2026 HEALTH PLAN

Rent A Center

TRIPLE-S SALUD

ESTAMOS CONTIGO

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

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Employer/Policy Holder: Rent A Center

Sponsor: SP0003362

Effective date: January 01, 2026

Triple-S Salud, Inc. (hereinafter referred to as Triple-S Salud) insures the active employees of the employer in the group insurance contract and the eligible dependents of said employees in accordance with the provisions of this policy / Certificate of Benefits (hereinafter policy), the medical policies and the payment policies established by Triple-S Salud, against medically necessary medical-surgical and hospitalization expenses, provided while the policy is in force, due to injuries or illnesses suffered by the insured member. This policy is issued in consideration of the statements in the group insurance contract, to the payment by the employer of the corresponding premiums in advance and according to the date on which the employer subscribes the group health insurance.

This policy is issued to bona fide residents of Puerto Rico, whose permanent residence is located within the Service Area, as defined in this policy, for a term of one (1) year as of the date shown on the insurance contract group This insurance may be continued for equal, consecutive and additional periods, through the payment of the corresponding premiums, for which the employer would be responsible in the first place, as the holder of the policy and the employee as insured and user of the medical plan, as available. ahead. All the terms of coverage will begin and end at 12:01 a.m., Official Time of Puerto Rico.

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

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

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

Thurman Justice
President of Triple-S Salud

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

CONTACTS

Customer Service Department

Our Customer Service Department is available whenever you have questions or concerns about the benefits or services Triple-S Salud offers to the members enrolled in this policy. They can also answer your questions, help you to understand your benefits, and provide information about our policies and procedures.

Customer Service Phone Number	**787-774-6060 or 1-800-981-3241 (toll-free)** **TTY users call TTY 787-792-1370 or** **1-866-215-1999 (toll-free)**
Business Hours for **Call Center:**	• Monday to Friday: 7:30 a.m. - 8:00 p.m. (AST) • Saturday: 9:00 a.m. – 6:00 p.m. (AST) • Sunday: 11:00 a.m. - 5:00 p.m. (AST)
Fax – Customer Service	**787-706-2833**
Teleconsulta	**1-800-255-4375 (24/7)**
BlueCard	**1-800-810-2583** www.bcbs.com
Mailing Address **Customer Service**	**Triple-S Salud, Inc.** **Customer Service Department** PO Box 363628 San Juan, PR 00936-3628
Email Address:	servicioalcliente@ssspr.com
Precertifications	**Triple-S Salud, Inc.** **Precertification Department** PO Box 363628 San Juan, PR 00936-3628 **Fax: (787) 774-4824**
Case Management Program **Clinical Management Programs: asthma, diabetes, heart failure, hypertension, COPD (Chronic Obstructive Pulmonary Disease), prenatal and Smoking Cessation**	**787-706-2552 or 1-866-788-6770** **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 (North Parking Lot entrance) Monday to Saturday: 9:00 a.m. - 6:00 p.m. (AST) Sunday: Closed	**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. (corner) Monday to Friday: 8:00 a.m. – 5:00 p.m. (AST)	**Arecibo** Caribbean Cinemas Building, Suite 101 PR-2, Km. 81.0 Monday to Friday: 8:00 a.m. – 5:00 p.m. (AST)
Ponce 2760 Ave. Maruca Monday to Friday: 8:00 a.m. – 5:00 p.m. (AST)	**Mayagüez** PR-114 Km. 1.1 Barrio Guanajibo Monday to Friday: 8:00 a.m. – 5:00 p.m. (AST)
Personas con necesidades especiales debido a: • **El inglés no es su lenguaje primario** • **Necesidades especiales**	Esta información está disponible en español, libre de costo. Además, si necesita servicios de interpretación para hablar en otro idioma que no sea inglés o español, favor de comunicarse con Servicio al Cliente al 787-774-6060. Llame a Servicio al Cliente si necesita ayuda en otro idioma o formato. Si necesita ayuda para leer o entender un documento, le podemos ayudar. Los materiales impresos pueden estar disponibles en otros formatos, incluyendo la evidencia de cubierta y la tarjeta del plan en Braille. Usuarios TTY pueden llamar al 787-792-1370 o 1-800-215-1999 (libre de costo) durante el siguiente horario: • Lunes a viernes: 7:30 a.m.- 8:00 p.m. (AST) • Sábados: 9:00 a.m.- 6:00 p.m. (AST) • Domingos: 11:00 a.m. - 5:00 p.m. (AST)
People with Special Needs	Call Customer Service if you need help in another language or format. If you want to speak in another language or need help to read or understand a document, we can help you. 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 TTY 787-792-1370 or 1-866-215-1999 (toll-free) during the following hours: • Monday to Friday: 7:30 a.m. - 8:00 p.m. (AST) • Saturday: 9:00 a.m. – 6:00 p.m. (AST) • Sunday: 11:00 a.m. - 5:00 p.m. (AST)
Internet Portal	www.ssspr.com Our members may register to our website, where they may complete transactions such as: • Obtain information about their benefits • Health education information • Obtain a Coverage Certification • Request identification card duplicates • Check reimbursement status

	• Obtain a student certification letter • Review your service history
Mobile Application, Triple-S Salud	Download our mobile app to access important information about your health plan coverage. 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	This automated phone line helps you solve issues regarding your health plan at any time of day. You just need to call (787) 774-6060 or 1-800-981-3241 (toll-free) to: • Check your eligibility and that of your dependents • Check a reimbursement status • Obtain guidance for some processes, such as submitting a reimbursement claim, requesting card duplicates, and certifications, among others

AST: Atlantic Standard Time

IMPORTANT NOTICE FOR PEOPLE WITH MEDICARE
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.

NOTICE ABOUT ERISA FOR THE EMPLOYEES OF THE PRIVATE COMPANY

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

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

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

ERISA Scope

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

ERISA Requirements

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

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

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

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

Claim of Benefits

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

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

CHANGES IN THE EFFECTIVE PLAN IN YOUR NEW YEAR POLICY

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

- No changes in benefits for 2026 year policy.

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ELIGIBILITY

WHO IS ELIGIBLE?

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

DATE OF COVERAGE

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

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

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

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

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

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

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

SPECIAL ENROLLMENT

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

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

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

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

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

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

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

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

        3. The effective date of the adoption.

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

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

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

    e. In the cases of newborns:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. When an insured employee or one of his/her eligible dependents (direct) did not enroll in the employer health plan during the open enrollment period, because he was participating in the Medicaid Program or the Children's Health Insurance Program (CHIP) and later loses eligibility in any of this program or becomes eligible to receive premium assistance under any programs. In these cases, the insured employee and his eligible dependents will be entitled to special enrollment and may request enrollment in the employer health plan within 60 days from the date of any of these events.

In those cases in which the main insured (non-custodian) of minors listed as dependents under the policy, or when insured members who are of legal age but who appear as eligible dependents under the policy, request compensation payment directly to your person for having paid for the covered medical services that are claimed, Triple-S Salud can remit the payment directly to said non-custodial parent or insured member.

HOW YOUR PLAN WORKS

Your coverage under this policy / certificate

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

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

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

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

Free Choice Plan

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

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

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

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

Medically Necessary Services

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

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

Medical-Surgical Services during a Hospitalization

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

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

Inpatient Hospital Services

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

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

Participating Providers in our Network

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

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

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

Special Contracts for Management

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

Compensation to Network Providers

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

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

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 Network in Puerto Rico

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

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

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

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 is no longer in 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.

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

New insured members with ongoing treatment

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

This course of treatment must be for a life-threatening illness or condition or a degenerative and disabling condition or disease. Insured members may continue the care of a non-participating provider if they are in the second or third trimester of pregnancy, when the coverage of this policy / certificate becomes effective. The insured members can continue with the medical care until the date of delivery and any post-delivery services directly related to it.

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

Your Right to participate in decision making about your treatment

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

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

Our plan cannot impose gag, penalty or other clauses that interfere with communication between you and your doctor. Your doctor (s) or health professional (s) coordinating your medical care must provide a

medical order for lab tests, x-rays, or medications so you can choose the facility in which you will be taking care of them. will receive the services.

Emergency room and urgent care services

Materials and medications included in the suture tray contracted with Triple-S Salud. It covers medicines and materials additional to those included in the suture tray, supplied in emergency / emergency rooms due to accident or illness conditions. A copayment or coinsurance applies for illness and accident, according to the Deductibles, Copayments and Coinsurance Table.

If a member requires urgent care for a condition, a lower copayment may apply if the patient visits an urgent care center from our provider network instead of an emergency room. 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. This plan covers urgent care. Your copayment in urgent care centers may be lower than at the emergency room. To see the participating urgent care centers, please see Triple-S Salud's Provider and Participant Directory.

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

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

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

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

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

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

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

Emergency and urgent services in the United States

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

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

The insured member is responsible for paying the coinsurance established for these services.

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.

Precertification of Services

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.

Maximize your plan benefits

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

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

Services that are not an emergency	**Emergency**
You should call your doctor or an emergency room	**Visit a nearest emergency room or call System 9-1-1**
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 with blood / Sudden dizziness, weakness, loss of coordination or balance, or loss of consciousness / numbness of the face, arm or leg / Seizures / Difficulty to breathe / Sudden blurred vision or sudden or unusual headache

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

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

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

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

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

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

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

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

- Evaluate with your doctor the drugs that are part of your treatment and that are included in our Drug List or Formulary. Use the preferred medications which are cost-effective and already proven for the treatment of conditions. In addition, they have been selected by the Pharmacy and Therapeutics Committee for their effectiveness. You have larger outlays when you use medications that are not preferred. Check your coverage description so you can see how much your out-of-pocket is for copayments and coinsurance.

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

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

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

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

TELECONSULTA[1]

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

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

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

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

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

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

Precertification of Services

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, concurrent and retrospective reviews to determine when services should be covered by the plan. The objective of these reviews is to promote the provision of medical care in a cost-effective manner by reviewing the use of medical procedures and, where appropriate, the level or provider that provides the service. Covered services must be medically necessary to be considered covered by the plan.

Case management

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

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

Disease Management Programs:

- Diabetes
- Hypertension and Congestive Failure
- asthma
- Obstructive Pulmonary Disease
- Prenatal-high risk pregnancies
- Chronic Kidney Disease

Complex case management:

- Immune disorders (Example HIV or AIDS)
- Cerebrovascular diseases
- Cystic Fibrosis
- Degenerative diseases (Example multiple sclerosis, ALS)
- High users
- Organ and tissue transplantation, including bone marrow, liver, kidney, heart, lung and pancreas
- Skin lesions (ulcers III and IV)
- Mental illness and substance abuse
- Strokes
- Cystic Fibrosis
- Pulmonary hypertension
- Cancer undergoing continuous chemotherapy treatment (head / neck, gastrointestinal, lung, ovary / uterus, brain, metastasis or terminal phase

Our Program is confidential and voluntary. In addition, it will help the insured person who participates in the program to coordinate their benefits and educate them in order to meet their needs related to their health care.

The insured person may be referred to the program by a doctor, social worker, hospital, discharge planner, family member or on their own, as well as other sources.

Eligibility to participate in the program will depend on the existence of effective options for the treatment of the health condition of the insured person. These may include: home health services, durable medical equipment, or admission to a specialty care facility and other services.

If the insured person meets the criteria of the program and agrees to participate, a group of nurses, doctors and a social worker with extensive clinical experience will assess the health needs of the insured person and determine the available alternatives for care. Coordination is based on the recommendations of the insured person's general practitioner or doctor. When the insured person is accepted into the program, the case manager will coordinate services and follow up through phone calls and personal visits.

If you need additional information, please contact us at the telephone numbers or by electronic mail (e-mail) that appear 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

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

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

Our plan covers:

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

Our plan does not cover:

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

Preventive Centers Program

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.

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.sspr.com and complete your questionnaire. Stay active, stay healthy!**

Triple-S Natural

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Educational Materials in the Internet Portal

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

Satisfaction surveys

The opinion of our insured members counts.

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

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

Benefits not covered by the plan

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

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

Previous instructions or Advance Directives

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

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

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

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

Informed decisions about your health care

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

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

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

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

COORDINATION OF BENEFITS (COB)

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

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

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

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

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

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

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

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

d. Order of Determination of Benefits

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

1) Non-dependent or dependent

a) Except for what is provided in subparagraph (b) of this paragraph, the plan that covers a person as non-dependent (for example, the plan that covers a person as an employee, member, subscriber, policyholder, or retired) is the primary plan and the plan that covers the person as dependent is the secondary plan.

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

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

2) Dependent Child Covered under More than One Plan

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

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

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

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

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

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

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

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

I. The plan that covers the custodial parent;

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

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

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

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

d)

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

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

3) Active Employee or Retired or Former Employee

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

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

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

4) COBRA or Extensions of Coverage Under State Law

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

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

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

5) Longer or Shorter Coverage Time

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

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

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

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

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

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

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

PREVENTIVE CARE COVERAGE

This policy cover the preventive services required by the federal laws Patient Protection and Affordable Care Act, Public Act No. 111-148 (PPACA), and the Health Care and Education Reconciliation Act of 2010, Public Act No. 111-152 (HCERA), the Health Resources & Services Administration, the CDC's Advisory Committee on Immunization Practices, the Department of Health, and as established by the United States Preventive Services Task Force (USPSTF). These services may be modified throughout the year. The following preventive care services are included in the medical or pharmacy coverage and have no deductible or cost sharing ($0 copayment or 0% coinsurance) as long as they are provided through participating 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 older adults: 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.

Preventive Service	Indication
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 Chicken Pox, 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 Health Insurance Code of Puerto Rico. *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.

Preventive Service	Indication
Ceasing tobacco use and medications: 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	According to Law No. 10 of January 3, 2020 "Law of the Right to Effective Breast Cancer Detection" establishes that within the preventive care benefits, the following are covered: • An annual mammogram for insured individuals 35 years or older. • An annual mammogram, follow-up treatment, or supplemental diagnostic tests (MRI/Sonomammograms) for insured individuals 40 years or older, who have breasts classified as heterogeneously dense or extremely dense. • An annual mammogram, follow-up treatment, or supplemental diagnostic tests for women at high risk of developing breast cancer due to their family history, their own cancer history, the presence of high-risk markers in their genetic profile, or any other factor determined by their doctor.
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

Preventive Service	Indication
	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.
Patient Navigation Services for Breast and Cervical Cancer Screening	The Women's Preventive Services Initiative recommends patient navigation services for breast and cervical cancer screening and follow-up, as relevant, to increase utilization of screening recommendations based on an assessment of the patient's needs for navigation services. Patient navigation services involve person-to-person (eg, in-person, virtual, hybrid models) contact with the patient. Components of patient navigation services should be individualized. Services include, but are not limited to, person-centered assessment and planning, health care access and health system navigation, referrals to appropriate support services (eg, language translation, transportation, and social services), and patient education.
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.
Screening and Counseling for Intimate Partner and Domestic Violence	The Women's Preventive Services Initiative recommends screening adolescent and adult women for intimate partner and domestic violence, at least annually, and, when needed, providing intervention services. Intimate partner and domestic violence includes physical violence, sexual violence, stalking and psychological aggression (including coercion), reproductive coercion, neglect, and the threat of violence, abuse, or both. Intervention services include, but are not limited to, counseling, education, harm reduction strategies, and appropriate supportive services.

Preventive Service	Indication
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.

Preventive Service	Indication
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 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

Preventive Service	Indication
	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.

Preventive Service	Indication
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.
Height, Weight and Body Mass Index	Measurements for children. Ages: (0) to (11) months, (1) to (4) years, (5) to (10) years, (11) to (14) years, (15) to (17) years.
Hematocrit or hemoglobin screening	Screening for all minors when there is a risk factor.
Hemoglobinopathies screening: newborns	Screening for sickle cell disease in newborns.
Hepatitis B Virus Infection 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 Health Insurance Code of Puerto Rico. 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.

Preventive Service	Indication
	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 the CDC recommendations.
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.
Maternal 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, Teenagers, and Adults

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

Vaccines, including catch-up immunizations, are covered based on the immunization schedule 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
- ROTA - Rotavirus vaccine
- ROTA - Rotavirus vaccine, human – Rotarix
- IPV - Poliovirus vaccine, inactivated – injectable
- Hib - Haemophilus influenza B vaccine
- Menomune - Meningococcal polysaccharide vaccine
- MCV - Meningococcal conjugate vaccine – Menactra and Menveo
- PPV - Pneumococcal polysaccharide vaccine
- FLU- Influenza Virus Vaccine
- PCV - Pneumococcal Conjugate Vaccine - Prevnar 13
- DTaP - Diphtheria, tetanus toxoid and acellular pertussis vaccine
- DT - Diphtheria, tetanus toxoid
- HPV* - Human Papilloma Virus (Gardasil, Cervarix, 9vHPV)
- Tdap - Tetanus, diphtheria and acellular pertussis
- Zoster - Shingrix
- MMR - Measles, mumps and rubella vaccine
- VAR - Varicella virus vaccine
- HEP A Hepatitis A vaccine
- HEP A-HEP B Hepatitis A and hepatitis B vaccine
- Td - Tetanus and diphtheria toxoid adsorbed
- HEP B - Hepatitis B vaccine
- Meningococcal B
- Pentacel
- DtaP-IPV-HEP B (Pediarix)
- Kinrix
- Dengue**
- Prevnar 20
- COVID

Covered vaccines with coinsurance

- Immunoprophylaxis for respiratory syncytial virus (Synagis, Palivizumab) – Requires prior authorization following the protocol established by Triple-S Salud.

*For members between the ages of 9 and 27. It also covers, as of the age of 9, for minors and teenagers with a history of sexual abuse or assault who have not started or completed the series of three (3) doses.

** For members between the ages of 9 and 16 who live in areas where dengue fever is endemic and who have previously tested positive for dengue fever. Six months after infection is confirmed, a 3-dose series will be administered with six-month intervals between doses, as per the recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC).

Note: For an updated version, please contact our Customer Service Department. The Company is in compliance with Administrative Order No. 2023-579 of the Department of Health, Act No. 101 of August 30, 2023.

Coverage of Services by Local or Federal Law

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

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

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

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.

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.

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 providers are covered only in case of emergency, as required by law, and are paid directly to the provider, after deducting the applicable copayment and/or coinsurance. This means that you are responsible for the full cost of the services rendered by non-participating providers.

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 "Outpatient Medical-Surgical and Diagnostic Services" and “How Does your Plan Work” 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 review the copayments and coinsurance presented in this policy 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 Does Your Plan Work".

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

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

Acts of Improper Discrimination

It constitutes undue discrimination:

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

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

It is a discriminatory act to request information about acts of abuse or the situation of abuse of the insured member, current or potential, or use such information, regardless of how it is obtained, except for limited purposes to comply with legal obligations or verify the claim made by the person to the effect that he is a victim of abuse.

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

How does your Coverage work?

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

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

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

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

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 rendered in the United States and it is not an emergency or it is available in Puerto Rico, Triple-S Salud shall pay the amount equivalent to the fee established in Puerto Rico, minus the corresponding 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.

AMBULATORY MEDICAL-SURGICAL AND DIAGNOSTIC SERVICES IN AMBULATORY FORM

- If the person is not admitted in the hospital, he/she will have the right to receive the following services, among others:

Benefits Description	You Pay
Treatment and Diagnostic Services	
• Services available at SALUS Clinics, including visits, diagnostic tests, laboratories, radiology, and imaging	$0.00 copayment
Medical professional services: • In the doctor's office, without limits on the number of visits **Note**: Supplies used in a gynecologist's medical office for covered diagnostic tests are included in the copayment of the visit.	$12.00 copayment for visit to a general practitioner $15.00 copayment for visit to a specialist $20.00 copayment for visit to a sub-specialist
• Visits to audiologists	$10.00 copayment per visit
• Visits to optometrists	$10.00 copayment per visit
• Visits to podiatrists, including routine foot care	$10.00 copayment per visit
• Visits to clinical psychologists	$15.00 copayment per visit
• In-home medical services by physicians who render this service	$15.00 copayment per visit
• Intra-articular injections, up to two (2) daily injections up to a maximum of twelve (12) injections per policy year, per member	Nothing
• Hospital emergency room services, including supplies and medications included in the suture tray contracted with Triple-S Salud. It also covers medications and supplies in addition to those included in the suture tray, provided in the emergency room because of accidents or illnesses. If the insured member calls Teleconsulta and receives the recommendation to go to an emergency room with a registration number; a lower copayment/coinsurance may apply for the use of said facilities. If a nonparticipating provider cannot process the number on his system for the exemption or reduction of the lower copayment/coinsurance, the member will pay it and will request reimbursement to Triple-S Salud for the amount that he would have been exempted or reduced. Psychiatric emergencies will also be covered as well as the transportation between health services providing institutions including ambulances certified by the Public Service Commission and the Department of Health in conformance with what is established in the last paragraph of Article 4.20(b) of Law No. 183 of August 6, 2008 and as indicated in the Ambulance Benefit section that appear under the section Services Provided by a Hospital or Another Facility and Ambulance Services. For diagnostic tests performed in the emergency room other than laboratory tests and X-rays, the coinsurances and limits that correspond to the ambulatory services will apply as stated in the policy.	$75.00 copayment for illness $50.00 copayment for accident $25.00 copayment, if recommended by Teleconsulta **Urgent Care:** • $35.00 copayment for illness • $25.00 copayment for accident
• Cryosurgery of the uterus • Vasectomy	Nothing

Laboratories, X-Rays and Other Diagnostic Tests Selective Preferred Network of clinical laboratories and radiology/imaging applies to some plans under this policy. Please see the Provider and Participant Directory for a list of participating facilities. Please refer to the table of benefits in this policy to check if the Selective Network applies to your plan.	
Tests such as: • Clinical laboratory, genetic tests **require precertification** • X-Rays • Nuclear medicine tests • Single Photon Emission Computerized Tomography (SPECT) • Sonograms • Angiography by magnetic resonance study (MRA) • Computerized tomography • Magnetic resonance study (MRI) • Pet CT and Pet Scan, subject to precertification • Electromyograms, • Gastrointestinal endoscopies • Electroencephalograms • Non-invasive cardiovascular tests • Vascular non-invasive tests • Electrocardiograms • Neurological tests and procedures • Audiological tests such as vestibular function tests and special diagnostic procedures • Polysomnography (study of sleeping disorders), up to one test of each type, per life • Bone density test for insured members under age 65 or when it is not provided as a preventive service as provided by federal law, but as follow-up test to a diagnosis or treatment of a condition • Mammographies, digital mammographies or sonomammographies when not rendered as preventive tests as provided by federal law, but as follow-up test to a diagnosis or treatment of a condition • Color doppler flow • Other diagnostic tests	35% coinsurance in Selective Network 50% coinsurance out of Selective Network 25% coinsurance for other diagnostic tests
• Pelvic exams and all types of vaginal cytological tests that may be required by a physician to detect, diagnose, and treat early stages of anomalies that may result in cervical cancer. • Thin Prep Pap	Nothing
Vision Care	
• Ophthalmologic diagnostic tests • Refraction test, one (1) test per insured member, per policy year, as long as the test is performed by an ophthalmologist or an optometrist.	25% coinsurance
Maternity Services (applies to the primary member, spouse and dependents) without waiting periods	
• Prenatal and postnatal preventive visits and services as defined by Health Resources and Services Administration (HRSA)	$15.00 copayment for the visit to the specialist

• Obstetrics services • Well baby care preventive services according to the ages and coverage recommended by the United States Preventive Services Task Force (USPSTF)	Nothing
• Sonograms, according to the clinical protocol	25% coinsurance
• Biophysical Profile	50% coinsurance
Surgeries	
• Surgeries performed on an outpatient basis. **Requires precertification** when necessary for a medical reason change of service level (hospitalization or ambulatory surgery center)	Nothing
Allergy care	
• Allergy tests, up to a maximum of fifty (50) tests per policy year, per member	Nothing
Treatment Therapy	
• Radiotherapy	25% coinsurance per therapy
• Chemotherapy in all its administration methods (intravenous, oral, injectable or intrathecal); according to the medical order of the specialist physician or oncologist. Oral chemotherapy is covered under the pharmacy benefit. • Cobalt	Nothing
• Dialysis and Hemodialysis: Services related to any type of dialysis or hemodialysis, as well as any complications and their corresponding hospital or medical-surgical services, will be covered for the first ninety (90) days from: a. the date in which the member became eligible for this policy for the first time; or b. the date in which he/she received the first dialysis or hemodialysis. This will apply when subsequent dialysis or hemodialysis are related to the same clinical condition.	Nothing
Respiratory Therapy (administered at the doctor's office)	
• Respiratory therapy (provided by physician specialized in allergies, pediatric allergies, anesthesia, pneumology and pediatric pneumology, and laboratories located within a hospital facility), up to two (2) daily sessions for a maximum of twenty (20) sessions per policy year, per member	$7.00 copayment per therapy
Physical Therapy	
• Physical therapy, provided by physiatrists or chiropractors, up to one (1) daily session and up to a maximum of twenty (20) sessions per policy year, per insured member. In the case of physical therapy provided under the supervision of a physiatrist, it does not require the direct intervention (face to face) of the doctor, but its	$7.00 copayment per therapy

availability in the place so that, if necessary, it can evaluate or recommend a change in the treatment plan.	
Durable Medical Equipment (DME)	
Rent or purchase, subject to a Precertification: • Rent or purchase of oxygen and necessary equipment for its administration. • Rent or purchase, according to the criteria established by Triple-S Salud, of wheel chair or hospital type bed. • Rent or purchase, according to the criteria established by Triple-S Salud, respirators and other equipment needed in case of respiratory paralysis. Services provided by non-participating physicians in Puerto Rico will be paid by indemnization based on the fees established by Triple-S Salud, after the corresponding coinsurance for the rendered service is deducted.	25% coinsurance
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 • Test Strips, up to 150 for 30 days • Insulin infusion pump and supplies ordered by the endocrinologist for insured persons diagnosed with Type 1 Diabetes Mellitus. The endocrinologist will determine the brand of the insulin infusion pump based on age, level of physical activity and knowledge of the condition of the insured person or caregiver. **Requires precertification.** • The provision of a Glucagon injection and replacement of said injection in case it is used or expires.	20% coinsurance; nothing for the supplies for the insulin infusion pump For the glucometers, the coinsurance for the durable medical equipment will apply.
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	Nothing

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 subject to member or his/her representative submitting evidence of medical justification and the registration of the member in the registry the Department of Health has created to this purpose. It also includes the supplies for the handling of technological equipment of the Mechanical Ventilator. • The mechanical ventilator services and services by skilled nurses with knowledge of respiratory therapy or respiratory therapists with knowledge on nursing, the supplies necessary for handling the technological equipment, and physical and occupational therapies will be covered at 100%. For the copayments and coinsurances for medical services, treatments, diagnostic tests, and prescription drugs, refer to the table of benefits of this policy.	
Home Health Care	
Triple-S Salud will cover these services if they begin within 14 days from the date the member was released from the hospital after a hospitalization of at least three (3) days and if they are rendered for the same condition or for any situation related to the condition for which the member was hospitalized. It covers the following services and supplies provided at the home of the Patient by a Home Health Care Agency certified by the Health Department of Puerto Rico. **Requires precertification.** • Nursing services - partial or intermittent services provided or under the supervision of a registered nurse. • Home Health Auxiliary Services – partial or intermittent services rendered primarily for the patient care. • Physical, occupational and speech therapies (habilitative and rehabilitative) – a maximum of 40 visits per insured member, per policy year. • Services provided by non-participating facilities in Puerto Rico or non-participating of the Blue Cross Blue Shield Association, will be paid by compensation based on the established fees, after deducting the corresponding coinsurance for the provided service. **Note:** These services must be supervised by a licensed physician and **their medical necessity must be certified in writing.**	25% coinsurance

Nutrition Services	
• **NUTRITION SERVICES FOR ANY CONDITION:** Triple-S Salud will pay for nutrition services, provided in Puerto Rico, by physicians specializing in nutrition or metabolic diseases. Visits to these specialists, duly certified by the government entity designated for such purposes, will be covered as long as they are medically necessary. Visits have a maximum benefit of six (6) visits per policy year, per insured person.	Nothing
Triple-S Natural	
• The program is available only through the Program's participating facilities. For a list of the participating facilities, refer to the Provider and Participant Directory. The plan covers up to six (6) visits per policy year, per insured member.	$15.00 copayment per visit
Other services for the treatment of disorders within the continuum of Autism	
This policy covers the services targeted for the diagnosis and treatment of persons with disorders within the Continuum of Autism without limits such as: a) Neurological exams b) Immunology c) Genetic tests, **subject to precertification** d) Laboratory tests for autism e) Gastroenterology services f) Nutrition services g) Physical therapy h) Physical, occupational, and speech/language therapy i) Visits to a psychiatrist, psychologist, with master's or doctoral degree and valid license issued by the Board of Examiners of Psychologists of Puerto Rico) or social worker (by reimbursement). j) Psychological tests and evaluations In compliance with the Act for the Hyperbaric Oxygenation Treatment of Individuals with Autism Spectrum Disorders, we cover therapeutic hyperbaric oxygenation treatments for individuals with autism if it is recommended by a medical practitioner and the treatment is allowed by federal law and regulations; and for other related purposes.	a) 25% coinsurance b) 35% coinsurance in Selective Network / 50% out of Selective Network c) 35% coinsurance in Selective Network / 50% out of Selective Network d) 35% coinsurance in Selective Network / 50% out of Selective Network e) 25% coinsurance f) $0.00 copayment g) $7.00 copayment h) $7.00 copayment i) $15.00 copayment j) $10.00 copayment

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

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

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

MEDICAL-SURGICAL SERVICES DURING PERIODS OF HOSPITALIZATION

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

Benefits Description	You Pay
Medical Surgical Services	
During hospitalization periods the insured member is entitled to receive the following medical-surgical services, among others: • Surgeries • Orthognathic surgery, subject to precertification • Cornea transplant, skin and bone graft, includes 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, as defined. • Rhinoplasty services	Nothing
• Diagnostic services • Treatments • Administration of anesthesia • Specialists consultation • Gastrointestinal endoscopies • Sterilization services • Hearing evaluations, including Neonatal Hearing Screening Test • Surgical Assistance • Chemotherapy in all its modalities of administration (intravenous, oral, injectable or intrathecal) and radiotherapy	Nothing
• Invasive cardiovascular tests • Lithotripsy procedure (ESWL); precertification required	25% coinsurance

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

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

Benefits Description	You Pay
Hospitalizations	
• Semi-private or isolation room up to a maximum of three hundred and sixty-five (365) days for regular hospitalizations	$100.00 copayment / preferred hospital $200.00 copayment / non-preferred hospital
• Meals and special diets • Use of telemetric services • Use of Recovery room • Use of *Step Down Unit* • Use of Intensive Care units, Coronary Care, Pediatric Intensive Care, and Neonatal Intensive Care • General nursing services • Administration of anesthesia by non-medical personnel • Clinical laboratory services • Medications, biological products, healing materials, products related to hyper alimentation and anesthesia materials • Production of electrocardiograms • Production of radiological studies • Physical therapy services • Use of physicians in training, interns and residents of the hospital authorized to render medical services to patients. • Respiratory therapy services • Use of the Emergency room when the member is admitted to the hospital • Use of other facilities, services, equipment and materials usually provided by the hospital and ordered by the physician in charge which have not been expressly excluded from the contract with the hospital	Nothing, these services are included in the payment of the hospitalization copayment

• Services related to any type of dialysis or hemodialysis, as well as any complications and their corresponding hospital or medical-surgical services, will be covered for the first ninety (90) days from: a. the date in which the member became eligible for this policy for the first time; or b. the date in which he/she receives the first dialysis or hemodialysis. This will apply when subsequent dialysis or hemodialysis are related to the same clinical condition. • Chemotherapy in all its modalities of administration (intravenous, oral, injectable or intrathecal) and radiotherapy • Blood for transfusions	Nothing, these services are included in the payment of the hospitalization copayment.
• Lithotripsy procedure (ESWL); precertification required	25% coinsurance
• Ambulatory surgery	$100.00 copayment
Maternity Hospital Care – (for the insured employee, spouse and direct dependents)	
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 Law 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. • Semiprivate or isolation room, assistance and physical care for the newborn, education on the care of the newborn for both parents, assistance and training on breastfeeding, orientation on in-home support and the performance of any treatment or medical test for the newborn or the mother. **Note:** To look up hospitals in your area, visit our webpage at www.ssspr.com, or refer to Triple-S Salud Provider and Participant Directory. If you need additional information, contact Customer Service.	$100.00 copayment / preferred hospital $200.00 copayment / non-preferred hospital
• Obstetrics services • Use of maternity ward • Production and interpretation of Fetal Monitoring • Use of Well-Baby Nursery **Note**: These services are included in the payment of the hospitalization copayment.	Nothing

Skilled Nursing Facilities (SNF)	
The plan will cover these services if they begin within fourteen (14) days from the date the insured member is discharged from a hospital, after a hospitalization of at least three (3) days and if they are rendered for the same condition or in relation to the condition for which the person was hospitalized. **Requires precertification.** • They are covered up to a maximum of one hundred twenty (120) days per policy year, per insured member. **Note**: These services must be supervised full-time by a licensed physician or a registered nurse **and their medical necessity must be certified in writing.**	Nothing
Ambulance	
• Air ambulance services in Puerto Rico, subject to medical necessity	Nothing
In accordance with Law 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 ground ambulance benefit is covered if the patient was transported: a) from his/her residence or from the place of the emergency to the hospital or skilled nursing facility; b) between hospitals or from a hospital to a skilled nursing facility – in cases where the institution that transfers or authorizes the discharge is not the appropriate facility for the covered service; c) from the hospital to the member's home, if the condition of discharged patient requires it. d) Between health services providing facilities, in case of psychiatric emergencies provided by ambulances certified by the Public Service Commission and the Department of Health.	In cases that are not emergency, this benefit is covered by reimbursement. The member pays the total cost and must send the claim to Triple-S Salud with the physician's report including the diagnosis. Triple-S Salud will reimburse you up to a maximum of **$80.00** per case.

CANCER SERVICES

In accordance with the requirements of Act No. 107 of 2012, this policy establishes 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 that may be required to detect, diagnose, and treat early stages of abnormalities that could lead to cervical cancer. Outpatient cancer treatment services, such as radiotherapy and cobalt are also covered.

In compliance with Act No. 275 of September 27, 2012, 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 diagnosed with cancer or cancer survivor, if there is a medical recommendation for such purposes. It covers all preventive services and benefits mentioned under the federal ACA Act for the early detection of breast cancer, as well as breast cancer studies and monitoring tests, such as visits to specialists, clinical breast exams, mammograms, digital mammograms, magnetic resonance mammograms, sonomammograms, and treatments such as, but not limited to, mastectomies, post-mastectomy reconstructive surgery to reconstruct the extracted breast, reconstruction of the other breast to achieve a symmetrical appearance, breast prosthesis, treatment for physical complications during all stages of mastectomy, including lymphedema (inflammation that sometimes occurs after breast cancer treatment), as well as any post-mastectomy reconstructive surgery necessary for the patient's physical and emotional recovery.

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

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

MENTAL HEALTH AND SUBSTANCE ABUSE

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

Benefits Description	You Pay
Mental General Conditions	
Treatment services for the mental health care: Hospitalizations for mental conditions, including partial hospitalizations, will be covered according to the justified medical necessity. • Regular admissions • Partial admissions **Note:** Medical-surgical services during hospitalization periods for mental conditions are covered according to the justified medical necessity.	$100.00 copayment / preferred hospital $200.00 copayment / non-preferred hospital $50.00 copayment for partial admissions / preferred hospital $100.00 copayment for partial admissions / non preferred hospital
• Electroshock therapy for mental conditions, covered according to the justified medical necessity and to the standard of the American Psychiatric Association (APA).	Nothing
• Special nursing services during hospitalizations for mental conditions are covered if ordered by a psychiatrist, for up to seventy-two (72) consecutive hours for each hospitalization.	Triple-S Salud reimburses for each period of eight (8) consecutive hours of services rendered by a graduate nurse up to **FIFTEEN DOLLARS ($15.00)** and up to **TEN DOLLARS ($10.00)** if services are rendered by a licensed practical nurse.
• Patient's visits to the office of the psychiatrist or psychologist (with an MA or PhD and a valid license issued by the Puerto Rico Board of Psychologist Examiners)	$15.00 copayment per visit
• Collaterals visits (immediate family), including marital counseling, provided by a psychiatrist or psychologist (with a master's or doctorate degree and a valid license issued by the Puerto Rico Board of Psychologist Examiners)	$15.00 copayment per visit
• Group therapy visits	$5.00 copayment per therapy

Others Psychological Evaluations	
• **Psychological evaluation**	$10.00 copayment
• **Psychological test:** The psychological tests required by the Law Num. 296 of September 1, 2000, known as the Law of Conservation of the Children and Adolescents' Health.	$10.00 copayment
Substances Abuse (drug addiction and alcoholism)	
• Regular admissions • Partial admissions **Note:** Medical-surgical services during hospitalization periods for drug addiction and alcoholism are covered according to the justified medical necessity.	$100.00 copayment / preferred hospital $200.00 copayment / non-preferred hospital $50.00 copayment for partial admissions / preferred hospital $100.00 copayment for partial admissions / non preferred hospital
• Patient's visits to the office of the psychiatrist or psychologist (with an MA or PhD and a valid license issued by the Puerto Rico Board of Psychologist Examiners)	$15.00 copayment per visit
• Collaterals visits (immediate family), including marital counseling, provided by a psychiatrist or psychologist (with a master's or doctorate degree and a valid license issued by the Puerto Rico Board of Psychologist Examiners)	$15.00 copayment per visit
• Group therapy visits	$5.00 copayment per therapy
Residential Treatment	
• 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**.	Nothing

EXCLUSIONS TO THE BASIC COVERAGE

This policy does not cover the following expenses or services:

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

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

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

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

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

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

7. Expenses for physical exams, tests, studies, vaccines, or any other procedure required by the insured employee's employer.

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

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

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

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

12. Expenses or services for new medical procedures or new medications not considered experimental or investigational, except as required by state or federal law. Nor are expenses for research studies or clinical trials (that is, clinical trials), devices,

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

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

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

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

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

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

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

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

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

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

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

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

24. Expenses for allergy immunotherapy.

25. Services rendered due to induced abortion.

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

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

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

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

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

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

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

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

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

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

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

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

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

39. Expenses for medical services in treatment of tympanometry and acupuncture.

40. Preventive services rendered by providers outside Puerto Rico.

41. 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.

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

43. 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.

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

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

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

47. 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.

48. 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.

49. 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.

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.

MAJOR MEDICAL COVERAGE

Benefits Description

Benefits

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

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

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

The excesses of the limitations set forth in the basic policy will be covered without limit, except as otherwise provided in the coverage.

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

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

- If the service is provided in Puerto Rico, the reimbursement will be made based on the scale of medical benefits established by Triple-S Salud for such purposes;

- If the service is provided outside of Puerto Rico, it will be paid based on the rates established by the plans of the Blue Cross and Blue Shield Association (BCBSA), to use the BCBSA participating providers, except otherwise specified in this policy.

- Services provided through non- participating providers outside Puerto Rico will not be covered, except in cases of emergency.

    - the percentage of the rate for non-participating providers established by the local site plan Blue Cross Blue Shield Association

    - or the greater of the following three amounts (adjusted to the shared costs of the network of participating providers): negotiated rate with participating providers, the amount of the usual, customary and reasonable (UCR) or the amount that Medicare would pay.

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

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

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

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

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

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

Deductibles:

a) $100.00 per person, per policy year

b) $300.00 per family, per policy year

Coinsurance:

1. Each insured member shall be liable, after the deductible is accumulated, of 20% of the covered medical expenses, up to a maximum amount of $2,000.00 per policy year.

2. Each insured family will be responsible, after the deductible is accumulated, of 20% of the covered medical expenses, up to a maximum amount of $6,000.00 per policy year.

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

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

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

1. 80% of the covered medical expenses incurred during a policy year, by the member or his/her dependent while insured. The members must first cover the cash deductible, provided that, they will be covered subject to the limitations established in this coverage.

2. After the disbursement, of the amount established in Deductibles (a) and Coinsurance (a) in the section of Covered Services (due to accumulation of the deductible and coinsurance responsibility of the insured member) for medical expenses covered and incurred by the main member or his/her dependents insured during a policy year, we will refund 100% of the covered medical expenses that exceed that amount to the person in this situation during the remaining policy year.

3. After the disbursement of the quantity established in Deductible (b) and Coinsurance (b) in the section of Covered Services (due to accumulation of the deductible and coinsurance responsibility of the insured member and his/her dependents insured) for medical expenses covered and incurred by the insured

member and the members of his/her family insured during a policy year, we will refund 100% of the medical expenses covered with respect to all insured members of his/her family during the remaining policy year.

4. The deductible applies separately to the employee and to each insured dependent for every policy year. The total deductible may not exceed the deductible amount established in the family contract for all the expenses incurred by your family members during any policy year.

B. COVERED MEDICAL EXPENSES: We will cover the medical expenses necessary for the treatment of injuries or diseases suffered by the insured member and by recommendation and approval of the physician in charge of the case when these are rendered outside of Puerto Rico, or in Puerto Rico when extends the benefits of the basic if they were limited or excluded.

1. Anesthesia and its administration

2. Mental Conditions, Drug Addiction and Alcoholism

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

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

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

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

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

4. Medical materials or supplies:

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

b. Surgical supplies such as bandages and gauze

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

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

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

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

9. Physicians services

10. Physical Therapy and Rehabilitation Services: Of the modality of treatment and duration prescribed by the physician in charge of the case and under the supervision of a surgeon specialist in physiatrist. In this case the supervision does not require direct intervention (face to face) of the physician but his/her availability is required, in place so that, if necessary, can evaluate or recommend a change in the treatment plan.

11. Services in Ambulatory Surgery Centers

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

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

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

    c. Surgical assistance

    d. Immunizations

    e. Mammoplasties, subject to Triple-S Salud precertification

    f. Sports Medicine

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

    h. Covered services provided by non-participating professionals and facilities

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

    j. Pre and postnatal services

    k. Tuboplasties

    l. Vasovasostomies

    m. Orthotic and orthopedic devices

    n. Chiropractor services – These services are limited to fifteen (15) visits for the combination of the different modalities included in the chiropractic treatment (manipulations and follow-up visits) per plan year, per insured member. Reimbursement will be made based on Triple-S Salud established fees. These services do not accumulate the **cash deductible** nor the coinsurance established on this coverage and may be covered through Assignment of Benefits.

    o. Maxivision (glasses and contact lenses): This service will be covered up to $150.00 every two years. The benefit will not be subject to the cash deductible nor the coinsurance established on this coverage and may be covered through Assignment of Benefits.

    p. Occupational and Speech therapy (outside post hospital services), up to a maximum of 40 therapies per policy year, per member.

EXCLUSIONS FOR THE MAJOR MEDICAL EXPENSES COVERAGE

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

This coverage excludes the following expenses:

1. Caused by war or armed international conflict.

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

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

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

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

6. Services provided by an air or maritime ambulance.

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

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

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

10. Expenses related to organ and tissues transplants.

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

ORGAN AND TISSUES TRANSPLANT COVERAGE

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

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

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

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

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

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

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

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

Benefits

Maximum Benefit	$2,000,000 per lifetime
Member pays	$0.00
Covered Organ transplant	Heart, heart-lung, lung (unilateral or bilateral), liver, pancreas-kidney, kidney
Medical Expenses Coverage	Recipient: It covers expenses directly related to the procedure; it includes evaluation, care prior to the surgery, transplant, care after surgery and immunosuppressive drugs. Organs (procurement): It covers expenses and services provided or related to obtaining, preservation and transportation of organs to be used in the covered transplant. Transportation, meals and accommodation - the maximum limit of covered expenses to be reimbursed to the insured member for transportation, meals and accommodation is $10,000 per each type of transplant. • Transportation - from and to the place of the surgery for the patient and a companion. If the patient is less than nineteen (19) years of

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

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

ORGAN AND TISSUES TRANSPLANT EXCLUSIONS

This policy does not cover the following expenses or services:

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

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

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

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

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

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

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

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

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

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

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

12. Services provided by air or sea ambulance.

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

PHARMACY BENEFIT FB-72 SUPREME 2025

General Information

- 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 generic 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.

- Pharmacy network applies is Better Access. For participating pharmacies, please refer to the directory.

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. 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 Over-the-Counter (OTC) drugs from the OTC Drug List.

- 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 FDA-approved 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). $0 copayment applies to services that are an integral part of the preventive service provided. Generic drugs will be covered as the only option except in categories where there is no generic version in the market. Contraceptive methods that are not on Drug Formulary will be evaluated through the medical exception process and will be covered at $0 copayment when medically necessary and determined by member's physician.
    - 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

- Drugs required by the following local laws are covered in Puerto Rico:

    a) Cancer: in compliance with Act No. 79 of August 1, 2020, “Ley Especial para Asegurar el Acceso al Tratamiento y Diagnóstico de los Pacientes de Cáncer en Puerto Rico” known as the “Gabriela Nicole Correa Act”, the following is established: Triple-S Salud does not refuse or deny any treatment included in the guidelines of the National Comprehensive Cancer Network (“NCCN Guideliness”) and/or approved by the Food and Drug Administration (FDA) that is agreed upon and/or within the terms and conditions of the health contract subscribed between the parties to any patient diagnosed with cancer or cancer survivor, when there is a medical recommendation to that end.

    b) Hereditary Angioedema: in compliance with Law No. 62 of April 16, 2024, Triple-S covers the diagnosis and treatment of the condition Hereditary Angioedema (HAE), which are not experimental, nor genetic modification.

    c) COVID: in compliance with Law No. 43 of April 16, 2020 (Law to combat COVID-19), Triple-S will not require a copayment, coinsurance, deductible, preauthorization, or referral to the member for the treatment of COVID-19.

- 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 90-Day Medication Dispensing Program in Pharmacies, Triple-S en Casa Drug Dispensing or Mail Order Drug Dispensing programs (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. 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, identified in the Formulary):** 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. Applies to a member who is using the drug for the first time, or if a period of more than six (6) months has elapsed since using any of the medications.

    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 $1,500 per dispensed prescription, to avoid billing errors.

    Medications requiring preauthorization are usually those with adverse effects, candidates for misuse to ensure their cost-effectiveness.

    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**: This program will apply whenever a specialty drug is required by State or Federal law, as well as when the employer selects specialty drug coverage. The 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
  - 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 Chapter 3 Exclusions 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 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.

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	$10.00
Tier 2 – Preferred Brand-Name Drugs	15% minimum $15.00
Tier 3 – Non-Preferred Brand-Name Drugs	25% minimum $25.00
Tier 4 – Preferred Specialty Products	30%
Tier 5 – Non-Preferred Specialty Products	30%
Oral chemotherapy	0%
Over-the-Counter Drug List	$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 dispensed through the 90-Day Pharmacy Dispensing Program, Triple-S en Casa or Mail-In Program (except insulins that cannot be mailed).

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 bioequivalent maintenance medications, the copay will be $0. **For information call 1-888-525-4842.**

Tier Structures Applicable to the Pharmacy Benefit	
90-day Supply	**Copayments/ Coinsurance**
Tier 1 – Generic Drugs	$20.00
Tier 2 – Preferred Brand-Name Drugs	11% minimum $30.00
Tier 3 – Non-Preferred Brand-Name Drugs	25% minimum $75.00
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	$20.00
Tier 2 – Preferred Brand-Name Drugs	11% minimum $30.00
Tier 3 – Non-Preferred Brand-Name Drugs	25% minimum $75.00
Drugs required by federal law, including prescription contraceptives, according to the Preventive Drug List.	$0.00

Preauthorization For Prescription Drugs

Certain medications require the member to obtain preauthorization. Usually are those with adverse effects, candidates for misuse to ensure their cost-effectiveness.

Physicians and pharmacies have received guidance on which medications need to be preauthorized. Those 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 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".

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.

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 List.

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, Litfulo.

   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, tirzepatide, 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, measles, 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, *somatrogon, somapacitan*)

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, Elfabrio, Roxadustat, Cibinqo, Opzelura, Saphnelo, Gefapixant, Korsuva, Skytrofa, Tezspire, Qulipta, Livmarli, Winrevair, 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, Altuviiio, Skyclarys, Filspari, Syfovre intravitreal, Xywav, Amphadase, Bronchitol, Cabtreo, Cuvrior, Daybue, Elfabrio, Fabrazyme, Hylenex, Iheezo, Joenja, Kalydeco, Lamzede, Leqembi, Lumryz, Omisirge, Onpattro, Opvee, Pulmozyme, Rivfloza, Sohonos, Symdeko, Trikafta, Veopoz, Vyjuvek, Wainua, Wakix, Xdemvy, Xiaflex, Zilbrysq, Voxzogo, Rezdiffra, Eohilia, Alyglo, Zelsuvmi, Exblifep, Tryvio, Vafseo, Zevtera, Lumisight, Palopegteriparatide, Glepaglutide, Mavorixafor, Seladelpar, Rezzayo, Xacduro, Pombiliti, Izervay, Omvoh, Rebyota, Jesduvroq, Veozah, Miebo, Inpefa, Vowst, Rystiggo, Velsipity, Bimzelx, Filsuvez, Donanemab.

11. Products used to treat Idiopathic thrombocytopenic purpura (Promacta, Nplate, Tavalisse, Doptelet, Alvaiz.)

12. Products used to treat amyloidosis (Tafamidis, Vyndamax, Vyndaquel).

13. Products used to treat amyotrophic lateral sclerosis (Radicava, Radicava ORS,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, Fabhalta, Voydeya).

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, Agamree, Elevidys, Duvyzat)
19. Antihemophilic agents will not be covered for prophylaxis treatment.

20. Products used for the treatment of Gaucher disease (Vpriv, Zavesca/Miglustat, Cerezyme, Elelyso, Ceredase, Cerdelga).

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

22. 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).

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

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

25. Treatment for sudden porphyria attack symptoms related to the menstrual cycle (hemin, Panhematin).

26. 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, Roctavian, Casgevy, Lenmeldy, Eladocagene exuparvovec, Fordadistrogene, Atidarsagene autotemcel, Prademagene zamikeracel, Fidanacogene, Kresladi, Adstiladrin)).

27. 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).

28. 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)).

29. New FDA approved drugs that become available after the effective date of this endorsement unless they are required by federal or local law.

30. 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.

DENTAL COVERAGE (DI-06)

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%

PROCEDURE FOR OBTAINING REIMBURSEMENT

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

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

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

d. You should include the following:

- Full name (including both last names) and contract number of the member who received the service
- Date of service
- Diagnostic Code (ICD-10) and/or diagnosis description
- Procedure Code (in force at the time 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 traveled distance and evidence of medical necessity, and the carrier's Incident Report
- If the services require a precertification, copy of such precertification

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

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

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

- The service code, tooth number, and restored surfaces (if applicable)
- Amount paid for each service
- If the member pays more than one visit under a single a receipt, he/she must send the exact dates of service **(MONTH, DAY, YEAR)** for which he/she paid.
- 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 must add:

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

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

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

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

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

PRECERTIFICATIONS

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

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

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

Precertifications for studies and procedures are processed by the attending physician, the clinical personnel appointed by the physician, or the facility where you will go for treatment. They will need to call Triple-S Salud Precertifications, the Triple-S Salud call center that addresses these cases, from Monday to Friday from 8:00 a.m. to 4:30 p.m. Providers may also check the eligibility of the studies and procedures on our website www.sspr.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
- Durable Medical Equipment
- Skilled nursing facility
- Home health care
- Residential treatment
- Non-emergency services obtained in the United States
- General anesthesia and hospitalization services for dental procedures on minors and physically or mentally disabled people who require them.
- Genetic tests
- Insulin infusion pump and supplies ordered by the endocrinologist for insured persons 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 PROCESSING PRECERTIFICATIONS

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

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

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

PRECERTIFICATIONS IN URGENT CASES

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

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

The notification on the adverse determination will include the following:

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

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

APPEALS FOR ADVERSE BENEFIT DETERMINATIONS

RIGHT TO APPEAL AN ADVERSE DETERMINATION

What is an Adverse Determination?

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

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

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

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

The member may request a review of the determination as explained 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. First Level Review of Grievances Related to an Adverse Determination

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

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. Ordinary Reviews of Grievances Not Related to Adverse Determinations

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

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. <u>Emergency Services</u>

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
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.

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

Right to high-quality Health Services

Services consistent with the generally accepted principles of medicine practice.

Rights regarding the collection and disclosure of information

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

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

Rights regarding the selection of plans and providers

Every individual has the right to:

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

Patient's right to continuity in their health care services

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

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

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

Right to access emergency services and facilities

- Free and unrestricted access to emergency services and facilities, 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 confidentiality of information and medical records

- To communicate freely, without fear and in strict confidentiality with your health care providers.
- Be confident that your medical records will be kept under strict confidentiality and will not be disclosed without your authorization, except for medical or treatment purposes, by court order, or as specifically authorized by law.
- Obtain receipt for the expenses incurred for total or partial payments, copayments, or coinsurance. The receipt must specify the date of service, name, provider's license number and specialization, name of the patient and the person paying for the services, description of services, amount paid, and signature of the authorized officer.
- Access or obtain a copy of your medical record. Your physician must give you the medical record copies within 5 business days from the date of request. Hospitals will have 15 business days to comply. They may charge you up to $0.75 per page, but no more than $25.00 per record. If the physician-patient relationship is severed, you are entitled to request the original record free of charge, regardless of whether you have outstanding debts with the health service provider.
- To receive a quarterly utilization report including, among other things: member's name, service type and description, date of service and provider, as well as the amount paid for the service. Members may access their quarterly utilization reports, which include an itemization of the services paid for them and their dependents, by registering as member in Triple-S Salud's website (www.ssspr.com).

Rights regarding complaints and grievances

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

Your responsibilities as a patient are:

- Provide the necessary information about health plans and 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.

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.

GENERAL PROVISIONS

1. **ACTIONS OF THIRD PARTIES**: If by fault or negligence from a third party, the member or any of his/her dependents suffers an illness or injury covered under this policy, Triple-S Salud shall be entitled to subrogate to the member's rights to claim and receive compensation from such third party, equivalent to the expenses incurred in treating the member, caused by such acts of fault or negligence. Triple-S Salud will only claim medical expenses paid in connection with the accident caused by the third party.

   Subrogation is a legal process by which an insurer asserts the member's rights against a third party who has caused them damages. If the member has an accident caused by fault or negligence of a third party (e.g., a school, a grocery store, or any other public or private establishment), they must fill out the Incident Report of the place where the accident happened. The member should provide Triple-S Salud with a copy of this report as soon as possible, including their name and contract number. This information may be sent by email to subrogation@ssspr.com or delivered to your plan administrator, who will then forward the documents to Triple-S Salud.

   This does not apply to car accidents, which are handled by the Automobile Accident Compensation Administration (ACAA, by its Spanish acronym), or to workplace accidents insured by the State Insurance Fund.

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

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

3. **BLUECARD® PROGRAM AND OUT-OF-AREA SERVICES:** Triple-S Salud has various relationships with other Blue Cross or Blue Shield licensees. These relationships are usually called "*Inter-Plan Arrangements*." These *Inter-Plan Arrangements* work based on the regulations and procedures issued by the Blue Cross Blue Shield Association ("*Association*"). If you access health care services outside Triple-S Salud's service area, the claim for these services may be processed through one of these *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 claim

   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 HostBlue.

   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 healthcare 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 that the sum paid by the member 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 charge 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 (only for members with major medical coverage)

General Information

If you are outside the United States, the Commonwealth of Puerto Rico, and the United States Virgin Islands ("BlueCard Service Area"), you may benefit from the *Blue Cross Blue Shield Global Core program* to access covered services. The *Blue Cross Blue Shield Global Core* Program is somewhat different from the BlueCard Program available in the *BlueCard* service area. For example, though the *Blue Cross Blue Shield Global Core* Program gives members access to a professional provider network for outpatient and inpatient services, the program is not in a *Host Blue* service area. Therefore, when 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 physician or hospital) outside the *BlueCard* service area, please call the *Blue Cross Blue Shield Global Core Service Center* at 1-800-810-BLUE (2583) or place a collect call to 1-804-673-1177, available 24 hours a day, seven days a week. An care coordinator, working jointly with a medical professional, can schedule a physician appointment or hospitalization, as needed.

Inpatient Services

In most cases, if you call the *Blue Cross Blue Shield Global Core Service Center* for help, hospitals will not require you to pay for the covered inpatient services, except for the 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 obtain a precertification for inpatient services that are not emergency services.**

Outpatient Services

Physicians, emergency rooms, and other outpatient service providers located outside the *BlueCard* service area typically require you pay the full amount when you receive 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 receive a reimbursement. For institutional and professional claims, you must complete a *Blue Cross Blue Shield Global Core* claim form and submit the claim form with the provider's itemized bill of account to the *Blue Cross Blue Shield Global Core Service Center* (see address on the form) to initiate the claim process. Follow the instructions on the claim form to ensure your claim is processed promptly. To receive a copy of the claim form, call Triple-S Salud or the *Blue Cross Blue Shield Global Core Service Center*, or find it online at www.bcbsglobalcore.com. If you need help with your claim, call the *Blue Cross Blue Shield Global Core Service Center* at 1-800-810-BLUE (2583) or place a collect call to 1-804-673-1177, available 24 hours a day, seven days a week.

4. **CLAIM NOTICE**: Written notice of the claim must be given to Triple-S Salud within twenty (20) days after the service has occurred or after said term, as soon as reasonably possible by the insured member or the employer A written notice given by the insured member, in your name, to Triple-S Salud, at your main office in San Juan, Puerto Rico or at your Service Centers around the Island, or to any authorized representative of Triple-S Salud , with enough information to be able to identify it is considered as a warning given to Triple-S Salud.

5. **CIVIL ACTIONS:** No civil action shall be taken to claim any rights of the person insured under this policy before sixty (60) days have elapsed after written proof of the service has been submitted, according to the requirements of this policy. No action shall be taken after three (3) years have elapsed from the date in which it was required that written proof of the service had to be submitted.

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

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

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

   For more information, please refer to our website: https://www.ssspr.com/en/privacy-policy or call the following numbers: (787) 774-6060 or free of charge to 1-800-981-3241, for telephone services for audio impaired (TTY/TDD) at (787) 792-1370 or free of charge to 1-866-215-1999.

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

   In case of employment termination, by discharge (provided it is not due to gross misconduct), resignation or reduction of hours, the COBRA Law establishes that the plan member in the group medical plan has the right to an extended coverage for 18 months. This coverage may also be available for his/her direct dependents. If the plan member under COBRA is disabled within 60 days of enrollment in coverage and his/her disability is certified by the Social Security Administration, after the qualified event, then the plan member under COBRA shall have the right to an 11-month extension under COBRA. Finally, in the case of a divorce or death of the employee,

then the spouse and the children shall have the right to a 36-month period of extended coverage. The direct dependent (child) shall have a period of 36 months if he/she loses eligibility under the plan. If the employee receives Medicare benefits, his/her spouse and dependents shall have the right to 36 months of extended coverage. The extended coverage under COBRA can terminated for the following reasons:

a. End of COBRA period;
b. Lack of payment;
c. Employer terminates the group health plan;
d. Member enrolls in Medicare;
e. Member enrolls in another health plan that does not have a waiting period;
f. Member commits a fault that according to the plan is just cause for cancelling his/her plan (example: submitting fraudulent claims).

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

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

9. **CONVERSION CLAUSE:**

a**.** If coverage under this policy ends because the employee is terminated from employment or no longer belongs to an employee class or classes eligible for coverage under the policy, the person is entitled to have Triple-S Salud issue an individual basic coverage, with no risk evaluation, within the different levels of metallic coverages approved for newly insured members requesting an individual health plan and accepting to pay the premiums of said individual health plan. The written application for enrollment in an individual plan will be submitted and the premiums paid to Triple-S Salud no later than thirty (30) days from the termination, provided that:

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

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

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

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

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

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

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

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

d. Is covered or is eligible for coverage under a health plan that provides healthcare coverage under which the spouse, custodial parent or guardian is eligible to be enrolled, except if said health plan is the Puerto Rico Government Health Insurance Plan (GHIP) or any other government health plan that is administered by the Health Insurance Administration.

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

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

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

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

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

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

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

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

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

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

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

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

    Moreover, the member and its dependents agree that it has not entered into this policy based upon representations from any carrier other than Triple-S Salud and that no person, entity or organization other than Triple-S Salud may be responsible for any obligation of Triple-S Salud, towards the member that may arise from this policy.

    What was previously stated will not create any additional obligation on the part of Triple-S Salud, unless these obligations arise from the provisions of this agreement.

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

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

15. **LETTER OF RIGHTS AND RESPONSIBILITIES OF THE PATIENT:** Triple-S Salud requires the insured members, or in the case of incapacitated persons or minors, the parents, guardians, custodians or persons in charge of said persons to read and become familiar with them. the "Patient Rights and Responsibilities Charter" or an adequate and reasonable summary thereof, as prepared or authorized by the Department of Health.

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

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

18. **PERSONAL RIGHTS:** The member may not yield, transfer, or waive in favor of a third party any of the rights and benefits that he/she may claim by this policy. It is provided that Triple-S Salud reserves the right to recover all expenses incurred in case the member, with expressed or implicit consent, allows non-members to use

the card issued by Triple-S Salud in his/her favor. It is also provided that recovery of such expenses will not prevent Triple-S Salud from terminating the insurance contract when illegal use of the card is discovered, or from filing a civil action for the prosecution of the member or the person making unlawful use of the card.

19. **PHYSICAL EXAMINATIONS:** Triple-S Salud will have the right and the opportunity to examine, at its own expense, the member when, and as frequently as it deems necessary, for audit purposes or fraud investigations.

20. **POLICY**: Document that Triple-S Salud issues to the holder of the policy. In addition, Triple-S Salud will provide you with a list of participating Triple-S Salud physicians and providers, as well as the Drug List or Formulary.

21. **PAYMENT OF CLAIMS**: As a rule, the benefits provided under this policy are payable directly to participating providers, except in cases of emergencies where payment is made as provided by law. Of the insured member having used non-participating providers in cases of emergencies, the services provided are paid directly to the provider.

    If the insured member has received post-emergency services, or post-stabilization services, that are covered under the health care plan, except for the fact that it is a non-participating provider, Triple -S Salud reimburses the insured member based on what is less between the expense incurred and the fee that would have been paid to a participating provider, after discounting the applicable copayment and / or coinsurance, as established in this policy. In addition, this policy also contains benefits that are paid based on compensation or reimbursement to the insured member even when the provider is a participant.

    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.

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

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

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

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

24. **RECOVERY OF PAYMENTS MADE IN EXCESS OR BY MISTAKE:** Triple-S Salud has the right to recover payments made in excess or in error to a member, retroactive for up to two (2) years from the date Triple-S Salud issued the payment. Triple-S Salud will contact the member as soon as it becomes aware that it has issued an erroneous or excess payment. Members will be required to notify Triple-S Salud when they realize they have received an erroneous or excess payment.

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

    The reinstated policy will only cover losses resulting from any accidental injury that may occur after the date of reinstatement and losses due to any illness that may begin more than ten (10) days after such date.

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

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

    a. Failure to pay premiums, considering the grace period;

    b. When the employer, the eligible employee or any of the eligible dependents performed an act that constitute fraud. In this case, Triple-S Salud may opt not to renew the health plan to the employer, the eligible employee, or the insured member for a period of one (1) year from the date of coverage termination;

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

    d. Failure to meet the minimum participation requirements of 100% of eligible employees working with employers and 75% for employers with 4 to 50 employees;

    e. Failure to meet employer contribution requirements;

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

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

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

27. **TRIPLE-S SALUD RIGHT TO AUDIT:** By subscribing to this policy the insured members accept, acknowledge and understand that Triple-S Salud, as payer of the health services incurred by the main insured and their dependents, has the authority to access your medical records to perform audits on all or any claim for health services that Triple-S Salud has paid.

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

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

- Loss of eligibility (for resignation or termination of employment)
- Loss of employer contributions, or
- Termination of coverage under COBRA

29. **RIGHTS UNDER LAW NO. 248 OF AUGUST 15, 1999 TO ENSURE ADEQUATE CARE FOR MOTHERS AND THEIR NEWBORNS DURING THE POSTPARTUM PROTECTION:** The aforementioned federal law establish the following:

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

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

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

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

30. **TERMINATION:** Triple-S Salud reserves the right to terminate this policy on the due date for lack of payment of any due premium, after the grace period, through written notice to the insured employee no less than thirty (30) days in advance. The termination shall not affect any claim for services rendered before the date of termination.

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

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

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

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

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

after the plan member has been discharged from the hospital.

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

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

The transition care period is subject to the payment of the corresponding premium and may be denied or terminated if the plan member and/or provider incurs in fraud against the insurance. The member can choose to enroll in a direct payment policy or choose the transition period for the plan termination. Once the termination transition period ends, the provisions set forth in the Conversion clause will apply.

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

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

32. **TOTAL COVERED SERVICE PAYMENT IF THERE IS NOT A PROVIDER:** In cases where a member needs a medically necessary service covered by the plan for which there is no contracted provider and it is not provided in your coverage that the service will be provided by reimbursement to the member, Triple-S Salud will coordinate and establish a special agreement with a non-participating provider for the provision of such services to the member. This will be subject to the terms and conditions of the policy of the member and the payment to the provider based on the fee established by Triple-S Salud for the services to be rendered.

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

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

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

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

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

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

34. **UNIQUE CONTRACT-CHANGES:** This policy, riders, and attached documents, if any, constitute the entire text of the insurance contract. No change to this policy will be valid until approved by the executive officer designated by the Board of Directors of Triple-S Salud and the Office of the Commissioner of Insurance of Puerto Rico before its use, and unless said approval is endorsed in the present document, or is attached to it. No agent has authority to change this policy or waive any of its provisions.

35. **WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA):** This policy provides coverage to the insured member for reconstructive surgery following a mastectomy, as well as the reconstruction of the other breast to maintain a symmetrical appearance, prostheses and any physical complications that may arise during all the stages of a mastectomy. These benefits will be provided based upon a consultation between the insured member and her physician, and are subject to the copayments and coinsurances set forth in her policy.

DEFINITIONS

BASIC COVERAGE

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

2. **ABUSE**: One or more of the following acts executed by a family member or former family member of the victim, anyone residing in the victim's house, a romantic partner, or any person in charge of their care:

    a. Attempting to cause or intentionally or recklessly causing another person bodily injury, physical harm, severe emotional distress, psychological trauma, rape, sexual assault, or involuntary sexual intercourse;

    b. knowingly engaging in an unwanted pursuit behavior towards the victim, including following the person without proper authority, under circumstances that place the victim in reasonable fear of harm to his/her bodily integrity;

    c. subjecting another person to false imprisonment, or

    d. cause knowingly or recklessly damage to property so as to intimidate or control the behavior of the victim

3. **ABUSE VICTIM**: A person against whom an act of abuse has been committed; who has currently or previously suffered injuries, illnesses, or disorders as a result from the abuse; or who seeks, may have sought, or had reason to seek medical or psychological treatment for abuse; or court-ordered protection or shelter from abuse.

4. **ABUSE VICTIM STATUS:** The fact or impression that a person is or has been a victim of abuse, regardless of whether the person has suffered any abuse-related health conditions.

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

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

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

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

    1. Regulated by law, holds a license from the regulatory agency responsible for granting such permits

under the laws and regulations of the jurisdiction of its location; or

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

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

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

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

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

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

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

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

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

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

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

13. ***BLUE CROSS AND BLUE SHIELD*** **PLAN**: Independent insurer under contract with the Association of Plans Blue Cross/Blue Shield) acquires the license to belong to the association of independent plans and allows the use of its marks.

14. **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.

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

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

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

18. **CONCURRENT REVIEW:** Utilization review carried out during the stay of the member in a facility or during the treatment of the member at the office of a health professional or another place where health care services are provided to members admitted or on an outpatient basis.

19. **CONDITION OF HIGH RISK**: A condition of long or short duration that entails or that has the probability of entailing a poor prognosis.

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

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

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

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

    b) In the case of a person covered by COBRA, according as per a provision of COBRA on coverage continuation, at the moment the person is no longer covered in conformance with said provision; and
    c) At the moment, a request is made on behalf of a person, if the request is made within twenty-four (24) months from the date of the termination of coverage as described in sections (1) or (2), whichever date is later.

23. **CHRONIC CONDITION:** A condition of long or permanent duration.

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

25. **CUSTOMARY CHARGE**: A charge is customary when it is within the set of usual charges billed by a service determined by most physicians or service providers with similar training and experience within a given area.and service providers with similar training and experience within a specific field.

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

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

    2. Biological or adopted children of the insured member or the spouse of the member as defined in this clause 25 (a) until they attain age 26. The children or the spouses of the member's dependents will not be eligible for coverage under this plan, except those included in paragraph 25(d) below, or the children of the spouse of the insured employee's child.

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

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

    5. Foster children will also be considered direct dependents until they attain age 26. The policyholder may demonstrate the status of the foster children providing to Triple-S Salud a sworn statement where he/she specifies when the relationship with the minor began, legal custody or the certification of the income tax returns of the last two years, among other evidences. It will be understood that foster children are those minors, who, without being biological or adopted children of the insured employee, have lived from their infancy under the same roof with the member in a parent-child relationship and that receive feeding as this term is defined by Article 142 of the Civil Code of Puerto Rico.

27. **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.

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

29. **ELIGIBILITY WAITING PERIOD:** Period of time which must pass before the member is entitled to receive certain benefits, under the health plan terms. The waiting period will not exceed ninety (90) days.

30. **ELIGIBLE EMPLOYEE:** It means an employee that works full-time during the minimum hours required by the employer-regular work week of thirty (30) hours or more, or part-time-less than seventeen and a half (17.5) hours per regular work week-for an employer, in which there is a goodwill

relationship between the employer and the employee, which is not established in order to purchase a health plan. In this computation employees that are absent of work because of a leave or a right recognized by law, such as benefits provided by the State Insurance Fund Corporation or the Family Leave Act of 1993. The term eligible employee" does not include temporary employees or independent contractors.

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

32. **EQUIPMENT, TREATMENT AND NON-AVAILABLE FACILITIES IN PUERTO RICO:** Treatment in facilities or with medical-hospital equipment not available in Puerto Rico, in the case of an insured member who, due to their health condition, requires these services.

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

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

35. **EXPERIMENTAL OR INVESTIGATIVE SERVICES:** Medical treatment:

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

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

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

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

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

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

36. **FAMILY CONTRACT:**

    1. The insurance that provides benefits to any insured employee, his/her spouse and his/her direct dependents as defined in clause 25 of this section. The premium for family contracts will apply in these cases.

    2. Should there be no eligible spouse as a direct dependent, as defined in clause 25, the insured member's contract with one (1) or more as direct dependents may, at his/her option, be considered a Family Contract or an Individual Contract with one (1) or more direct dependents, as defined in clause 25 of this section. In both alternatives, the premium will be the same.

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

37. **FEES**: The fixed amount used by Triple-S Salud to pay its participating physicians or providers for the covered services rendered to members when these are not paid by any other method.

38. **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.

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

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

- The availability, rendering or quality of health care, including grievances related to adverse determinations that may result from a utilization review;
- The payment or handling of claims or indemnification for health care services; or

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

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

42. **HEALTH INFORMATION**: Means whether oral or recorded information or data in any form or medium:

    a. That is created or received by the insurer or the health services organization, related to physical, mental, or behavioral health, or past, present or future conditions of the person, or dependent, the provision of health care to an individual, or past, present, or future payments for the provisions of health care to an individual.

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

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

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

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

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

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

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

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

these agencies in accordance with the law, or

3. Meets all of the following requirements:

    1. An agency that holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing support services to the home.

    2. It has a full-time administrator.

    3. It keeps written records of services provided to the patient.

    4. Its staff includes at least one (1) Registered Nurse (R.N.)

    5. Its employees are bonded and provided with malpractice and professional liability insurance.

47. **HOSPICE:** Special care for persons with terminal diseases whose life expectancy is 6 months or less.

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

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

50. **HOST BLUE:** Blue Cross or Blue Shield Plan of the area where the service is received under the Blue Card Program. The Host Blues determine a negotiated price, which is indicated in the conditions of each of the contracts with the Host Blue. The negotiated price made available to Triple-S Salud by Host Blue may be represented by one of the following:

    a. The real price. The actual price is the current payment rate at the time the claim is processed without any further increase or reduction, or

    b. Estimated price or approximate price. The approximate price is a negotiated payment rate, in force at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the supplier and other transactions that are related and not related to the claims. Such transactions may include, but are not limited to, recovery from fraud and abuse, reimbursements for suppliers not applied to a specific claim, retrospective arrangements and payments related to performance or

    c. Average rate or average price. The average price is a percentage of the charges billed for covered services in effect at the time a claim is processed representing the total payments negotiated by Host Blue with all of its health care providers or a similar classification with its providers and other transactions that are related and not related to claims. Such transactions may include the same as those indicated above for an approximate price.

51. **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.

52. **INDIVIDUAL CONTRACT**: The insurance that provides benefits to any eligible single or married employee without including the spouse, as defined in clause 25, Direct Dependent, as an insured member. Said employee has the option to include in his insurance any eligible direct dependent, as defined in clause 25 of this section, by paying the corresponding additional premium

    The inclusion of dependents may only be done at the time of acquiring this policy or on the date of renewal of this policy, except as provided in the sections on Subscription and Special Subscription Changes of this policy or any other provision of law.

53. **ILLNESS:**

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

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

        1) That services are rendered to the female member regardless of her marital status
        2) Any service rendered for a therapeutic abortion.

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

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

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

57. **IRO**: The Independent Review Organization (IRO) is an organization that is accredited to conduct independent medical reviews. These reviews will be carried out by an independent physician.

58. **MEDICAL EMERGENCY:** A medical or behavioral condition that manifests itself with acute symptoms of sufficient severity, including severe pain, so that a wise, prudent person with an average knowledge of medicine and health can deduce that the lack of Immediate medical attention can seriously endanger the health condition of the person affected by such condition or it would result in a dysfunction of any member or organ of the body or, with respect to a person insured during their pregnancy, the health of the insured member or the fetus, or in the case of a behavioral disorder, may put the health condition of said person or other persons in serious danger; cause problems in the bodily functions of said person; cause serious dysfunction of any organ or part of the body of said person or serious disfigurement.

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

    1. Severe chest pain
    2. Serious or multiple injuries
    3. Severe respiratory distress
    4. A sudden change in mental state (for example, disorientation)
    5. Severe bleeding
    6. Pain or conditions that require immediate attention, such as heart attack or suspected acute appendicitis
    7. Poisoning
    8. Seizures

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

59. **MEDICAL NEED**: Means everything that a licensed physician prudent and reasonable understands that it is medically necessary above all that service or health procedure that is provided to a patient for the purpose of preventing, diagnosing or treating a disease, injury, disease, disease or its symptoms in a way that:

    1. Agree with the generally accepted standards of medical practice, considering the modern means of communication and teaching

    2. Be clinically appropriate in terms of type, frequency, grade, location and duration of health services or procedures;

    3. The determination of medical necessity is not made merely for the convenience of the patient or physician or for the economic benefit of the insurer, health service organization or other health plan provider, of the

medical treatment itself or of another provider of medical care. medical care;

4. Be within the scope of the practice and / or medical specialty of the or the licensed medical professional who determined the medical necessity;

5. That said determination of medical necessity is based on clinical evidence that supports the determination and is duly documented by the physician who treated the patient.

60. **MEDICAL OR SCIENTIFIC EVIDENCE:** Means evidence produced by any of the following sources:

- Peer-reviewed studies, published or accepted for publication by specialized medical journals that comply with nationally-recognized standards for scientific texts;
- Peer-reviewed medical publications, including those related to therapies that have been evaluated and approved by institutional review boards, the biomedical compendia, and other medical journals that comply with the indexing criteria of the National Institutes of Health Medical Library, in the Medicus Index (Medline), and those of Elsevier Science Ltd. In Excerpta Medicus (EMBASE);
- Medical journals recognized by the Secretary of Health and Human Resources of the United States Government, pursuant to the federal Social Security Act;
- The following regulations:
    - The American Hospital Formulary Service-Drug Information;
    - Drug Facts and Comparisons®;
    - The American Dental Association Accepted Dental Therapeutics; and
    - The United States Pharmacopoeia-Drug Information;
- The findings, studies, or investigations conducted by or under the sponsorship of federal government agencies and by federal research institutes recognized in the United States of America, which include:
    - The federal Agency for Health Care Research and Quality;
    - National Institutes of Health;
    - National Cancer Institute;
    - The National Academy of Sciences;
    - Centers for Medicare and Medicaid Services (CMS); and
    - Any national board recognized by National Institutes of Health whose purpose is to evaluate the efficiency of healthcare services;
- Any additional medical or scientific evidence comparable to the provisions in Subsections (A) to (E) cited above.
- Categorical exclusion - means the specific provision established by Triple-S to not cover a prescribed drug, identifying it by its scientific or commercial name.

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

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

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

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

65. **MAXIMUM OUT-OF-POCKET AMOUNT:** It is the maximum amount stated in the policy that a person must pay during the policy year. Before the person reaches the out-of-pocket amount stated in this policy, the person will pay the deductibles, copayments, or coinsurances for essential medical-hospital care and prescription drugs, as described in the table of benefits, received from the plan participating providers. Once the insured member reaches the maximum out-of-pocket amount stated in the policy, the plan will pay 100% of the medical expenses covered under this policy. Services rendered by non-participating providers, payment for medical expenses not covered under this policy and the premium paid to Triple-S Salud for the plan, are not considered eligible expenses for the accumulation of the out-of-pocket maximum.

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

67. **MEDICARE:** Federal law on Health Insurance for **the** Elderly, Title XVIII of the 1965 Amendments to the Social Security Act as constituted or amended thereafter.

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

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

70. **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.

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

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

    b. are an integral part of a covered service;

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

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

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

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

73. **NUTRITION SPECIALIST:** Health professional specialized in nutrition and

alimentation certified by the government entity designated for said purposes.

74. **OPTIONAL DEPENDENTS:** In addition, under a family contract, an optional dependent will be a person who for some reason does not qualify as a direct dependent, but is handicapped, and the insured member has a final judgment granting custody or guardianship.

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

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

77. **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.

78. **PERSONAL REPRESENTATIVE**:

    (1) A person expressly authorized in writing by the member to represent him or her, for purposes of the Puerto Rico Health Insurance Code;
    (2) a person authorized by law to consent in the member's absence;
    (3) an immediate relative of the member, or the member's attending health care professional when the member is unable to provide consent;
    (4) a healthcare professional when the member's health insurance requires that a healthcare professional request the benefit; or
    (5) in case of an urgent care request, a healthcare professional that has knowledge about the member's medical condition.

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

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

81. **PREAUTHORIZATION**: It means the process of obtaining prior approval of the health insurance organization or insurer, which is required under the terms of the coverage of the health plan, for the dispensing of a prescription medication.

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

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

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

84. **PREMIUM:** Means the specific money amount paid to the insurance company, in this case Triple-S Salud, as the condition to

receive the benefits of a health plan for the eligible employees of an employer. The premium collected from an member cannot be changed during the contract year, unless there is a change in the affiliation of the employer, the family group of the eligible employee or the benefits of the health plan requested by the employer.

85. **PREVIOUS QUALIFYING COVERAGE OR EXISTING QUALIFYING COVERAGE**: Means benefits or coverage provided by one of the following:
    a. Medicare Program, Medicaid, Civilian Health and Medical Program of the Uniformed Services (TRICARE) or any other program sponsored by the government.

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

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

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

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

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

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

86. **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.

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

88. **PSYCHOANALYSIS**: Psychoanalysis is based on a set of theories related to the conscious and unconscious mental processes and the interaction between them. It is a therapy modality used to treat people with chronic life problems on a mild to moderate scale. Psychoanalysis should not be used as a synonym for psychotherapy, since they do not pursue the same goal. This service is not covered in this policy, as expressed in the Exclusions Section.

89. **PSYCHOLOGICAL EVALUATION:** Initial interview to obtain personal and clinical history of the member, as well as his/her description of symptoms and problems. The psychological evaluation must be performed by a Psychologist with a master's or doctoral degree in Psychology, licensed from a duly accredited graduate program, and with valid license, issued by the Puerto Rico Board of Psychologist Examiners.

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

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

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

93. **REASONABLE CHARGE:** A charge is reasonable when it satisfies the usual and customary criteria or it may be reasonable if, in the opinion of an appropriate Review Committee, it deserves special consideration according to the complexity of the management of the particular case.

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

95. **RESCISSION OF COVERAGE:** Triple-S Salud may decide to terminate its contract with retroactive effect on the basis of fraud or intentional misrepresentation of substantial data as prohibited by this plan. The termination shall be notified in writing thirty (30) days in advance and the participant or member has the right to request review of this termination.

96. **RESIDENTIAL TREATMENT:** High-intensity and restrictive care services for patients with mental health conditions, including drug addiction and alcoholism, and co-morbid conditions that are difficult to handle at home and in the community, which have not responded to other less restrictive treatment levels. This treatment integrates clinical and therapeutic services that are coordinated and supervised by an interdisciplinary team in a structured environment, 24 hours a day, 7 days a week. The facility must be a hospital institution accredited by Medicare, the *Joint Commission*, and the Department of Education, and clinical teachers must be accredited under Act No. 30. They must also have the ASSMCA license for drug administration and storage, as well as an interdisciplinary staff (clinical personnel, psychiatrist, psychologist, and registered nurses).

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

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

99. **REQUEST FOR URGENT CARE:**

    1. A request for a health care service or treatment for which the established time period for non-urgent care determinations:

        a) Could endanger the member's life, health, or full recovery; or

        b) In the opinion of a physician with knowledge of the member's health condition, would expose the person to pain that cannot be

adequately managed without the healthcare service or treatment requested.

2. When determining if the request will be treated as urgent, the person representing the health insurance company or insurer will exercise the prudent judgment of a layperson with average healthcare and medicine knowledge. If a physician with knowledge of the member's health condition decides to submit an urgent care request under subsection (1), the health insurance company or insurer will treat said request as one for urgent care.

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

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

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

103. **SPECIAL CONDITIONS**: A condition of low prevalence or rare occurrence.

104. **SPECIAL ENROLLMENT:** Instance in which it is allowed to subscribe dependents at any time in the health plan, as a result of a qualified event such as loss of eligibility under another group plan, marriage and births, among others.

105. **STANDARD REFERENCE COMPENDS ("STANDARD REFERENCE COMPENDIA"):** MEANS:

- The American Hospital Formulary Service-Drug Information;
- The American Medical Association Drug Evaluation or
- The United States Pharmacopoeia- Drug Information

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

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

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

109. **SKILLED NURSING FACILITY:**

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

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

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

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

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

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

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

6) It is not, other than incidentally, a home for the aged, blind, or deaf, a hotel, a home care facility, a maternity home, or a home for

alcoholics, or drug addicts, or the mentally ill.

7) It is not a hospital

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

111. **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.

112. **TRANSPLANT:** A procedure or series of procedures through which an organ or tissue is:

a) removed from the body of a person called donor and implanted in the body of another person called recipient; or

b) removed and implanted in the body of the same person

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

114. **URGENCY:** Means a medical condition caused, that does not expose the risk of imminent death or the integrity of the person, and that can be treated in medical offices or offices of extended hours, not necessarily in emergency rooms, but which, If not treated at the right time and in the right way, it could become an emergency.

115. **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.

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

117. **UTILIZATION REVIEW ORGANIZATION**: Entity hired by a health insurance company or insurer to perform utilization reviews, if it is not the health insurance organization or insurer itself conducting the review of its own health insurance plan. It will not be considered as a requirement for the health insurance company or insurer to subcontract an independent entity to carry out the utilization review processes.

MAJOR MEDICAL COVERAGE

1. CASH DEDUCTIBLE: The annual amount in cash which must accumulate before being entitled to the benefits provided by the insurance of major medical expenses.

2. CASH EXPENSE: Any covered medical expense applicable to the annual deductible in cash for a policy year, except the costs for outpatient mental conditions. In addition, the portion of the 20% of covered medical expenses, the responsibility of the insured member.

3. IMPLANT: A device, object or material that is placed inside the body with the purpose of preserve configuration, offer stability, or offer temporary or permanent stimulus to a body part. They are covered as it is established in the policy.

4. **MEDICAL MATERIALS OR SUPPLIES:** Those, which, for their diagnostic or therapeutic characteristics, are essential for the effectiveness of the care plan, ordered by the physician for the treatment or diagnosis of the patient's illness or injury.

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

6. **ORTHOTIC DEVICES:** External accessories that restrict, eliminate or redirect the movement of a weak or ill part of the body, as, for example: claps, bracers, corsets, splints, casts for injured ligaments, etc.

7. **PROSTHESIS:** External replacement for a dysfunctional body part, that is fabricated and adapts to the measures and individual necessity of the person who is receiving it, with the purpose of providing function or mobility. It may substitute a part of the body that does not work properly or is missing. These are covered as it is established in the policy.

8. **SURGICAL ASSISTANCE:** When a licensed physician actively assists the lead surgeon in performing a covered surgical procedure, which because of its complexity justifies the necessity of assistance.

9. **SCALE OF MEDICAL BENEFITS:** Scale based on which services covered and received by the insured member will be paid, when such services cannot be paid under the concept of usual, customary and reasonable charge. The Scale of Medical Benefits will apply in Puerto Rico.

ORGAN AND TISSUES TRANSPLANT

1. **PRE-EXISTING CONDITIONS:** Physical or mental conditions suffered by a member which were initially manifested prior to the issuance of the policy; or that existed prior to the issuance and for which the member received treatment.

2. **ORGAN TRANSPLANT INSURANCE:** An insurance independent from the health plan that the eligible member may have with Triple-S Salud. Said provides coverage for the organ transplant only, as defined in the Benefits Section of this policy. The covered benefits will be payable by indemnization or assignation of benefits. To be eligible for this benefit, you will have to be subscribed in the basic coverage.

3. **PRE-TRANSPLANT**: Evaluation and preparation of a member to receive a tissue or organ transplant.

4. **PROCUREMENT:** Those expenses incurred in connection with locating, removing, preserving and transporting an organ or tissue including also the evaluation before the surgery and surgical removal of the donor organ or tissue. Benefits will be provided only for procurement of a donor organ or tissue that is used for a transplant for which benefits are provided under this rider, unless the scheduled transplant is canceled because of the member's medical condition or death and the organ or tissue cannot be transplanted to another person. These expenses will only be covered only if the recipient is covered by the Plan. For bone marrow transplant, the term donation is used instead of procurement.

5. **SECOND MEDICAL OPINION**: Requirement that Triple-S Salud or his authorized representative makes an opinion from a physician other than the physician in charge of the case and selected by Triple-S Salud, in cases in which Triple-S Salud determines that there was a need for such an opinion, before the insured member receive the service. Triple-S Salud may require a second medical opinion, by doctors appointed by this, for those procedures in which in the opinion of Triple-S Salud or his authorized representative may need to obtain such an opinion.

6. **TRANSPLANT:** Means a procedure or a series of procedures by which an organ or tissue is either:

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

    b. Removed from and replaced in the same person's body.

PHARMACY COVERAGE

1. **ACUTE DRUGS:** Medications prescribed to treat non-recurrent diseases, such as antibiotics. These 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. **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.

22. **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.

23. **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.

24. **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.

25. **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.

26. **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.

27. **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.

28. **PRESCRIPTION DRUGS WITH REPETITIONS (REFILLS):** Prescription containing written indications from the physician authorizing the pharmacy to dispense a drug on more than one occasion.

29. **SPECIALTY PRODUCTS:** Drugs or products for the treatment of chronic and high-risk conditions that require special administration and management. Conditions requiring specialized medications include, but are not limited to, Rheumatoid Arthritis, Plaque Psoriasis, Hemophilia and Multiple Sclerosis.

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.

DENTAL COVERAGE

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.

SERVICE CENTERS

In Triple-S, we are here to help you.

Contact us at your convenience.

MAIN OFFICE
1441 F.D. Roosevelt Ave.
San Juan

PLAZA LAS AMÉRICAS
2nd Level

PLAZA CAROLINA
2nd Level

ARECIBO
Caribbean Cinemas Building
Suite 101

CAGUAS
Angora Building
Luis Muñoz Marín Ave.

MAYAGÜEZ
114 road, km 1.1
Castillo Community

PONCE
2760 Maruca Ave.

SERVICE CALL CENTERS

787.774.6060
Toll Free: 1-800-981-3241
TTY / TDD: 787-792-1370
TTY Toll Free: 1-866-215-1999

SERVICE HOURS (AST):
Monday to Friday from 7:30 a.m. to 8 p.m.
Saturday from 9 a.m. to 6 p.m.
Sunday from 11a.m. to 5 p.m.