
INTRODUCTION

TRIPLE-S SALUD, INC, San Juan, Puerto Rico

An Independent Licensee of the Blue Cross and Blue Shield Association

(Hereafter referred to as Triple-S Salud)

The group health plan of **IATSE National Health & Welfare Fund** provides coverage to its participant employees and the eligible dependents of said employees, according to the provisions of this contract and the medical coverage established by Triple-S Salud, against medically necessary surgical and hospitalization services rendered while the contract is in force, as a result of injury or illness suffered by the participating person. This contract is issued considering the declarations made in the attached copy of the application and payment by the employer of the incurred claims and the administrative cost of the Plan.

Under this group health plan, Triple-S Salud acts as claims administrator, and as such it will pay claims according to the terms and conditions established in the plan documents. In addition, Triple-S Salud makes available its network of participating providers to the participants and beneficiaries of this group health plan.

This contract is issued to bona fide residents of Puerto Rico whose permanent residence is located within the Service Area, as defined in this contract, for the period of one (1) year from **January 01, 2016**. This contract may be continued, for equal, consecutive and additional periods through the payment of the incurred claims and the administrative cost of the Plan, which is the responsibility of the employer as first place, as the holder of the contract and the employee as the beneficiary and user of the medical plan, arranged as follows. All the terms of coverage begin and end at 12:01 a.m., official Puerto Rico time.

Triple-S Salud will not deny, exclude or limit the benefits of a covered person because of a preexisting condition, regardless of the age of the participant. This contract is not a supplementary policy or contract to the Federal Health Service Program for the Elderly (Medicare). Review the Health Insurance Guide for persons with Medicare available through the health insurer.

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



Ramón M. Ruiz Comas
Chairperson, Board of Directors



Pablo Almodóvar Scalley
President and Chief Executive Officer

Keep this document in a safe place; the same includes the benefits entitled to a beneficiary of Triple-S Salud. This document is modified by riders for such reason we exhort you to keep this certificate for future references of amended sections. Always refer to the riders attached to this contract as they contain the accurate information concerning the benefits included in your Health Plan.

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BASIC COVERAGE

ELIGIBILITY

Each participant employee of the IATSE National Health & Welfare Fund will be eligible for the plan offered by this contract subject to any limitation included in the fund's application.

ELIGIBLE DEPENDENTS

Triple-S Salud will follow the rules of the IATSE National Health & Welfare Fund as to who is an eligible dependent, including opposite sex domestic partners.

COVERAGE DATE

The start date of coverage for an employee and his/her eligible dependents will be determined by the Fund based on its rules. Information on the Fund's eligibility rules is set forth in its Summary Plan Description for Health Plan C, available on its website, iatsenbf.org and upon request.

CHANGES

Please see the summary plan description of the Fund as to when you are eligible to add eligible dependants to your coverage, including special enrollment rights.

COVERED SERVICES

The benefits provided by this contract are contained in the general classification as follows. These benefits are subject to the terms and conditions already specified for them and will be provided only for the participating person living within the Service Area.

The contract of the employee and his/her eligible dependents under this contract, will be the same as respects to coverage, except in the case of maternity benefits, as illness definition, which are only available to the female participating and/or the participating person spouse of the participating employee.

Under our plan, there is a maximum of disbursements that people pay for medical services and hospital covered according to their type of contract. The maximum amount of disbursement is \$6,350 in an individual contract and \$12,700 in contract couple or family. This is the maximum amount that the insured pay during the year policy by concept of essential medical services and hospital care covered under the policy when you visit providers inside the network, including the purchase of prescription drugs, as described in the Table of Benefits. Once the person reaches the amount that applies according to the type of contract, he/she will not have to do additional disbursements for rest of the policy year. Services provided through non- participating providers, payments made by the insured person for services not covered under this policy as well as the monthly premium paid to Triple-S Salud by the plan, are not considered eligible expenditure for the accumulation of pocket maximum.

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

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

Participant employee and their spouses, over the age of sixty-five (65), who are covered by both Parts of the Medicare Program, can be covered under the benefits of this contract.

Triple-S Salud does not select the participating medical surgeon, hospital or laboratory the participating person requires. Benefits covered by this contract are not cumulative or subject to waiting periods.

The participating person, medical-surgeon, hospital and participant facility will be advised about hospital admissions that require a previous authorization or notification within 24 hours or the next working day. Some studies, diagnostic tests and surgical procedures will require a previous authorization from Triple-S Salud. The participating person, medical-surgeon and participant facility will be notified about procedures for which a previous authorization is required.

In those cases for which Triple-S Salud requires previous authorization for services rendered, Triple-S Salud will not be responsible for the payment of said services if they have been rendered or received without authorization from Triple-S Salud. Triple-S Salud may require a second medical opinion from physicians it designates for those procedures in which, according to Triple-S Salud, said opinion is necessary.

Services covered by this contract, and rendered by non-participating physicians, providers or facilities will be covered only when rendered outside of Puerto Rico and will be paid by Triple-S Salud as established in the Compensation to the Participating person section of this contract.

Triple-S Salud can establish, as means for authorizing the payment for covered services, payment policies for health conditions that require a specialized management and for which Triple-S Salud requires a particular contract with a provider to be able to manage such cases. There are certain conditions that, because of their particular characteristics, require that Triple-S Salud reviews the utilization of those services closely, to avoid fraud towards the insurer or abuse of those services. Triple-S Salud policies are directed to achieve an adequate administration of these particular cases, in order to guarantee a fair treat for all participating person under similar conditions, at the same time guarantee a cost effective management. This clause will not be interpreted as an elimination or reduction of benefits covered under this contract.

Services Covered Coverage by Federal or Local Law

Preventive screening services, according to the age of the preschool child, required by Law 296 of September 1, 2000 and in conformance with Normative Letter N-AV-7-8-2001 of July 6, 2001 are covered under this contract. These services include the general physical exam, vision and hearing screening tests, clinical laboratory tests (including tuberculine test), psychological and screenings for psychosocial assessments, screening for asthma and epilepsy, according to the standards established by the Health Department, the Medicaid Program, the Program for Mothers, Children and Adolescents and the American Academy of Pediatrics.

This contract covers preventive services required by required by federal Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA) and the Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152 (HCERA) and as established by the United States Preventive Services Task Force (USPSTF). These preventive care services, as detailed below, are included in the basic coverage and have \$0 copayment or 0% coinsurance, as long as they are provided through participating physicians and providers:

- A lifetime screening for abdominal aortic aneurysm (AAA) by ultrasonography in men aged 65 to 75 who have ever smoked.
- Screening and behavioral counseling interventions to reduce alcohol in adolescents for alcohol and substance abuse, for alcohol in adults of 18 years of age or older who are engaged in risk patterns or in danger of falling in a risky or hazardous drinking pattern of alcohol consumption, including behavior interventions.
- Aspirin supplements for men and women of certain ages.
- High blood pressure screening in children of all ages and adults aged 18 years or older.
- Cholesterol or lipid disorders screening for men age 20 to 35, if they are at risk of coronary heart disease; men aged 35 or older; women aged 45 or older, if they are at high risk of coronary heart disease, children of all ages.

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- Occult blood test for colorectal cancer screening, sigmoidoscopy or colonoscopy in adults from 50 to 75 years of age.
 - Depression screening for adults and screening for severe depression disorder for adolescents (aged 12 to 18), when the procedure has been established to ensure a precise diagnostic, psychotherapy (cognitive, behavioral or interpersonal) and follow up.
 - Screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated with greater 135/80mmg).
 - Nutritional counseling for adults at high risk of chronic diseases.
 - HIV screening tests in adolescents and adults at higher risk from age 15 to 65 years. Younger adolescents and older adults who are at increased risk must also be screened, as well as all pregnant women.
 - Screening for obesity on adults and those with a body mass index of 30kg/m² or higher, must be referred to intensive multicomponent behavior interventions.
 - Preventive counseling on sexually transmitted infections for high risk adults.
 - Tobacco use screening for all adults and cessation interventions for tobacco users, and expanded counseling to pregnant tobacco users.
 - Syphilis screening for all adults and pregnant women at high risk.
 - Routine screening iron deficiency for anemia in asymptomatic pregnant women.
 - Screening for asymptomatic bacteriuria with urine culture to pregnant women between 12 to 16 weeks of gestation or on the first prenatal visit, if later.
 - Breast cancer genetic test counseling for women at higher risk of breast or ovarian cancer.
 - Mammography screening for breast cancer every one to two years for women over 40 years of age; biennial screening for women between 50 and 75 years of age.
 - Counseling on preventive chemotherapy for breast cancer for women at high risk
 - Breastfeeding support and counseling by a trained professional during pregnancy or post-partum period, including breastfeeding equipment.
 - Cervical cancer screening for sexually active women between 21 and 65 years of age through cytology (PaP, every three years); Human papilloma virus screening combined with cytology every five (5) years for women aged 30 to 65.
 - Chlamydia infection screening to pregnant women age 24 or under and other women at higher risk, whether pregnant or not.
 - Food and Drug Administration approved contraceptive methods, sterilization procedures, oral contraceptives, patient education and counseling for women with reproductive capacity. As prescribed.
 - Screening and counseling for domestic and interpersonal violence.
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- Folic acid supplements for women who may become pregnant.
 - Gestational diabetes screening for women 24 to 28 weeks pregnant and on the first prenatal visit for women at high risk of developing gestational diabetes.
 - Gonorrhea screening for sexually active women, including those who are pregnant if they are at high risk of contracting the infection.
 - Hepatitis B screening to pregnant women at their first prenatal visit.
 - Human Papilloma virus ADN test every three (3) years in woman, with normal cytology results, who are thirty (30) or older.
 - Osteoporosis screening for women age 65 or older and in younger women, whose risk of bone fractures is equal to, or greater than that of a 65 years old white woman who has additional risk factors.
 - Rh(D) blood typing and antibody testing to all pregnant women at their first prenatal care visit; repeated antibody testing for all unsensitized Rh(D) negative women at 26 to 28 weeks' gestation, unless the biologic father is known to be Rh(D) negative.
 - Preventive annual care for adult women in order to obtain the recommended preventive services that are age and developmentally appropriate, including preconception care and many services for prenatal care. This well-woman visit is annual, although Health and Human Services (HHS) recognizes that several visits may be needed to obtain all necessary recommended preventive services depending on a woman's health status, health needs and other risk factors.
 - Autism screening for children at 18 and 24 months of age.
 - Behavioral assessment for children of all ages.
 - Cervical dysplasia screening for all sexually active females.
 - Congenital hypothyroidism screening for newborns.
 - Developmental screening and monitoring for children under 3 years of age.
 - Dyslipidemia screening for children of all ages at higher risk of lipid disorders.
 - Fluoride chemoprevention supplements for children without fluoride in their water sources
 - Hearing screening tests for all newborn
 - Medical history for all children throughout their development: 0 to 11 months, 1 to 4 years and 5 to 10 years.
 - Hematocrit or Hemoglobin screening for children.
 - Iron supplements for children ages 6 to 12 months at risk for anemia.
 - Screening for lead for children at risk of exposure
 - Screening for obesity in children age 6 and older as well as referrals to comprehensive intensive behavioral interventions to promote improvement in weight status.
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- Gonorrhea preventive medication for the eyes of all newborn.
 - Height, Weight and Body Mass Index measurements for children of all ages
 - Hemoglobinopathies or sickle cell screening for newborns.
 - Oral Health risk assessment for young children, ages 0 to 11 months, 1 to 4 years, 5 to 10 years.
 - Phenylketonuria (PKU) screening for this genetic disorder in newborns.
 - High-intensity behavioral counseling and screening to prevent sexually transmitted infection (STI's) for all sexually active for adolescents at higher risk.
 - Tuberculin testing for children at higher risk of tuberculosis.
 - Vision screening for all children at least once between the ages 3 to 5 to detect amblyopia
 - Vaccines; for specific coverage information, please refer to the Vaccines section at the end of the section Ambulatory Medical-Surgical and Diagnostic Services.

For more information about the preventive services covered , you can access the following link: <http://www.healthcare.gov/center/regulations/prevention.html>.

This contract also covers the annual preventive visit, the preventive screening tests and vaccines as established by the Centers for Medicare and Medicaid Services (CMS), in accordance with Law 218 of August 30, 2012 and as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the Advisory Committee on Immunization of the Puerto Rico Department of Health. These include some of the preventive services and vaccines mentioned in the previous paragraph, as well as the following services:

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

This contract also complies with the requirements of Law No. 239 of September 13, 2012, for covered services as detailed in this contract shall be offered by psychology professionals trained at master's degree or doctorate level, with training and experience to offer health services, who are duly licensed by the Psychology Examining Board of Puerto Rico.

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

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

This contract covers all the preventive services and benefits listed under the ACA federal law for early detection of breast cancer. Pursuant to Law No. 275 of September 27, 2012, this contract also covers studies and monitoring tests for breast cancer such as visits to specialists, breast clinical exams, mammographies, digital mammographies, magnetic resonance mammography and sonomammography. It also includes, but does not limit to, treatments such as: mastectomy, reconstructive surgery after mastectomy for the reconstruction of the

breast removed, the reconstruction of the other breast to achieve an asymmetric appearance, breast prosthesis, treatment for physical complications during all the stages of the mastectomy, including lymphedema (an inflammation that sometimes occurs after breast cancer), as well as any other reconstructive surgery for the physical and emotional recovery of the patient.

The participant person will be responsible of paying directly to the participating provider the copayment or coinsurance stated in the Table of Benefits that appears in this contract.

This contract provides any eligible participating person, including those diagnosed with HIV or AIDS, with physical or mental incapacity, every coverage offered under this contract.

COMPENSATION TO THE PARTICIPATING PERSON

If any person with rights to the benefits under this contract receives services from non-participating professionals or facilities outside of Puerto Rico, or services based on compensation, unless otherwise indicated in this contract, Triple-S Salud will pay directly to the participating person the expense incurred up to the amount that would have been paid to a participating professional or facility or according to the amount specified for the benefit. If the service is rendered in the United States of America and is not precertified or an emergency, Triple-S Salud will pay the amount equivalent to the established fee in Puerto Rico.

AMBULATORY MEDICAL-SURGICAL AND DIAGNOSTIC SERVICES IN AMBULATORY FORM

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

Benefits Description	You Pay
Treatment and Diagnostic Services	
Medical professional services: <ul style="list-style-type: none"> • Visits to physicians/surgeons office, with no limit on the number of visits 	\$5.00 co-payment for visits to a generalist physician \$15.00 co-payment for visits to a specialist physician \$15.00 co-payment for visits to a sub-specialist physician
<ul style="list-style-type: none"> • Visits to an audiologist 	\$5.00 co-payment per visit
<ul style="list-style-type: none"> • Visits to an optometrist 	\$5.00 co-payment per visit
<ul style="list-style-type: none"> • Visits to a podiatrist 	\$5.00 co-payment per visit
<ul style="list-style-type: none"> • Visits to a clinical psychologist 	\$15.00 co-payment per visit
<ul style="list-style-type: none"> • Visits to a Chiropractor 	\$15.00 copayment per visit
<ul style="list-style-type: none"> • Medical services at the home of the participating person by physicians who render this service. 	\$15.00 co-payment per visit
<ul style="list-style-type: none"> • Intra-articular injections will be limited to two (2) daily injections up to a maximum of twelve (12) injections per contract year, per participating person. 	Nothing
<ul style="list-style-type: none"> • Services at hospital emergency rooms, materials and medications included in suture trays contracted with Triple-S Salud. It also covers medications and materials in addition to those included in the suture tray, provided in emergency room because of accident or illnesses. Copayment applies for illness or accident. Participant members may call Teleconsulta and if they recommend going to an emergency room, they will provide a registration number with which the participant will pay a lower copayment for the use of the facilities. For diagnostic tests provided in emergency rooms, that are not X-rays and laboratories, coinsurances and/or limits for the outpatient benefit apply, including X-rays interpretation; as specified in this contract. 	\$20.00 co-payment for illness or accident Nothing if recommended by Teleconsulta
<ul style="list-style-type: none"> • Cryosurgery of the uterus limited to one (1) procedure per contract year, per participating person. • Services for tuberculosis conditions. • Sterilization 	Nothing
<ul style="list-style-type: none"> • Preventive services with no copayment or coinsurance, required by federal laws <i>Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA)</i> and the <i>Health Care and Education Reconciliation Act de 2010, Public Law No. 111-152 (HCERA)</i> and according to the United States Preventive Services Task Force are covered under this contract. 	Nothing

Vaccines *	
<ul style="list-style-type: none"> • Pentacel vaccine, covered up to five (5) years. • Pediarix (DTaP-IPV-HepB) and Kinrix vaccines are covered up to seven (7) years. • Tetanus Toxoid is covered without age limitations. 	\$5.00 copayment per vaccine
<ul style="list-style-type: none"> • Respiratory syncytial virus vaccine (palivizumab), subject to Triple-S Salud Precertification. 	Nothing of coinsurance
Preventive Vaccines	
<ul style="list-style-type: none"> • Rotavirus vaccine is covered up to eight (8) months. • Pneumococcal conjugated (PCV- Pevnar 13 and Pevnar), covered up to five (5) years. • Hemophilus Influenza B (HIB), is covered up to six (6) years. • DTaP vaccine and DPT/HIB are covered up to seven (7) years. • Polio vaccine is covered up to eighteen (18) years • Tdap vaccine is covered up to nineteen (19) years. • Zoster (Zostavax) vaccine is covered starting at sixty (60) years and up. • Hepatitis B (Pediatric and adult), Hepatitis B (<i>dialysis or immunosuppressed</i>), Varicella, DT, Pneumococcal Polysaccharide (PPV), Meningococcal Conjugate (MCV), Meningococcal Polysaccharide (Menomune), Influenza, Hepatitis A, Td and MMR are covered without age limitations. • HPV (Human Papilloma Virus- Gardasil and Cervarix), covered up to twenty seven (27) years. <p>Note: *Vaccines are covered until the person reaches the stipulated age</p>	Nothing

Laboratories, X-Rays and Other Diagnostic Tests	
<p>Tests such as:</p> <ul style="list-style-type: none"> • Clinical Laboratories • X-Rays • Nuclear medicine tests • Computed Tomography • Single Photon Emission Computed Tomography (SPECT) • Sonogram • Magnetic Resonance Studies (MRI/MRA) • Gastrointestinal endoscopies • Electromyograms • Ophthalmologic diagnostic tests • Electroencephalograms • Non-invasive cardiovascular tests • Non-invasive vascular tests • Electrocardiograms • Polysomnography (study of sleeping disorders) will be limited to one test of each type, per life, per participant person. • Other diagnostic tests • The refraction exam is covered when it is made by a specialist in ophthalmology or optometry and up to one (1) exam per year contract, per participating person. 	25% coinsurance
<ul style="list-style-type: none"> • Preventive services with no copayment or coinsurance, required by federal laws <i>Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA)</i> and the <i>Health Care and Education Reconciliation Act de 2010, Public Law No. 111-152 (HCERA)</i> and according to the United States Preventive Services Task Force are covered under this contract. 	Nothing

Maternity Services	
<ul style="list-style-type: none"> • Services without waiting periods for the participating person, wife in family contracts and daughters as direct dependents. • Prenatal and postnatal services received by the participating person with maternity benefits coverage. 	\$15.00. co-payment for the visit to the specialist for prenatal and postnatal visits
<ul style="list-style-type: none"> • Hospitalization • According to the Law on Protection of Mothers and Newborns, admissions to the hospital in case of delivery will be covered for a minimum of 48 hours in case of natural delivery and 96 hours in case of cesarean section delivery, unless the physician, after consulting the mother, orders the release of the mother and/or the newborn. 	\$50.00 co-payment for birth hospitalization
<ul style="list-style-type: none"> • Obstetrics services • Use of Maternity Ward and Fetal Monitoring production • Use of Well Baby Nursery • Use of the Step Down Unit 	Nothing
<ul style="list-style-type: none"> • Visits for well baby care during the participating person baby's first year. 	\$15.00 copayment per visit
<ul style="list-style-type: none"> • Preventive services with no copayment or coinsurance, required by federal laws <i>Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA)</i> and the <i>Health Care and Education Reconciliation Act de 2010, Public Law No. 111-152 (HCERA)</i> and according to the United States Preventive Services Task Force are covered under this contract. 	Nothing
<ul style="list-style-type: none"> • Biophysical Profile, per participating person with right to maternity, up to one (1) per pregnancy. 	50% coinsurance for Biophysical Profile
Allergy care	
<ul style="list-style-type: none"> • Allergy tests are limited to a maximum of fifty (50) tests per contract year, per participating person. 	Nothing
Treatment Therapy	
<ul style="list-style-type: none"> • Radiotherapy 	25% coinsurance per therapy
<ul style="list-style-type: none"> • Chemotherapy and Cobalt 	Nothing
<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> a. the date in which the participating person became eligible for this contract for the first time; or b. the date in which he/she received the first dialysis or hemodialysis. <p>This will apply when subsequent dialysis or hemodialysis are related to the same clinical condition.</p> 	Nothing

Respiratory Therapy	
<ul style="list-style-type: none"> Respiratory therapy (provided by surgeon specialized in allergies, pediatric allergies, anesthesia, pneumology and pediatric pneumology, and laboratories located within a hospital facility), up to two (2) daily sessions up to a maximum of twenty (20) sessions per contract year, per participating person. 	\$5.00 co-payment per therapy
Physical Therapy	
<ul style="list-style-type: none"> Physiotherapy, provided by physician or chiropractor, limited to one (1) daily session up to a maximum of twenty (20) sessions per contract year, per participant person. In the case of physiotherapy provided by a physician, supervision does not require the direct intervention (face to face) of the physician, but needs to be available in the location to evaluate and recommend a change in the treatment plan. 	\$5.00 co-payment per therapy
Chiropractor services	
<ul style="list-style-type: none"> Up to thirty (30) manipulations per contract year, per participant person. 	<p>\$15.00 co-payment per visit</p> <p>\$5.00 co-payment per manipulation</p> <p>If the insured receives services from a non-participating chiropractor, they will be reimbursed at 100% from Triple-S Salud established fees, after applying the corresponding copayment. Besides, services may be covered through Assignment of Benefits.</p>
Durable Medical Equipment (DME)	
<p>Rent or purchase, subject to a precertification:</p> <ul style="list-style-type: none"> Rent or purchase of oxygen and necessary equipment for its administration. Rent or purchase, according to the criteria established by Triple-S Salud, of wheel chair or hospital type bed. Rent or purchase, according to the criteria established by Triple-S Salud, respirators, ventilators, and other equipment for the treatment in case of respiratory paralysis. 	25% coinsurance
Mechanical Ventilator	
<ul style="list-style-type: none"> Includes the services of a skilled nurse with knowledge in respiratory therapy, physical and occupational therapy for participant patients under the age of twenty (21). These services are covered subject to the presentation, by the participant patient or his/her representative, of justified medical evidence and proof of registration in the registry established by the Health Department for these patients. 	Nothing

<ul style="list-style-type: none"> The services of a skilled nurse with knowledge in respiratory therapy, acquainted with the use of a mechanical ventilator, and physical and occupational therapies are covered up to a maximum of eight (8) hours of service per day. 	
Home Health Care	
<p>The following services and supplies are covered:</p> <ul style="list-style-type: none"> Home Health Care - the following services and provisions provided in the home of the patient by an Agency of Home Health Care certified by the Health Department of Puerto Rico. These services will be covered if they begin within the next fourteen (14) days of being discharged from a hospitalization of at least three (3) days and if they are lent because of the same condition or in relation to the condition by which he/she was hospitalized. These conditions do not apply for the services related to the mechanical ventilator. Nurse Services - partial or intermittent, provided or under the supervision of a graduate nurse, up to a maximum of two (2) daily visits. Home Health Care for Auxiliary Services - partial or intermittent, rendered primarily for the care of the patient. A visit by a member of the Agency of Home Health Care in the home or four (4) hours of service by an auxiliary, will be considered as one visit in the home. Physical, Occupational and Speech Therapy - will be covered up to a maximum of forty (40) visits per contract year. A visit by a member of a home health care team or four (4) hours of home health aid service will be considered as one home health care visit. <p>Note: A surgeon-physician must supervise these services and certify in writing his/her medical necessity. He/she must recertify the medical necessity when Triple-S Salud therefore requires it.</p>	25% coinsurance
Nutrition Services	
<ul style="list-style-type: none"> NUTRITION SERVICES TREATMENT OF MORBID OBESITY: Triple-S Salud will pay for nutrition services rendered in Puerto Rico by physicians specialized in nutrition or metabolic illnesses. Visits to these specialists, duly certified by the Commonwealth's governmental entity designated for this purpose, will be covered as long as they are medically necessary and are just and associated to the treatment of morbid obesity. Visits will be limited to a maximum of three (3) visits per contract year, per participating person. 	Triple-S Salud will reimburse up to a maximum of TWENTY DOLLARS (\$20.00) for each visit.

Other services for the treatment of disorders within the continuum of Autism	
<p>This contract covers the services targeted for the diagnosis and treatment of persons with disorders within the Continuum of Autism without limits such as:</p> <ul style="list-style-type: none"> • Neurological tests • Immunology • Genetic testing • Laboratory tests for autism • Services of Gastroenterology • Nutrition services • Occupational therapy and speech • Visits to a psychiatrist, psychologist, with master's or doctoral degree and valid license issued by the Board of Examiners of Psychologists of Puerto Rico) or social worker (by reimbursement). • Psychological evaluations and tests 	<ul style="list-style-type: none"> • Neurological tests - 25% coinsurance • Immunology - 25% coinsurance • Genetic testing - 25% coinsurance • Laboratory tests for autism - 25% co-insurance • Services of gastroenterology - 25% coinsurance • Services of nutrition - \$0.00 copayment • Occupational therapy and speech therapy- \$7.00 copay • Physical therapy - \$5.00 copay • Visits to a psychiatrist, psychologist, with master's or doctoral degrees and current license issued by the Board of Examiners of Psychologists of Puerto Rico) or social worker (by reimbursement) - \$15.00 copay • Psychological evaluations and tests - \$10.00 copay

Preventive Service Centers

This benefits offers the benefits required by the federal Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA) y la Health Care and Education Reconciliation Act de 2010, Public Law No. 111-152 (HCERA), as set forth by the United States Preventive Services Task Force (USPSTF) *at participating centers*. The insured persons must coordinate an appointment with the Participating Center to receive the services provided under their contract. It also includes an initial evaluation and another evaluation after the tests are performed.

Among the services offered, there are the following:

Evaluation	<ul style="list-style-type: none"> ✓ Medical history ✓ Physical exam ✓ Screening for depression ✓ Counseling on: Alcoholism, Tobacco, Risky behaviors, Sexuality, Cancer, Domestic violence, Prevention of falls, Diet and Nutrition 	<p style="text-align: center;">\$0.00 copay</p>
Preventive Screening Tests 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 copay, refer to sub-section on Services Covered by Federal or Local Law in the benefit certificate.	<ul style="list-style-type: none"> ✓ CBC ✓ Cholesterol ✓ PAP (cervical cancer) ✓ Chlamydia ✓ Gonorrhea ✓ Syphilis ✓ HIV ✓ Glycosylated Hemoglobin ✓ Visual Examination 	<p style="text-align: center;">\$0.00 copay</p>
Referrals	<ul style="list-style-type: none"> ✓ Screening mammography ✓ Vaccines ✓ Bone density scan ✓ Colonoscopy ✓ Sigmoidoscopy ✓ Others 	<p style="text-align: center;">According to coverage</p>

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 copays or coinsurances that correspond to your coverage will apply. Please refer to the Table of Benefits. 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.

MEDICAL-SURGICAL SERVICES DURING PERIODS OF HOSPITALIZATION

- Triple-S Salud agrees to pay based on the rates established for said purposes for those services covered herein that are rendered to the participating person during hospitalization periods by surgeons freely chosen by the former. Only surgeon services that are normally available in the hospital in which the participating person is hospitalized shall be covered during any hospitalization period.
- No person covered hereunder that is hospitalized in a semi-private room of the hospital, shall be bound to pay any amount to a participating surgeon for services covered hereby rendered by the surgeon. Medical fees in these cases shall be paid directly by Triple-S Salud to the participating surgeons based on the fees established for said purposes.

Benefits Description	You Pay
Medical Surgical Services	
<p>During periods of hospitalization, the participating person will have the right to receive the following medical/surgical services, among others:</p> <ul style="list-style-type: none"> • Surgery • Diagnostic services • Treatment • Administration of anesthesia • Epidural anesthesia • Specialists consultations 	Nothing
<ul style="list-style-type: none"> • Skin, Bone and Corneal Transplants: Expenses to obtain and transport materials necessary for skin, bone and corneal transplants will be covered on the basis of reimbursement to the participating person. Triple-S Salud will pay 100% of the fees it has established for these services. • Gastrointestinal endoscopies • Rhinoplasty services • Sterilization • Hearing evaluations, include Neonatal Hearing Screening Test • Inyectable Chemotherapy medications and radiotherapy 	Nothing
<ul style="list-style-type: none"> • Orthognathic surgery (Mandibular and maxillary osteotomy [Le Fort]). Excludes expenses related with materials for orthognathic surgery (Mandibular and maxillary osteotomy [Le Fort]). 	Nothing
<ul style="list-style-type: none"> • Gastric Bypass Surgery for the treatment of morbid obesity, up to one (1) surgery per lifetime, as long as the services is available in Puerto Rico. Requires precertification. 	Nothing
<ul style="list-style-type: none"> • Invasive cardiovascular tests • Lithotripsy procedure (ESWL) 	25% coinsurance

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

- It shall be required that the person to be hospitalized for reason of lesions or illness pays to the participating hospital at the time of admission the hospital admission co-payment. This amount is not reimbursable by Triple-S Salud. For the calculation of any period of hospitalization, the day of admission shall be counted, but the day in which the patient is released by the physician-surgeon in charge of the case will not be counted.
- Triple-S Salud shall not be responsible for the services received by any participating person if the same remains in the hospital after having been discharged by the physician-surgeon in charge of the case, nor will it be responsible for any day or days that may be granted to the patient to be absent from the hospital during the same hospitalization period.
- Hospitalization services shall be extended in case of maternity or secondary conditions to pregnancy, only if the person is entitled to the maternity benefit. Ambulatory Surgery Center services will be covered in accordance with contract established by Triple-S Salud.
- When a participating person uses a private room in a participating hospital, the hospital will apply to the use of the private room half of the cost contracted by Triple-S Salud, being able to charge the patient the difference between the normal cost of the private room and half of the cost contracted by Triple-S Salud. The other hospitalization expenses of the participating person, covered hereby shall be included in the remaining half of the cost contracted between the participating hospital and Triple-S Salud and therefore it could not charge any difference to the insure.

Benefits Description	You Pay
Hospitalizations	
<p>Triple-S Salud agrees to pay for services contracted with the corresponding hospital institution during the hospitalization of the participating person during the effectiveness of the plan of the eligible person, as long as that hospitalization is ordered in writing by the physician in charge of the case and it is medically necessary. The basic services contracted with a participating hospital include:</p> <ul style="list-style-type: none"> • Semi-private or quarantine room up to a maximum of three hundred and sixty-five (365) days for regular hospitalizations. 	\$50.00 co-payment for regular admission
<ul style="list-style-type: none"> • Ambulatory surgeries 	Nothing
<ul style="list-style-type: none"> • Food and special diets • Use of telemetric services • Use of Recovery room • Use of Step Down Unit • Administration of anesthesia by non-medical personnel • Clinical laboratory services • Medications, biological products, healing materials, products related to hyper alimentation and anesthesia materials. • Production of electrocardiograms • Production of radiological studies • Physical therapy and rehabilitation services 	Nothing, these services are included in the payment of the hospitalization copayment.

Hospitalizations (cont.)	You Pay
<ul style="list-style-type: none"> • 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 participating person 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. • Use of Intensive Care units, Coronary Care, Pediatric Intensive Care, and Neonatal Intensive Care. • 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: <ul style="list-style-type: none"> a. the date in which the participating person became eligible for this contract for the first time; or b. the date in which he/she receives the first dialysis or hemodialysis. <p>This will apply when subsequent dialysis or hemodialysis are related to the same clinical condition.</p> • Injectable chemotherapy medicines and radiotherapy • Blood for transfusions • Sterilization services for male or female. • Post-hospitalization services - These services shall be supervised by a physician surgeon and its medical need must be certified by written. Triple-S Salud may require a re-certification for these services if it deems it necessary. It covers services in a Skilled Nursing Facility as established in the Limitations Section. 	<p>Nothing, these services are included in the payment of the hospitalization copayment.</p>
<ul style="list-style-type: none"> • Lithotripsy procedure (ESWL) 	<p>25% coinsurance</p>

Skilled Nursing Facilities (SNF)	
<p>These services will be covered if they start no further than fourteen (14) days after the participating person is released from a hospital, having been hospitalized at least three (3) days and, if the services are provided due to the same condition or in relation to the condition for which he/she was hospitalized.</p> <ul style="list-style-type: none"> • Will be covered up to a maximum of one hundred twenty (120) days per contract year, per participating person. • Services provided by non-participating facilities in Puerto Rico or non participating of the <i>Blue Cross and Blue Shield Association</i>, will be paid by indemnization based on the fees established for the rendered service. <p>Note: A physician must supervise these services and certify in writing his/her medical necessity. He/she must recertify the medical necessity when Triple-S Salud therefore requires it.</p>	Nothing
Ambulance	
<ul style="list-style-type: none"> • Air ambulance services in Puerto Rico, subject to medical necessity 	Nothing
<p>AMBULANCE SERVICES: Over land ambulance services rendered in or outside of Puerto Rico are covered based on reimbursement to the participating person of the appropriate fees as determined by Triple-S Salud, in accordance with the distance covered. When services are used through 911, Triple-S Salud will pay directly to the provider. The service will be covered only if all of the following requirements are met:</p> <ol style="list-style-type: none"> a. the patient was transported by an ambulance service as defined in Definition Section, AMBULANCE SERVICES; b. the patient had an illness or injury for which other modes of transportation were contraindicated; c. the patient forwards the claim to Triple-S Salud with a medical certification that includes the diagnosis; and, d. the invoice for this service indicates the place where the participating person was picked up and where he/she was taken. <p>This benefit is covered if the patient was transported:</p> <ol style="list-style-type: none"> 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 - this if the institution that transfers or authorizes the discharge is not the appropriate facility for the covered service; c. from the hospital to the residence. 	Up to a maximum of EIGHTY DOLLARS (\$80.00) per case, by reimbursement.

MENTAL HEALTH AND DRUG ABUSE AND SUBSTANCES ADDICTION

Benefits Description	You Pay
Mental General Conditions	
<p>Treatment services for the mental health care:</p> <p>Hospitalizations for mental conditions, including partial hospitalizations, will be covered according to the justified medical necessity.</p> <ul style="list-style-type: none"> • Regular admission • Partial admission 	<p>\$50.00 co-payment for regular admission</p> <p>\$50.00 co-payment for partial admission</p>
<ul style="list-style-type: none"> • Electroshock therapy for mental conditions will be covered according to the justified medical necessity and to the standard of the American Psychiatric Association (APA). 	Nothing
<ul style="list-style-type: none"> • Special nursing services during hospitalizations for mental conditions. These services are covered if ordered by a psychiatrist, 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.
<ul style="list-style-type: none"> • Patient's visits to the office of the participating psychiatrist are covered without limits, subject to medical necessity. 	\$15.00 copayment per visit
<ul style="list-style-type: none"> • Visits of immediate family members (collaterals) are covered without limits, subject to medical necessity. 	\$15.00 copayment per visit
<ul style="list-style-type: none"> • Visits for group therapy (of patients) are covered without limits, subject to medical necessity. 	\$5.00 copayment per therapy
Others Psychological Evaluations	
<ul style="list-style-type: none"> • Psychological evaluation 	\$10.00 copayment
<ul style="list-style-type: none"> • 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)	
<ul style="list-style-type: none"> Regular admission Partial admission <p>Hospitalizations for drug addiction and alcoholism including detox treatment and partial hospitalizations are covered without limits, subject to medical necessity.</p>	<p>\$50.00 co-payment for regular admission</p> <p>\$50.00 co-payment for partial admission</p>
<ul style="list-style-type: none"> Patient's visits to the office of the participating psychiatrist are covered without limits, subject to medical necessity. 	\$15.00 copayment per visit
<ul style="list-style-type: none"> Visits of immediate family members (collaterals) are covered without limits, subject to medical necessity. 	\$15.00 copayment per visit
<ul style="list-style-type: none"> Visits for group therapy (of patients) are covered without limits, subject to medical necessity. 	\$5.00 copayment per therapy
Residential Treatment	
<ul style="list-style-type: none"> Covers residential treatment for drug abuse and alcoholism up to a maximum of ninety-(90) days per contract year, per participant person, as long as there is a medical justification and the services are available in Puerto Rico. Requires precertification. 	Nothing

MAJOR MEDICAL COVERAGE

Benefits Description

Individually Eligibility/Coverage Date

A. INDIVIDUAL ELIGIBILITY:

Every participant person and his/her eligible dependents with the basic contract of Triple-S Salud for hospital, medical-surgical and ambulatory services, will be eligible for the coverage under major medical coverage. The eligibility of a participant person will be determined by the Fund under its rules.

B. DATE OF COVERAGE

Any eligible dependent will be covered at the participant's effective date or at the date on which such person become eligible as a dependent, whatever occurs later. The date of coverage of a participant person will be determined by the Fund under its rules.

Benefits

This coverage is provided under a cost reimbursement arrangement with the Fund and administered by Triple-S Salud and are subject to the terms and conditions of the contract for hospitalization, medical-surgical, and ambulatory services of Triple-S Salud which are not in conflict with the benefits and conditions of this coverage.

The covered medical expenses under the Major Medical coverage will be directly paid to the participating person or through Benefit Assignment according to Triple-S Salud established fees and to the following amounts applicable to the participating person and each one of his/her eligible dependents.

Each participating person or family will be responsible, after accumulating the cash deductible and the coinsurance established in the Limitations section, for the covered medical expenses, up to the maximum amount established in the Limitations section.

Each participating person or family will be responsible for the difference between the incurred expenses and the established fees for the reimbursement of the covered medical expenses.

In order to get reimbursement of covered medical expenses, the person must be participating person by the basic contract 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 offered only for those participating person who live permanently in the service area.

Worldwide expenses for services received in or outside the hospital will be paid as long as these services are medically necessary and are related to an illness, accident, pregnancy, birth or medical condition, according to the following: if the service is rendered in Puerto Rico, the reimbursement will be made as established in the Limitations section; if the service is rendered outside of Puerto Rico, the payment will be made according to the reasonable charge of the area on which the services are rendered; or based on the rates established by the Blue Cross and Blue Shield Association plans.

All services rendered outside of Puerto Rico will be paid only through this coverage subject to Triple-S Salud' Precertification, except in cases of emergency or if otherwise stated in the Limitations section. In those cases in which services are rendered without a Precertification or are not emergency, these services will be paid directly to the participant person based on Triple-S Salud established fees for participating providers or through Assignment of Benefits.

Services that require preauthorization on Basic coverage keep this requirement in the Major Medical coverage.

The incurred expenses for covered services that are originated because of a medical emergency while the affected participating person is outside Puerto Rico, will not require precertification, but will be subject to the corroboration by Triple-S Salud of its reasoning and medical necessity.

Major Medical Benefits Covered

The participating person can apply for a Benefit Assignment when the services to be received are not available in Puerto Rico, subject to a preauthorization by Triple-S Salud for such benefit. Surgeon, hospital and facilities non-participating of the Blue Cross Blue Shield Association, that accept the Benefit Assignment will bill Triple-S Salud directly for the services rendered to the participating person.

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 contract year, by the participating person or his/her dependent while participating person, when they exceed the total of deductible basic benefits and after the accumulation of the cash deductible and subject to the limitations established in this coverage.
 2. After a disbursement of the amount established in the Major Medical Limitations Section (1a and 2) of cash expenses (as a result of the accumulation of the deductible and coinsurance for which the participating person is responsible) for covered medical expenses incurred by the participating person or his dependent during a contract year, a 100% reimbursement covered medical expenses that exceed said amount will be paid to the person in such situation during the remaining contract year.
 3. After a disbursement of the amount established in the Major Medical Limitations Section (1b and 3) of cash expenses (due to deductible accumulation and coinsurance responsibility of the participating person and dependents) for covered medical expenses incurred by the participating person or participating person members of his/her family during a contract year, a 100% reimbursement of the covered medical expenses regarding the participating person members of his/her family will be paid during the remaining contract year.
 4. The cash deductible separately applies to the participant person and each one of his/her dependents per each contract year, except that:
 - a. If two (2) or more members of his/her family are injured in the same accident, only one cash deductible (amount corresponding as deductible per person) will be applied for that contract year against all the expenses incurred as a result of such accident.
 - b. No more than the total cash deductibles for a family contract, as established in the Limitations section, will be applied to all expenses made by family members of the participating person during any contract year.
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Major Medical Benefits Covered

B. COVERED MEDICAL EXPENSES: Medical expenses for treatment of injuries and illness suffered by the participant person will be covered when approved and recommended by the attending physician

1. Anesthesia and its administration

2. Durable medical equipment (only for services outside of Puerto Rico):

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

Purchase option for these benefits requires a Triple-S Salud precertification.

3. Medical materials or supplies:

- a. Covered drugs prescribed by a physician-surgeon during hospitalization periods.
- b. Surgical supplies such as bandages and gauze.

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

5. 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 immediate family or does not reside in the participating person home.

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

7. X-ray and laboratory services - For diagnostic and treatment purposes.

8. Ambulatory Services for mental conditions, drug addiction and alcoholism

9. Physiotherapy and rehabilitation services - Of the type and duration prescribed by the attending physician and provided by or under the supervision of a physiatrist.

10. Services in ambulatory surgical centers

11. Orthoptic training - Recommended by a physician in written form and provided by a qualified technician or optometrist.

12. Radiotherapy - Using x-ray, radon, radium and radioactive isotopes.

Covered Medical Expenses (Cont.)

13. **Other services:** The following services will be covered provided that they are considered medically necessary. Those services that are not considered necessary, are not in accordance with the generally accepted principles of medical practice, are experimental or investigative services or are provided in excess of those that are generally required for the diagnosis, prevention or treatment of an illness, injury, malfunction of the organic system, or the condition of pregnancy are excluded.
- a. Hearing aids and auditory tests, as established in the Limitations section.
 - b. Prosthetic devices or implants to replace physical organs or parts or to aid in their functioning, as prosthesis, pacemakers and valves, etc. Replacement is excluded.
 - c. Surgical assistance
 - d. Immunizations
 - e. Mammoplasty, subject to a Triple-S Salud precertification
 - f. Sports medicine
 - g. Orthognathic surgery (Mandibular and maxillary osteotomy [Le Fort])
 - h. Cardiac rehabilitation: These services will be covered if provided by a surgeon specializing in physical therapy, exercise physiology and rehabilitation techniques. Its purpose is to minimize physical and psychological disabilities, which results from a cardiovascular illness. Reimbursed according to the reasonable charges of the area were services are rendered and the medical necessity dispositions established by Triple-S Salud.
 - i. Services rendered by non-participant facilities and providers.
 - j. Intravenous or inhalator anesthetics applied at the dentist's or dental surgeon's office.
 - k. Pre and postnatal services
 - l. Tuboplasty
 - m. Vasovasostomy

MAJOR MEDICAL LIMITATIONS

1. Cash Deductible:
 - a. Per person -\$100.00 per contract year
 - b. Per family - \$300.00 per contract year
2. Each participant person will be responsible, after accumulating the cash deductible, for 20% of the covered medical expenses, up to a maximum of \$2,000 per contract year.
3. Each participant family will be responsible, after accumulating the cash deductible, for 20% of the covered medical expenses, up to a maximum of \$6,000 per contract year.
4. For services rendered in Puerto Rico the reimbursement will be based in the medical benefits schedule established by Triple-S Salud for those purposes.
5. Hearing aids are limited up to a maximum of **Two Hundred and Fifty Dollars (\$250.00)** per contract year, per participant person and auditory test is limited to one (1) test per contract year, per participant person.

Tissue and Organ Transplant

ELIGIBILITY

This benefits will be available for all employees classified as active and the eligible dependents covered in Triple-S Salud's basic hospital, surgical-medical and ambulatory service contract; as long as they fulfill the eligibility criteria established by the Fund and those dispositions applicable by law.

BENEFITS

Benefits under this contract are subject to the terms and conditions established for such. Benefits are offered exclusively to those participant persons with permanent residence in the Service Area.

Triple-S Salud is responsible for the payment of services rendered to the participant person subject to the dispositions of this coverage contract and the following conditions:

1. Benefits covered are for each contract year and each person covered by this contract, except established otherwise. The benefits that are not used within a contract year will not accumulate for the next contract year.
2. Triple-S Salud does not compromise to designate the Transplant Network physician, facility or laboratory to render their services to the participant members.
3. Triple-S Salud or its authorized representative could require a second medical opinion, with physicians designated by the company, when considered necessary.
4. The participant person, physician, hospital facility and Transplant Network facility will be informed about the pre-certification procedure. In those cases that Triple-S Salud requires a precertification previous to the rendered services, Triple-S Salud will not be responsible for the payment of such services if they are received without such precertification from Triple-S Salud or its authorized representative.

The benefits are limited to human organ and tissue transplant and are subject to Precertification by Triple-S Salud or its authorized representative. These services are covered only through Triple-S Salud contracted facilities and outside of Puerto Rico. Triple-S Salud covers a 100% of the established fees by Triple-S Salud with these providers and facilities, subject to no coinsurance or deductible.

MEDICAL COVERED EXPENSES

1. **Organ transplant** - heart, heart/lung, lung (single and double), liver, pancreas/kidney and kidney transplant are covered. The expenses for the transplant are covered as follows:
 - a. **Recipient** - expenses directly related to the transplant procedure including evaluation, pre-operative surgical and post-operative care, transplant, and immunosuppressive drugs.
 - b. **Organs (Procurement)** – expense or services rendered or related with the obtainment, conservation, and transportation of the organs to be used in the transplant are covered.
 - c. **Transportation, meals, and lodging expenses** – The maximum limit of covered expenses for transportation, meal, and lodging plan is \$10,000 for each kind of transplant.
 - 1) Transportation – to and from the place of the surgery for the patient and its companion. If the patient age is a minor under nineteen (19) years old, transportation for two companions will be covered (parents or the persons holding the legal custody of the patient).
 - 2) Meal and lodging - up to a maximum of \$150 per person or \$200 daily for two people (parents or the persons holding the custody of the patient who is under nineteen (19) years old).
 - d. **Re-transplant**
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Tissue and Organ Transplant

Bone marrow transplant- covers allogeneic, autologous, syngeneic, and hematopoietics stock cells transplants are covered if they are related to the following conditions and illnesses: breast cancer, non-malignant hematological disorders as plastic anemia, acute lymphoblastic leukemia, acute non-lymphoblastic leukemia, acute myeloblastic leukemia, acute and cronic myeloblastic leukemia in remission, infantile malignant osteopetrosis, Wiskott-Aldrich syndrome, Hodgkin disease, lymphomas others than Hodgkin's type, advanced step neuroblastomas and severe combined Immunodeficiency.

The following expenses for this transplant are covered:

- a. **Receiver:** covers the expenses directly related with the procedure; includes the evaluation, pre-surgical care, transplant, post-surgical care, and immunosuppressive drugs.
- b. **Bone marrow donation and storage:** Expenses and services rendered or related with the obtainment, preservation, and transportation of the tissues to be used in the covered transplant.
- c. Pre-transplant **chemotherapy and/or irradiation treatment** before the transplant
- d. **Ambulatory Care**-Post-transplant outpatient care directly related to the transplant
- e. **Transportation, meals, and lodging** – the maximum limit of covered expenses for this transportation, meals, and lodging plan is \$10,000.00 for each kind of transplant.
 - 1) Transportation – from and to the place of the surgery for the patient and one companion. If the patient is minor than nineteen (19) years of age, the transportation will be covered for two companions (parents or the persons holding the custody of the patient).
 - 2) Meals and lodging – up to a maximum of \$150.00 daily per person or \$200.00 daily per two persons (parents or the persons holding the custody of the child if the patient is minor than nineteen (19) years of age).
- f. **Re-transplant**

Precertifications : Precertifications Procedure for Organ and Tissue Transplant cases

1. The referral for the transplant service will be done immediately via telephone, fax or personally at Triple-S Salud, through the information room.
2. The eligibility and coverage will be verified.
3. Once the coverage is confirmed, the specialty of the physician that made the referral will be verified and if the referral meets all the previous established medical criteria. This is in reference to all limitations and contradictions for the different types of transplants.
4. The Triple-S Salud transplant specialist will offer an initial orientation about the transplant coverage and its alternatives. A precertification will be issued for the referral to one of the Triple-S Salud Transplant Participants Network.
5. Triple-S Salud will coordinate with the selected institution in representation of the participant person and the physician, the referral to receive the Transplant services, subject to it (the selected institution) be part of the Triple-S Salud's Transplant network.
6. The Transplant Program of the selected Institution will coordinate a clinical evaluation for the transplant candidate, based on its criteria for patients selection and will keep a direct communication with Triple-S Salud.
7. The participant person will request a precertification from Triple-S Salud for the transplant services throughout all its stages.

Triple-S Salud and the selected institution will coordinate all claims for the transplant services.

PHARMACY COVERAGE (FO-02)

Benefits

This coverage is issued in consideration of the payment by your employer of the corresponding claims and administrative costs and will be subject to the terms and conditions of the basic coverage that are not in conflict with the benefits and conditions of this coverage.

This benefit follows the Food and Drug Administration (FDA) guidelines. These include dosage, drug equivalence and therapeutic classification, among others.

This coverage provides benefits for the prescription drugs included in the Prescription Drugs List, pursuant to a written prescription issued by a licensed physician or dentist to the participant member, his/her eligible dependents, if they have the pharmacy benefits and while the pharmacy coverage is in force. The dispensing of prescription drugs is subject to the copayments or coinsurances that appear in the column You Pay.

In this coverage the dispensing of generic drugs is the first option, when the generic drug is available.

This contract covers generic or brand-name medications which label contains the legend «Caution: Federal law prohibits dispensing without prescription» and insulin. Also, some Over-the-Counter (OTC) medications are covered, as established in the Limitations section. Some maintenance medications may be obtained through the mail-order pharmacy program or the 90-day drug-dispensing program at pharmacies.

The insureds covered under an individual plan, a complementary coverage to the Medicare Program (also known as Medigap) or a Medicare Advantage plan, will not be entitled to the benefits offered through this Pharmacy coverage.

The benefits are covered as follows:

- 1. Services Rendered by Participating Pharmacies:** If the medications are supplied by a participating pharmacy, it shall not charge or collect from the participating person any amount in excess of the deductible or coinsurance established.
- 2. Services rendered by Non-Participating Pharmacies in the United States of America:**

If the medications are supplied by a non-participating pharmacy in the United States of America, the participating person shall have the right to receive a reimbursement of the incurred expenses, as established in the Limitations section of this coverage, minus any applicable deductible or coinsurance as established. The medications are covered only when provided in pharmacies located in the United States of America or its possessions.

Benefits Description	You Pay
Coverage Type	
<p>This pharmacy coverage has the following principal characteristics:</p> <ul style="list-style-type: none"> • Dispatch of medications subject to a List of Medications. • Generic drugs dispatch as first option. <ul style="list-style-type: none"> ➤ Generic drugs will be dispensed as the first option, except for those drugs not available on the market. If the participant person does not choose the generic drugs as first option, he/she will have to pay the copayment for generic drugs in addition to the difference in cost between cost of the brand-name drug and the cost of the generic drug. • This pharmacy benefit requires the use of first line prescription drugs (first step) prior the use of other specific prescription drugs (second line) which are not recommended as an initial treatment to treat the same condition. The edit is assigned by our Pharmacy and Therapeutics Committee, as a clinical protocol for the use of a prescription drug after evaluating its safety, efficacy and cost and do not apply to plan members that are stable with the use of second line prescription drugs. 	<p>\$5.00 for generic drugs</p> <p>\$8.00 for preferred brand-name drugs</p> <p>\$10.00 for brand-name drugs</p> <p>20% or \$10.00 whichever is higher, for drugs outside the List of Medications (non-preferred)</p> <p>\$0 copayment for Over the Counter (OTC) medications, medications required by federal laws, including oral contraceptives and contraceptives approved by the FDA, with a prescription from the physician.</p>

Supply

1. The amount of medications supplied, as originally prescribed, shall be limited to a fifteen (15) uninterrupted day supply for non-maintenance medications.
2. Supply for thirty (30) consecutive days for some maintenance medications and for tranquilizers included in the benzodiazepines family. Refer to the Limitations section.
3. The amount of medication supplied, as originally prescribed and shall be limited to one (1) supply and up to five (5) refills for medications with a thirty- (30) day supply. The prescriptions must include a written notice from the physician surgeon authorizing the repetition.
4. Prescriptions issued by physicians with no instructions for use or amount of medication stated shall only be dispensed for a forty-eight (48) hour supply. Example: A physician writing the following instructions: "Use when necessary (PRN, by its Latin acronym)"
5. Medications shall not be refilled before a 75% of the supply has been used up from the day of the last dispense or after six (6) months from the date of the original prescription, except as otherwise is established by the legislation regulating the dispensing of controlled prescription drugs.
6. Supply for ninety (90) consecutive days for medications supplied through the mail-order pharmacy program or the 90-day drug-dispensing program at pharmacies.

Mail order program or 90-days dispensing program in participant pharmacies	You Pay
<p>The program have the following characteristic:</p> <p>Supply for ninety (90) consecutive days for medications supplied through the mail-order pharmacy program or the 90-day drug-dispensing program in participating pharmacies.</p> <p>Note: This program is limited to some maintenance drugs. The exclusions and limitations mentioned in this coverage will apply to this program.</p>	<p>\$10.00 for generic drugs</p> <p>\$16.00 for preferred brand-name drugs</p> <p>\$20.00 for brand-name drugs</p> <p>20% or \$30.00 whichever is higher outside the List of Medications (non-preferred)</p>

Limitations

1. The participant person receiving services rendered by non-participating pharmacies outside of Puerto Rico, shall have the right to receive reimbursement for medications covered in an amount not exceeding seventy five per cent (75%) of the fee established by Triple-S Salud.
2. Medications with a thirty (30) day supply are limited to: products for diabetes, including insulin, thyroid medications and its derivatives, nitroglycerin, diuretics, digital preparations, medicines for hypertension, blockers, antiarthritic, anticonvulsive, anticoagulant, hemorrheologic, sex hormones, vasodilator, oral medications for cancer, ulcers, medications for asthma, cholesterol medications, medications for Parkinson® and glaucoma. Medications for ulcers are limited to Tagamet®, Zantac®, Pepcid®, Acid®, and Carafate®.
3. Tranquilizers defined, as benzodiazepines (i.e. Valium®, Xanax®, Tranxene®, and Halcion®) will be covered only when prescribed by a psychiatrist.
4. The generic drugs will be dispensed as first option, except when they do not exist in the market.
5. Psychotherapeutic drugs will be covered with a thirty (30) day supply with refill if psychiatrist or neurologists prescribe them. If prescribed by other specialties the supply will cover fifteen (15) days without refills.
6. Drugs supplied through the Mail-Order Pharmacy Program or the 90-Day Drug-Dispensing Program are limited to some maintenance drugs.
7. The specialized products will be dispensed through the Exclusive Specialized Pharmacy Network (ESPN).
8. Over the Counter (OTC) drugs covered include: *Prilosec® OTC*, *Omeprazole OTC*, *Claritin®*, *Zaditor® OTC*, *Prevacid 24 HR OTC®*, *Alaway®*, *Zyrtec® OTC* and its generic version, as well as any other drug Triple-S Salud decides to include. Some doses of aspirin are covered for participants of eighteen years and older, and contraceptives approved by the FDA. The same are included in the List of Medications. To obtain the drug through his/her pharmacy coverage it is required that your physician writes a prescription, indicating the choice of the OTC drug and the OTC contraceptives. The rest of the OTC drugs remain excluded.
9. The Pharmacy and Therapeutics Committee will continuously review the drugs included in the List of Drugs. The List of Drugs contains those drugs considered as covered. The Pharmacy and Therapeutics Committee will evaluate each new drug for inclusion in the List of Drugs. Because of the dynamic nature of this process, the Pharmacy and Therapeutics Committee may require the inclusion or exclusion of drugs, when changes or advances in practice standards related to an illness or treatment area occur.

General Dispositions

- It will be required to present the participant card to the Triple-S Salud participating pharmacy when services are received to obtain benefits under this coverage. When medications are dispensed, the participant person shall sign for the services received and present a second identification with photograph.
 - If your physician surgeon prescribed a medication not covered in your pharmacy benefit, he/she can make you a new prescription with a covered medication. This applies when therapeutic classification is covered and other treatment options are available.
 - The continuous use of medication to treat a chronic disease is not considered as an abuse by the standards of the medical practice. Triple-S Salud reserves the right to cancel the contract or recover expenses made to any participant person when it is identified that the use of a medication is assigned to maintain some condition considered as an addiction or when the use of that same medication establishes an abuse of it, according to the methods accepted in the medical practice, even when this medication has been ordered by a physician surgeon, dental surgeon or podiatrist and aggress with the other terms of the coverage.
 - Triple-S Salud pharmacy network will provide covered services to all eligible participant person according with the pharmacy benefit manager contracted fees.
 - A pharmacy is not obligated to fill a prescription if by any reason according to its professional judgment, the same should not be filled. This does not apply to decisions made by pharmacies related to the fees established by Triple-S Salud.
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BASIC COVERAGE EXCLUSIONS

The contract does not cover the following expenses or services:

1. Services rendered while the person's plan is not in effect.
2. Services that may be received in accordance with laws for Compensation for Accidents on the Job, employer's liability, private plans for compensation for accidents on the job, automobile accidents (ACAA), and services available through state or federal legislation which the participant person is not legally obliged to pay. Such services will also be excluded when they are denied by the government agencies concerned because of noncompliance or violation of requirements or provisions of above indicated laws, even when the noncompliance or violation does not constitute a crime.
3. Services for treatment arising from the commission of a crime or violation of the laws of the Commonwealth of Puerto Rico or any other country by the covered person.
4. Services received without charge or defrayed through donations.
5. Expenses or services for personal comfort such as telephone, television or custodial services, rest home, convalescent home, or home care.
6. Services rendered by health professionals, who are not doctors of medicine or odontology, except audiologist, podiatrists, optometrists, clinical psychologists, chiropractors and others specified in the contract..
7. Expenses for physical examinations required by the employer of the participant person.
8. Reimbursement of expenses covering payments made by a participant person to any participating provider despite not being required to do so by this contract.
9. Expense for services rendered by non-participating physicians/surgeons, hospitals, laboratories, and other providers in Puerto Rico, except for emergency cases which will be covered according to the established in this contract.
10. Services that are medically unnecessary, services considered experimental or investigative in nature, as defined in the Federal Food and Drug Administration (FDA), U.S. Department of Human and Health Services (DHHS), the Commonwealth's Department of Health, or services that are not in accord with the medical contract established by the Technology Evaluation Coverage Manual (TEC) of the Blue Cross and Blue Shield Association for specific indications and methods ordered.
11. Expenses or services for new medical procedures not considered experimental or of an investigative nature until such time as Triple-S Salud determine its inclusion in the coverage offered under this contract. Besides, medical expenses related to clinical trials, tests and medications administered to be used as part of the studies, are not covered neither the medical expenses that must be paid by the entity carrying out the study. This provision also applies when the participant person enrolls to the clinical trial to treat an illness that should threatens his/her life, for which there is no an effective treatment and obtain his/her physician authorization for participate in the study, because this one offers the patient a potential of life. In this case, Triple-S Salud will cover the patient's routine medical expenses, be it understood that Triple-S Salud does not consider the medical expenses related to the clinical trial, the tests to be used as part of the study or the expenses that must be paid by the entity conducting the clinical trial. Once included in coverage, Triple-S Salud will pay for those services an amount that is not greater than the average amount it would have paid if the medical service had been rendered through conventional methods, until such time a fee is established for those procedures.

12. Expenses for cosmetic surgery or beautification, treatment to correct defects of physical appearance, mammoplasties or plastic reconstruction of the breast to reduce or increase its size (except for a reconstruction after a breast cancer mastectomy), surgical intervention and medical treatment whose purpose is to control obesity, except for morbid obesity treated in Puerto Rico; liposuction treatment, abdominoplasty and abdominal rhytidectomy, and sclerotic solutions injected into varicose veins of the legs. In addition, hospital, medical/surgical services and complications associated to these are excluded independently of the existence or nonexistence of medical justification for the procedure.
13. Expenses for orthopedic or orthotic devices, prosthesis, or implants (except for breast prosthesis after a mastectomy) among other artificial instruments. Hospital and medical/surgical services necessary for implantation of these will be covered.
14. Expenses for contraceptive devices, except those required by the Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA), the Health Care and Education Reconciliation Act de 2010, Public Law No. 111-152 (HCERA). In addition, related services and complications are also excluded.
15. Surgical intervention whose purpose is to surgically reestablish the ability to procreate. In addition, hospital services and employed complications are excluded.
16. Services for treatment for infertility or related to insemination through artificial means. In addition, hospital and medical/surgical services, and related complications are excluded.
17. Expenses for scalenotomy services - division of the scalene anticus muscle without resection of the cervical rib.
18. Expenses brought about by the transplant of organs and tissues (e.g., heart, heart-lung, kidney, liver, pancreas, bone marrow, etc.). Additionally, hospitalization, pre-transplant evaluation, complications, chemotherapy and immune suppressant medications related to transplants are excluded. Those organ and tissue transplants specifically included in the contract y will be covered.
19. Expenses for medical services in acupuncture treatment, tympanometry, and interpretation of fetal monitoring.
20. Expenses for sports medicine, natural medicine, musical therapy, psychoanalysis, cardiac rehabilitation and Positron Emission Tomography (PET).
21. Expenses for occupational therapy or speech therapy, except for those that are rendered as post-hospitalization services.
22. Intravenous analgesia services or analgesia administered through inhalation in the office of the oral surgeon or dentist.
23. Surgical assistance services, regardless if there is a medical justification for it.
24. Dental or odontology. In addition, hospital, medical/surgical services and complications associated to them.
25. Services necessary for the treatment of the temporomandibular articulation syndrome (articulation of the jawbone) whether by the application of prosthesis devices or using any other method to correct the condition.
26. Expenses for the excision of granulomas or radicular cysts (periapical) originated by infection of the tooth pulp; services necessary to correct the vertical dimension or occlusion, removal of exostosis (mandibular or maxillary torus, etc.).
27. Expenses related with materials for orthognatic surgical (Mandibular and maxillary osteotomy [Le Fort])
28. Expenses for allergy immunotherapy.
29. Services rendered covering an induced abortion.
30. Services rendered in Ambulatory Surgery Centers for procedures that may be performed in the surgeon's office.

31. Hospitalizations for services or procedures that can be performed in an ambulatory manner.
32. Expenses for services resulting from the administration of an employer drug detection program as well as any rehabilitation treatment if the participant person results positive. If the participant person enrolls in a rehabilitation treatment because of the positive result in the drug detection test, he/she is eligible to the rehabilitation treatment benefit covered by this contract whenever it is not related to the mentioned program.
33. Expenses brought about by war or international armed conflict.
34. Laboratory tests that do not have codes in the laboratory manual, will be evaluated individually before being considered for payment and Triple-S Salud determines its' inclusion or exclusion in the coverage under this contract. Triple-S Salud will determine the laboratory tests that will be covered under this contract. The laboratory tests considered experimental or investigative will not be considered for payment by Triple-S Salud.
35. Immunizations for intentions of trips or against occupational dangers and risks.
36. Expenses for sea ambulance.
37. Services rendered by residential treatment facilities outside of Puerto Rico, whether a medical justification exists or not.
38. Surgeries for the removal of excess skin, except if the physician certifies that it is necessary to remove the skin because it affects a body part function.
39. Expenses for Thin Prep Pap and Color Doppler Flow.

MAJOR MEDICAL COVERAGE EXCLUSIONS

The exclusions of the Basic Coverage for hospitalization, medical-surgical, and ambulatory services will apply to this coverage, except those services that are specifically mentioned as covered services. The excess of the established limitations in the basic coverage will be covered without limit, or as provided by this coverage.

This coverage does not cover the following expenses:

1. Those caused by war or armed international conflict.
2. Dental services for the care and treatment of teeth and gums.
3. Eyeglasses, orthopedic or orthotics instruments, except those needed due to accidental injuries.
4. Services during confinement in an institution which is, primarily a school, an institution for training, a place of rest, a place for the aged, or a nursing home.
5. Services rendered by a social worker including a psychological or psychiatric social worker.
6. Air or sea ambulance services.
7. Services for chronic renal disease such as dialysis and hemodialysis, including hospital and medical-surgical services and associated complications.
8. Expenses for post-hospitalization services in a Skilled Nursing Facility Care or in a Home Health Care.
9. Expenses for copayments and coinsurance that are applicable to the basic contract of hospitalization, medical-surgical, ambulatory services, and its riders.

ORGAN AND TISSUE TRANSPLANT EXCLUSIONS

This contract does not cover the following expenses or services:

1. Services rendered while the contract is not in force.
2. Services available with a federal or state arrangement for which the participant person does not have to pay. Said services will be also excluded when they are denied by the related government agency, regarding breach or violation of the requirements or dispositions of the laws stated before, even when said violation or breach does not constitute a crime.
3. Services for treatment arising from the commission of a crime or violation of the laws of the Commonwealth of Puerto Rico or any other country by the covered person.
4. Services received without charge or defrayed through donations.
5. Expenses or services for personal comfort such as telephone, television or custodial services, rest home, convalescent home, or home care.
6. Services rendered by health professionals, who are not doctors of medicine or odontology, except audiologist, podiatrists, optometrists, clinical psychologists, chiropractors, and others specified in the contract.
7. Reimbursement of expenses covering payments made by an participant to any participating provider despite not being required to do so by this contract.
8. Services that are medically unnecessary, services considered experimental or investigative in nature, as defined in the

Federal Food and Drug Administration (FDA), U.S. Department of Human and Health Services (DHHS), the Commonwealth's Department of Health, or services that are not in accord with the medical contract established by the Technology Evaluation Coverage Manual (TEC) of the Blue Cross and Blue Shield Association for specific indications and methods ordered.

9. Expenses or services for new medical procedures not considered experimental or of an investigative nature until such time as Triple-S Salud determine its inclusion in the coverage offered under this contract. Once included in coverage, Triple-S Salud will pay for those services an amount that is not greater than the average amount it would have paid if the medical service had been rendered through conventional methods, until such time a fee is established for those procedures.
10. Expenses and services related to organ and tissue transplant or received without a precertification of Triple-S Salud or its authorized representative.
11. Expenses or services for procedures done to participants with neurological and severe physical damage, with presence of an existent sickness that may shorten the life expectancy of the participant, or that said participant presents a bad adaptive psychiatrist or social condition.
12. Expenses brought about by war or international armed conflict.
13. Expenses for special nurses services and home visits.
14. Rendered services by air or sea ambulance.

PHARMACY COVERAGE EXCLUSIONS

The exclusions of the basic coverage for hospitalization, medical-surgical, and ambulatory services apply to this coverage, except those services that are mentioned specifically as covered services. Triple-S Salud will not be responsible for the charges that correspond to the following benefits:

1. Medications which do not bear on their labels the legend: *Caution: Federal law prohibits dispensing without prescription ([OTC] over the counter)*, except those medications included in the Triple-S Salud's OTC program and some doses of aspirin for insureds of eighteen years and older.
2. Charges for artificial instruments (needles, syringes, lancets strips, glucometers and similar instruments, whether used or not with therapeutically purposes.
3. The following medications are not covered whether or not they bear the federal legend: *"Caution: Federal law prohibits dispensing without prescription"* and are in the List of Medications.
 - a. Cosmetic medications or any related products with the same purpose (hydroquinone, minoxidil solution, efformitine, finasteride, monobenzone, dihydroxyacetone and bimatropost).
 - b. Fluoride products for dental use (except for children between six months and six years of age) and dermatological conditions such as pediculosis or scabies (lindane, permethrin, crotamiton, malathion and ivermectin); dandruff control products including shampoos (pyrithione zinc 1%), lotions and soaps: baldness control treatments as Rogaine® (minoxidil topical soln) and pain medications (Nubain® and Stadol®).
 - c. Obesity control and related medications used in its treatment (benzphetamine, diethylpropion, phendimetrazine, phentermine and mazindol).
 - d. Diet products (Foltx®, Metanx®, Limbrel® and Folbalin Plus®).
 - e. Infertility medications (follitropin, clomiphene, menotropins and urofollitropin), fertility medications, impotence treatment (tadalafil, alprostadil, vardefanil, sildenafil and yohimibna) or implant medications (levonorgestrel implant, goserelin, sodium hyaluronate, hyaluronan and hylan).
 - f. Medications used as diagnostic tool (*thyrotropin, dipyridamole IV 5mg/ml, gonadorelin HCl, cosyntropin y glucagon*) and medications for immunization (hepatitis A & B, influenza, encephalitis, measles, mumps, poliovirus, papillomavirus, rabies, rotavirus, rubella, varicella, yellow fever, zoster, cholera, haemophilus b, lyme disease, meningococcal, plague, pneumococcal, typhoid, tetanus toxoid, diphteria, immune globulin, respiratory syncytial virus, palivizumab, pagademase bovine, staphage lyphates **and it's combinations**, allergy tests).
 - g. Products used as vitamins and nutritional supplements for oral use, except for some doses of folic acid for women and some presentations of iron supplements for children between six months and twelve years of age, 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.
 - h. Oral vitamins (alone or combined with other vitamins minerals and folic acid) and injectable (niacin, ascorbic acid, thiamine riboflavin, vitamin E, pyridoxine

dihidrotaquisterol, multivitamins with minerals, multivitamins with iron, multivitamins with calcium, B vitamin complex-biotin-D- folic acid, B-complex with vitamin C –folic acid and flavonoids).

- i. Medication classified as alternative medicine treatment (valerian root, european mistletoe, glucosamine-chondroitin-PABA-vitamin E, and alpha lipoic acid).
4. Products that are considered experimental or investigative for the treatment of certain conditions for which the Food and Drug Administration has not authorized their use. In addition, this policy does not cover medical expenses related to clinical trials, nor the tests and medications administered as part of the trials, or the medical and pharmacy expenses that are to be paid by the entities conducting the clinical trials. This clause is applicable even if the plan member has enrolled in a clinical trial to treat a life-threatening condition for which there is not effective treatment and if the physician has approved the plan member's participation in said trial because it offers the patient potential benefit.
5. Services rendered by non-participating pharmacies in Puerto Rico.
6. Refills ordered by a dentist or podiatrist.
7. Expenses for anti-neoplastic injectable agents.
8. Contraceptive methods as well as the services and any complications related to them, except those required for women by the federal law.
9. Any new medication of the excluded therapeutic classifications (category) will also be considered as an exclusion.
10. Triple-S Salud reserves the right to choose those prescription drugs it will include in its pharmacy coverage. Any expense for new prescription drugs will not be covered until said prescription drug is evaluated and Triple-S Salud Pharmacy and Therapeutics Committee recommends its inclusion in the Prescription Drug Coverage.
11. Also are excluded trypan blue solution, lacosamide IV, carmustine intracranial implants (wafer), degarelix acetate IV, viaspan, sodium tetradecyl sulfate, polidocanol, morrhuate sodium, intrapleural talc, peritoneal dialysis solution, and homeopathic products in all presentations.
12. Medications for organ and tissue transplant (cyclosporine modified, tacrolimus, sirolimus, cyclosporine, mycophenolate sodium, everolimus, azathropin, belatacept and basiliximab).
13. Blood and its components (hetastarch 6%/NaCl IV, rheomacrodex IV, human albumin and plasma protein fraction).
14. Contraceptives that are not approved by the FDA. In addition, contraceptives approved by the FDA without presentation of a doctor's prescription will not be covered.
15. Acne medications (*adapalene, benzoyl peroxide, isotretinoin, sulfur, tretinoin, clindamycin phosphate topical, erythromycin topical, sodium sulfacetamide/sulfur and it's combinations*).
16. Smoking control products, (*bupropion HCL (smoking deterrent), vareniciline*).
17. Growth hormones (*somatropin, somatrem*).
18. Nutrients (*Dextrose, Lyposyn, Fructose, Alanicem, L-Carnitine, Tryptophan*).
19. Anaphylaxis medications (*epinephrine device*).

REIMBURSEMENTS PROCEDURE

Claims for reimbursement:

- a. Must be sent to: Triple-S Salud, PO Box 363628, San Juan, PR 00936-3628; and
- b. Must include the following:
 - Name and contract number of the participant person who received the service.
 - Date of service
 - Diagnosis code (ICD-9)
 - CPT code
 - National Provider Identifier (NPI)
 - Stamp or letterhead with provider's name, address, and specialty
 - Number and description of services received
 - Amount paid
 - Provider or participant signature and licensee
 - Reason for requesting reimbursement
 - In the case of ambulance services, you must include information about the distance traveled, as well as evidence of medical necessity.
 - For services that require a Preauthorization, include a copy of the Preauthorization.
 - In cases where surgical assistance was needed, please send a copy of the surgery report indicating the participation of the surgical assistant. If the surgery report does not indicate the participation of the surgical assistant, please submit a certification from the surgeon.

To request reimbursement for pharmacy services include:

- Official receipt from the pharmacy.
- Name and number of the contract of the participant person receiving the services.

- Name of the medication
 - Daily dosis
 - Number of the prescription
 - Amount dispensed
 - National code of the medication (NDC)
 - National Provider Identifier (NPI) of the pharmacy and the doctor who prescribes
 - If you paid a participating pharmacy: indicate the reason
 - Indicate cost per medication
2. You must send Triple-S Salud written notice of the claim within 20 days following the date the service was received, or as soon as it is reasonably possible for the participant person or the employer, as long as it does not exceed a one-year term from the date the service was rendered.
 3. Triple-S Salud has up to 15 days to send an acknowledgement of receipt after it receives the claim. Notifications sent to any of the persons designated by the participant to receive claims on his behalf will be considered notifications sent to the participant, as long as the authorization is valid and has not been revoked. If the person is not authorized, and receives a notification on behalf of the participant, the person must inform it to the claimant within the next 7 days and must indicate us the name and the address of the person that should receive the notification.
 4. Triple-S Salud will conduct the investigation, make the adjustment and solve any claim in the shortest period within 90 days after it received the request. If Triple-S Salud cannot solve the situation within the term previously stated, it will keep in its records the documents evidencing a fair cause to exceed this term. The Insurance Commissioner has the authority to request the immediate solution of any claim, if he understands that the process is being delayed unduly and unreasonably.

PREAUTHORIZATION

Triple-S Salud offers quality care. For this reason, the Preauthorization process is available. This guarantees that you and your family will receive the adequate level of care for your health condition. The purpose of the Preauthorization is to establish coordinated care measures to ensure that hospital and ambulatory services are rendered in an adequate place, at the moment needed and by the adequate professional. It also helps to verify the participant person's eligibility for the service he/she is requesting.

The physician, hospital, or facility are oriented on those services must be preauthorized. The Preauthorization may be for a hospital or for ambulatory services.

Requests of preauthorization for studies and procedures will be made by the attending physician, the clinical personnel he/she designates or the facility where you will receive the service. The person may call to Triple-S Salud Preauthorizations Department, Triple-S Salud' call center that attends to these cases Monday to Friday from 7:00 a.m. to 6:00 p.m. Providers can also precertify some tests and procedures using our portal on the Internet www.ssspr.com available 24 hours 7 days.

Some of the services for which you or your physician must request a preauthorization to Triple-S Salud, as long as your coverage includes them, are:

- Organ and tissue transplants
- Services in the United States
- Maxillary or mandibular osteotomy

For preauthorizations or if at the moment you need a medical service you have any question on whether or not you should request a preauthorization, or if you need additional information, contact our Customer Service Department at (787) 774-6060.

You may submit the required information by fax or mail.

Main Office: (787) 749-0265

Regional offices' fax numbers:

Arecibo: (787) 817-2609

Caguas: (787) 706-4030

Mayaguez: (787) 833-4960

Ponce: (787) 843-1722

Mail:

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

PREAUTHORIZATION PROCEDURE

Triple-S Salud has 15 days from the receipt of the precertification for elective procedures to:

- a. Notify their benefit determination; or
- b. Request you additional information. You will have 45 days to provide the information requested.
- c. Inform you that they need more time to make their determination. This extension may be of up to fifteen (15) days.

PRECERTIFICATIONS IN URGENT CASES

You may need Triple-S Salud to consider your precertification request urgently. This may be due to a health condition which, according to the opinion of the attending 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 care or treatment for which precertification is requested. In said cases, the attending physician must certify the urgency of the precertification. The request in these cases may be oral or in writing. 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 48 hours 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 date of expiry 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 code of the denial and its meaning, as well as a description of the standards, if any, used for the determination;
- Reference to the specific provisions of the plan on which they based their determination;
- 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 and expedite review procedures, including the terms 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 participant person free of charge;
- If the adverse determination considered the judgment of medical necessity, in the experimental or investigative 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 participant person.

You have the right to contact the Office of the Insurance Commissioner or the Health Ombudsman to request help at any moment and have the right to file a lawsuit in a competent court when you exhaust Triple-S internal grievance procedures. The Office of the Insurance Commissioner is located at GAM Tower, Urb. Caparra Hills Industrial Park, 2 Tabonuco Street suite 400, Guaynabo, PR, and you can contact them at (787) 304-8686. The Office of the Health Ombudsman is located at Mercantil Plaza, 1501 Ponce de León Ave., Hato Rey, PR and you can contact them at (787) 977-

0909 (Metro Area) or the toll-free number 1-800-981-0031.

**EXPEDITE (FAST) APPEALS OF
PRECERTIFICATIONS DENIED ON URGENT
CASES**

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

PRECERTIFICATIONS FOR PRESCRIPTION DRUGS

Certain prescription drugs need a precertification for the patient to obtain them. Prescription drugs that require a precertification are usually those that may have adverse side effects, are candidates to inappropriate use, or related to high costs.

The physicians and the pharmacies are instructed on the prescription drugs that must be precertified.

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

PROCEDURE FOR THE TRANSMITTAL OF PRECERTIFICATIONS

Triple-S Salud has a period of 72 hours (3 days) from the receipt of the prescription drug precertification request for the following:

- a. Notify its determination or
- b. Request documentation to the physician, the participant, or the pharmacy, if it has not received the documentation required.

If the requested documentation for the evaluation of the prescription drug is not received within 72 hours, Triple-S will send a notice to the participant requesting the additional information needed within a term that does not exceed 45 days. The participant may send the information by fax, identifying said information with his contract number.

If Triple-S Salud does not make a determination regarding the precertification request or notifies the participant within the established term (72 hours; 36 for controlled prescription drugs) the participant will have the right to receive a thirty (30)-day supply of the prescription drug object of the precertification request, as requested or prescribed, or in the case of step therapy, for the terms provided by in the coverage.

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

EXCEPTION PROCESS FOR PRESCRIPTION DRUGS

The participant can request Triple-S Salud to make an exception to the coverage rules as long as the prescription drug is not exclusion. An exception is when the participant requests us to cover a prescription drug that is not included in his pharmacy benefit.

There are prescription drugs that are classified as categorical exclusion. This means that the plan has established a specific provision for not covering a prescription drug identifying it by its scientific or commercial name.

Types of exceptions

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

- The participant can request us to cover his prescription drug even when it is not in our Formulary or Prescription Drug List.
- The participant can request us to cover a medication that has been or will be removed from the Formulary or Prescription Drug List.
- The participant can request us a handling exception, which implies that the drug prescribed will not be covered until the participant complies with the step therapy requirement or that has a limit to the amount to be dispensed.
- The participant can request us a duplicate therapy exception if there is a change in doses or the physician has prescribed another drug from the same therapeutic category.
- Another exception the plan can grant is for prescription drugs whose use do not have the approval of the Food and Drugs Administration (FDA). These prescription drugs are usually not covered, except in those health conditions in which its efficiency has been proved for that other

use, according to reference books that include the medical categories for their approval or denial.

How to make the request

The participant, his authorized representative, or the prescribing physician can request the exception request through:

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

Information required for the approval of your exception request

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

- Name of the patient
- Contract number
- Primary diagnosis
- Reason for which the participant cannot use none of the prescription drugs:
 - In the formulary that is a clinically acceptable option to treat the illness or the medical condition; e
 - The first step prescription drug in step therapy
- Reason for which a greater dose is required or why the physician prescribes another prescription drug of the same therapeutic category.

How Triple-S Salud processes a prescription drug by exception

Triple-S Salud has a timeframe of 72 hours from the date it receives the request, or the date of receipt of the communication, to notify the participant or his personal representative its determination on the exception request. In case of controlled drugs, the term will not exceed 36 hours. If we do not receive the information, we will proceed to close the request and will send a notification the person. However, closing the application request does not mean that the participant person cannot submit such claim again.

Triple-S Salud will request the prescribing physician or the pharmacy the information necessary to evaluate the request by telephone, fax or any other electronic means.

In case it was the participant the one who submitted the request, the person will be contacted by telephone and will be indicated the additional information that must be provided by the prescribing physician to evaluate the case, the time he has to send it and the fax to which he must send the information.

If we do not receive the information within the timeframe set, we will proceed to close the case for lack of information. We will notify in the denial letter the appeal process and the details of the information that was missing. The notification will be sent to the participant person and, if applicable, to his personal representative and the physician prescribing the prescription. However, closing the request does not mean that the participant person cannot submit said claim again.

If Triple-S Salud, does not make its determination within the timeframe set (72 hours; 36 hours for controlled drugs) the participant will be entitled to receive a 30-day supply of the drug object of the request, as requested or prescribed, or in the case of step therapy, for the terms provided by the coverage.

Triple-S Salud will make a determination regarding the exception request before the person finishes the prescription drug provided. If the determination is not made and the notification is not issued during this period, coverage will be maintained in the same terms and continuously. This, as long as the prescription drug is being prescribed and is considered to be safe, and until the limits of the applicable benefits are fully spent.

Coverage-determination-notification process

The process for notifying a denial in cases that do not comply with the non-coverage criteria of the Formulary, precertification, step therapy, quantity limit, duplicate therapy, use not approved by the FDA, includes:

- The specific reasons for turning the request down;
- References to the evidence or documentation, which include the clinical review criteria, practice guidelines as well as clinical and medical evidence considered to make the determination to deny the request;
- Instructions on how to request a written statement of the clinical, medical or scientific justification for turning the request down; and
- Description of the process and the procedures to submit a grievance to appeal the denial.

The denial will be issued in a manner that the participant person can easily understand, or if applicable, easy to understand to his personal representative. If we turn down an exception request, the participant person or the physician may appeal our determination through the process of Appeals to Adverse Benefits determinations.

Right to Appeal an Adverse Determination For IATSE National Health & Welfare Fund Participants

- **Adverse Determination** - is a determination that includes a denial, reduction or termination of your coverage or a failure to make a payment for a particular benefit when the adverse determination has been based on:
 - Eligibility to the plan
 - A service not covered by the plan
 - Exclusion for a preexisting condition; on an exclusion based on how the injury or illness occurred; or an exclusion from a provider in the provider's network or other limitations on covered services.
 - An experimental, investigative, or not medically necessary or appropriate service.

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

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

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

RIGHT TO APPEAL AN ADVERSE DETERMINATION OF COVERAGE

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

APPEALS PROCEDURE

1. First Internal Level of Appeal

You or your authorized representative (refer to the requirements for appointing a representative, as described later in this document), must submit your

appeal, in writing, within 180 days following the date you received the notification on adverse determination. When you submit your appeal, you may request assistance from the Patients' Advocate, the Ombudsman or a lawyer of your preference (at your cost). For your appeal to be considered, it must include the following, if applicable:

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

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

If your case is considered to be Urgent, Triple-S Salud will notify its decision within a period that does not exceed 72 hours, from the date the completed application for appeal was received. Incomplete applications will not be considered, until they meet the requirements thereof. Urgent appeals means those appeal requests that correspond to services or medical treatment in which the timeframe to complete the regular appeal process (a) may jeopardize the life or the health of the plan member or the ability of a vital organ of the body to function at its maximum capacity, (b) or by physician's opinion the participant person may be under severe pain that can't be handled without medical care or treatment subject to the appeal.

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

2. Second Internal Level of Appeal:

If you do not agree with Triple-S Salud's decision on your first appeal, you have the right to request a second appeal within 60 days from the date Triple-S Salud notified its decision on your first appeal. With this second request for appeal, you must include a copy of all the documents related to your first appeal, a statement explaining why you believe Triple-S Salud's decision on your first appeal was incorrect and additional evidence to support your allegations.

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

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

3. External Appeal Process:

If you do not agree with the determination made in the second internal level of appeal, you have the right

to an external appeal administered by Empire BlueCross BlueShield on behalf of the IATSE National Health & Welfare Fund. Please contact Empire at the address below:

Empire BlueCross BlueShield
Medical Management Appeals Department
Mail Drop 60
PO Box 11825
Albany, NY 12211

You or your authorized representative may submit the request for external evaluation if:

- 1) Your case determination involves medical judgment (for example: medical need, effectiveness of the treatment received or to be received, level of care, among others)., or
- 2) Rescission of Coverage, as previously defined.

Case determinations based on coverage exclusions are not eligible for external appeal.

When to Request External Review

You must submit your request for external review in writing and mail it to Empire BlueCross BlueShield at the address above (but see below for Urgent Care Claims). To be eligible for External Review you must 1) first exhaust the two levels of internal appeals described above and 2) submit your request within four months of the notice that your claim was denied after the second level of review.

How to Request External Review

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

External Review for Urgent Care Claims

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

In urgent care cases, you may begin a request for expedite external evaluation by calling toll-free at 800-634-5605. In these cases the examiner must provide the final determination as soon as your medical conditions require and never later than 72 hour from the date it received the request. If you have an urgent care situation and you are being treated for this condition, the final determination must be notified within 24 hours. In these cases the examiner can provide the notification orally, but must issue the written notice within 48 hours.

Where to Find More Information about External Review

For more information about External Appeals, please review the Summary Plan Description for the IATSE National Health & Welfare Fund, available on its website, www.iatsenbf.org, or upon request, 1-800-456-FUND (3863). You may also contact Empire BlueCross BlueShield directly by calling toll-free at (800) 634-5605.

4. Limitation on When a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review. If the final decision is adverse to you, you have the right to bring a civil action under ERISA § 502(a). The law also permits

you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act (ERISA) without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than three years after the end of the year in which medical services were provided

RIGHT TO BE ASSISTED

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

RIGHT TO APPOINT A REPRESENTATIVE

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

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

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

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

**IMPORTANT NOTICE FOR PERSONS WITH
MEDICARE.**

**THIS INSURANCE PLAN MAY DUPLICATE SOME
MEDICARE BENEFITS**

**This is not a complementary insurance towards
Medicare**

This insurance plan provides limited benefits, if you comply with the conditions of this contract for expenses related to the specific services numbered in this contract. You will not pay your copayments or coinsurances to Medicare and it is not a substitute complementary insurance to Medicare.

**This insurance plan duplicates Medicare's
benefits when:**

- Some of the services covered by this contract are also covered by Medicare.

Medicare pays for extended benefits for services medically necessary without having the reason for which you may need it. These include:

- Hospitalization
- Medical services
- Other approved services

Before you buy this Insurance

- ✓ Verify the coverage in all of the health plan policies that you may have.
- ✓ For more information about Medicare and the complementary insurance for Medicare, revise the Health Insurance Guide for persons with Medicare available through the insurance company.
- ✓ In order to receive assistance for the understanding of your health insurance plan, please contact the Office of the Insurance Commissioner of Puerto Rico or with an insurance orientation governmental program for advanced aged persons.

GENERAL DISPOSITIONS

- 1. BENEFIT CERTIFICATES:** Triple-S Salud will issue the contract holder an individual certificate to be given to every participant person, stating the protection to which each participant person is entitled. In addition, Triple-S Salud will provide a list of Triple-S Salud participating suppliers to every participant person.
- 2. BLUECARD PROGRAM:** Triple-S is an independent licensee of the Blue Cross Blue Shield Association (BSBSA). Like other Blue plans, Triple-S participates in a program called BlueCard. Triple-S participants who receive covered services outside Puerto Rico benefit from this program.

This benefit translates into savings for the participant, who is responsible for paying any applicable coinsurance, copayment or deductible for the services that he or she receives. When these services are received outside Puerto Rico, the claims are generally processed through the BlueCard Program. If the claims are in fact processed through BlueCard, the applicable amount for the coinsurance, copayment or deductible will be determined based on the least amount between the sum billed by the provider and the negotiated fee that Triple-S pays the Blue plan of the area where the services were received.

Under the BlueCard Program, when participants receive covered health-care services within the geographic service area of the Host Blue, Triple-S will be continue to be responsible to you for the compliance with contract obligations. However, the Host Blue will only be responsible, in accordance with applicable BlueCard Program policies, if existing, for providing services such as contracting with its participating providers and handle all interaction with their participant providers.

The computation of your responsibility for claims for covered health-care services received outside Triple-S' geographic area and processed by the BlueCard Program will be determined based on the fee that Triple-S pays to the Host Blue.

The methods used by a Host Blue to determine a negotiated fee vary among Host Blues, depending on the conditions of the contracts with their respective providers. In those cases in which claims for rendered services are paid based on the negotiated amount or fee, the fee can represent:

1. the billed fee.
2. an estimated amount (equivalent to an adjustment of the total estimated payments resulting from the agreements or other arrangements between the Host Blue with its participating providers).
3. a discount from the billed charges (equivalent to the average savings that the Host Blue expects to receive from every one or a specific group of its participant providers).

The Host Blue can prospectively adjust the estimated amount or average discount to correct the previous fees in the BlueCard Program's claims, if the payments were underestimated or overestimated. However, the amount paid by the employee is a final fee and will not be affected by those prospective adjustments. In addition, the use of a liability calculation method of Estimated Price or Average Price may result in some portion of the amount paid by the group being held in a variance account by the Host Blue Plan, pending settlement with its participating providers. Because all amounts paid are final, the funds held in a variance account, if any, do not belong to the group and are eventually exhausted by provider settlements and through prospective adjustment to the negotiated prices.

Nevertheless, the laws of some states may require a Host Blue either to use a basis for calculating the coinsurance, copayment or deductible for covered services that does not reflect the entire savings realized or expected, on a particular claim, or to add a surcharge. In these cases, the amount of the coinsurance, copayment or deductible will be determined based on the methods established by the laws of that state.

Refund of Overpayments

The BlueCard Program requires that the Host Blue where the participant received the service and the provider that rendered the service refund any excess payment that they have received, which has been identified, whether or not in the course of an audit or payment review. In these cases the Host Blue is allowed to deduct from the total recovered any amount that it must pay to a third party that helps it identify or recover the amount paid in excess. After making the applicable deduction, the net amount recovered, if any, will generally be applied through a claim-by-claim adjustment or prospective adjustment, as established by the BlueCard Program.

BlueCard Program Fees

The group will reimburse to Triple-S the fees that it has to pay as required by the BlueCard Program to the Host Blue Plans of the place where the participant received services, to the Blue Cross and Blue Shield Association and to the other providers that render services through the BlueCard Program. Some of these fees are determined per processed claim. In this case, the fees may be charges for access or administrative expenses, Central Financial Agency fees and for transactions of ITS. Other BlueCard Program fees can be for the 800 number and the provider directory. According to BlueCard Program procedures, the BlueCard Program fees can be revised from time to time.

One may communicate with a Triple-S representative if one wishes to have a list of the charges for BlueCard Program fees.

The participant person could identify available facilities that participate in the BlueCard program, through the website www.bcbs.com or by calling our Customer Service Centers at the numbers located at the back of the plan card.

3. **CIVIL ACTIONS:** No civil action may be taken to claim any rights of the participant person under this contract before sixty (60) days have elapsed after written proof of the service has been submitted, according to the requirements of this contract. No action may 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.

Triple-S Salud will not be obliged to respond to the participant person for any act or omission of fact or right that, due to the negligence of the provider or any other cause, is reason for claim by the participant person and circumstance under which the provider may be liable.

4. **CLAIM PAYMENTS:** The benefits provided under this contract will be paid to the participating professional or provider, or directly to the participant person if a non-participating facility or provider was used or services were received, even if rendered by participating providers, are paid based on reimbursement, as long as all reports and evidenced required by Triple-S Salud is submitted. All claims must be submitted no later than one (1) year from the date the service was received. Once the notice about the claim has been received, Triple-S Salud will send the participant person the model of the Reimbursement Request Form. If this model is not provided within fifteen (15) days from the date Triple-S Salud received the claim notice, Triple-S Salud will not be able to deny the claim for the simple fact that it was not submitted in the model form, as long as the participant person presents his claim on time along with all the supplementary documents necessary to process it.
5. **COBRA (Consolidated Omnibus Budget Reconciliation Act):** Coverage under COBRA will be provided in accordance with the Fund's rules.
6. **CONFIDENTIALITY:** Triple-S Salud will maintain the confidentiality of your medical information and claims. Only the following people will have access to it:
 - a. Triple-S Salud and its contractors when both are the administrators of the contract;
 - b. Public officials investigating or filing a judicial or civil action;
 - c. Bona fide individuals participating in an educational or medical

investigation in which the identity of the participant person is not necessary; or

- d. When according to a federal or state law, a reimbursement related with a National Medical Support Notice and subject to an order or resolution of an authorized administrative agency or court is paid to a different person other than the main holder.

7. CONVERSION CLAUSE:

- a. If coverage under this contract ends because of termination of the participating person employment or because the person belongs to a class or classes of eligible for coverage under the contract, that person has the right to have Triple-S issue a Direct Payment Policy without evidence of insurability. Triple S Direct policies available for conversion are Triple S Direct or Triple S Direct Plus Alternative I, exclusively.

Written application for the Direct Payment Policy will be processed and the first premium will be paid to Triple-S on or before thirty-one (31) days after the end of said cessation, and, in addition:

- 1) The participant person will be able to select the Direct Payment Policy that is most convenient among the plans offered under this clause and his/her coverage will be subject to the terms and conditions of the Direct Payment Insurance Policy.
- 2) The Direct Payment Policy premium will be in accordance with the fee in effect at Triple-S applicable to the form and the benefits of the Direct Payment Policy, according to the risk category to which that person belongs at that moment and the age reached by the Direct Payment Policy's effective date. The health at the time of the conversion will not be an acceptable basis on which to determine a risk classification.
- 3) The Direct Payment Policy should also cover the participant person

spouse or direct dependents if they were covered on the date of termination of the group plan. At Triple-S' option, a separate Direct Payment Policy may be issued to cover the spouse or direct dependents.

- 4) The Direct Payment Policy will be active upon termination of coverage under the group contract.
 - 5) Triple-S will not be obligated to issue a Direct Payment Policy to cover a person who has the right to receive similar benefits under any insurance coverage or under the Medicare Program of the Social Security Act, as amended, if such benefits, provided simultaneously under the Direct Payment Policy, would result in over the plan according to the insurer's standards.
- b. If this group plan ends or is amended in such a way as to terminate the coverage of any category of participant person, all persons included in that group plan by the date of termination and whose contract terminates after having been participating under the plan for at least three (3) years before the date of said cessation, will have the right to have Triple-S issue a Direct Payment Policy subject to the conditions and limitations provided by clause 1 of this section.
 - c. Subject to the conditions and limitations under clause 1 of this section, the privilege of conversion will be granted to:
 - 1) the spouse or direct dependents of the participant person whose coverage under the group contract ceases because of the death of that person;
 - 2) the spouse or direct dependents of the person whose coverage ceases because they do not qualify as family members under the group contract even though the participant person continues to be covered under the group plan;

d. If a participant person under the group contract loses coverage under the Direct Payment Policy described in clause 1 of this section, while he/she qualifies for the Direct Payment Policy issued, but before the Direct Payment Policy is in effect, the benefits for which he/she would be eligible under such policy will be payable by claim against the group contract although a Direct Payment Policy has not been requested nor payment of the first premium been effected.

e. If an individual participant under this group contract acquires the right to obtain a Direct Payment Policy under the terms of the group contract without evidence of insurability, subject to applying and paying the first premium within the period specified in the contract, 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 contract beyond the period provided in the contract.

The additional period expires 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 date of expiration provided in the contract. A written notice delivered to the individual or mailed by the contract holder to the last known address of the individual will be considered notice according to this paragraph. If an additional period is granted to exercise the right to conversion, as provided here, and if the written application for said Direct Payment Policy, accompanied by the first premium, is made during the additional period, the Direct Payment Policy enter into effect upon termination of the plan under the group contract.

f. Subject to the other conditions stated above, the participant person will have conversion rights, as long as the group plan premium has been paid up to one of the following dates. Provided that, in

order to apply to the right of conversion, the participant person will update the payment of the premium, in the event that his/her employer has not done so.

- 1) Date of termination of employment; or
- 2) Date of termination of his/her condition as a member of a class or classes eligible for coverage under the group plan; or
- 3) Date on which the group contract terminates; or
- 4) Date in which the contract is amended in such a way that it ends coverage of the category of participant person to which the person belongs.

g. If the person whose group insurance terminates is interested in another individual coverage not specified in this clause, he or she may fill out the enrollment form for the policy, but the eligibility to this coverage will be subject to evidence of insurability.

8. COORDINATION OF BENEFITS: When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

- A. (1) The primary plan shall pay or provide its benefits as if the secondary Plan or plans did not exist.
- (2) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals paid or provided by the primary plan.
- (3) When multiple contracts providing coordinated coverage are treated as a single plan under this regulation, this section only applies to the plan as a whole. The coordination among the component contracts is governed by the

terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with this regulation.

- (4) If a person is covered by more than one secondary plan, the order of benefit determination rules of this regulation decides the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall consider the benefits of the primary plan or plans and the benefits of any other plan, which under the rules of this regulation, has its benefits determined before those of that secondary plan.

B. (1) Except as provided in Paragraph (2), a plan that does not have order of benefit determination provisions that are consistent with this regulation is always the primary plan unless the provisions of both plans, regardless of the provisions of this paragraph, state that the complying plan is primary.

- (2) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and plan type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. Plan may consider the benefits paid or provided by another Plan only when, under the rules of this regulation, it is secondary to that other plan.

D. Order of Benefit Determination

Each plan determines its order of benefits using the first of the following rules that applies:

- (1) Non-Dependent or Dependent

(a) Subject to Subparagraph (b) of this paragraph, the plan that covers the person other than as a dependent, for example as an participating person, member, subscriber, contract holder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

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

(I) Secondary to the plan covering the person as a dependent; and

(II) Primary to the plan covering the person as other than a dependent (e.g. a retired participating person),

(ii) Then the order of benefits inverts, and the plan covering the person as an participating person, member, subscriber, contract -holder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

(2) Dependent Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent for the

longer period of time is the primary plan.

(b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply in regards to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(I) The plan covering the custodial parent;

(II) The plan covering the custodial parent's spouse;

(III) The plan covering the non-custodial parent; and then

(IV) The plan covering the non-custodial parent's spouse.

(c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.

(3) Active Participating Person or Retired or Laid-Off Participating Person

(a) The plan that covers a person as an active participant that is, an participant who is neither laid off nor retired or as a dependent of an active participating person is the primary plan. The plan covering that same person as a retired or laid-off participating person or as a dependent of a retired or laid-off participating person is the secondary plan.

(b) If the other plan does not have this rule, and as a result, the plans do not agree on the order benefits will be paid, this rule is ignored.

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

(4) COBRA or State Continuation Coverage

(a) If a person whose coverage is provided through COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as a participating person, member, subscriber or retiree or covering the

person as a dependent of an participating person, member, subscriber or retiree is the primary plan and the plan covering that same person through COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

- (b) If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (c) This rule does not apply if the rule in Paragraph (1) can determine the order of benefits

(5) Longer or Shorter Length of Coverage

- (a) If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer time is the primary plan and the plan that covered the person for the shorter time is the secondary plan.
- (b) To determine the length of time a person has had coverage under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.
- (c) The start of a new plan does not include:
 - (i) A change in the amount or scope of a plan's benefits;
 - (ii) A change in the entity that pays, provides or administers the plan's benefits; or
 - (iii) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.
- (d) The length of time a person has been covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for

a group plan, the date the person first became a member of the group will be used as the date from which to determine the length of time the person has had coverage under the present plan.

- (6) If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

If you have coverage under more than one health benefit plan, you should file all your claims with each plan.

9. EXEMPTION OF PARTICIPANT PERSONS' LIABILITY:

The provider will not bill the participant person for services whose payment Triple-S Salud has denied because of noncompliance with the criteria of reasonableness and medical necessity established by Triple-S Salud.

10. IDENTIFICATION:

Triple-S Salud will issue a card to each participant person, which they are required to present to any Triple-S Salud participating provider from whom services are requested, so that they may be identified as covered under this contract. In addition, the participant person should present a second identification with a photograph.

11. INDIVIDUAL TERMINATION:

Triple-S Salud will not cover services used after termination of coverage. The participating person will be responsible for payment of these services.

12. MANDATORY COVERAGE:

This contract is subject to laws and federal and local regulations that may require, while the contract is active, that additional hospital, surgeon-medical services be covered even if they are not a part of the covered services when this contract was effective.

13. PERSONAL RIGHTS:

The participant person may not yield, transfer or waive in favor of third party any of the rights and benefits that he/she may claim by virtue of this contract. Triple-S Salud reserves the right to recover all expenses incurred in case the participant person, with express or implicit consent, permits non- participant

person 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 canceling the plan contract when illegal use of the card is discovered, nor from filing suit to have the participant person or uninsured user of the card prosecuted.

14. QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) PROCEDURES:

The participant person can request from the fund a copy of these documents free of charge.

15. RECOVERY OF PAYMENTS MADE IN EXCESS OR BY MISTAKE:

The participant person could receive payments that do not apply or are in excess of what is really owed. The participant person has the obligation of notify Triple-S Salud when he/she becomes aware of the mistake. Triple-S Salud will contact the participant person when it realizes that a wrong or excessive payment was made. Triple-S Salud has the right to recover payments made in excess or by mistake to a plan member, up to a period of two (2) years retroactively from the date in which Triple-S Salud issued the payment.

16. RIGHTS UNDER THE LAW FOR MOTHERS AND NEWBORNS PROTECTION:

The aforementioned federal laws establish the following:

- a. Mother and newborn hospitalizations due to birth will not be limited to less than 48 hours if birth occurs through natural means or less than 96 hours in case birth occurs through cesarean.
- b. Insurers and group plans may, nevertheless, cover shorter stays, if the physician, after consulting the mother, orders that mother or the newborn leave the hospital before reaching the aforementioned terms.
- c. If the mother and newborn are discharged in a shorter period of time to the provisions of paragraph (a) of this article but in accordance with subsection (b), the cover will provide for a follow-up visit within forty-eight (48) hours following.

Services will include, but are not limited, to the assistance and physical care for the benefit of the minor, education on care of the child for both parents, assistance and training on lactation, guidance on in-home support and the realization of any treatment and medical tests for both the infant and mother.

- d. Neither insurers nor group plans will design benefits or include deductibles or coinsurances that imply a disadvantageous treatment to any portion of the hospitalization.
- e. In addition, the law does not allow the requirement of preauthorization for those hospital stays within the scope of the law provisions. Nevertheless, the law permits the requirement of a preauthorization to use some providers or to reduce payments in which the participant person might need to incur. Triple-S Salud will not request this preauthorization.

17. THIRD PARTY ACTIONS:

If because of fault or negligence of a third party the participant person or any of the dependents suffers an illness or an injury covered under the contract, Triple-S Salud will have the right to subrogate in the rights of the participant person in order to claim and receive from that third party compensation equivalent to the expenses incurred in treating the participant person as a result of such negligent acts.

The participant person is obliged to acknowledge Triple-S Salud' right of subrogation and will be responsible for notifying Triple-S Salud of all actions initiated against the third party; provided that if the participant person acts in otherwise, the participant person will be responsible to pay for such expenses to Triple-S Salud.

The participant person acknowledges Triple-S Salud right to transact in his/her behalf actions necessary to recovery of the expenses incurred as a consequence of the blame or negligence of the third party.

18. TIME LIMITS FOR CERTAIN DEFENSES:

- a. After two (2) years of having issued this contract, no false declaration (except fraudulent declarations) made by any participant person under the plan may be used to cancel the plan coverage for that person or to deny a claim for services that began after said period of two (2) years.
- b. No claim for services that began after two (2) years from the date this contract was issued will be reduced or denied because of the existence of illness or physical injury before the effective date of this contract that was not excluded from this contract by its specific name or description effective on the date of the service.

19. TRANSFER OF COVERAGE: If the participant person moves to an area covered by another plan affiliated to the Blue Cross and Blue Shield Association and the participant person requests it, Triple-S Salud will handle the transfer to the plan that services the area in which the participant person will reside.

The new plan should offer the participant person at least the group contract conversion. This is a type of contract normally offered to the participant person who leave a group and request coverage as individuals. Conversion Policy offers coverage without the requirement of a medical examination or health certificate.

If the participant person accepts the conversion contract, the new plan will credit the time he/she was participant at 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 others who have the same type of coverage. Fees and benefits available in the new plan may vary significantly from those offered by Triple-S Salud.

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

The participant person may acquire additional information about the Transfer Program by calling our offices.

20. TRIPLE-S SALUD' RIGHT TO AUDIT:

Once subscribed to this contract, the participant person and his/her dependents accept, acknowledge and understand that Triple-S Salud, as payer of the health services incurred by the main contract holder and his/her dependents, has the authority to access his/her medical information to audit all or any health service claims that Triple-S Salud has paid.

21. UNIQUE CONTRACT-CHANGES:

This contract, endorsements and attached documents if there are any, constitute the integral text of the plan contract. No change in this contract will be valid until it has been approved by the executive official designated by the Board of Directors of Triple-S Salud, and unless said approval is endorsed in the present document or is attached to it. No agent has authority to change this contract or waive any of its provisions.

22. WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA):

This contract provides coverage for reconstructive surgery following a mastectomy, as well as the reconstruction of the other breast to maintain a symmetrical appearance, prostheses and any physical complications originated during all mastectomy stages. These benefits will be provided based upon a consultation between the participant female and her physician, and are subject to the coinsurance and deductibles established by the contract.

DEFINITIONS

BASIC COVERAGE

1. **9-1-1 SYSTEM:** A fast emergency call answering system of public security, with the means to assure that the executive agencies who render public security be available to attend any service claims adequate and rapid in emergency situations.
 2. **PARTICIPANT EMPLOYEE:** An employee determined to be eligible for benefits by the Fund.
 3. **AMBULANCE SERVICES:** Transportation services received in a vehicle legally authorized by the corresponding government entity to operate as a vehicle for ambulance services.
 4. **AMBULATORY SERVICES:** Services covered under this contract, received by the participant person while he/she is not admitted as a patient in a hospital.
 5. **AMBULATORY SURGERY CENTER:** A specialized institution;
 - a. When regulated by law: holding a license from the regulatory agency responsible for granting such permits under the laws and regulations of the jurisdiction of its location; or
 - b. When not regulated by law; complying with the following requirements:
 - 1) To be established, equipped, and operated according to the laws and regulations in effect in the jurisdiction of its location, for the primary purpose of providing surgical services.
 - 2) To be operated 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 by a qualified doctor, who at the moment of practicing such procedures, holds a similar practice in at least one hospital (as defined) in the area.
 - 3) To require in all cases, except those requiring local anesthesia, a licensed anesthesiologist to apply the anesthesia and be present during the complete surgical procedure.
 - 4) To provide two (2) operating rooms and at least one post anesthesia recuperation room; fully equipped to perform x-rays and laboratory diagnostic tests; with trained personnel and the necessary instruments to face any foreseeable emergencies including a defibrillator, a tracheotomy set and blood bank or any other supplies, but not limited to any one of these.
 - 5) To provide full-time service of one or more trained male and female graduate nurses (R.N.) for the care of patients in the operating rooms and post-anesthesia recuperating rooms.
 - 6) To hold a written contract with at least one hospital in the area for the immediate hospitalization of patients who develop complications or require post-surgery hospitalization.
 - 7) To maintain an adequate 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 those who have undergone a local anesthesia procedure.
6. **BARIATRIC SURGERY:** Surgical procedure to control the morbid obesity, which can be practiced through four techniques, gastric bypass, adjustable band, intragastric balloon and sleeve gastrectomy. Triple-S Salud will only cover, as required by Law, the gastric

bypass subject to precertification. Other surgeries will not be covered.

7. **BENEFITS ASSIGNMENT:** Process used when a non participating surgeons, hospitals and facilities of the Blue Cross Blue Shield outside of Puerto Rico, accept to give the necessary services to an participant person billing directly to Triple-S Salud according to the reasonable charge of the area on which the services is rendered.
8. **BLUE CROSS PLAN:** Independent concessionary of the Blue Plans Association (Blue Cross/Blue Shield).
9. **BLUE SHIELD PLAN:** Independent concessionary of the Blue Plans Association (Blue Cross/Blue Shield).
10. **BLUECARD PROGRAM:** Program that allows the claim processing for services covered out of the Puerto Rican geographic area and that will be paid based on the negotiated fees by the Blue Cross Plan or the Blue Shield area.
11. **CLINICAL PSYCHOLOGIST:** Professional licensed by the Board of Psychologists of Puerto Rico, and that owns doctoral degree in clinical psychology of a university, school or credited training center.
12. **COBRA LAW:** Public Law 99-272, Title X, Consolidated Omnibus Budget Reconciliation Act (COBRA), requires that every employer with twenty (20) or more participating person who sponsors group medical plan provide participating person and relatives, in certain situations, temporary coverage (called Continued Coverage) when coverage under the plan ends.
13. **COINSURANCE:** The percentage of established fees that the participant person will pay to the participating physician or provider or any other provider, at the time services covered are received, as his contribution to the cost of the services received, as established in the contract and notified to the participating physician or provider. This amount is not reimbursable by Triple-S Salud.
14. **COLLATERAL VISITS:** Interviews with immediate relatives of the participant person hereunder in a psychiatrist's office.
15. **COPAYMENT:** A fixed amount to be paid by the participant person to the participating physician or provider or any other provider, at the time covered services are received, as his contribution to the cost of the services received, as established in the contract and has been notified to the participating physician or provider. This amount is not reimbursable by Triple-S Salud.
16. **COSMETIC SURGERY:** That surgery, whose purpose is to improve the individual appearance and not to restore function or correct deformities. Purely cosmetic surgery does not turn into reconstructive surgery for reasons of a psychiatric or psychological reasons.
17. **CUSTOMARY CHARGE:** A charge is considered customary when it falls under the usual charges for a determined service by a large number of physicians or providers of services with similar training and experience in a specific area.
18. **ELIGIBLE DEPENDENTS:** as defined by the Fund who are enrolled in accordance with the Fund's rules. The following are considered eligible dependents:
 - the *spouse* to whom you are legally married or your *domestic partner* (as defined below)
 - your children, regardless of marital, financial dependency, or student status, through the end of the calendar year in which they turn age 26. Children are your natural children, stepchildren, children required to be recognized under a *Qualified Medical Child Support Order (QMCSO)* and adopted children (including a proposed adopted child during a waiting period before finalization of the child's adoption.) A foster child is not included.
 - unmarried *dependent children* over age 26 who are unable to do any work to support themselves because of a physical handicap or mental illness, developmental disability or mental

retardation, as supported by a Social Security disability award. The incapacity must have started before the child reached age 19, and proof that the dependent continues to be eligible for Social Security disability benefits may have to be provided periodically. Initial written proof of the child's disability must be submitted to the Fund Office within 31 days after the child's 19th birthday. Coverage under this extension ends if the *dependent child* marries or becomes able to earn a living.

Domestic partners are defined under the Plan as two same sex adults, neither of whom is married (to anyone other than the domestic partner) or legally separated, who either:

- resided with each other for at least six months prior to the application for benefits and who intend to live continuously with each other indefinitely, or
- were legally married in a state or country legalizing same-sex marriage or same-sex civil *unions*.

In addition, to be recognized as *domestic partners*, the two adults must:

- not be related by blood or in any manner that would bar marriage in their state of residence, and
- be financially dependent on each other, and
- have an exclusive, close and committed relationship with each other, and
- not have terminated the domestic partnership (or same-sex marriage or same-sex civil *union*).

To cover a *domestic partner* under Plan C, you must apply for coverage for your *domestic partner*. In addition, you must satisfy one of the two following requirements:

- You must submit to the Fund Office a certificate of registration, civil *union* or marriage. If you live in an area that offers registration of *domestic partners* (such as New York or San Francisco),

you must register as *domestic partners* and submit the registration to the Fund Office; or

- You must submit to the Fund Office a notarized Affidavit of Domestic Partnership and a notarized Statement of Financial Interdependence (available at www.iatsenbf.org or from the Fund Office). You will be required to demonstrate financial interdependence by submitting proof of two of the following:
 - a joint bank account (statement, check or passbook with both names)
 - a joint credit card account (statement with both names)
 - a joint loan obligation (note or other loan origination document with both names)
 - joint ownership of a residence (deed or other sale/transfer document with both names, property or water tax document with both names)
 - a joint lease of a residence (lease with both names)
 - common household expenses (phone, electric bills with both names, public assistance document with both names)
 - joint ownership of a vehicle (title in both names)
 - joint wills (copy of will or wills, with each party naming the other as *beneficiary* and/or executor)
 - power of attorney (copies of powers of attorney with each party naming the other party and no limitation on the term of the documents)
 - health care proxies (copies of health care proxies/living wills, with each party giving the other party the power to make health care/non-resuscitation decisions upon incapacitation)

- life insurance (copy of policy with one party naming the other as *beneficiary*)
- retirement benefits (copy of *beneficiary* designation form with one party designating the other as *beneficiary*).

Proof of the ongoing nature of the domestic partnership may be requested annually. If you are providing Plan C coverage for a *domestic partner* and your domestic partnership ends for any reason, you must immediately file a written notice of dissolution of the domestic partnership with the Fund Office.

19. DURABLE MEDICAL EQUIPMENT:

Equipment that can be used repeatedly. Its principle use is to serve a medical purpose, and not to serve the person or the injury. This must be appropriate for using in the patient's home and its medical necessity must be certified. It does not include equipment that is used outside of the home or whose function is limited to convenience.

20. EXPERIMENTAL OR RESEARCH SERVICES: Medical treatment that:

- a. is considered experimental or investigative and is not in accordance with the medical contract established by the Technology Evaluation Coverage Manual (TEC) of the Blue Cross and Blue Shield Association on specific indications and methods ordered;
- b. Does not have the final approval of the appropriate regulatory agency (e.g., Federal Food and Drug Administration (FDA), U.S. Department of Human and Health Services (DHHS), the Commonwealth's Department of Health) or;
- c. Scientific evidence is insufficient according to the scientific evidence available, it does not support conclusions on the effect of technology on the medical results obtained;

- d. Have positive results reported that are insufficient to counterbalance, in an acceptable manner, the negative results of the treatment;
- e. Is not more beneficial than other already established alternate treatment;
- f. Does not lead to improvement beyond the investigative phase.

21. FAMILY CONTRACT: The plan that provides benefits to any eligible participant person and his/her enrolled eligible dependents.

22. FEE: The fixed amount used by Triple-S Salud to pay its participating providers for the covered services rendered to the participant person when these services are not paid through another payment method.

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

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

- a. Is approved as a Home Health Agency under Medicare, or
- b. Is established and operated in accordance with the applicable laws of the jurisdiction in which it is located, and where licensing is required, has been approved by the regulatory authority having responsibility for licensing under the law, or
- c. Meets all of the following requirements:
 - 1) An agency holds itself forth to the public as having the primary purpose of providing a home health care delivery

system bringing supportive 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 Graduate Nurse (R.N.)
- 5) Its participating persons are bonded and provides mal-practice and mal-placement plan.

25. HOSPITALIZATION SERVICES: Services covered by this contract received by the participant person while being a patient in a hospital.

26. HOST BLUE: Blue Cross Blue Shield plans of the area where services are rendered under the Blue Card Program.

27. ILLNESS:

- a. Any non-occupational illness contracted by any participant person; however, illnesses for which hospitals are unable to admit the patient, by law or regulation, once these illnesses are diagnosed, will not be covered under the contract.
- b. Maternity and secondary conditions due to the pregnancy will be considered illnesses under coverage offered by the contract, subject to the following conditions:
 - 1) Services are rendered to the participant person regardless her marital status or as spouse of an participant person under a family contract which includes both spouses.
 - 2) Any service rendered for an abortion provoked for therapeutic reasons but only if the maternity is covered by the contract.

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

29. INJURIES: Any accidental injury suffered by the participant person not due to an automobile or on-the-job accident that requires hospitalization to receive medical treatment.

30. INDIVIDUAL CONTRACT: The plan that provides benefits to any eligible single or married participant person not including the spouse.

31. PARTICIPANT PERSON: Any person eligible who holds the plan coverage to whom Triple-S Salud gives him/her the right to the benefits established under this contract issued in the name of the participant group and assumes the established responsibilities under this contract.

32. INTENSIVE CARE SERVICES: Services covered by this contract, rendered to the participant person in duly authorized facilities for intensive care of interned patients. Includes Intensive Care Units and Coronary Units.

33. INTENSIVE CARE UNIT: Separate, clearly designated service area reserved for patients in critical condition, seriously ill, requiring constant audiovisual observation, as prescribed by the bedside physician. Additionally, it provides room and nursing 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 interned in this area.

34. MAXIMUM OUT OF POCKET: It is the maximum amount stated in the policy that a person must pay during the policy year. Before the person reaches the out-of-pocket amount stated in this policy, the person will pay the deductibles, copays and coinsurances for medical care received from

the plan participating providers. Once the insured person reaches the maximum out-of-pocket amount stated in the policy, the plan will pay 100% of the medical expenses covered under this policy. Services rendered by non-participating providers, payment for medical expenses and the premium paid to Triple-S Salud for the plan, are not considered eligible amounts for the accumulation of the out-of-pocket maximum.

- 35. MEDICAL EMERGENCY:** Sudden and unforeseen onset of a condition that requires medical or surgical attention. This attention should be received immediately after the condition appears or as soon as possible, but in no case after twenty-four (24) hours of its appearance.
- 36. MEDICALLY NECESSARY SERVICES:** Those services that are provided by a participating physician, physician group or provider to support or reestablish the participant person's health and are determinate and provided according to standards of good medical practice.
- 37. 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
- 38. MORBID OBESITY:** It is the excess of fat in the body determined by a corporal mass of 35 or higher.
- 39. NON-PARTICIPATING PHYSICIAN OR PROVIDER:** Physician, medical group or provider who does not have a contract active with Triple-S Salud.
- 40. NUTRITION SPECIALIST:** Health professional specialized in nutrition and certified by the governmental entity designated for said purposes.
- 41. PARTIAL PSYCHIATRIC HOSPITALIZATION:** Facilities and services organized to care for patients with mental conditions who require hospital care in day or evening programs of less than twenty-four (24) hours.
- 42. PARTICIPATING PHYSICIAN OR PROVIDER:** Physician, hospital, primary care centers, diagnostic and treatment centers,

dentist, laboratory, pharmacy, prehospital emergency medical care centers or any other person or entity in PR authorized to provide medical care under direct contract with Triple-S Salud or through a third party who renders health services to participant person's or beneficiaries of Triple-S Salud.

- 43. PSYCHOANALYSIS:** The psychoanalysis is based on a set of theories related to the conscious and unconscious mental processes and the interaction between these. It is a modality of used therapy to treat people who present/display chronic problems of life in a scale of slight to moderate. The psychoanalysis should not be used like synonymous for the psychotherapy, since they do not pursue the same objective. This service is not covered in this contract, as expressed in the section of Exclusions.
- 44. PSYCHOLOGICAL EVALUATION:** Initial interview to obtain personal and clinical history of the participant person, as well as his/hers description of symptoms and problems. The psychological evaluation must be performed by a Psychologist with a degree of Doctor in Psychology, licensed from a graduated program, duly accredited and with effective license, issued by the Board of Psychologists of Puerto Rico.
- 45. PSYCHOLOGICAL TEST:** Use of instruments solely dedicated to measure the intellectual abilities or capability of an individual to dominate a specific area. Psychological tests to be administered in each specific case will be subject to the Clinical Psychologist's professional opinion. Test must be administered, verified, and interpreted by a Psychologist with a degree of Doctor in Psychology, licensed from a graduated program, duly accredited and with effective license, issued by the Board of Psychologists of Puerto Rico.
- 46. CONTRACT YEAR:** Period of twelve (12) consecutive months for which the Fund acquires or renews Triple-S Salud plan.
- 47. PREAUTHORIZATION:** Advance authorization from Triple-S Salud for the payment of any of the benefits covered under this plan and its riders, in cases deemed necessary by Triple-S Salud.

Some of the objectives of the preauthorization are: evaluate if the service is medically necessary, evaluate the adequacy of the place of service, verify the eligibility of the participant person for the requested service and if it is available in Puerto Rico. Preauthorizations will be evaluated based on the preauthorizations policies that Triple-S Salud established through the time. Triple-S Salud will not be liable for payment of services if they have been rendered or received without this authorization from Triple-S Salud.

48. REASONABLE CHARGE: A charge is reasonable when it satisfies the criteria of usual and customary or may be reasonable if, in the opinion of an appropriate Review Committee, it merits special consideration in view of the complexity of handling the particular case.

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

50. RESIDENTIAL TREATMENT: Services of high level intensity care and is restrictive, for patients with mental health conditions including drug abuse and alcoholism, and comorbid conditions that are difficult to manage at home or at a community and that have not responded to other less restrictive treatment levels. Also, integrates the clinical and organizational therapeutic services, and are supervised by an inter-disciplinary team in a structured environment 24 hours a day, 7 days a week.

51. SECOND MEDICAL OPINION: The requirement of Triple-S Salud of an opinion of a physician other than the physician in charge of the case, chosen by Triple-S Salud in those cases in which Triple-S Salud determines that an opinion is necessary, before the participant person receives the service.

52. SERVICE AREA: The area within which the participant person is expected to receive the majority of medical/hospital services. In this plan, the service area is Puerto Rico since benefits provided are available only to those

persons who are permanently residents of Puerto Rico.

53. SERVICES NOT AVAILABLE IN PUERTO RICO: Treatment within facilities or with hospital-medical equipment not available in Puerto Rico, in the case of a patient whose health condition requires treatment.

54. SERVICES NOT COVERED: Those services, which are:

- a. Expressly excluded from the participant person's plan;
- b. An integral part of another covered service;
- c. Rendered by a medical specialist, that has not been acknowledged by Triple-S Salud for payment.
- d. Are considered experimental or investigative by the corresponding entity as established in the plan.
- e. Are provided for the convenience or comfort of the participant person, participating physician or the facility.

55. SESSIONS: Two or more modes of treatments of physical or respiratory therapy.

56. SKILLED NURSING FACILITY:

- a. It is a 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's:
 - 1) It is operated in accordance with the applicable laws of the jurisdiction in which it is located.
 - 2) It is under the supervision of a licensed physician, or registered graduate nurse (R.N.), who is devoted full time to such supervision.
 - 3) It is regularly engaged in providing room and board and

provides twenty-four hour a day skilled nursing care for sick and injured persons during the convalescence stage of an injury or sickness.

- 4) It maintains a daily medical record of each patient who is under the care of a duly licensed physician.
- 5) It is authorized to administer medication and treatment to patients on the order of a duly licensed physician.
- 6) It is not, other than incidentally, a home for the aged, blind or deaf, a hotel, a domiciliary attendance home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.
- 7) It is not a hospital

57. SPECIAL CASES: The case of a participant patient whose health condition requires treatment within facilities or with medical-hospital equipment not available in Puerto Rico.

58. SPECIAL INSCRIPTIONS: Instance in which the employee and their eligible dependents can subscribe to the health plan at any time as a result of a specific event qualified as marriage, births and deaths, among other events.

59. SPORTS MEDICINE: Branch of medicine that treats illnesses or injuries caused by sports activities including the preventive and preparatory phases necessary to maintain good physical and mental condition.

60. TELE-CONSULTA: A service Triple-S Salud provides to its participant person through which the plan member may receive orientation on questions related to his/her health. This telephone number is taken care of by nursing professionals, seven (7) days a week, twenty-four (24) hours a day. When calling this line, if the participant person receives a recommendation to go to the emergency room, he/she will be provided with a register number that must be presented at the moment of receiving the

services. In case of illness, when presenting this number at the hospital, the participant person will pay a smaller copayment to use the facilities. The telephone number to call Tele-consults is located at the back of the identification card of the participant person of Triple-S Salud.

61. TREATMENT PLAN: Detailed report of the procedures recommended by the physician to treat the medical needs of the patient based on the medical examination made by the physician.

62. UNNECESSARY SERVICES: The physician and the medical plan disagree on the patient's need of a particular service, the plan company does not pay for this service, the medical treatment have not been considered by Triple-S Salud to be included in the plan or there are other reasons not to cover the service billed.

63. USUAL CHARGE: The one most frequently charge patient by physicians/surgeons or particular service providers for a determined service.

MAJOR MEDICAL COVERAGE

1. CASH EXPENSES: Any covered medical expense, which can be applied to the annual cash deductible for a contract year, with the exception of expenses for mental disorders in ambulatory basis. The 20% portion of covered medical expenses, which is the participant person responsibility is also considered as a cash expense.

2. CASH DEDUCTIBLE: The annually cash amount that must be accumulated before having right to the benefits provided by the Major Medical Coverage.

3. IMPLANT: An internal device which replaces an organ or a part of the body such as: knee, valve replacement, etc.

4. MEDICAL BENEFITS SCHEDULE: Any covered services under the Major Medical Coverage which is not payable based on usual, reasonable, and customary charge. This medical benefit schedule applies in Puerto Rico.

5. 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.

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

7. 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.

8. PROSTHESIS: This is an external device that replaces an organ or a part of the body such as: an eye, leg, arm, etc.

9. 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.

ORGAN AND TISSUES TRANSPLANT

1. 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.

2. 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. GENERIC DRUGS: Chemical name or non commercial name of these medication with the same active ingredient and which have identical potential, dosage form, administration, bioavailability and which are considered to be therapeutically equivalent to the brand-name drug.

2. COINSURANCE: Percentage of fees to be paid by the participant person to the pharmacy at the moment services are rendered, as his/her contribution to the cost of the services received, as established in the contract and notified to the participating pharmacy. Triple-S Salud will not reimburse this amount.

3. COPAYMENT: The fixed preauthorized amount to be paid by the participant person to the pharmacy at the moment services are rendered, as his/her contribution to the cost of the received services, as established in the contract and notified to the participating pharmacy. Triple-S Salud will not reimburse this amount.

4. DRUGS (MEDICATION): (a) any substance that bears on its label the following legend as required by federal law: CAUTION: Federal law prohibits dispensing without prescription, and (b) Insulin.

5. LIST OF MEDICATIONS: Represent a group of registered brand-name drugs that have been evaluated by the Pharmacy and Therapeutics Committee and are considered safe, efficient and cost effective; that they assure the therapy quality, minimizing the inadequate utilization that may harm the patient's health.

6. MAINTENANCE DRUGS: Maintenance drugs are those that are less likely to change in dosage or therapy due to side effects, when monitoring serum concentration or therapeutic response over the course of a prolonged therapy. In addition, maintenance drugs are those that

are commonly used to treat a chronic disease when an end of therapy cannot be determined. Therapy with the drug is not considered curative. Maintenance drugs are administered in a continuous manner (for more than 90 days) rather than intermittently.

7. **NEW PRESCRIPTION DRUGS:** Are new drugs entering the market. They are generally evaluated by the Pharmacy and Therapeutics Committee within a period not exceeding 90 days from their approval by the Food and Drugs Administration.
8. **NON-PARTICIPATING PHARMACY:** Any pharmacy that has not subscribed a provider contract with Triple-S Salud.
9. **NON PREFERRED DRUGS:** Evaluated medications for which was determined there was another existing alternative available in the market that is secure and effective for the treatment of the condition.
10. **OVER THE COUNTER (OTC) MEDICATIONS:** Those drugs that do not have a federal legend and, therefore, can be sold without a prescription. A panel of experts has evaluated them, their use has been determined safe, and effective for managing health related conditions.
11. **PARTICIPATING PHARMACY:** Any pharmacy that has subscribed a provider contract with Triple-S Salud.
12. **PHARMACY:** Any establishment legally authorized to supply drugs.
13. **PHARMACY AND THERAPEUTICS COMMITTEE:** It is a working Committee, assigned, among other activities, to evaluate the effectiveness of new medications and make recommendations and utilization protocols for them. After the Committee evaluations, it will determine the inclusion of medications within the pharmacy coverage.

This Committee is composed of a general practitioner, a pediatrician, an ob-gyn, a registered nurse, clinical pharmacists and pharmacists. If a physician with a specialty in the field of medicine to be evaluated is necessary, assistance is requested from panel of specialists including the subspecialties of cardiology, endocrinology, psychiatry, infectology, pneumology, oncology, nephrology, ENT, ophthalmology and others, as necessary. The Committee holds monthly meetings to share findings in utilization reports and new medications that have been introduced in the market.

14. **PHARMACY PROGRAM OF DISPENSING A 90 DAY SUPPLY AT THE PHARMACY:** Program that allows the participant person to obtain a supply of ninety (90) days of his/her maintenance medications through participating pharmacies of the program.
15. **PHARMACY PROGRAM OF SENDING MEDICATIONS BY MAIL:** Program that allows the participant person to receive his/her maintenance medications through the Postal Service of the United States of America.
16. **PREFERRED BRAND-NAME:** Brand-name medications evaluated by the Pharmacy and Therapeutics Committee, which require a lower deductible.
17. **PRESCRIPTION:** Written request for medicines issued by a physician or dental surgeon legally authorized to effect said requisition in the ordinary course of his/her practice.
18. **PRESCRIPTION REFILL:** a prescription of medicines that has a repetition indicated in writing by the physician.
19. **REGISTERED MARK:** A medication that is offered to the public as a commercial name or a trademark.

CONTACTS

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Saturday: 9:00 A.M. to 6:00 P.M.
Sunday: 11:00 A.M. to 5:00 P.M.

Faxes-Customer Service: 787-706-4014/787-706-2833
Fax – Reimbursement: 787-749-4032

Service Centers

Plaza Las Americas Shopping Mall

Second Level
M-F 8am-7pm
Sat. 9am-6pm
Sun. 11am-5pm

Caguas

Angora Building
Luis Muñoz Marín Ave. Esq.
Troche St.
M-F 8:00am-5pm

Ponce

Galería del Sur Building
1046 Ave. Hostos, Suite 218
L-V 8:00 a.m. – 5:00 p.m.

Plaza Carolina Shopping Mall

Second Level
M-F 9am-7pm
Sat. 9am-6pm
Sun 11am-5pm

Arecibo

Caribbean Cinemas Building
Suite 101, Road #2
M-F 8:00am-5pm

Mayagüez

Rd. 114, Km. 1.1 (Near Comunidad Castillo
intersection) Bo. Guanajibo
L-V 8:00 a.m. – 5:00 p.m.

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