (787) 749-4949** – They will offer you guidance on the process you should follow to request an exception.
- **Fax 787-774-4832** of the Pharmacy Department: You must send all the documentation 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 Supreme Drug Formulary that would be a clinically acceptable alternative to treat the member's disease or medical condition.
- The alternative prescription medication included in the Supreme Drug 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's 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.

Process a prescription drug by exception

1. Upon receiving a medical exception request, Triple-S Salud will ensure it is reviewed by appropriate health care professionals who, in making their determination, will consider the specific facts and circumstances that apply to the member for whom the request has been submitted, using proven clinical review criteria:

    - Based on solid clinical, medical, and scientific evidence, as well as the pertinent practice guidelines, in accordance with the corresponding state and federal laws and regulations, as long as the service provided, is recognized by the generally accepted standards of health and medical practice, in accordance with modern means of communications and teaching.

2. The health care professionals designated by Triple-S Salud to review medical exception requests will make sure that the determinations made will correspond to the benefits and exclusions provided in the member's health plan. These professionals must possess experience in drug management. The aforementioned determinations will be set out in a report, which will include the qualifications of the health care professionals who made the determination.

3. Triple-S Salud will make a determination on the submitted request and notify the member or their personal representative with urgency required by the medical condition, but not later than 72 hours after receiving all the information required or from the date the request or communication is received from the prescribing physician, whichever date is later. For controlled medications, this period shall not exceed 24 hours.
    a. In order to evaluate your request, Triple-S Salud will ask the physician or the pharmacy for the required clinical information by phone, fax, or any other electronic means.

    b. If the member submitted the request, and additional clinical information is needed to complete the evaluation of the medication, the member will receive a phone call where he/she will obtain instructions on which additional information needs to be provided by the physician in order to evaluate the case, the deadline to receive it, and the fax number to send it.

    c. If the required clinical information is not received within 72 hours, we will proceed to close the request and will immediately notify the member and, if applicable, their personal representative and the prescribing physician. The notification will include details about the missing information. Closing the request does not mean the member may not submit the claim again.

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

4. If Triple-S Salud fails to make a determination regarding the medical exception request or fails to notify it within the aforementioned period:

   - The member will be entitled, for a 30-day period, to a supply of the prescription drug that is the object of the request, based on the requested or prescribed supply, or in the case of step-therapy, based on the terms provided in the coverage.

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

5. If Triple-S Salud fails to make a determination regarding the medical exception request or fails to notify it before the member finishes their drug supply, the coverage will be maintained continuously and under the same terms, as long as the drug 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 a medical exception request, the drug will be covered and the member will not be required to request an approval for refills or for new prescriptions to continue the same drug treatment, as long as:

   a. the drug is being prescribed for the same illness or health condition; and
   b. the drug is considered safe for the current policy year.

7. Triple-S Salud shall not establish a level of copayment or coinsurance that is applicable only to those drugs approved via exception requests.

8. Any denial to an exception request:

   - Will be notified to the member or, if applicable, to their personal representative, in writing, or by electronic means if the member has agreed to receive information this way.

   - Will be notified to the prescriber by electronic means or, at their request, in writing.

   - May be appealed. In the denial notice, the member will be informed of their right to file a request to appeal the denial, as established in the policy, to which this endorsement is attached, in the section Appeals for Adverse Benefit Determinations.

9. Process to notify the coverage determination

   The process to notify a denial in cases that do not meet the criteria established for off-Drug Formulary coverage, preauthorizations, step-therapy, amount limits, duplicate therapies, and use not approved by the FDA includes:

   a. The specific reasons for the denial;

   b. References to the evidence or documentation, which include the clinical review criteria and practice guidelines, as well as any clinical, medical, and scientific evidence, 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.

SUPREME PHARMACY BENEFIT EXCLUSIONS

The policy exclusions, to which this endorsement is attached, 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. Medications without prescription, except those included in the Triple-S Salud OTC Program.

2. Charges for artificial instruments, hypodermic needles, syringes, lancets, strips, 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 legend:

   a. Medications with cosmetics purposes, or any related product with the same purpose (hydroquinone, efformitine, monobenzone, dihydroxyacetone, Onabotulinum toxin A, Botulinum toxin A 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, Olumiant.

   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, semaglutide, setmelanotide, naltrexone-bupropion, and mazindol).

   f. Dietary products (Foltx®, Metans®, Folbalin Plus® and Cerefolin®).

   g. Medications to treat infertility (follitropin, clomiphene, menotropin, urofollitropin, ganirelix, cetrorelix acetate progesterone vaginal insert, leuprolide acetate inj. kit 5 mg/ml (1mg/0.2ml)), and fertility.

   h. Impotence (tadalafil, vardefanil, sildefanil, avanafil).

   i. Implant (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). Additionally, any other drug approved by the FDA.

   j. Intracranial carmustine implant (used to treat malignant gliomas or 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, tofersen and calfactant)

   l. Devices (sodium hyaluronate, hyaluronan and hylan)

   m. Medications used in tests with diagnostic purposes (thyrotropin, dipyridamole IV 5mg/ml, gonadorelin HCl, cosyntropin, glucagón Diagnostic Injection Kit 1 MG (does not apply to patients diagnosed with diabetes Mellitus Type 1),, barium sulfate, diatrizoate, iohexol, iopoamidol, iopromide, lidodixanol, othalamate, loversol, manitol, technetium gadoterate, gadopentetate, gadodiamide,

tricophyton,tropicamide, tuberculin,and antigens, leuprolide acetate inj kit 5 mg/ml (1mg/0.2ml)) Corticorelin Ovine Triflutate, Adenosine, Secretin Acetate, Dexamethasone Diagnostic Test Oral Kit, Aminolevulinic Acid, Glucose Tolerance Test, Histamine Phosphate Intradermal, Indigotindisulfonate Sodium, Cardio-Green Injection, Lymphazurin, Sincalide, Regadenoson, Macimorelin, metyrapone, Histamine, Benzylpenicilloyl Polylysine, Methacholine, Arginine HCl, Secretin Acetate, Geref Diagnostic, Indocyanine Green).

n. Immunization drugs (hepatitis A & B, influenza, encephalitis, measels, mumps, poliovirus, papillomavirus, rabies, rotavirus, rubella, varicella, yellow fever, zoster, cholera, haemophilus b, lyme disease, meningococcal, plague, pneumococcal, typhoid, tetanous toxoid, diphteria, immune globulin, respiratory syncytial virus, palivizumab, pagademase bovine, stephage lyphates, Rho D immune Globuline) 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 policy, to which this endorsement is attached.

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

p. Oral vitamins: (niacin, ascorbic acid, thiamine, riboflavin, vitamin E, pyridoxine, dihydrotachysterol, multi-vitamins with added minerals, multi-vitamins with added iron, multi-vitamins with added calcium, vitamin B complex - biotin - D - folic acid, vitamin B complex with vitamin C, flavonoids and bioflavonoids), except for prenatal vitamins, folic acid and injectables that are covered.

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. Sclerosants (intrapleural talc, ethanolamine, polidocanol, sodium tetradecyl)

t. 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 to provide 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 will cover the patient's routine medical expenses, according to the terms and conditions established in this endorsement. Routine medical expenses are any medically necessary expenses required for the study (clinical trials), which are normally available to members under this plan, whether or not they are participating in a clinical trial, as well as services to diagnose and treat any complications resulting from the study, according to the coverage established in this endorsement.

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 Supreme Drug 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 Supreme Drug Formulary. Any new medication included in the excluded therapeutic classifications (categories) will also be considered an exclusion.

10. Exclude Trypan Blue solution (azoic dye used in histological stains to help differentiate between living cells and dead cells), intravenous lacosamide Vimpat®, degarelix acetate inj., sodium tetradecyl, polidocanol, 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 for varicose veins), sodium morrhuate, intrapleural talc, solution for peritoneal dialysis and homeopathic products in all their presentations (natural products used to treat different conditions on an individual basis). The following medications (Brand-name and generic) are excluded: Xuriden, Signifor, Cuprimine, Austedo, Lucentis intravitreal, Orkambi, Keveyis, Uptravi, Impavido, Emflaza, HP-Acthar, Tepezza, Givlaari, Zokinvy, Oxlumo, Danyelza, Evkeeza, Nulibry, Rebif, Ilaris, Isturisa, Elaprase, Xyrem, Ponvory, Lupkynis, Aduhelm, Bylvay, Nexviazyme, Leqvio, sabatolimab HR-MDS, Ligelizumab, Pegunigalsidasa, Roxadustat, Cibinqo, Opzelura, Saphnelo, Gefapixant, Korsuva, Skytrofa, Tezspire, Qulipta, Livmarli, Sotatercept, Rezurock, Recarbio, Scenesse, Krystexxa, Artesunate, Uplizna, Enspryng, Oxbryta, Cosentyx, Vuity, Rethymic, Ryplazim, Vyvgart, Cortrophin Gel, Addyi, Vyleesi, Entereg, Zynrelef, Pyrukind, Vabysmo, Enjaymo, Mozobil, Somryst, Remicade (only applies to brand-name drug), Simponi, Tremfya, Yohimbine, Alprostadil, Zynteglo, Amvuttra, Onpattro, Cablivi, Tarpeyo, Terlivaz, Stelara (only applies to brand-name drug), Altuviiio, Skyclarys, Filspari, Syfovre intravitreal, Xywav.

11. Products used to treat Idiopathic thrombocytopenic purpura (Promacta, Nplate, Tavalisse, Doptelet.)

12. Products used to treat amyloidosis (Vyndamax).

13. Products used to treat amyotrophic lateral sclerosis (Radicava, Relyvrio, Qalsody).

14. Products used for the treatment of idiopathic pulmonary fibrosis (Ofev, Esbriet).

15. Products used for the treatment of paroxysmal nocturnal hemoglobinuria (Soliris, Ultomiris, Empaveli).

16. Products used to treat primary biliary cholangitis (Ocaliva).

17. Products used for the treatment of spinal muscular atrophy (Spinraza, Zolgensma, Evrysdi).

18. Products used for the treatment of Duchenne muscular dystrophy (Exondys 51, Vyondys 53, Viltepso, Amondys 45)

19. Products used for the treatment of hereditary angioedema (Takhzyro, Cinryze, Firazyr, Orladeyo, Kalbitor, Ruconest, Berinert, Haegarda)

20. Antihemophilic agents will not be covered for prophylaxis treatment.

21. Products used for the treatment of Gaucher disease (Vpriv, Zavesca/Miglustat, Cerezyme, Elelyso, Ceredase, Cerdelga).

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

23. Products used for the treatment of smoking addiction (varenicline). This is a categorical exclusion, except as 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).

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

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

26. Treatment for sudden porphyria attack symptoms related to the menstrual cycle (hemin, Panhematin).

27. Gene therapy: Any treatment, drug, or device that alters the body's genes, genetic correction, or gene expression (Abecma, Breyanzi, Imlygic, Luxturna, Tecartus, Yescarta, Zolgensma, Carvykti (ciltacabtagene autoleucel, Skysona, Xenpozyme, Hemgenix)).

28. Cell therapy: Any treatment where intact living cells are transferred to a patient to help relieve or cure a disease. Cells can come from the patient (autologous cells) or from a donor (allogenic cells) (Allocord, Clevecord, Ducord, Gintuit, Hemacord, Kymriah, Laviv, Maci, Provenge, Ryplazim, StrataGraft).

29. Chimeric antigen receptor T-cell therapy (CAR-T): Any treatment or therapy where the patient's own immune cells (T cells) are modified to express a receptor on their surface that recognizes structures (antigens) on the surface of malignant cells, Carvykti (ciltacabtagene autoleucel)).

30. New FDA approved drugs that become available after the effective date of this endorsement unless they are required by federal or local law.

31. Expenses for injectable agents that require administration by a health care professional; these are covered under the health coverage for hospital, medical-surgical and outpatient services

TRIPLE-S SALUD, INC.

(which shall be henceforth referred to as Triple-S Salud)

1441 Roosevelt Ave. San Juan, Puerto Rico

Independent licensee of Blue Cross Blue Shield Association

Dental Endorsement

Group Name: Petsmart

Group Number: SP0003239 (ORV1) **Effective Date: January 1, 2025**

This endorsement is part of the policy to which it is attached, and it is issued in consideration of the corresponding premium payments in advance. It is subject to the policy terms and conditions not in conflict with the terms and conditions of this endorsement and is issued in accordance with the payment policies established by Triple-S Salud.

This document features the benefits which are provided by this dental endorsement for you and your eligible dependents.

We encourage you to read this document thoroughly and keep it close for future reference, and that you talk with your dentist about the policies established by Triple-S Salud for covered services.

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

Thurman Justice
President of Triple-S Salud

Please keep this document in a safe place so you may refer to the benefits described in this endorsement as part of your Health Care Plan.

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DEFINITIONS

1. **COINSURANCE:** Percent of the established fees that the member pays directly to the dentist when receiving services, according to the Summary of Coinsurance presented at the end of this endorsement.

2. **DENTIST:** An odontologist legally authorized to practice the profession of dentist.

3. **FEE SCHEDULE:** The fees established by Triple-S Salud for the services covered under this endorsement. Both the participating dentist and the member agree to accept these fees as the total payment for each service covered under the dental endorsement. These fees are subject to the terms and conditions stated in this endorsement.

4. **MAXIMUM BENEFIT:** Maximum limit of benefit amounts per lifetime or policy year.

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

6. **ORTHODONTICS:** Branch of odontology related to the diagnosis and treatment necessary to prevent and correct malocclusions.

7. **PARTICIPATING DENTIST:** A dentist with a regular license issued by the corresponding governmental entity, who is a bona-fide member of the College of Dental Surgeons of Puerto Rico and has signed a contract with Triple-S Salud to offer dental services.

8. **PERIODONTICS:** Branch of odontology related to the diagnosis and treatment of diseases in the gums and other tissues that help support the teeth.

9. **PREDETERMINATION OR PREDETERMINATION OF BENEFITS:** Evaluation of the treatment plan suggested by the dentist before delivering services, in order to determine the expenses to be covered by Triple-S Salud.

10. **TREATMENT PLAN:** A detailed report on dentist-recommended procedures to treat the dental needs of the member. This report can be found in the evaluation carried out by the same dentist.

COVERED DENTAL SERVICES

Please refer to the limitations and exclusions sections, which take precedence over the benefits described in this section. The covered benefits are subject to the payment policies established by Triple-S Salud. We encourage you to talk with your dentist about the applicable rules and limitations, as per the Participating Dentist's Manual, before receiving services.

Act No. 352 of December 22, 1999 requires insurers to provide coverage for general anesthesia, hospitalization, and dental services to pay for the general anesthesia and hospitalization expenses in certain dental procedures for minors, adolescents, or individuals with physical or mental disabilities. These services will be covered in the following cases, pursuant to the law:

- If a pediatric dentist or maxillofacial or oral surgeon from a hospital medical faculty, licensed by the Commonwealth of Puerto Rico, according to Act No. 75 of August 8, 1925, as amended, determines that the patient's condition or ailment is considerably complex, according to the criteria established by the American Academy of Pediatric Dentistry;

- If the patient, due to his/her age, impairment, or disability, is unable to withstand or tolerate pain, or to cooperate with the indicated treatment for dental procedures;

- If an infant, minor, adolescent, or member with a physical or mental disability has a medical condition where it is essential to perform dental treatments under general anesthesia at an outpatient surgical center or hospital, because it would otherwise pose a significant risk to the patient's health;

- If local anesthesia would be ineffective or contraindicated due to acute infection, anatomical variations, or allergic conditions;

- If the patient is an infant, minor, adolescent, or has a mental or physical disability, and is in a state of fear or anxiety that would impede conducting any dental treatment under traditional procedures for dental treatments, and his/her condition is such that postponing or deviating from the treatment would result in pain, infection, dental loss, or dental morbidity;

- If a patient has suffered severe or extensive dental trauma, where the use of local anesthesia would compromise the quality of service or be ineffective in managing pain and apprehension.

This service requires a predetermination and the corresponding coinsurance applies, as established in the Summary of Coinsurance found at the end of this endorsement.

The following documents must be sent to Triple-S Salud for their corresponding evaluation:

- Member's diagnosis
- Member's medical condition
- Reasons to justify the member receiving general anesthesia to undergo dental treatment, according to the previously established criteria.

Triple-S Salud will have up to two (2) business days from the date they receive the documents to approve or deny the request.

A. DIAGNOSTIC SERVICES

1. Initial comprehensive oral evaluation
2. Periodic oral evaluation
3. Limited oral evaluation (emergency)
4. Individual periapical and bitewing X-ray imaging
5. Panoramic X-ray imaging or complete series of radiographic images (full mouth)
6. Occlusal X-ray images
7. Cephalometric X-ray images
8. Pulp vitality test

B. PREVENTIVE AND RESTORATIVE SERVICES

1. Dental prophylaxis (cleaning)
2. Topical fluoride application for members under 19 years old and adults with special conditions
3. Topical fluoride varnish application for children under 5 years old
4. Fixed space maintainers
5. Recementation of space maintainers, inlays, crowns, post and core
6. Post and core construction
7. Amalgam (silver) and composite resin restorations for anterior and posterior teeth
8. Fissure sealants in permanent posterior teeth
9. Stainless steel crowns in deciduous teeth
10. Provisional crown
11. Protective (sedative) restoration
12. Crown repair

C. ENDODONTIC SERVICES

1. Direct and indirect pulp capping
2. Apicoectomy for anterior, bicuspid, and molar teeth
3. Apexification
4. Root canal treatment and retreatment for anterior, bicuspid, and molar teeth
5. Pulpotomy

D. PERIODONTIC SERVICES

1. Periodontal evaluation
2. Periodontal maintenance
3. Root planing
4. Gingivectomy

5. Bone surgery
6. Bone grafting
7. Provisional extracoronal splinting
8. Scaling, presence of moderate to severe inflammation

Expenses for periodontic services are covered in accordance with the fees established for said purposes, until completing the established maximum benefit. These services require predetermination.

E. PROSTHETIC SERVICES

1. Partial and complete dentures
2. Individual crowns for permanent teeth
3. Fixed bridges
4. Recementation of crowns and fixed bridges
5. Adjustment and repair of crowns, fixed bridges, complete and partial dentures, including rebase/reline

F. ORAL SURGERY SERVICES

1. Simple and surgical extractions
2. Excision of pericoronal gingiva
3. Alveoloplasty
4. Removal of exostosis
5. Frenulectomy

G. ADJUNCTIVE GENERAL SERVICES

1. Dental services are offered in a hospital or outpatient surgery center (hospital call)
2. Desensitizer application
3. Occlusal adjustment

H. ORTHODONTIC SERVICES

1. Diagnostic services (radiographies and study models)
2. Active treatment, including the necessary appliances
3. Retention treatment after active treatment

REIMBURSEMENT

Orthodontic services are reimbursed to the member, based on 100% of the expense submitted, until completing the established maximum benefit.

LIMITATIONS

A. DIAGNOSTIC, PREVENTIVE AND RESTORATIVE SERVICES

1. The initial comprehensive oral evaluation is covered, one (1) every three (3) years. It may be performed again by the same dentist or office after three (3) years from your last assessment (initial or periodic evaluation).

2. Follow-up or periodic oral evaluation, and emergency evaluation are covered, up to two (2) per policy year for each kind, per member, and at intervals of no less than six (6) months from the last date of service.

3. Individual periapical X-ray images are covered, up to six (6) per policy year, per member.

4. The complete series or panoramic X-rays are covered, no more than one every three (3) policy years per member, and they are mutually exclusive.

5. Bitewing X-ray imaging is covered, up to one (1) pair per policy year, per member.

6. Dental prophylaxis (cleaning) is covered, up to two (2) per policy year, per member, at intervals of no less than six (6) months from the last date of service.

7. Topical fluoride or varnish treatment is covered, up to two (2) per policy year, at intervals of no less than six (6) months, and they are mutually exclusive.
8. Fissure sealants are covered for minors under the age of 14, one per lifetime, per tooth, in permanent posterior teeth with unfilled occlusal surfaces.

9. Amalgam (silver) and composite resin restorations are covered, one (1) every two (2) years per tooth and surface.

10. Fixed space maintainers are covered for minors under the age of 14, one per quadrant or arch, per lifetime.

B. ENDODONTIC SERVICES

Apicoectomies, treatments and retreatments are covered, one per lifetime, per tooth.

C. PERIODONTIC SERVICES

1. Covered periodontic services are subject to a $1,000.00 maximum benefit per policy year, per member and require predetermination.

2. The amount that is not used in a policy year is not transferable to the following policy year.

3. The periodontal evaluation will be considered for coverage, one (1) per member per Periodontist or Office of the same specialization. It may be repeated after 3 years have elapsed since the last comprehensive or periodical periodontal evaluation.

4. Periodontal maintenance is covered, one every six (6) months, after concluding active therapy.

5. Root planing is covered, one service per quadrant, every two (2) years.

6. Scaling is covered, once a year, as long as a minimum of 12 months has passed since the last periodontal maintenance or dental prophylaxis (D1110).

7. Provisional extracoronal splinting is covered, up to one (1) per quadrant every three (3) years.

8. Gingivoplasty and gingivectomy are covered, up to one (1) of the two services per quadrant every 3 years.

9. The gingival flap includes root planing and is covered up to one (1) per quadrant every 3 years, while the apically positioned flap is covered, one per quadrant, per lifetime.

10. Bone surgery, one (1) per quadrant every 3 years.

11. Bone grafts, one (1) per tooth, per lifetime, and tissue membranes, one (1) per quadrant every 3 years

12. Free tissue graft is covered, one (1) per tooth, per lifetime

D. PROSTHETIC SERVICES

1. Covered prosthetic services are subject to a $1,000.00 maximum benefit per policy year, per member.

2. The amount that is not used in a policy year is not transferable to the following policy year.

3. Fixed crowns and bridges are covered up to one (1) every 5 years per tooth or area, subject to Triple-S Salud's service predetermination. To cover a fixed bridge, natural teeth must be present on both sides of the edentulous area.

4. Fixed and removable prosthesis are limited to one every 5 years.

E. ORAL SURGERY

1. Removal of torus palatinus, up to one (1) per maxillary arch every 5 years

2. Removal of lateral exostosis and removal of torus mandibularis, up to one (1) per quadrant, every 5 years

F. ADJUNCTIVE GENERAL SERVICES

The hospital call service is covered, one every 6 months for minors or members who are unable to receive the service at a dental office due to health conditions.

G. ORTHODONTIC SERVICES

1. These benefits are only available to eligible employees and their direct dependents, and they are covered with no age limits.

2. Orthodontic services are subject to a maximum lifetime benefit of $1,000.00 per member.

PREDETERMINATION OF SERVICES

When the member uses services from participating dentists, they will be in charge of requesting Triple-S Salud a predetermination for the services that require one, before offering them.

INDEMNITY TO THE INSURED PERSON

If a member receives covered services from a non-participating dentist in Puerto Rico or outside Puerto Rico, Triple-S Salud will reimburse the member the lesser amount between the cost incurred and the fee that would have been paid to a participating provider in Puerto Rico for the same service, based on the fees established by Triple-S Salud, after deducting the applicable coinsurance. These services are subject to the limits set forth in this endorsement.

EXCLUSIONS

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

1. Any service that is not included as a covered service in the description of this coverage
2. Endodontic treatments for primary (deciduous) teeth
3. Root canal retreatment, in case of a resulting endodontic infection if the member did not get the tooth properly restored
4. Replacement or repair of orthodontic appliances
5. Dental implants and all related services, except crowns over implants when a natural tooth is present on both sides of the edentulous area, which makes a conventional fixed bridge viable.
6. Permanent crowns for primary (deciduous) teeth
7. Services for aesthetic or cosmetic purposes

INDIVIDUAL ELIGIBILITY

Non-retired employees and their direct insured dependents in the group policy, who are sixty-five (65) or older, may subscribe to the benefits of this dental coverage. The eligibility of optional dependents, if applicable, will end when they turn sixty-five (65).

SUMMARY OF COINSURANCE

BENEFIT	COINSURANCE
DIAGNOSTIC, PREVENTIVE AND RESTORATIVE SERVICES	0%
ENDODONTIC SERVICES	20%
PERIODONTIC SERVICES - Maximum benefit of $1,000.00 per policy year	20%
PROSTHETIC SERVICES - Maximum benefit of $1,000.00 per policy year	50%
ORAL SURGERY SERVICES	20%
ADJUNCTIVE GENERAL SERVICES	0%
ORTHODONTIC SERVICES - Maximum lifetime benefit of $1,000.00 -100% reimbursement of the submitted charge or assignment of benefits for those providers who agree to bill Triple-S Salud directly.	0%