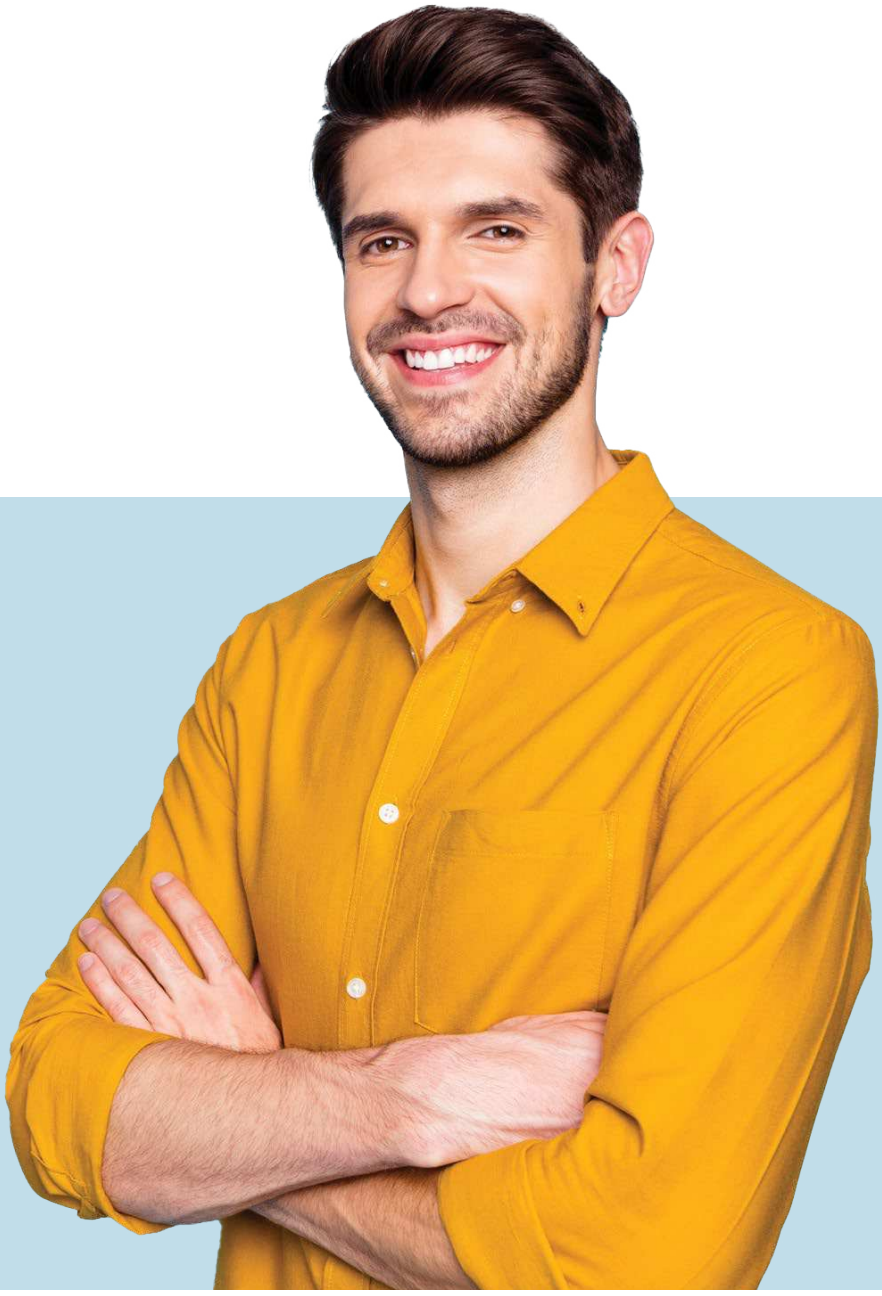
Pocket Policy



2023

TRIPLE-S SALUD

BlueCross BlueShield of Puerto Rico

A great network. A great life.

TRIPLE-S SALUD, INC.

1441 Ave. Roosevelt, San Juan, Puerto Rico
Independent licensee of Blue Cross Blue Shield Association

TRIPLE-S POCKET POLICY (TRIPLE-S DIRECTO POS)
INTRODUCTION (metal-VALUE plans)

Triple-S Salud, Inc., (hereinafter referred to as Triple-S Salud) insures you and your eligible dependents in conformity with the provisions of this policy and the medical and payment policies established by Triple-S Salud, against expenses for medically necessary medical-surgical and hospitalization services, as well as pharmacy and dental services, provided while the policy is in force due to injuries or diseases contracted by any of the covered people, as provided below. This policy is issued in consideration of your enrollment application statements and the upfront payment of the corresponding premiums.

This policy is issued to bona fide residents of Puerto Rico, whose permanent residence is located within the Area of Service, as defined in this policy, for one (1) year or less (if you enroll outside the fixed annual enrollment period) from the date of validity of the contract issued to the member. This policy ends on December 31, 2023. You may keep this policy in force provided that you pay the premiums on time, as stipulated in the General Provisions Section, Subsection 18 - PREMIUM PAYMENT. The benefits of this policy are not cumulative; they do not accumulate from one year to the next.

Triple-S Salud will renew this policy, at the option of the member and in accordance with the applicable local and federal laws and regulations, except as provided for in the General Provisions Section, Subsections 4 - INDIVIDUAL CANCELLATION and 30 - TERMINATION, with prior written notice to you. Also, Triple-S Salud will not renew the coverage of a dependent after he/she reaches the age limits for the coverage, as stipulated in this policy. All the terms of coverage begin and end at 12:01 a.m., Puerto Rico time.

Triple-S Salud may take action, in accordance with what is established in the Individual Cancellation Clause in the General Provisions Section of this policy, or based on any other related provision in the policy, concerning anyone who intentionally provides false or fraudulent information when applying for enrollment to the insurance.

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

Starting in 2014, the Health Insurance Code and the Affordable Care Act have guaranteed that all non-grandfathered (unprotected) plans offered in individual and small-group markets (inside or outside the medical insurance exchange market) will include comprehensive coverage for services, also known as essential health benefits. These essential benefits, as defined by law and by Puerto Rico's reference plan, are classified into the following ten categories: emergency services; hospitalization; outpatient services; maternity and newborn care; mental health and substance abuse, including behavioral health treatment; prescription drugs; rehabilitation, habilitation, and medical equipment services; laboratory services; preventive, wellness and chronic disease management services; pediatric services, including dental and vision care.

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

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

Juan R. Serrano
Chief Strategy Officer & President

Please keep this document in a safe place. It includes the benefits to which you are entitled as a Triple-S Salud member.

CONTACTS

Customer Service Department

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

Customer Service Phone Number	**787-774-6060 or 1-800-981-3241 (toll-free)** **TTY users call TTY 787-792-1370 or 1-866-215-1999 (toll-free)**
Business Hours for Call Center:	• Monday to Friday: 7:30 a.m. - 8:00 p.m. (AST) • Saturday: 9:00 a.m. – 6:00 p.m. (AST) • Sunday: 11:00 a.m. - 5:00 p.m. (AST)
Fax – Customer Service	**787-706-2833**
Teleconsulta	**1-800-255-4375 (24/7)**
BlueCard	**1-800-810-2583** www.bcbs.com
Mailing Address Customer Service	**Triple-S Salud, Inc.** **Customer Service Department** PO Box 363628 San Juan, PR 00936-3628
Email Address:	servicioalcliente@ssspr.com
Precertifications	**Triple-S Salud, Inc.** **Precertification Department** PO Box 363628 San Juan, PR 00936-3628 **Fax: (787) 774-4824**
Case Management Program	**787-706-2552** **TTY users, please call 787-792-1370 or 1-866-215-1999** **Fax: 787-744-4824**
Programs for Chronic Condition Management (asthma, diabetes, heart failure, prenatal, hypertension, COPD [Chronic Obstructive Pulmonary Disease], Living without Smoke)	**Monday to Friday, from 7:00 a.m. - 6:30 p.m. (AST)** **Saturday: 8:00 a.m. - 4:30 p.m. (AST)** **Fax: 787-744-4824** commercialclinicalmanagement@ssspr.com

Service Centers	
Plaza Las Américas (second floor, North Parking Lot entrance) Monday to Friday: 8:00 a.m. - 6:00 p.m. (AST) Saturday: 9:00 a.m. – 6:00 p.m. (AST) Sunday: Closed	**Plaza Carolina** (Second level, next to the Post Office) Monday to Friday: 9:00 a.m. – 6:00 p.m. (AST) Saturday: 9:00 a.m. – 6:00 p.m. (AST) Sunday: 11:00 a.m. – 5:00 p.m. (AST)
Caguas Angora Building Luis Muñoz Marín Ave. & Troche St. (corner) Monday to Friday: 8:00 a.m. – 5:00 p.m. (AST)	**Arecibo** Caribbean Cinemas Building, Suite 101 PR-2, Km. 81.0 Monday to Friday: 8:00 a.m. – 5:00 p.m. (AST)
Ponce 2760 Ave. Maruca Monday to Friday: 8:00 a.m. – 5:00 p.m. (AST)	**Mayagüez** PR-114 Km. 1.1 Barrio Guanajibo Monday to Friday: 8:00 a.m. – 5:00 p.m. (AST)
Persons who may need assistance due to: • ***Spanish is not the primary language*** • ***Special Needs***	This information is available for free in English. Also, if you need oral interpretation services into any language other than Spanish or English please contact our Call Center at 787-774-6060. Call Customer Service if you need free help in another language or format. If you need help reading or understanding our documents, we can also help. Written materials may be available in other formats, For telephone services for the hearing-impaired (TTY), call 787-792-1370 or 1-866-215-1999 (toll-free) within the following business hours: • Monday – Friday 7:30 a.m. - 8:00 p.m. (AST) • Saturday 9:00 a.m. – 6:00 p.m. (AST) • Sunday 11:00 a.m. - 5:00 p.m. (AST)
People with Special Needs	Call Customer Service if you need help in another language or format. If you want to speak in another language or need help to read or understand a document, we can help you. Printed materials may be available in other formats, including Braille. Law No. 162-2020: in the case of blind enrollees, the evidence of coverage and identification card will be issued in the Braille system. TTY users can call our Customer Service Department at TTY 787-792-1370 or 1-866-215-1999 (toll-free) during the following hours: • Monday to Friday: 7:30 a.m. - 8:00 p.m. (AST) • Saturday: 9:00 a.m. – 6:00 p.m. (AST) • Sunday: 11:00 a.m. - 5:00 p.m. (AST)
Internet Portal	www.ssspr.com Our members may register to our website, where they may complete transactions such as: • Obtain information about their benefits

	• Health education information • Obtain a Coverage Certification • Request identification card duplicates • Address changes • Check reimbursement status • Obtain a student certification letter • Review your service history
Mobile Application, Triple-S Salud	Download our mobile app to access important information about your health plan coverage. The Triple-S Salud app lets you: • View and email your plan ID card to your doctors, so you can get the services you need even if you don't have your card with you. • View your health plan coverage and benefits. • Pay for your health plan. • See the health care services you've received. This way, you can keep a log of the health services you and your family have received. • Find your nearest health care provider to fit your needs. • Easily find contact information for Triple-S Salud, such as phone numbers, office locations, and email address. Go to: https://salud.grupotriples.com/mi-triple-s/ IMPORTANT: The Mi Triple-S application is only available to insured members of Triple-S Salud's health plans and dependents over 18 years old.
Telexpreso	This is your direct contact with Triple-S Salud. This automated phone line helps you solve issues regarding your health plan at any time of day. You just need to call (787) 774-6060 or 1-800-981-3241 (toll-free) to quickly manage your health plan. The Telexpreso system lets you: • Pay your health plan • Check your eligibility and that of your dependents • Check a reimbursement status • Obtain guidance for some processes, such as submitting a reimbursement claim, requesting card duplicates, and certifications, among others
Teleconsulta MD®	Virtual interactive consultation with a physician from any place within the Puerto Rico geographic region. Visit our website to access the service through a mobile device or computer. For a $10 copay, you may consult with general practitioners, family physicians, internists, or licensed psychologists and pediatricians, among other specialists, during the following hours: • Monday to Sunday, from 6:00 a.m. to 10:00 p.m. (AST) AST – Atlantic Standard Time. To learn more about our specialists and our business hours, please visit the TeleConsulta MD platform.

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

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

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

Medicare usually covers most of these expenses.

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

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

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

Before You Buy This Insurance

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

IMPORTANT NOTICE ABOUT INDIVIDUAL PLAN ENROLLMENT

Triple-S Salud will provide coverage to anyone who requests an individual plan that is available for the individual health plan market, without applying risk assessments or waiting periods for preexisting conditions.

Guaranteed health plan enrollment will be provided within fixed enrollment periods; an annual initial enrollment period. This initial enrollment period spans from October 1, 2022 to January 31, 2022, with an effective date of January 1, 2023.

If the person applying for a health plan does not enroll within the aforementioned fixed enrollment period, he/she may do it later. Provided that:

- If the application for enrollment to the individual plan is received between the 1st and the 15th day of the month, coverage will be effective the 1st day of the next month.
- If the application is received between the 16th and the 31st day of the month, coverage will be effective on the first day of the second month from the date the application was received.

In such cases, the policy and any attached endorsements will have a waiting period of thirty (30) days for preventive services and ninety (90) calendar days from the policy's effective date for all other covered services, except for cases of emergency/urgent care as required by law.

The waiting period of ninety (90) calendar days does not apply to people who apply for an individual plan as a result of the following qualifying events:

a) Events according to the Special Enrollment section.
b) Conversion policies through which Triple-S Salud offers its available individual basic health plans at any time of the year. This will apply only to members who exercise their right to conversion to a Triple-S Salud group plan within a term no greater than thirty-one (31) days.
c) Members who are switching over from a plan with another insurance company and have not been without coverage for sixty-three (63) days or more, and whose last plan was a group plan. The member must have been enrolled over eighteen (18) months. During this time, the individual may have been enrolled to an individual or group plan.
d) If the individual was eligible to coverage from the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) and already selected it and exhausted it.
e) If the individual was left without group or individual coverage due to the bankruptcy, dissolution, or license revocation of the insurance company with which he/she had insurance, and submits his/her application to the new insurer within sixty-three (63) days after the insurance company’s bankruptcy declaration, dissolution, or license revocation.

If the person had prior qualifying coverage with benefits that are not comparable or do not exceed those offered in the coverage of the individual basic silver health plan, Triple-S Salud will offer the individual basic bronze health plan to that person until the next initial annual enrollment period, when he/she may select the individual basic health plan he/she prefers.

For health plan renewals, if the member does not renew the individual basic health plan during the established enrollment period, he/she may renew it, provided it is done within thirty (30) days from the termination of the aforementioned enrollment term.

Triple-S Salud may require the health plan applicants in the individual market to complete a medical questionnaire where they will provide information about their conditions, prescription drugs, and the care they receive to manage their health condition, as well as information about their attending primary care physician. The information from this questionnaire will be used only and exclusively to enroll the member in the disease management programs established for these purposes.

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DEFINITIONS

1. **90-DAY PRESCRIPTION DRUG DISPENSING PROGRAM:** Voluntary program that allows members to obtain a 90-day supply of certain maintenance drugs through participating pharmacies in this program.

2. **9-1-1 SYSTEM:** Response system for public security emergency calls, through the 9-1-1 number created by virtue of Act No. 144 of December 22, 1994, as amended, known as the "Act for the Speedy Attention of Public Safety 9-1-1 Emergency Calls" or "9-1-1 Calls Act".

3. **ABUSE:** One or more of the following acts, whether performed by a member or former member of the victim's family, someone residing in the victim's home, a romantic partner, or anyone in charge of the victim's care:

   (1) Attempting to cause or causing, either intentionally or by negligence, bodily harm, physical harm, severe mental anguish, psychological trauma, assault, sexual battery or rape;

   (2) Knowingly engaging in persecution of the victim, or even pursuing the victim, without authorization, in circumstances where the victim could reasonably believe that his or her physical integrity is in danger;

   (3) Restricting the victim's freedom; or

   (4) Causing, either knowingly or by negligence, damage to the property in order to intimidate or control the victim's behavior.

4. **ABUSE VICTIM**: Someone who has been abused; who has currently or previously suffered injuries, illnesses, or disorders resulting from the abuse; or who is seeking or has sought, or may have a reason to seek, medical or psychological treatment due to the abuse; or legal protection or shelter to prevent abuse.

5. **ABUSE VICTIM STATUS:** The fact or belief that the person is or has been the victim of abuse, regardless of whether the person has suffered a health condition associated with said abuse.

6. **ACUTE DRUGS:** Drugs prescribed to treat a non-recurrent disease (for example: antibiotics). These drugs have no refills.

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

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

9. **ANNUAL PHARMACY DEDUCTIBLE:** The annual cash amount that must be accumulated before entitlement to the benefits under this policy. All members insured under individual or family contracts shall be responsible for the payment of covered services until they accumulate the annual coverage deductible. Afterwards, they may pay the plan's copayments and/or coinsurance, as established in the Table of Deductibles, Copayments, and Coinsurance shown at the end of this policy.

10. **ASSIGNMENT OF BENEFITS:** The process by which non-participating physicians, hospitals, and facilities agree to provide necessary covered services (in Puerto Rico and United States) to the member and bill Triple-S Salud for such services based on the fee for participating providers.

11. **BARIATRIC SURGERY:** A surgical procedure for obesity control, which can be performed via four techniques: gastric bypass, adjustable band, intragastric balloon, or sleeve gastrectomy. Triple-S Salud will

only cover, as required by law, the gastric bypass, subject to precertification. Adjustable bands, intragastric balloons, and sleeve gastrectomies will not be covered.

12. **BLUECARD *PROGRAM*:** The program that allows the processing of claims for covered services outside the geographic area of Puerto Rico, which will be paid based on the fees negotiated by the *Blue Cross* or *Blue Shield* Plan in the area.

13. **BLUE CROSS BLUE SHIELD PLAN*:*** Independent insurer that, through a contract with the Blue Plans Association (*Blue Cross/Blue Shield*), acquires the license to belong to the association of independent plans and to use its trademarks.

14. **CHRONIC CONDITION:** A long-term or permanent health condition.

15. **CLINICAL REVIEW CRITERIA:** It means the documented screening procedures, summaries of decisions, clinical protocols, and practice guidelines used by the health insurance company or insurer to determine the medical necessity and adequacy of the health care service. These practice guidelines are not required for the Health Care Professional when performing their duties while providing health care services according to the corresponding state and federal laws and regulations, and as long as the service provided is recognized by the generally accepted standards of medical practice and health care, in light of the latest communication and learning methods. The professional diagnosis will be the absolute ruling criteria to determine the treatment to follow on a patient. Therefore, the professional criteria may not be altered by the insurance company. Notwithstanding the foregoing, the provisions of this subsection must comply with the applicable federal laws and regulations.

16. **COHABITANTS:** Two single adults with full legal capacity, not related by family ties within the fourth degree of consanguinity and second degree of kinship, subject to a sustained and affective cohabitation in a voluntary, stable, public, and continuous manner for no less than one (1) year, who inhabit a common residence without being married to each other, and intend to continue cohabiting indefinitely.

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

18. **COMMERCIAL CLAIM:** A final claim for reimbursement for items or services covered by a provider or facility to a member, enrollee, or beneficiary of an individual or group health insurance plan with major medical expense coverage.

19. **COMMISSIONER:** Commissioner of Insurance of Puerto Rico.

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

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

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

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

24. **COORDINATED CARE:** A model of health care offered to the member by their primary care physician, or any other plan doctor belonging to the preferred specialist network, in which the physicians share the member's clinical information to provide their services and establish a treatment plan based on the member's specific needs. The primary care physician is responsible for evaluating the member's health regularly and coordinating, by way of an electronic or written consultation, the medical services they need in a more streamlined and integral manner with the other providers in the plan's preferred network. This mode of care provides financial incentives, as well as other kinds, to encourage members to use Triple-S Salud participating providers, that is, those who are under the administration, hire, or employment of Triple-S Salud.

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

26. **COVERAGE RESCISSION:** Triple-S Salud may decide to retroactively terminate its contract on the basis of fraud or intentional misrepresentation of substantial data on behalf of the member or the person applying for a health plan on behalf of someone else. This rescission will be notified in writing thirty (30) days in advance, and the participant or member has the right to request a review of this determination.

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

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

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

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

    It is the group plan health coverage the policyholder has before enrolling to this plan, provided that the person has not had substantial coverage interruption.

28. **CUSTODIAL CARE:** Personal attention or assistance permanently provided to a person for daily activities such as bathing, dressing, eating, getting in and out of chairs and beds, moving around, using the bathroom, preparing meals, nutrition, and supervising drug use. Custodial care does not require continued oversight from medical personnel.

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

30. **DEDUCTIBLE:** The annual cash amount that must be accumulated before entitlement to the benefits under this policy. In this case, it may apply to certain pharmacy coverages, depending on the selected plan. All members insured under individual or family contracts shall be responsible for the payment of covered services until they accumulate the annual coverage deductible. Afterwards, they may pay the plan's

copayments and/or coinsurance, as established in the Table of Deductibles, Copayments, and Coinsurance at the end of this policy.

31. **DENTIST:** An odontologist legally authorized to practice the profession of surgeon-dentist.

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

    a. The spouse (person with whom one is married after complying with the ceremonies and formalities required by law) of the policyholder, included in a family contract while this policy is in force, provided that the member lives with said spouse. In case of cohabitation, the policyholder must supply an affidavit to be included, to certify their cohabiting relationship, as established in the Definitions Section.

    b. Biological or adopted children of the policyholder or his/her spouse or cohabitant, as defined in subsection 39a above, until they reach twenty-six (26) years of age. The spouses of policyholder's children, the children of policyholder's children –except those included in subsection 39d below– and the children of spouses of policyholder's children are not be eligible under this plan.

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

    d. Non-emancipated minors who are the policyholder’s grandchild or consanguineous family member will be eligible as direct dependents, as long as the member holds permanent custody of such minor as awarded by a final and firm court judgment; this direct dependent may remain in the plan until he/she reaches twenty-six (26) years of age. The primary policyholder's grandchild is also eligible as a direct dependent, as well as blood relatives of any age if they are declared disabled by final court decree and the court awarded their guardianship to the primary policyholder. In either case, any primary policyholders who wish to enroll a grandchild or blood relative as a direct dependent under this clause must certify their status as custodians or guardians and submit the final court decree awarding them the permanent custody or guardianship, as the case may be.

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

33. **DURABLE MEDICAL EQUIPMENT:** Equipment that is primarily used to serve a medical purpose and whose medical necessity must be certified. These medical equipments include, but are not limited to, hospital-type beds, wheelchairs, oxygen equipment, and walkers, among others.

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

35. **ELIGIBLE PERSON:** Someone who resides in Puerto Rico and who is not eligible for insurance under their employer-sponsored health plan. The term can include members, spouses, children, and cohabitants for whom:

    a) There was creditable coverage, and that, as of the effective date, has accumulated the creditable coverage periods as provided by HIPAA (eighteen [18] months or more).

b) No more than sixty-three (63) days have elapsed between the last creditable coverage and the effective date of this policy

c) The person is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act, or a state plan pursuant to Title XIX of such Act (Medicaid), or a successor program for such plans.

d) His/her most recent coverage within the accumulated creditable coverage periods was not terminated due to non-payment of premiums or fraud.

36. **ENROLLMENT PERIOD:** Period of time in the year when individuals may enroll in a health plan. This period must expire before the health plan coverage becomes effective, and during which the insurer is not required to provide the benefits.

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

38. **EXPERIMENTAL OR RESEARCH SERVICES:** Medical procedures that:

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

    b. do not have final approval from the corresponding regulatory body (e.g.: *Food and Drug Administration (FDA)*, *Department of Health and Human Services (DHHS)*, Puerto Rico Department of Health); or

    c. have insufficient scientific evidence, according to the available scientific evidence, to arrive at a conclusion about the effect of the treatment or technology on the medical results obtained; or

    d. have insufficient reported positive results to acceptably counterbalance the treatment's negative outcomes; or

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

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

39. **FAMILY CONTRACT:**

    a. The insurance that provides benefits for any eligible person, his/her spouse or cohabitant, and his/her direct dependents, as defined in subsection 39 of this section. In these cases, the premium corresponding to the family composition will apply.

    b. If there is no eligible spouse as defined in subsection 39, the contract of policyholders with one (1) or more eligible direct dependents may, at their option, be considered a Family Contract or an Individual Contract with one (1) or more direct dependents; as defined in subsection 39 of this section.

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

40. **FDA:** United States Food and Drug Administration. Also known as the Federal Drug Administration.

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

42. **GENERIC DRUGS (Tier 1):** A generic drug is formulated with the same active ingredient as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are approved by the U.S. Food and Drug Administration (FDA). Some drugs require pre-authorization or have limits due to age, quantity, specialty, or step therapy.

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

44. **GENETIC INFORMATION:** Information about genes, genetic products, and inherited characteristics that may be derived from the person or a relative. This includes information about the carrier's status and information gleaned from laboratory tests identifying mutations in specific genes or chromosomes, physical examinations, family history, and direct gene or chromosome analyses.

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

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

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

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

46. **HEALTH CARE PROFESSIONAL:** A physician or any other professional health care who is licensed, accredited or certified by the corresponding entities to provide certain health care in accordance with the corresponding state laws and regulations.

47. **HEALTH INFORMATION:** Information or data, be it verbal or recorded in the way and medium in which:

    (a) it is created or received by the insurer or health care organization.

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

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

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

48. **HEALTH PLAN: An insurance contract, policy, certificate, or subscription agreement with a health insurance company, health services organization, or any other insurer, furnished in consideration or in exchange for the payment of a premium, or on a prepaid basis, through which the health insurance company, health services organization, or insurer is bound to provide or pay for the rendering of certain medical services, hospital services, major medical expenses, dental services, mental health care, or services related to the provision thereof.**

49. **HIGH-RISK CONDITION:** A long-term or short-term health condition that entails or may entail a poor prognosis.

50. **HIPAA (1996 Health Insurance Portability and Accountability Act):** Federal Public Law No. 104-191 of August 21, 1996. It regulates everything related to portability and continuity of coverage in the group and individual markets, contains provisions to combat fraud and abuse in health coverages and in the provision

of health services, as well as the administrative simplification of health plans. This law is applicable in our jurisdiction and supersedes the Puerto Rico Insurance Code.

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

52. **HOME HEALTH CARE AGENCY:** An agency or organization that provides an at-home medical assistance program and:

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

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

    c. Meets all of the following requirements:

        1. It is an agency that is introduced to the public with the primary objective of providing a system that offers medical assistance and support services at home.

        2. It has a full-time administrator.

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

        4. Its staff includes at least one graduate registered nurse (RN).

        5. Its employees are bonded, and it provides professional misconduct and malpractice liability insurance.

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

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

55. **HOSPITALIZATION SERVICES:** Services covered by this policy and received by the member while they are admitted as a hospitalized patient.

56. **HOST BLUE*:*** BLUE *Cross* or *Blue Shield* Plan of the area where the service is received under the Blue Card program.

57. **Hybrid Plan:** Medical care plan during a visit to a medical office or virtual visit.

58. **ILLNESS:**

    a. Any non-occupational disease contracted by any member. Any diseases for which hospitals are unable, by law or regulation, to admit the patient after being diagnosed, shall not be covered under this policy.

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

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

        II. Any service provided to induce an abortion for therapeutic purposes.

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

60. **INDIVIDUAL CONTRACT:** The insurance that provides benefits to any eligible employee, unmarried or married, without including the spouse, as defined in the subsection of this policy, a Direct Dependent, as a member. This employee will have the option to include any eligible direct dependent in their insurance, as defined in this policy, by paying the corresponding additional premium.They may also include optional dependents, as defined in this policy, provided that they pay the corresponding additional premium.

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

61. **INJECTABLE ANTINEOPLASTIC AGENTS:** A drug administered by infusion that inhibits or prevents the development of cancer by preventing the growth, maturation, and proliferation of malignant cells.

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

63. **INSURER:** Any entity subject to the insurance laws and regulations of Puerto Rico or to the Commissioner's jurisdiction, who contracts or agrees to contract for the provision, supply, arrangement, or payment of the costs for health care services, or for their reimbursement, including for-profit and non-profit hospital and health services corporations, health service organizations, or any other entity providing health benefits, service, or care plans.

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

65. **INVOLUNTARY OUT-OF-NETWORK SERVICES:** Medical or health care services that:

    - Are covered by a managed plan of medical or health care services provided by a network;
    - Are rendered by a non-participating medical or health care provider; and
    - When a member uses an in-network facility to receive covered medical or health care services, but the network services are not available at this facility, regardless of the reason, including accidental services received as part of a covered procedure.
      Involuntary out-of-network services rendered by non-participating providers include laboratory tests ordered by an in-network medical or health care provider and performed by an out-of-network laboratory.

66. **IRO**: The Independent Review Organization (IRO) is an accredited organization that conducts independent medical reviews. These reviews are conducted by an independent physician.

67. **KNOWINGLY, VOLUNTARILY, AND SPECIFICALLY SELECTED AN OUT-OF-NETWORK PROVIDER:** This means that the member elected to receive services from a specific provider in the full knowledge that said provider is outside their health plan network, even though the member had the opportunity of being seen by a network provider. The provider's sole disclosure of their network status, in and of itself, does not imply that the member's decision to proceed with the treatment is an election “knowingly” made by the member.

68. **LEGALLY ELIGIBLE CLAIM WITH NO SURPRISES:** A claim incurred by a member covered by the insurance or plan during any plan year starting on January 1, 2022 for an item or service within the following categories: • Emergency services (including post-stabilization care) rendered by a non-participating

provider; • Any non-emergency item or service offered by a non-participating provider at a facility (including hospitals, hospital outpatient departments, and outpatient surgery centers).

69. **A LEGALLY ELIGIBLE CLAIM WITH NO SURPRISES**: It includes any previously described claims that would otherwise not be subject to a state law on surprise bills. All claims for ERISA self-funded plans and any claim for fully insured plans in states that don't have the applicable laws on surprise bills are subject to the No Surprises Act.

70. **LICENSED PHYSICIAN:** A person who requests to be and is authorized to practice medicine and surgery in Puerto Rico by previously obtaining a license from the Puerto Rico Board of Medical Licensure and Discipline, in accordance with the provisions of the Law and these Regulations.

71. **MAIL ORDER PHARMACY PROGRAM:** Voluntary program that allows members to receive certain maintenance drugs through the United States Postal Service.

72. **MAINTENANCE DRUGS:** Drugs that require prolonged therapy and have a low probability of changes in dosage or therapy due to side effects. Also, drugs whose most common use is to treat a chronic illness when a therapeutic end cannot be determined.

73. **MAXIMUM ANNUAL OUT-OF-POCKET:** Maximum amount established to be paid by the person during the policy year. Before reaching the maximum annual out-of-pocket set forth in this policy, the member must pay the deductibles, copayments, or coinsurance for essential medical-hospital care, drugs, and essential dental services, as established in the Table of Deductibles, Copayments, and Coinsurance received through the plan's participating providers. After the member reaches the maximum out-of-pocket established in this policy, the plan will pay 100% of the medical expenses covered by the policy.

74. **MEDICAL EMERGENCY:** A medical or behavioral condition that manifests itself through sufficiently severe acute symptoms, including severe pain, which a prudent person with an average knowledge of medicine and health could infer that, in the absence of immediate medical attention, it could seriously endanger the health of the person affected by such condition or result in a serious dysfunction of any members or organs; or in the case of pregnant person, endanger the health of that person or the fetus; or in the case of a behavioral disorder, it could seriously threaten the health of that person or of others; cause problems in a person’s bodily functions; or cause serious dysfunction or disfigurement in any of the person’s organs or body parts.

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

    a. Severe chest pain

    b. Serious or multiple injuries

    c. Severe respiratory difficulty

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

    e. Severe bleeding

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

    g. Poisoning

    h. Seizures

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

75. **MEDICAL NECESSITY:** Anything that a prudent and reasonable licensed physician understands is medically necessary, including any health services or procedures rendered to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, condition, or its symptoms, in a manner that:

    (a) Is in accordance with the generally accepted standards of medical practice, and in keeping with current methods of communication and education;

    (b) Is clinically appropriate in terms of the type, frequency, extent, location, and duration of the health services or procedures;

    (c) The medical necessity is not determined merely for the convenience of the patient or the physician, or for the financial benefit of the insurer, health care organization, or other health plan carriers, the providers of the selfsame medical treatment, or any other health care provider;

    (d) It is within the scope of the medical practice and/or specialty of the licensed health care provider who determined the medical necessity; and

    (e) That the medical necessity is determined based on clinical evidence supporting such determination and is duly documented by the treating physician.

76. **MEDICAL OR SCIENTIFIC EVIDENCE:** It means evidence produced by any of the following sources:

- Expert peer-reviewed papers, published or approved for publication in specialized medical journals that meet nationally recognized criteria for scientific texts;
- Expert peer-reviewed medical publications, which include publications related to therapies that have been evaluated and approved by institutional review boards, biomedical compendia, and other medical publications that meet the indexing criteria for the Index Medicus (Medline) of the National Institutes of Health National Library of Medicine, and for Elsevier Science Ltd. In Excerpta Medica (EMBASE);
- Medical journals approved by the United States Secretary of Health and Human Services in accordance with the U.S. Social Security Act;
- The following standards:
    - The American Hospital Formulary Service-Drug Information;
    - Drug Facts and Comparisons®;
    - The American Dental Association Accepted Dental Therapeutics; and
    - The United States Pharmacopoeia-Drug Information;
- Findings, studies, or research conducted by or under the sponsorship of federal government agencies and federal research institutes recognized in the U.S., including:
    - The federal Agency for Health Care Research and Quality;
    - The National Institutes of Health;
    - The National Cancer Institute;
    - The National Academy of Sciences;
    - The Centers for Medicare and Medicaid Services (CMS); and

- Any national board recognized by the National Institutes of Health whose purpose is to evaluate the effectiveness of health care services;

- Any additional medical or scientific evidence that is comparable to those listed in paragraphs (A) to (E) above.

- Categorical exclusion: It means the specific provision established by Triple-S for the non-coverage of a prescription drug, identifying the drug by its scientific or commercial name.

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

78. **MEDICARE:** Federal Law on Health Insurance for Elderly People, Title XVIII of the 1965 amendments, the law of Social Security as constituted or as subsequently amended.

79. **MEDICAL OR HEALTH CARE FACILITY, OR FACILITY:** Health care facilities, as defined by Law No. 101 of June 26, 1965, as amended, known as the "Health Facilities Act", including hospitals, satellite emergency departments, outpatient surgery centers, or outpatient care centers at hospitals providing outpatient surgery services.

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

81. **METABOLIC SYNDROME:** A series of diseases or risk factors in a single individual that increase his/her probability of developing cardiovascular disease or diabetes mellitus. People suffering from metabolic syndrome have at least three of the following risk factors: excessive abdominal fat, high blood pressure (hypertension), abnormal levels of blood fats (lipids), cholesterol and triglycerides, and hyperglycemia (high blood sugar levels).

82. **MORBID OBESITY:** Excess of body fat, as determined by a Body Mass Index (BMI) greater than or equal to 35. This condition is part of metabolic syndrome and is a risk factor for the development of other conditions, such as hypertension, cardiac disease, orthopedic problems, sleep apnea, skin problems, circulation problems, diabetes mellitus, acidity, psychological problems, anxiety, infertility, and pulmonary embolism, among others. Studies show that it is a condition that may arise from multiple factors, such as genetics, the environment, and psychological causes, among others. This means that it can be caused by excessive nutrition, metabolic disorders, or hereditary factors.

83. **NEW DRUGS:** Drugs that have been recently introduced in the market. They are evaluated by the Pharmacy and Therapeutics Committee for a period not to exceed ninety (90) days after being approved by the *Food and Drug Administration* (*FDA*).

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

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

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

    b. are an integral part of a covered service;

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

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

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

86. **NON-PARTICIPATING DENTIST:** A surgeon-dentist that has not signed a contract with Triple-S Salud to provide dental services.

87. **NON-PARTICIPATING PHARMACY:** Any pharmacy that has not signed a contract with Triple-S Salud to provide services to members.

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

89. **NON-PREFERRED BRAND-NAME PRESCRIPTION DRUG (Tier 3):** A drug is classified as non-preferred because there are alternatives in the previous tiers that are more cost-effective or have fewer side effects. If the member obtains a non-preferred brand-name prescription drug, he/she will have to pay a higher cost for the drug. Some drugs require pre-authorization or have limits due to age, quantity, specialty, or step therapy.

90. **NON-PREFERRED SPECIALTY PRODUCTS (Tier 5):** Identifies the drugs or products in the Drug List that are offered under the Specialty Drug Program. Drugs in this tier have a higher cost than the specialty products in Tier 4. These are used to treat chronic and high-risk conditions that require special administration and handling. Some drugs require pre-authorization or have limits due to age, quantity, specialty, or step therapy.

91. **NUTRITIONIST:** Health care professionals certified by the governmental entity designated for such purposes, who specialize in food and nutrition.

92. **ORTHODONTICS:** Branch of dentistry related to the diagnosis and treatment necessary to prevent and correct malocclusions.

93. **OUTPATIENT SERVICES:** Services covered by this policy and received by the member while they are not admitted as a hospitalized patient.

94. **PREFERRED PCP NETWORK (PPN)-** Network of doctors of excellence and quality, who meet the state requirements to practice medicine and are prepared to provide routine and preventive care and basic medical services for the treatment of illness or injury. This network is made up of general practitioners, family doctors, paediatricians, internists and gynecologists. Pursuant to Law 79-2020, Triple-S Salud may allow that, in cancer patients, an oncologist could be considered a PCP, but in such a case, the oncologist must offer his consent.

95. **TRIPLE-S PARTICIPANT AND PROVIDERS NETWORK -** Network of physicians who meet state requirements to practice medicine and are prepared to provide routine care, preventive care, and basic medical services for the treatment of illness or injury. This is a network of providers, in addition to the Preferred PCP network, that is made up of PCP physicians, specialists, subspecialists, and health care professionals.

96. **OUTPATIENT SURGERY CENTER:**

    A specialized facility:

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

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

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

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

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

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

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

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

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

97. **OVER-THE-COUNTER DRUGS (OTC):** These are drugs without federal legend that can be sold to clients without a physician's prescription.

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

99. **PARTICIPATING PHARMACY:** Any pharmacy that has signed a contract with Triple-S Salud to provide services to members.

100. **PARTICIPATING PHYSICIAN OR PROVIDER:** All physicians, hospitals, primary service centers, diagnosis and treatment centers, dentists, laboratories, pharmacies, pre-hospital emergency medical services, or any other person or entity authorized to provide health care services in Puerto Rico, that under direct contract with Triple-S Salud, or through a third party, provides health care services to Triple-S Salud members.

101. **PHARMACIST:** A person who is licensed to prepare, mix, and administer drugs and who practices within the scope of such license.

102. **PHARMACY:** Any legally approved establishment to dispense drugs.

103. **PHARMACY AND THERAPEUTICS COMMITTEE:** A committee or similar body consisting of an uneven number of employees or external consultants hired by an insurer or health insurance company. The members of the Pharmacy and Therapeutics Committee are health care professionals, such as physicians and pharmacists, with knowledge and expertise regarding:

- The adequate manner, from a clinical perspective, of prescribing, administering, and overseeing the use of prescription drugs for outpatients; and
- Reviewing and assessing the use of these drugs, as well as intervening with such usage.

If the Pharmacy and Therapeutics Committee includes members who represent the pharmacy benefit manager or the insurer or health insurance company, these members may only contribute with operational or logistical concerns, but they will not have a vote in any decisions regarding the inclusion or exclusion of prescription drugs in the Drug List.

104. **PERIODONTOLOGY:** Branch of dentistry related to the diagnosis and treatment of diseases in the gums and other tissues that help support the teeth.

105. **PERSONAL REPRESENTATIVE:**

(1) Someone who has been expressly authorized in writing by the member to represent them for the purposes of the Puerto Rico Health Insurance Code.

(2) Someone authorized by law to provide consent in lieu of the member;

(3) An immediate relative of the member, or their treating health professional, if the member is unable to give their consent;

(4) A health care professional if the member's health plan requires a health care professional to request the benefit; or

(5) In the case of an urgent care request, a health professional who has knowledge of the member's medical condition.

106. **POLICYHOLDER: Person who maintains an insurance contract with Triple-S Salud in an individual plan, which entitles them to the benefits established in the policy issued to their name, and assumes the responsibilities established in the policy. This person has paid a premium for themselves or their dependents, if any, who are also covered by the individual health plan, and is responsible for the continued payment of the premiums, according to the terms of the individual health plan.**

107. **POLICY YEAR:** Period of twelve (12) consecutive months for which the member acquires or renews their insurance with Triple-S Salud. This time period may be shorter if the person enrolls outside the fixed annual enrollment period.

108. **PREAUTHORIZATION:** Process to obtain prior approval from the insurer or health insurance company, which is required under the health plan terms of coverage to dispense a prescription drug.

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

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

110. **PREDETERMINATION OF BENEFITS:** Evaluation of the treatment plan suggested by the dentist before providing services to determine the member's eligibility, the scope of the covered benefits, limits and exclusions, and the applicable copayment under the member’s contract.

111. **PREFERRED SPECIALTY PRODUCTS (Tier 4):** Identifies the drugs or products in the Drug List that are offered under the Program of Medications for Special Conditions. Drugs in this tier include generic drugs, biosimilar drugs (generic versions of biological products), and brand-name drugs. These are used to treat

chronic and high-risk conditions that require special administration and handling. Some drugs require pre-authorization or have limits due to age, quantity, specialty, or step therapy.

112. **PREMIUM:** The specific amount of money paid to an insurer as a condition to receive health plan benefits, including fees and other charges associated with the health plan. The premium charged to a member can only be changed once within a period of twelve (12) months to reflect: (1) Changes in the member's family composition; or (2) Health plan changes requested by the member.

113. **PRIMARY CARE PHYSICIAN (PCP):** Doctor who meets the state requirements to practice medicine and is prepared to provide routine and preventive care, as well as basic medical services to treat an illness or injury. Provides health care to the member. The primary care physician may be a generalist, a family physician, a pediatrician, an internist, or a gynecologist. According to Law No. 79-2020, Triple-S Salud may allow cancer patients to consider an oncologist as their PCP, provided that the oncologist provides their consent.

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

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

116. **PSYCHOLOGICAL TESTS:** The use of instruments dedicated to measure an individual's intellectual skills or ability to master a particular area. The psychological tests to be used in each case will be subject to the professional judgment of a psychologist with a master's or doctoral degree, who has the knowledge to administer, correct, and interpret them, should be graduated from a duly accredited graduate program, and have a current license issued by the Puerto Rico Board of Psychologist Examiners.

117. **PSYCHOLOGIST:** Professional licensed by the Puerto Rico Board of Examiners of Psychologists, as defined in Law No. 96 of June 4, 1983, as amended, known as the "Act to Regulate the Practice of the Profession of Psychology in Puerto Rico," who has training, knowledge, skills, and experience in offering services that include but are not limited to prevention, description, or diagnosis of behavior; psychological evaluations; therapeutic intervention for psychological disorders of varying degrees of severity; and counseling services related to the intellectual, emotional, behavioral, interpersonal, family, social, and occupational functioning of individuals and groups.

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

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

120. **PREFERRED BRAND-NAME PRESCRIPTION DRUGS (Tier 2):** There are certain drugs that have been selected by the Pharmacy and Therapeutics Committee as preferred agents after evaluating their safety, efficacy, and cost. They are identified as Tier 2. For therapeutic classes where there are no generic equivalents available, we urge members to use drugs identified as preferred as their first choice. Some drugs require pre-authorization or have limits due to age, quantity, specialty, or step therapy.

121. **PRESCRIPTION:** An order issued by a person who is licensed, certified, or legally authorized to prescribe drugs, addressed to a pharmacist to dispense a prescription drug.

122. **PRESCRIPTION DRUG:** A drug that has been approved or regulated for marketing and distribution by the Food and Drug Administration (FDA), and which is required by Puerto Rico or United States law to be provided with a prescription.

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

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

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

126. **RECONSTRUCTIVE SURGERY:** Surgery that is performed on abnormal bodily structures with the intention of improving functionality or appearance defects that have resulted from congenital defects, diseases, or trauma.

127. **RESIDENTIAL TREATMENT:** High-intensity and restrictive care services for patients with mental health conditions, including drug addiction and alcoholism, and co-morbid conditions that are difficult to handle at home and in the community, which have not responded to other less restrictive treatment levels. This treatment integrates clinical and therapeutic services that are coordinated and supervised by an interdisciplinary team in a structured environment, 24 hours a day, 7 days a week. The facility must be a hospital institution accredited by Medicare, the Joint Commission and the Department of Education, and the clinical faculty must be accredited under Act 30. It must also possess a pharmacy license from ASSMCA to administer and store drugs, as well as an interdisciplinary team (clinicians, psychiatrists, psychologists, and registered nurses).

128. **REST OR CONVALESCENCE HOME:** A private residential institution that is equipped to care for people who cannot fend for themselves, such as the elderly or people with chronic illnesses.

129. **RETROSPECTIVE REVIEW:** Benefit request review that is conducted after the health care service was provided. It does not include claim reviews that are only meant to evaluate documentation accuracy or correct code usage.

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

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

132. **SESSIONS:** Two or more treatment modalities for physical or respiratory therapy.

133. **SKILLED NURSING CARE UNIT**:

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

    b. An institution that meets the following conditions:

1. It is directed in accordance with the applicable laws of the jurisdiction where it is located.
2. It is supervised by a licensed physician or graduate registered nurse (*RN*) who is dedicated full-time to such supervision.
3. It regularly provides rooms, meals, and continuous skilled nursing services, 24 hours a day, to sick and injured people during the convalescence phase for an injury or illness.
4. Keeps medical records for every patient under the assistance of a duly qualified physician.
5. It is authorized to administer drugs and treatment to patients as per the instructions of a duly qualified physician.
6. It is not, other than incidentally, a site for the elderly, blind, or deaf, a hotel, a house for home care, a maternity home, or an institution for alcoholics, drug addicts, or the mentally ill.
7. It is not a hospital.

134. **SPECIAL CONDITION:** A rare or low-incidence condition.

135. **SPECIAL ENROLLMENT:** Cases where it is allowed to enroll dependents in the health plan at any time as a result of a qualified event, such as marriage, births, and deaths, among others.

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

137. **SPECIALTY PHARMACIES:** Pharmacies that provide services for chronic and high-risk conditions requiring the administration of specialized drugs to plan members.

138. **SPORTS MEDICINE:** Branch of medicine that deals with diseases and injuries resulting from sports activities, including the preventive and preparatory stages necessary to stay in good physical and mental condition.

139. **SPOUSE:** Person of the same gender or of a different gender whom the plan member has legally married.

140. **STANDARD REFERENCE COMPENDIA:** It means:

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

141. **STEP THERAPY *(ST)*:** The protocol that specifies the sequence in which prescription drugs must be dispensed for certain medical conditions. In some cases, we require that the member use a drug first as therapy for his/her condition before we cover other drugs for the same condition (first step drugs). For example, if Drug A and Drug B are both used to treat your medical condition, we require that the member use Drug A first. If Drug A does not work for the member, then we will cover Drug B (second step drugs).

142. **SUBSTANTIAL INTERRUPTION OF COVERAGE**: A period of sixty-three (63) consecutive days during which the person has not had any creditable coverage. Waiting or enrollment periods are not taken into account to calculate this term.

143. **DRUG LIST:** Guide of the drugs selected by the Pharmacy and Therapeutics Committee of Triple-S Salud, which contains the therapies necessary for a high-quality treatment. Pharmacy coverage benefits are determined according to the drugs included in the Drug List. This selection is made based on the safety,

effectiveness, and cost of the drugs that ensure the quality of therapy, minimizing misuse that could affect the patient's health.

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

145. **TELECONSULTA MD ®:** Interactive virtual service by smartphone or computer, where the member may conduct a medical consultation with a generalist, internist, primary care physician, pediatrician, or psychologist who has been certified to practice telemedicine, pursuant to Law No. 168 of 2018. To learn more about our specialists and our business hours, please visit the TeleConsulta MD platform.

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

147. **THERAPEUTIC CLASSIFICATION:** Categories used to classify and group drugs in the Drug List by the conditions they treat or the effects they produce in the human body.

148. **TREATMENT PLAN:** A detailed report on the procedures recommended by the physician to treat the patient's medical needs, which can be found in the physical examination done by the same physician.

149. **URGENCY**: It means a sudden medical issue that does not pose an imminent risk of death or serious harm to the person, and that can be treated at a medical office or after-hours clinic, not necessarily in an emergency room, but which, if not treated promptly and adequately, could become an emergency.

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

151. **URGENT CARE REQUEST:**

    (1) A health care treatment or service request for which the prescribed time to make a non-urgent determination of care:

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

        b. In the opinion of a physician with knowledge of the member's health condition, would expose the individual to pain that cannot be managed adequately without the requested health care service or treatment.

    (2) In determining whether the request will be treated as an urgent care request, the individual representing the health insurance company or insurer will exercise the judgment of a prudent layman with average knowledge of health and medicine. If a physician with knowledge of the member's health condition decides to submit a request for urgent care, as defined in subsection (1), the health insurance company or insurer shall treat the request as an urgent care request.

152. **USUAL CHARGE:** The usual charge is the most frequent charge physicians or service providers make to patients for a specific service.

153. **UTILIZATION REVIEW ORGANIZATION**: An entity contracted by a health insurance company or insurer to perform a utilization review if it is not the health insurance company or insurer that performs its own health plan review. This shall not be construed as a requirement for the health insurance organization or insurer to subcontract an independent entity to perform the utilization review processes.

154. **WAITING PERIOD:** It means the period of time a member must wait before becoming eligible for certain benefits under the terms of the health plan. This policy has a waiting period of thirty (30) days for preventive services and ninety (90) days for all other covered services. Nonetheless, there is no waiting period for emergency / urgent care services.

155. **WRITTEN OR ELECTRONIC CONSULTATION:** Written or electronic order (issued through the Mi Triple-S application), signed by the primary care physician and used to facilitate coordinated access to care. With this order, the primary care physician requests and recommends that the member receive the covered services from other providers in participating preferred networks, in accordance with the terms of this policy. A consultation is effective only as of the date the order is issued, and its valid time period will be limited based on the policies and regulations established by Triple-S.

CHANGES IN ENROLLMENT

After a person enrolls, he/she cannot make changes in his/her insurance until the next contract renewal date, unless such changes are necessary for any of the following reasons:

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

2. Divorce of the main policyholder: If the policyholder gets divorced during the term of this policy, the change request to discontinue the insurance must be submitted within thirty (30) days after the date of divorce, which must be proved with the Divorce Decree and its corresponding Notification. The change will be effective the first day of the month after the month when the Divorce Decree was notified by the Court.

3. Termination of a cohabiting relationship: When the policyholder ends their cohabiting relationship with a partner during the term of this policy, the change request to discontinue the insurance must be submitted within thirty (30) days after the date the relationship ended.

   For contract changes due to the termination of a cohabiting relationship, the policyholder must obtain a Sworn Statement for Termination of Insurance for Cohabiting Partner, and submit it to Triple-S Salud as proof.

4. A son/daughter, grandson/granddaughter, blood relative, or foster child, as per the definition for direct dependent in this policy, is no longer eligible as a direct dependent. When the direct dependents mentioned in this subsection reach the age of twenty-six (26) years, the date of the birthday will be considered the date of change for the cancellation of coverage. The cancellation will be effective the first day of the month after the birthday.

All policyholders must complete the enrollment application in all its parts and send or deliver it at the main Triple-S Salud office or at their other Service Centers around the Island. The same norm will govern any change request for the insurance, except changes due to age, which may be done automatically by Triple-S Salud. Triple-S Salud may verify the member's eligibility to meet the necessary requirements to obtain the benefits this policy provides

SPECIAL ENROLLMENT

A person may enroll in this policy at any time, or enroll his/her eligible dependents, when any of the following conditions occur, and under the following terms and limitations:

1. Marriage of the main policyholder: If the policyholder gets married during the term of this policy, they may include their spouse under their insurance if the change request is submitted to Triple-S Salud within thirty (30) days after the date of marriage, including proof via Marriage Certificate. In this case, the insurance will be effective the first day of the month after Triple S-Salud receives the request.

2. Policyholder's cohabitant: If the policyholder initiates a relationship subject to sustained cohabitation and emotional bonds, where the cohabitation is voluntary, stable, and continuous, they may include their partner under their insurance within thirty (30) days after the date the cohabitation started. The policyholder must obtain a Sworn Statement for the Inclusion of Cohabitant Couples and submit it to Triple-S Salud as proof. In such cases, the insurance shall be effective on the first day of the month after Triple S-Salud receives the request.

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

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

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

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

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

        ii. The date when an order was issued providing custody of the minor to the member that intends to adopt him/her; or

        iii. The effective date of adoption.

    d. Coverage for newborns, newly adopted children, or foster children:

        1. includes health care services for injuries or illnesses, including the care and treatment of congenital defects and malformations diagnosed by a physician; and
        2. is not subject to exclusions for preexisting conditions.

    e. In the case of newborns:

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

2. If the member fails to provide notice or pay the premium, the plan may opt not to continue providing coverage for the dependent minor beyond the 30-day period Nonetheless, if the member makes all payments due no later than four (4) months after the child's date of birth, the child's coverage will be reinstated.

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

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

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

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

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

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

In cases where (non-custodial) primary policyholders with underage dependents in their policy or members of legal age who are covered by the policy as eligible dependents request compensation to be paid directly to themselves because they paid for covered medical services that are being claimed, Triple-S Salud may issue a direct payment to the non-custodial parent or member.

4. The eligible person enrolled or did not enroll in a health plan unintentionally or in an inadvertent or erroneous manner, as a result of the error, misrepresentation, or lack of action from officials, authorized representatives, or employees from Triple-S Salud, the Department of Health and Human Services (HHS), or their instrumentalities, as evaluated and determined. In such cases, Triple-S Salud will take the necessary measures to correct or eliminate the effects of said error, misrepresentation or lack of action.

5. An eligible person or member requests a new health plan due to a change of residence.

6. The member demonstrates that the health plan in which he/she is enrolled substantially violates the terms of the contract with such person.

7. The person becomes eligible for the first time or becomes eligible again. In such cases, where the existing coverage under an eligible employer group plan is no longer affordable or even provide a minimum value for the following year of the employer health plan, eligible individuals will be allowed to enroll on or before the end of the coverage under such employer plan.

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

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

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

HOW YOUR PLAN WORKS

Your coverage under this policy

You (the "Policyholder") have acquired a policy from Triple-S Salud and hold a contract with Triple-S Salud. Your policy, your application form, and other documents you completed at the time of joining the plan are part of your contract with Triple-S Salud. You and your dependents are entitled to the benefits described in this Policy.

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

The benefits provided by this basic policy are not cumulative or subject to waiting periods, except when applicable because the enrollment was done outside of the fixed annual enrollment period. The benefits will not be subject to waiting periods if the person applies for the plan outside the fixed annual enrollment period as a result of a qualifying event, as established in the section Important Notice About Individual Plan Enrollment.

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

Access Model
This is a hybrid plan that adapts to yourr needs. Triple-S Salud offers you primary care and urgent care in a visit to a medical office or virtual visit, through its PCP Pocket network, to provide you with the help, answers, and care you need. For details of virtual care, refer to the Teleconsulta MD section.

With this POS health plan model, the insured person obtains a coordinated care to address their health needs. The covered services are available through participating providers, including, medical doctors, hospitals, facilities among others through the Preferred Networks and the Triple-S Salud Participant and Providers Network.

With this coverage, the insured person is free to visit the provider of their choice within the Preferred Networks or the Network of Participants and Providers of Triple-S Salud. Note that the difference between visiting a provider from the Preferred Networks versus a provider from the Triple-S Salud Participant and Provider Network is in the amount you pay for the covered service.

We recommend that you always select a Primary Care Physician (PCP) to coordinate your services with other providers. It will help you identify the medical care you need with other specialist doctors in the preferred network.

The insured person may access medical services in several ways:

1. Visiting the family doctor or PCP. You can also make a virtual visit through Teleconsulta MD. These visits have no copay.
2. **Using a consultation, written or electronic, from a Pocket Network PCP to visit a Pocket Preferred Network specialist, subspecialist or health professional:**
   Visiting a PCP or Teleconsulta MD providers, and if necessary, they will give you a written consultation to see a Red Pocket specialist, subspecialist or health professional.
   a. The consultation will only be necessary to visit a Pocket Network specialist, subspecialist or health professional. For other covered services with a medical order from a Red Pocket specialist, subspecialist or health professional (as applicable), you may access them without a consultation.
   b. The insured person does not pay for the visit to the specialist or subspecialist, within the Red Pocket.

3. **Without using a consultation, written or electronic, from a network PCP to visit a specialist, subspecialist or health professional:**
   Visiting a specialist, subspecialist or health professional from the Pocket Network or from the Triple-S Salud Participant and Provider Network without a written or electronic consultation from a PCP.
   a. The insured person pays a copayment for the visit to the specialist, subspecialist or health professional, from the Pocket Network or Network of Participants and Providers of Triple-S Salud.
   b. If you select a PCP and decide to go directly to a specialist or subspecialist without consulting the PCP, the insured will pay the copayment according to the DEDUCTIBLES, COPAYMENTS AND COINSURANCES table.

When visiting the Preferred Hospital Network and Partial Hospitalization, the insured person pays a lower copayment than when visiting a hospital in Triple-S Salud's Non-Preferred Hospital Network. Also, if the insured person visits the Preferred Network for other services, the copayment or coinsurance will be less than if he visits the Triple-S Provider and Participant Network.

You can visit any Triple-S Salud participating pharmacy or dentist as well as providers of Triple-S Natural, Selective Laboratory Network and Selective Imaging Center Network without a consultation, written or electronic, from the primary care physician or PCP. For these services, the same copayment or coinsurance will always apply.

There are certain rules of the Triple-S Salud plan that you must follow in order for services to be covered, such as: visiting certain providers to receive specific services, precertification for services before receiving them, use of the Drug List, medications generics as the first option and use of network doctors and providers, among other rules.

Medically Necessary Services

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

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

Medical-Surgical Services During Hospitalization

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

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

Hospitalization Services

For the purposes of the coverages provided in this policy, hospitals participating in the Triple-S Salud Network have been classified based on the quality of their hospital facilities. The first category is the **Preferred Hospital** network, where your copayment for admission fees is lower. The second category is the **Non-Preferred Hospital** network, including the remaining contracted hospitals, where you pay a higher admission fees. To verify which hospitals are preferred and non-preferred, please read the section on Preferred Networks in the Triple-S Salud Participants and Providers Directory. Any other hospital classification included in the Triple-S Salud Participants and Providers Directory does not apply to this policy.
Any member being admitted due to injury or illness is required to pay the participating hospital, at the time of admission, the copayment established for admission. The member will also be responsible for paying any other services provided during hospitalization that require copayments or coinsurance, as defined in this policy. Copayments and coinsurance are non-refundable.

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

Participating providers in our network

We hold contracts with physicians, facilities and providers all over the Island to provide services to our members. It is essential for you to know and access our Providers and Participants Directory at any time.

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

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

Special Management Contracts

Triple-S Salud may establish a particular contract with a provider for health conditions that require, or for which Triple-S Salud requires, specialized management. There are certain conditions that, due to their particular characteristics, require Triple-S Salud to closely review the utilization of services to prevent insurance fraud or service abuse. Triple-S Salud policies are aimed at ensuring an adequate management of these particular cases, so as to guarantee equal treatment for all members under similar conditions while also guaranteeing a cost-

effective management. This policy is not construed as an elimination or reduction of the benefits covered under this policy.

Compensation to Network Providers

The services provided by participating providers are paid based on the established fee for each service, in accordance with the contract between the participant and Triple-S Salud. When requesting a service, the member is required to show the plan identification card that proves he/she is eligible to receive services from the provider. The card will show the coverage the member is entitled to.
If you need additional information about the fees or rates paid to participating physicians or providers for a specific service, please call Customer Service at the number listed on the back of the member identification card.

Services Outside the Contracted Provider Network in Puerto Rico

The services covered by this policy that are provided by non-participating physicians or providers of Triple-S Salud are covered only in cases of emergency, including air ambulance, as required by law, and will be paid directly to the provider based on the contracted fee that would have been paid to a participating provider, after deducting the applicable copayment and/or coinsurance, as provided in the policy.

If the member receives health care services from a non-participating provider after receiving the post-stabilization or emergency services covered under the health plan, Triple-S Salud will reimburse the member based on the lesser amount between the expense incurred and the fee that would have been paid to a participating provider, after deducting the applicable copayment and/or coinsurance, as established in the policy, provided that there is a compelling medical reason why the patient cannot be transferred to a participating provider.

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

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

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

Transition

When a provider abandons the Triple-S Salud Network

If a provider cancels (voluntarily or involuntarily) or the health plan is terminated, the member shall be notified of such cancellation at least 30 days before the effective date of cancellation.

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

In the case of a cancellation, and subject to the payment of the premium, the member shall be entitled to continue receiving benefits for a transition period of 90 days. If the member is hospitalized on the date of cancellation and the discharge date was scheduled before the termination date, the transition period will be extended 90 days after the member's date of discharge.

If a member is pregnant and the cancellation occurs during the second trimester, the transition period will be extended until the member's date of discharge after delivery or the newborn's date of discharge, whichever is last. If a patient is diagnosed with a terminal condition before the plan's termination date and he/she continues receiving services for that condition before the plan's termination date, the transition period will be extended for the remainder of the patient's life.

New members with ongoing treatment

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

This course of treatment must be for a life-threatening disease or condition, or a degenerative and debilitating condition or disease. Members may also continue receiving care from a non-participating provider if the member is in her second or third trimester of pregnancy when this policy of coverage becomes effective. Members may continue receiving health care up until the date of delivery and for any post-partum services directly related to it. To continue receiving services from a non-participating provider under the aforementioned circumstances, the provider must accept our fees as payment for such services. The provider must also agree to provide the necessary medical information about the member's health care and accept our policies and procedures, including those to ensure the quality of health care, to obtain a precertification and a plan of treatment approved by the Plan. If the provider agrees with these conditions, the member will receive the covered services as if they were provided by a participating provider. The member shall be liable only for copayments and coinsurance applicable to his/her coverage.

Emergency Services

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

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

Urgent Care

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

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

Maximize your plan benefits

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

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

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

Remember: if you feel **ill**, are **injured**, or **need health advice, call Teleconsulta.** Nursing professionals will offer you advice to decide whether you should:

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

Visit a general practitioner or primary care physician instead of visiting multiple medical specialists to properly diagnose and treat a condition. General practitioners or primary care physicians may be an Internal Medicine Specialist, Family Medicine Specialist, General Practitioner, Pediatrician, Gynecologist, Obstetrician-Gynecologist, or Geriatrician. According to Law No. 79-2020, Triple-S Salud may allow cancer patients to consider an oncologist as their PCP, provided that the oncologist provides their consent.

Your primary care physician will coordinate the necessary and preventive services according to your age and health condition, as well as any necessary health care services with other medical specialists and providers from the Triple-S Salud network.

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

- Use generic drugs as your first choice to treat your condition whenever they are available.
    - A generic drug is a copy of a brand-name drug whose patent has expired. A patent gives pharmaceutical companies the sole right to sell a drug while it is effective. When a patent expires, companies may sell generic versions of the available brand-name drug.
    - A generic drug has the same use and works in the same way in the body as brand-name drugs. It has the same active ingredient and it is equal in dosage, safety, and quality, as required by the Food and Drug Administration (FDA).
    - Generic medications can also mean savings for you, since they cost much less than brand-name drugs. In addition, copayments and/or coinsurance for generic drugs are usually lower. Please note that, if you are using a brand-name drug for which there is a generic available, you could receive the same benefits at a lower cost.

- Use Over-the-Counter (OTC) drugs with a $0 copayment under the Triple-S Salud program. The list includes drugs for stomach conditions, allergies, and eye drops that have demonstrated to be safe and

effective, and also represent lower costs for the health plan. Please remember you need to submit a physician's prescription for the OTC drug.

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

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

  Our plan offers all the preventive services required by law at no cost to you. This means you pay nothing out-of-pocket for services such as annual physical checkups and preventive gynecological appointments, preventive mammograms and other tests, vaccines, and much more. These are important steps to stay healthy, so you should maximize this benefit to promptly detect any health issues.

- Significantly reduce your out-of-pocket expenses by always using network providers. Triple-S Salud provides a comprehensive provider network in and outside Puerto Rico. Remember that our plan covers non-participating providers only in emergency cases. This means that you will be responsible for the total cost of non-emergency services received from non-participating providers.

- Use the PCP Preferred Network with a $0 copayment. Also, use the SALUS Clinics and the Preferred Hospital Network, which offer lower copayments/coinsurances than the rest of the network.

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

Teleconsulta[1]

Teleconsulta is an optional phone service that offers health care guidance, available 24 hours a day, 7 days a week, 365 days a year.

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

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

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

Teleconsulta offers you the benefit that, if the professional nurse recommends you "visit an Emergency Room", you will be given a number that may reduce your copayment/coinsurance at the Emergency Room (available only in Puerto Rico, depending on what is established by your coverage. For more information, please refer to your plan's Table of Deductibles, Copayments, and Coinsurance). This does not apply in case of an accident. If a non-participating provider cannot process the number to reduce your copayment/coinsurance in their system, the member may pay and request a reimbursement from Triple-S Salud for the amount that would have been reduced.

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

Service Precertification /Preauthorization for Prescription Drugs

There are certain services and drugs that require prior approval from Triple-S Salud before the member can receive them. Either the member or the provider is responsible for requesting a service precertification. Please refer to the Sections on Precertifications, Precertification Procedures, and Preauthorizations for Prescription Drugs for a detailed list of the services that require a service precertification or prescription preauthorization, as well as the process the member or provider should follow to obtain the plan's precertification.

Get an Updated Copy of the Drug List

Your prescription drug coverage under this policy is subject to a Drug List. The list is available on our website: www.ssspr.com.

If you would like to obtain a copy of the Drug List, call Customer Service.

[1] Teleconsulta is an exclusive service for Triple-S Salud members, managed by an independent contractor for health hotline information and guidance services.

Case Management

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

Disease Management Programs:

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

Complex case management:

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

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

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

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

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

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

Clinical Management

The benefits offered by this Policy are subject to precertifications and concurrent and retrospective reviews to determine when those services should be covered by the plan. The objective of these reviews is to promote the provision of medical care in a cost-effective way by revising the usage of medical procedures and, as the case

may be, the level or provider rendering the service. Covered services must be deemed medically necessary to be covered by the plan.

Clinical Management Program

The Clinical Management Program is designed to reach the entire population, as it focuses on identified needs based on the predominance of health conditions in our community. The pertinent interventions are provided to individuals within a given population to reduce health risks and improve the quality of the provided services.

This program is intended to provide comprehensive care in order to improve coordination and cover the healthcare needs of our (adult and pediatric) insured members and their families, and, in turn offer preventive education and service coordination.

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

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

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

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

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

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

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

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

- **Contigo Mamá Program:** This program educates members on the importance of early prenatal care and the risk factors to watch out for. During their pregnancy, members will receive educational brochures on how to take care of their pregnancy and their baby. They will also receive orientation phone calls from a clinical manager specialized in prenatal care and additional education at workshops offered by health educators. After enrolling and participating in the program, the insured member will be able to receive our postnatal In-Home Support service. If the member does not enroll or participate in the program, this benefit will not be covered. The benefit consists of in-home support for everyday activities, such as light house cleaning (cleaning, laundry, washing dishes), preparing meals, help with bathing and getting dressed, and medication reminders. The benefit covers up to 16 hours (four [4] hours per day for up to four [4] days) per policy year after the baby is born. Although the prenatal stage is not a chronic illness, it can lead to a series of complications due to preexisting illnesses or conditions. The prenatal nurse helps coordinate the acquisition of a Zofran pump for insured members with hyperemesis gravidarum and the injections to prevent premature birth for members with high-risk pregnancies.

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

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

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

Your coverage when you participate in a Clinical Trial

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

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

Our plan covers:

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

Our plan does not cover:

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

Preventive Centers Program

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

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

Triple-S Natural

Triple-S Natural is a program that lets you obtain certain healthcare services using an alternative medicine model. The member will be responsible for paying the established copayment, which is shown in the Table of Deductibles, Copayments, and Coinsurance at the end of the policy.

The Triple-S Natural Program combines the fields of conventional and alternative medicine, providing up to 6 services per year, per insured member, and includes the following types of therapy:

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

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

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

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

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

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

The program is only available through participating plan providers. For a list of the participating providers, please refer to the Triple-S Salud Participant Directory, visit our website www.ssspr.com, search our mobile application, or call Customer Service for information about participating providers near you.

Tool for Health Risk Assessment (HRA)

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

Educational Materials in our Website

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

Satisfaction Surveys

The opinion of our members matters.

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

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

Benefits Not Covered by the Plan

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

Before receiving said medical service, treatment, or medication, we recommend you check the Exclusions Sections in your benefits policy, as well as any endorsement to it, to verify whether it is covered. We also recommend you talk with your physician or service provider about the treatment alternatives covered under the plan to reduce your payments, or about coverage options under programs with other organizations that may provide you additional help.

Advance Directives or Instructions

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

If a disease disables you from communicating, the decisions regarding your health will be taken by another person, and not always in accordance to what you would have wished.

As per Puerto Rico law, the closest relative of legal age—first of which is the patient's spouse—shall be the one to make the decisions about accepting or rejecting medical treatment. Therefore, it is important to take a few moments to write your advance directives.

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

Informed Decisions About Your Health Care

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

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

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

Coverage of Services by Local or Federal Law

This policy provides the member with all the benefits offered under this policy, including the services required by local and federal law.

Preventive screening services, based on the age of the preschooler, as required by Act No. 296 of September 1, 2000, are covered by this policy. In accordance with normative letter No. N-AV-7-8-2001, the Department of Education is responsible for ensuring that every child has received their annual medical check-up by the beginning of every school year. This medical exam must include a physical evaluation, mental health assessment, oral health care, vision and hearing screening, as well as all periodic screenings recommended by the American Academy of Pediatrics.

In compliance with Law No. 97 of May 15, 2018 (Bill of Rights of Persons with Down Syndrome), as amended by Law No. 13 of March 25, 2022, this policy covers the required services for members who have had Down Syndrome since birth, including genetic testing, neurology, immunology, gastroenterology and nutrition, medical visits and tests referred by physicians, as well as therapeutic services such as physical, occupational, and speech therapy, as well as any other necessary therapy, with a remedial approach to independent or assisted living for adults over 21 years old. These services will be covered based on the quantities and frequency ordered by the provider or specialist, subject to the copayments and coinsurances established in the policy.

Vaccines. This policy also covers the vaccines established by the Centers for Medicare & Medicaid Services (CMS), and as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the Advisory Committee on Immunization Practices of the Puerto Rico Department of Health. For information specific to this coverage, please refer to the section on Standard Vaccine Coverage for Minors, Adolescents, and Adults.

In order to comply with Law No. 43 of April 16, 2020 ("Law to Address COVID-19"), Triple-S Salud will not require any copayment, coinsurance, deductible, precertification, or referral from its members for medical care, studies, analyses, diagnoses, and treatment related to COVID-19, including hospitalization, as long as these services are provided in Puerto Rico.

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

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

Acts of Unlawful Discrimination

Unlawful discrimination is:

- Denying, refusing to issue, renew or reissue, cancelling, or terminating the plan coverage, or increasing the premium or add-on charges, on the grounds that the member has been the victim of abuse; or
- Excluding, limiting coverage, or denying claims based on the member's status as a victim of abuse.

It is a discriminatory act to request or use information about the actual or potential acts of abuse or the status of abuse of the member, regardless of how such information is obtained, except for the limited purpose of complying with legal obligations or verifying the person's claim that they are a victim of abuse.

It is a discriminatory act to terminate the group coverage of a victim of abuse because the coverage was originally issued to the abuser and the abuser has divorced or separated from the victim or has lost custody of the victim, or because the abuser's coverage has otherwise been terminated voluntarily or involuntarily. The provisions herein do not preclude Triple-S Salud from requiring the victim to pay the full premium for medical plan coverage, or from requiring, as a condition for coverage, that the victim of abuse reside or work within the health plan service area, if such requirements equally apply to all current or potential members.

How Your Coverage Works

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

Aside from the monthly payments for the plan (the "premium"), the member also pays part of the costs when receiving health care covered by the plan. There are different types of out-of-pocket costs: deductibles, copayments, and coinsurances, up to the maximum out-of-pocket for the coverage. For details about your plan copayments, coinsurance, and deductibles, please refer to the Table of Deductibles, Copayments, and Coinsurance at the end of this policy.

COORDINATION OF BENEFITS (COB)

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

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

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

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

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

B. 1) Except for what is provided later in paragraph (2), if a plan has not provided a priority order for the coordination of benefits in accordance with this section, it is deemed a primary plan, unless the provisions for both plans, regardless of what is stated in this paragraph, state that the plan establishing the order for the coordination of benefits is the primary plan.

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

C. A plan may only take into account the benefits paid by another plan if, under these rules, it is a secondary payer in relation to the other plan.

D. Order of Determination of Benefits

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

1) Non-dependent or dependent

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

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

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

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

2) Dependent Child Covered Under More than One Plan

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

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

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

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

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

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

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

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

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

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

d)

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

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

paragraph (a), between the parent(s) of the dependent minor(s) and the dependent spouse.

3) Active Employee or Retired or Former Employee

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

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

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

4) COBRA or Extensions of Coverage Under State Law

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

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

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

5) Longer or Shorter Coverage Time

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

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

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

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

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

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

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

GENERAL PROVISIONS

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

   The member recognizes Triple-S Salud's right of subrogation and will have the responsibility to notify Triple-S Salud of any actions initiated against said third party, provided that the member will be responsible for issuing payment to Triple-S Salud for such expenses, should he/she act otherwise.

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

   Whenever you receive care services outside Triple-S Salud's service area, you should get it from two types of provider. Most participating providers hold a licensee contract with Blue Cross and/or Blue Shield in the other geographic area ("*Host Blue*"). Some providers ("non-participating providers") are not under contract with the *Host Blue*. Below we explain how Triple-S Salud pays both types of providers.

   Types of Claims

   All types of claims meet the requirements to be processed through Inter-Plan Arrangements, as described above, except for any dental care, prescription drug benefits and vision care benefits that could be handled by Triple-S Salud to render these services.

   A. **BlueCard® Program**

      In the BlueCard® Program, when you receive covered services within a *Host Blue* service area, Triple-S Salud will remain liable for fulfilling what was agreed in the contract. However, the *Host Blue* is responsible for contracting and processing most interactions with its participating health care providers.

   Whenever you obtain covered services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for the covered services will be calculated based on the lesser value between:

   - The covered charges billed for your covered services, or
   - the negotiated price that the Host Blue has provided for Triple-S Salud.

   This "negotiated price" will often include a simple discount that shows the true price the Host Blue pays your health care provider. Sometimes, it is an estimated price that takes into account any special arrangements with your provider or a specific provider group, which may include various kinds of deals, payment of incentives, and other credits or fees. It may sometimes be an average price, based on a discount that results in average prospective savings for health care providers after taking into account the same type of transactions that happen at an estimated price.

   The estimated price and the average price also take into account adjustments to correct overestimates or underestimates of past price changes to correct the prices of past claims as noted above. However, these adjustments will not affect the price we use for your claim, as they will not be applied retroactively to the claims already paid.

The *Host Blues* decide whether to use a real price, an approximate price, or an average price. *Host Blues* using either an approximate price or an average price may prospectively increase or reduce these prices to correct overestimates or underestimates of previous prices (i.e., prospective adjustments could mean that the regular price reflects additional amounts or credits for claims due to be or already paid or received by providers). However, the *BlueCard* Program requires that the amount paid by the members be the final price; no future price adjustments shall result in an increase or reduction to price determinations for past claims. To determine the premiums, Triple-S Salud takes into account the method of payment used by the *Host Blue* to pay out claims.

B. Federal / State Taxes / Surcharges / Fees

In some cases, federal or state laws or regulations may impose a surcharge, tax, or other applicable fees on insured accounts. If appropriate, Triple-S Salud will include any such surcharges, taxes or fees to determine the premium.

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

If the covered services are rendered outside Triple-S Salud's service area by providers not participating in the network, the amount you pay for such services will be based on either: the local fee for providers not participating in *Host Blue*, or the agreed-upon fees established by applicable state law. In such cases, you may be responsible for paying the difference between the amount billed by the non-participating provider and the payment to be made by Triple-S Salud for the covered services, as set out in this paragraph. Payments for out-of-network emergency services are regulated by the applicable state and federal laws.

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

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

   Triple-S Salud, Inc. does not exclude persons nor treats them differently because of their ethnic origin, color, nationality, age, disability, or sex.
   We offer free assistance and services to people with disabilities so they may communicate with us effectively. We also offer free language services to people whose first language is not English.

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

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

   If the member receives post-stabilization services or services after the emergency, which would have been covered under the health care plan except for the fact that they were provided by a non-participating provider, Triple-S Salud will reimburse the member for that part of the costs, as provided in the policy.

   For Triple-S Salud to be able to compensate or reimburse the member in these cases, the member must provide a claim notice in writing to Triple-S Salud within twenty (20) days after receiving the service or as soon as reasonably possible, but no later than one (1) year from the date the service was rendered, unless evidence is submitted that it was impossible to submit the claim within the stated period of time.

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

7. **COVERAGE RENEWAL**: Triple-S Salud will renew the individual health plan for the member or dependent, at the option of the member, in accordance with the applicable federal laws and regulations, except in the following cases:

    a. Non-payment of premiums or contributions, in accordance with the health plan terms, or if Triple-S Salud has not received the premium payments in due time.
    b. The member or the member's representative has committed an act or incurred in a practice that constitutes fraud, or has intentionally made false representations about material facts.
    c. Triple-S Salud has decided to discontinue the offering of all individual health plans it manages or issues in Puerto Rico, and it has notified its determination to not renew the health plan to:

        i. the Office of the Commissioner of Insurance, in writing and at least ninety-five (95) days prior to the date of non-renewal

        ii. all members, in writing and at least ninety (90) days prior to the date of non-renewal.

    d. If the Office of the Commissioner of Insurance determines that continuing the health plan would not respond to the best interests of the members, or would affect the insurer's ability to comply with its contractual obligations.

    e. If the Commissioner determines that the health plan formulary is obsolete and can be replaced with a comparable coverage, Triple-S Salud discontinues the obsolete product in Puerto Rico, and also notifies its determination to not renew the obsolete health plan:

        i. To the Office of the Commissioner of Insurance, in writing and at least one hundred and eighty-five (185) days prior to the date of non-renewal;

        ii. To all members, at least one hundred and eighty (180) days prior to the date of non-renewal;

        iii. It offers each member of the obsolete product the option to purchase all other individual health plans currently offered by Triple-S Salud in Puerto Rico; and

        iv. When Triple-S Salud exercises the option to discontinue the obsolete product and offer the coverage option in accordance with subsection (iii), Triple-S Salud acts in a uniform manner, without considering the member's claims experience or health-related factors, or those of his/her dependents who could be eligible for coverage.

    f. For health plans that are offered through a preferred network plan, the member no longer resides, lives, or works in the established geographical service area, provided that the coverage is terminated according to this subsection, without considering the factors related with the member's health condition.

8. **GRACE PERIOD:** A grace period of ten (10) calendar days will be granted for each premium payment due after the first premium, during which the policy will continue in force.

9. **INDEPENDENT LICENSEE OF BLUE CROSS BLUE SHIELD ASSOCIATION:** The member hereby expressly acknowledges and knows that this policy constitutes a contract only between the member and Triple-S Salud, Inc., which is an independent corporation and operates under a license of the *Blue Cross Blue Shield Association*, an association of Independent Plans affiliated to *Blue Cross Blue Shield* (the Association), allowing Triple-S Salud, Inc. to use its *Blue Cross Blue Shield* brand of service in Puerto Rico, and that Triple-S Salud, Inc. is not contracted as an agent of the Association.

The member agrees and accepts that he/she has not acquired this policy based on representations from any person other than Triple-S Salud, Inc. and that no other person, entity, or organization, other than Triple-S Salud, Inc., may be liable for any of Triple-S Salud Inc.'s obligations with the member, created under this policy.

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

10. **IDENTIFICATION:** Triple-S Salud will issue a card to each member, which they will be required to present to any participating Triple-S Salud provider whose services they request in order to have them covered under this policy. The member must also present a second photo identification.

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

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

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

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

14. **MODEL FOR CLAIMS:** Upon receipt of a claim notice, Triple-S Salud will provide the claimant with the models that it regularly provides to submit a proof of service. If these models are not provided within fifteen days after said notice was given, it will be understood that the claimant has complied with the requirements of this policy in terms of proof of service, if they submit, within the time established in this policy to submit proof of service, written proof covering what happened and the nature and scope of the service for which the claim is being filed.

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

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

17. **PERSONAL RIGHTS:** The rights and benefits of this policy are not transferable, and no member may assign, transfer, or alienate any of the rights or benefits that he/she could claim under the policy in favor of third parties. Triple-S Salud reserves the right to recover all expenses incurred if the member, with his/her express or implied consent, allows uninsured persons to use the member card issued in his/her name by Triple-S Salud. In addition, the recovery of such expenses will not prevent Triple-S Salud from being able to cancel the insurance

contract when it discovers the illegal use of the card, nor will it prevent the filing of a grievance so that the member or the person using such card illegally is prosecuted criminally.

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

19. **PREMIUM PAYMENT:** The primary policyholder is responsible for paying the policy premium; providing that such responsibility covers the entire premium due until the policy's date of termination, according to the clause of Termination. The policyholder will remain liable in his/her personal capacity for the payment of the premiums, regardless of any arrangement that the member could do with a third party to manage or pay the premiums on his/her behalf.

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

    Triple-S Salud reserves the right to alert any credit agency, institution, or entity, in detailed form, about the policyholder's breach of payment.

    If the member's age is incorrect, the premium will be adjusted based on the correct age.

20. **PROOF OF SERVICE:** If the member files a claim for services, proof of such services must be provided in writing to Triple-S Salud within ninety (90) days after the services are received. Failure to submit such proof within the required time will not invalidate or reduce any claim if submitting the proof was not reasonably possible within said time, as long as such proof is submitted as soon as it is reasonably possible but, except in the absence of legal capacity, no later than one (1) year from the date the proof would otherwise be required. The policyholder consents and authorizes any professional or service provider to provide reports to Triple-S Salud, which will be kept confidential, regarding the diagnosis and services supplied to him/her or to any dependent member dependent. These reports will be used only and exclusively to determine the contracted rights and obligations under the policy.

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

22. **REINSTATEMENT:** If an overdue premium is not paid before the end of the grace period, subsequent acceptance of premium payment by Triple-S Salud or an authorized representative, without need for a reinstatement request, shall be sufficient to reinstate the policy. If Triple-S Salud or the authorized representative asks for a request, a conditional receipt for the premium will be given. If the request is approved, this policy shall be reinstated as of the date of approval. In the absence of such approval, this policy will be reinstated on the forty-fifth day after the date of the conditional receipt, unless there has been written notice of the denial.

    The reinstated policy only covers losses resulting from an injury occurring after the date of reinstatement, or from an illness beginning after ten (10) days of such date. In all other cases, your rights and those of Triple-S Salud remain the same, subject to any provisions stipulated or attached to the reinstated policy.

    Any premium accepted for reinstatement will be applied to a period for which premiums have not been paid, provided that no premium is applied to a period greater than sixty (60) days prior to the reinstatement date.

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

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

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

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

    c. If the mother and the newborn are discharged within a shorter time frame than what was established in subsection (a) of this item, but, as per subsection (b), the coverage provides for a follow-up visit within the next forty-eight (48) hours.

    d. Insurers will not design benefits or include copayments or coinsurance that imply an unfavorable treatment during some portion of the hospital stay.

    e. In addition, the law does not allow requiring a precertification for stays that are within the provisions of the law. However, the law allows requiring a precertification to use some providers or to reduce the expenses that a member may incur. Triple-S Salud will not require this precertification.

25. **SINGLE CONTRACT - CHANGES:** This policy, including its endorsements and added documents, if any, constitutes the full text of the insurance contract. No change to this policy will be valid until it is approved by the executive officer designated by the Board of Directors of Triple-S Salud and the Office of the Commissioner of Insurance of Puerto Rico prior to its use, unless such approval is herein endorsed or attached. No authorized representative has the authority to change this policy or waive any of its provisions.

26. **SUMMARY OF BENEFITS:** Triple-S Salud will provide the policyholder with a Summary of Benefits and Coverage (SBC), which includes the structure of copayments, limitations, and exclusions in your plan, a list of participating physicians and providers, and the Drug List.

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

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

    Subject to any premium payment, in the case of a provider or health plan termination, the member may continue receiving the same benefits during a transition period of ninety (90) days from the plan or provider's date of termination.

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

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

    b. If a member is in her second trimester of pregnancy by the termination date of this policy and the provider has been offering medical treatment related to the pregnancy before such termination date, the transition

period for pregnancy-related services shall be extended until the member's date of discharge from hospitalization for delivery or the newborn's date of discharge, whichever of the two is latest.

c. If the patient is diagnosed with a terminal condition before the date of termination of the policy, and the provider has been offering medical treatment related to this condition prior to that date, the transition period will be extended for the patient's remaining lifetime.

The transition care period is subject to payment of the premium and may be denied or terminated if the member and/or the provider commit fraud against the insurance.

28. **TIME FOR CLAIM PAYMENTS:** The payment for services to be issued in accordance with this policy shall be made immediately after receiving written proof of such services.

29. **TOTAL PAYMENT FOR COVERED SERVICES IF THERE IS NO PROVIDER:** If a member has medical need for a service covered by the plan but for which there is no contracted provider, and the coverage does not state whether the service will be available by reimbursement to the member, Triple-S Salud will coordinate and establish a special agreement with a non-participating provider for the provision of such services to the member. This will be subject to the terms and conditions of the member's policy, and to the provider payment based on the fee established by Triple-S Salud for the services to be provided.

30. **WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA):** This policy provides coverage to the member for reconstruction of the breast where a mastectomy was performed, as well as coverage for the reconstruction of the other breast to produce a symmetrical appearance, the prosthesis, and any physical complications that arise at any stage of the mastectomy. These benefits are provided in consultation between the member and her physician and will be subject to the coinsurance and copayments established in this policy.

Protections for the member under Law No. 134 of September 1, 2020, and Article 48.050 of the Health Insurance Code of Puerto Rico

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

If you receive emergency services in Puerto Rico, the facility will not bill you in excess of any deductible, copayment, or coinsurance applicable to the services received within the participating provider network. Please, review the sections “How Does Your Plan Work” and “Urgent Care and Emergency Services” to learn more about how services rendered by non-participating providers are handled in emergency cases.

Triple-S Salud has a variety of relationships with other Blue Cross Blue Shield (BCBS) plans in the United States. Whenever you access health care services outside the geographic area Triple-S Salud serves, you will receive the service from two types of providers: participants who have a contract with another BCBS plan in that geographic area and those who do not have a contract. Providers that are not BCBS participants are only covered in case of emergency, and you may be responsible for the difference between the amount billed by the non-participating provider and the payment Triple-S Salud issues for the services. Please review the section Extended Coverage in the Unites States to learn more. Please refer to the Table of Deductibles, Copayments, and Coinsurance section to learn more about your payment responsibility when obtaining services covered under this policy.

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

You are entitled to:

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

• Obtain information about the allowed amount that Triple-S Salud will reimburse, as well as information about the member's payment liability, including an explanation that the member will need to cover the difference between the allowed amount as defined by Triple-S and the charges billed by an out-of-network provider. Please refer to Services Outside the Contracted Provider Network in Puerto Rico in the section How Your Plan Works.

• Obtain examples of anticipated costs for frequently billed services outside the contracted provider network. For example, you may be charged over $140 for a CT scan (computerized tomography) interpretation performed by a radiologist or receive a bill of over $2,500 for robotic assisted surgery. These examples are for illustrative purposes, and the amount charged
may differ from what is presented since the non-participating provider determines the cost of the service.

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

Any other information the Commissioner deems appropriate and necessary to ensure that the member receives enough of the information needed to estimate the cost of an out-of-network service and make an informed health care decision.

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

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

Your Benefits Information and all communications to the member and to the provider regarding reimbursements will include a clear and concise notice from Triple-S Salud that any inadvertent and unintentional out-of-network charges are not subject to collection or billing beyond the financial responsibility incurred under the terms of the network service contract. Any collection or billing efforts from the provider must be immediately notified to the insurance company's customer service department, to the phone number provided as part of the Benefits Information and in all communications to the member regarding reimbursements.

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

The general purpose is to stop all surprise charges in health plan bills and establish consumer protections, transparency, cost controls, and responsibility outside the provider network, and other related objectives.

On the other hand, in accordance with Law No. 134 and Article 48.120 of the Health Insurance Code of Puerto Rico, please be advised of your right to contact the Office of the Commissioner of Insurance of Puerto Rico (OCS, by its Spanish acronym) to report or dispute a charge outside the contracted network, by calling (787) 304-8686, by mail to 361 Calle Calaf, PO Box 195415, San Juan, PR 00919, or by visiting the OCS offices at World Plaza Building, 268 Muñoz Rivera Ave., San Juan, PR 00918.

Any attempt made by the provider to collect or bill should be reported immediately to the Customer Service Department, at 787-774-6060. You have the right to contact the Office of the Commissioner of Insurance to report or dispute a charge for a service rendered by a non-participating provider:

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

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

General Information on Protections

Triple-S Salud will send each member a written notice, in the form and manner instructed by the Commissioner of Insurance, on the protections provided to members, in accordance with Chapter 48.120 of the Health Insurance Code of Puerto Rico. The notice will include information on how consumers may contact the Office of the Commissioner of Insurance to report or dispute an out-of-network charge. This notice will also be published in Triple-S Salud's website.

The Office of the Commissioner of Insurance will publish an informative notice on its website regarding the protections offered in this Chapter and how consumers may report and submit complaints before the Office regarding out-of-network charges, as well as information and guidance on the arbitration procedures presented, in accordance with Article 48.100 of this Chapter.

YOUR RIGHTS AND RESPONSIBILITIES AS A PATIENT

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

Right to high-quality Health Services

Services consistent with the generally accepted principles of medicine practice.

Rights regarding the collection and disclosure of information

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

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

Rights regarding the selection of plans and providers

Every individual has the right to:

- Select health care plans and providers that are appropriate and best fit his/her needs without being discriminated against based on socio-economic status, ability to pay, preexisting medical conditions, or medical history, regardless of age.

- A network of enough authorized providers to ensure that all the services covered by the plan will be accessible and available without unreasonable delay and in reasonable geographical proximity to the members' residences and workplaces, including access to emergency services twenty-four (24) hours a day, seven (7) days a week. All health care plans offering health service coverage in Puerto Rico must let each patient receive primary health care services from any participating primary service provider selected, pursuant to the provisions in the health care plan.

- Let every member receive the specialized health care services necessary or appropriate to maintain their health, according to the referral procedures established in the health care plan. This includes access to qualified specialists for patients with special conditions or health care needs, to ensure that members will

have fast and direct access to the qualified providers or specialists selected from the plan's provider network. If the plan requires a special authorization for such access to qualified providers or specialists, the plan will guarantee an appropriate amount of visits to cover the health needs of these members.

Patient's right to continuity in their health care services

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

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

Right to access emergency services and facilities

- Free and unrestricted access to emergency services and facilities, when and where the need arises, and without precertification or waiting periods.

- Reliable and detailed information regarding the availability, location, and proper use of emergency facilities and services in their respective locations, as well as provisions regarding the payment of premiums and reimbursement of costs related to such services.

- If emergency services are rendered by a non-participating provider, the member will only pay the applicable copayment or coinsurance.

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

- The right to participate, or have your parent, guardian, custodian, caretaker, spouse, relative, legal representative, proxy, or any person designated by court for such purpose to fully participate, in the decisions about your health care.

- Receiving all the necessary information and available treatment options, costs, risks, and chances of success for these options.

- The use of advance directives or guidelines concerning your treatment, or appointing someone to act as your guardian if necessary to make decisions. Your health care service provider shall respect and abide by your treatment decisions and preferences.

- No health care plan may impose gag clauses, penalties, or any other type of clause that interferes with the communication between patients and physicians.

- All health care providers are required to provide medical orders for laboratory tests, x-rays, or drugs so you may choose the facility where you will receive the services.

Right to respect and equal treatment

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

Right to confidentiality of information and medical records

To communicate freely, without fear and in strict confidentiality with your health care providers.

- Be confident that your medical records will be kept under strict confidentiality and will not be disclosed without your authorization, except for medical or treatment purposes, by court order, or as specifically authorized by law.

- Obtain receipt for the expenses incurred for total or partial payments, copayments, or coinsurance. The receipt must specify the date of service, name, provider's license number and specialization, name of the patient and the person paying for the services, description of services, amount paid, and signature of the authorized officer.

- Access or obtain a copy of your medical record. Your physician must give you the medical record copies within 5 business days from the date of request. Hospitals will have 15 business days to comply. They may charge you up to $0.75 per page, but no more than $25.00 per record. If the physician-patient relationship is severed, you are entitled to request the original record free of charge, regardless of whether you have outstanding debts with the health service provider.

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

Rights regarding complaints and grievances

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

Your responsibilities as a patient are:

- Provide the necessary information about health plans and account payments. To know the rules for the coordination of benefits.

- To inform the insurer of any instance or suspicion of fraud against the health insurance. If you suspect fraud has been committed against the health insurance, you must contact our Customer Service Department at 787-774-6060 or through our website www.ssspr.com.

- Provide the most complete and accurate information about your health, including previous illnesses, medications, etc. Participate in every decision related to your health care. To know the risks and limitations of medicine.

- To learn about the health plan's coverage, options, benefits, and other details.

- To comply with your health plan's administrative procedures.

- To adopt a healthy lifestyle.

- To inform your physician about any unexpected changes in your condition.

- To confirm that you clearly understand the course of action recommended by the health care professional.
- To provide a copy of your advance directives.
- To inform your physician if you foresee any problems with the prescribed treatment.
- To recognize the provider's obligation to be efficient and fair in providing care to other patients.
- To be considerate, so that your individual actions do not affect others.
- To resolve any differences through the procedures established by the insurer.

APPEALS FOR ADVERSE BENEFIT DETERMINATIONS

RIGHT TO REQUEST AN APPEAL AFTER AN ADVERSE DETERMINATION

What is an Adverse Determination?

- A determination made by the insurer or a utilization review organization, to deny, reduce, or terminate a benefit, or to not pay the benefit in part or in full, since in applying the utilization review techniques, based on the information provided and according to the health plan, the requested benefit does not meet the requirements for medical necessity and appropriateness, the place where the service is provided, or the level or effectiveness of care, or it is determined that it is experimental or investigative in nature;
- The denial, reduction, termination, or absence of payment for a benefit, either partial or in full, by the insurer or utilization review organization, based on the determination of the member's eligibility to participate in the health plan; or
- The determination resulting from a prospective or retrospective review in which the benefit is denied, reduced, terminated, or not paid, in part or in full.

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

RIGHT TO APPEAL AN ADVERSE DETERMINATION

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

APPEALS PROCEDURE

1. <u>First Level Review of Grievances Related to an Adverse Determination</u>

You or your authorized representative must submit the appeals in writing within **180 calendar days** from the date you received the first written notice of the adverse determination in order to have it evaluated, regardless of whether it is accompanied with all the information necessary to make the determination. Triple-S Salud will provide the member with the name, address, and phone number of the person or organization appointed to

coordinate the first level review on behalf of Triple-S Salud. If the grievance arises from an adverse determination related to a utilization review, it will be assigned to one or more clinical peers of the same or a similar specialty as the health care professionals who normally manage the case for which the adverse determination was made. These clinical peers must not have participated in the initial adverse determination. If more than one clinical peer is appointed, they will have the adequate expertise to evaluate your case.

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

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

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

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

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

In your appeal, you may request assistance from the Commissioner of Insurance, the Advocate of Health, or your preferred lawyer (at your own expense).

To request assistance, please contact:

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

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

Advocate of Health
PO BOX 11247

San Juan, PR 00910-2347
Phone: 787-977-0909

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

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

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

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

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

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

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

This determination will include:

- The qualifications and credentials of the individuals who participated in the first level review process (the reviewers);
- The statement of interpretation made by the reviewers of the grievance;
- The reviewers' determination with the medical justification or contractual basis to allow the member or his/her personal representative to respond to the claims;
- The evidence or documentation used as basis for the determination.

If after the first level review, the determination is adverse, it must also include:

- The specific reasons for an adverse determination;
- Reference to the health plan's specific provisions on which the determination is based;
- A statement regarding the member's rights to access or obtain free copies of the documents, records, and other relevant information used in the appeals review.
- If Triple-S Salud used a rule, guideline or internal protocol, or other similar criteria, in order to arrive at the adverse determination, a copy of such rule, guideline, protocol, or any other similar criteria used as a basis for the adverse determination must be furnished, free of charge, at the request of the member or, if applicable, their personal representative;

- If the adverse determination is based on medical necessity or the treatment's experimental or investigative nature, or on a similar exclusion or limitation, a written explanation of the scientific or clinical rationale followed to make the determination, or a statement saying an explanation will be provided to the member or, if applicable, to his/her personal representative, free of charge, at his/her request.
- If applicable, it must include the instructions to request a copy of the rule, guideline, internal protocol, or any other similar criteria used as a basis for the determination, and an explanation of the scientific or clinical rationale followed to make the determination.
- It must include a statement describing the process used to obtain an additional voluntary review, as well as the deadlines for such review, in case the member wishes to request it. It must also include a description of how to obtain an independent external review, in case the member decides not to request a voluntary review, and the member's right to initiate a lawsuit before a competent court.
- If also applicable, it must include a statement saying that Triple-S Salud and you may have other available options to voluntarily resolve disputes, such as mediation or arbitration, and your right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health to obtain guidance, learn more about available options, and request assistance, as well as the contact information for such cases.

2. Ordinary Reviews of Grievances Not Related to Adverse Determinations

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

Triple-S Salud will inform you of your rights within three (3) working days from receiving the grievance, and it will appoint one or more people who have not previously managed the issue that is the object of the grievance. Triple-S Salud will also provide you, the member, or their personal representative, if applicable, the name, address, and phone number of the people assigned to conduct the ordinary grievance review.
Triple-S Salud will notify you in writing of its determination, no later than thirty (30) calendar days after receiving the grievance. Once you have been notified of Triple-S Salud's decision, the determination shall include the names and titles of the officers or experts involved in the evaluation of your grievance, as well as a statement of the interpretation made by the grievance reviewers.

It must also include:

- the determination of the examiners in clear terms, and the contractual base or medical justification so you may respond to these considerations;
- Reference to the evidence or documentation used as basis for the determination;
- If applicable:
  - a written statement that includes the description of the process to obtain an additional voluntary review in case the member wishes to request it
  - The procedure to be followed and the required deadlines for the review
  - A description of the procedures to obtain an independent external review, if the member decides not to request a voluntary review.
  - The member's right to initiate proceedings before a qualified court.
  - Triple-S Salud and you may have other options for the voluntary settlement of disputes, such as mediation or arbitration. To determine the available options, please contact the Commissioner of Insurance.
  - a notice of the member's right to contact the Commissioner's Office or the Office of the Advocate of Health to request guidance and help, including the phone number and address of the Commissioner's Office and the Office of the Advocate of Health. You have the right to contact the

Office of the Commissioner of Insurance or the Office of the Advocate of Health to request assistance. The contact information for these Offices appears below.

RIGHT TO ASSISTANCE

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

- The Office of the Commissioner of Insurance is located at 361 Calle Calaf, World Plaza Building, 268 Muñoz Rivera Ave., San Juan, PR 00918, or you may call (787) 304-8686.

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

RIGHT TO APPOINT A REPRESENTATIVE

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

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

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

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

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

3. **Voluntary Level of Grievance Reviews**

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

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

- Request, within the specified time, an opportunity to appear in person before the review panel appointed by Triple-S Salud
- To receive from Triple-S Salud copies of all documents, records and other non-confidential and non-proprietary information related to the request for an additional voluntary review.
- Present his/her case before the review panel
- Submit written remarks, documents, records, and other materials related to the request for additional voluntary review, to be considered by the panel both before and during the review meeting

- If applicable, ask questions to the review panel representatives
- Obtain assistance or representation from anyone, including a lawyer

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

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

In terms of requests for additional voluntary review of an issued determination, Triple-S Salud appoints a review panel comprising Triple-S Salud employees or representatives, in order to assess the request, and you or your authorized representative may attend in person or by phone to explain your request. Any individual who participated in the first level review may be a member of the panel or appear before the panel only to provide information or answer the panel's questions. Triple-S Salud will ensure that the people performing the additional voluntary review are health care professionals with appropriate expertise and that the people conducting the additional voluntary review are not health plan providers of the member and have no financial interest in the outcome of the review.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- The qualifications and credentials of the members of the review panel
- A statement of the interpretation made by the review panel regarding your request and all relevant facts.
- The justification for the determination made by the review panel.
- References of the evidence or documentation the review panel used as the basis for the determination.

If the request for additional voluntary review involves an adverse determination, it must include:

- Instructions to request a written statement of medical justification, including the clinical review criteria used in making the decision.
- If applicable, a statement describing the procedures to obtain an independent external review of the adverse determination, in accordance with the Puerto Rico Health Insurance Code.

It shall also include a notice of the member's right to contact the Commissioner’s Office or the Office of the Advocate of Health to request help at any time, including the phone number and address of the Commissioner’s Office and the Office of the Advocate of Health. The contact information for these Offices is included in this Section, under Right to Assistance.

4. <u>Expedited Reviews of Grievances Related to Adverse Determinations</u>

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

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

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

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

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

This determination will include:

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

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

- The specific reasons for an adverse determination;
- Reference to the health plan's specific provisions on which the determination is based;
- A statement about the member's rights to access or obtain free copies of the documents, records, and other relevant information used in the evaluation of the appeal, including any rules, guidelines, internal protocols, or any other similar criteria used to substantiate the determination.
- If the adverse determination is based on medical necessity or the treatment's experimental or investigative nature, or on a similar exclusion or limitation, a written explanation of the scientific or clinical rationale followed to make the determination, or a statement saying an explanation will be provided to the member or, if applicable, to his/her personal representative, free of charge, at his/her request.
- If applicable, it should also include instructions to request a copy of the rules, guidelines, internal protocols, or any other similar criteria on which the determination was based, an explanation of the scientific or clinical rationale followed to make the determination, and a description of the process to obtain an additional voluntary review, as well as any relevant deadlines, in case the member wishes to request it.
- It should also include a description of how to obtain an independent external review, if the member decides not to request a voluntary review.
- A statement that the member is entitled to file a lawsuit with a competent court.
- If applicable, it must also include a statement saying that Triple-S Salud and you may have other available options for voluntary dispute resolution, such as mediation or arbitration.
- A notice of the right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health to obtain guidance, available options, and to ask for help, as well as information about the numbers to call in these cases.

- You have the right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health to request assistance.
- Triple-S Salud may provide notice verbally, in writing, or electronically.
- If the adverse determination is notified verbally, Triple-S Salud shall provide written or electronic notice no later than three (3) days after the verbal notification.
- Nothing herein shall be construed to limit Triple-S Salud's ability to waive an adverse determination without following the procedure prescribed herein.

To request assistance, please contact:

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

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

Advocate of Health
PO BOX 11247
San Juan, PR 00910-2347
Phone: 787-977-0909

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

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

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

5. Procedures for Utilization Review and Ordinary Determination of Benefits

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

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

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

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

- Determine that the extension is necessary due to circumstances beyond the control of Triple-S Salud; and

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

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

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

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

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

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

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

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

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

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

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

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

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

- Determine that the extension is necessary due to circumstances beyond the control of Triple-S Salud; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Procedure for Expedited Utilization Review and Determination of Benefits

Triple-S Salud has established written procedures for expedited utilization reviews and benefit determinations, and to notify members of its determinations regarding requests for urgent care. It is stated as part of the procedures that, if the member does not follow the procedures to file an urgent care request, Triple-S Salud must notify the member of such deficiency and of the procedures that must be followed to file the request correctly.

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

In the case of urgent care requests, Triple-S Salud shall notify the member of its determination, regardless of whether it is adverse, as soon as possible, taking into account the member's health condition, but no later than twenty-four (24) hours from the time the request is received, unless the member has not provided sufficient information for Triple-S Salud to determine whether the benefits requested are covered and payable under this policy.

If the member has not provided sufficient information for Triple-S Salud to make a determination, Triple-S Salud will notify the member of the deficiency, either verbally or, if the member so requests, in writing, and will advise the member of the specific information needed, as soon as possible but no later than twenty-four (24) hours from receipt of the request.

Triple-S Salud shall provide the member with a reasonable deadline to submit the specified additional information, but such deadline shall not be shorter than forty-eight (48) hours from notification of the deficiency.

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

If the member fails to submit the specified additional information within the provided time, Triple-S Salud may deny certification of the requested benefit. In the event that an adverse determination is made, Triple-S Salud shall notify such determination as explained in this section.

In the case of concurrent urgent care review requests in which the member requests an extension of treatment beyond the originally approved time frame or amount of treatments, if the request is made at least twenty-four (24) hours prior to the expiration of the original term or if the amount of previously approved treatments is met,

Triple-S Salud shall make its determination regarding the application and notify the member as soon as possible, taking into account the member's health condition, but no later than twenty-four (24) hours from receipt of the application.

For the purpose of calculating the required deadline for Triple-S Salud to make its determination, the time period will begin the day Triple-S Salud receives the application in accordance with its established procedures to file applications, regardless of whether the filing included all of the information required to make the determination.

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

- Sufficient information to identify the benefit requested or the claim made, including applicable data such as date of service, provider, amount of claim, Diagnostic Code and meaning, and Treatment Code and meaning;

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

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

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

- A description of the internal grievance procedures established by Triple-S Salud in accordance with the Puerto Rico Health Insurance Code, including the time lines applicable to such procedures.

- A description of the internal expedited review procedures established by Triple-S Salud in accordance with the Puerto Rico Health Insurance Code, including the time lines applicable to such procedures.

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

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

- An explanation of the member's right to contact, as appropriate, the Office of the Commissioner or of the Advocate of Health for assistance at any time, and the right to file a lawsuit in a competent court when the Triple-S Salud internal grievance process is concluded, including the contact information for the Office of the Commissioner and of the Advocate of Health.

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

7. <u>Emergency Services</u>

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

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

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

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

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

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

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

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

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

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

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

Notice of Right to External Review

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

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

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

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

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

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

the date the internal grievance was filed, the member may file a request for external review since they will be deemed to have exhausted the internal grievance process.

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

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

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

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

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

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

Office of the Commissioner of Insurance
Investigations Division
OCS Mailing Address
PO Box 195415 San Juan, PR 00919
361 Calle Calaf World Plaza Building 268 Ave. Muñoz Rivera, San Juan, PR 00918
Phone: 787-304-8686
www.ocs.pr.gov

- **Email:** investigaciones@ocs.pr.gov

Request for External Review

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

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

Requirement to Exhaust the Internal Grievance Process

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

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

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

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

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

- If the member has a health condition where the time required for an expedited internal grievance review would endanger their life, health, or full recovery; or
- If the adverse determination entails a denial of coverage based on a determination that the recommended or requested service or treatment is experimental or investigative in nature and the member's physician certifies in writing that such service or treatment would be significantly less effective if not initiated promptly.

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

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

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

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

Ordinary External Review

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

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

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

- If the requester was insured at the time the health care service was requested or, in the case of a retrospective review, was a Triple-S Salud member at the time the health care service was provided;
- If it could be reasonably understood that the health care service subject to adverse determination or final adverse determination is a covered service under Triple S-Salud, except if Triple-S Salud has determined it is not covered because it does not meet the criteria of medical necessity, appropriateness, location where the health care service is provided, level of care, or effectiveness of the service;

- If the member has exhausted the Triple-S Salud internal grievance process, except when the Triple-S Salud internal grievance process is not required to be exhausted; and
- If the member has provided all information and forms required by the Commissioner to process the requests for external review, including the authorization form for the disclosure of health information.

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

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

If the request:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- The member;
- Triple-S Salud;

- The Commissioner.

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

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

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

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

Expedited External Review

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

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

A final adverse determination, provided that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Send written confirmation of the determination to the member, Triple-S Salud , and the Commissioner; and

- Include the information in the written notice.

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

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

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

External Review for Adverse Determinations Based on Experimental or Investigative Treatment

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

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

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

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

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

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

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

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

Upon receipt of Triple-S Salud's notification that the request meets the criteria for review, the Commissioner will promptly appoint an independent review organization to perform an expedited external review; notify Triple-S

Salud as to which independent review organization was appointed, and send written notice to the member that their request was eligible and approved for expedited external review.

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

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

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

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

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

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

The member's attending physician:

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

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

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

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

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

If the request:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Each clinical reviewer shall analyze all of the information and documents received from Triple-S Salud and any other information submitted in writing by the member.

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

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

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

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

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

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

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

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

- A description of the member's health condition;
- A description of the relevant factors taken into account to determine whether there is sufficient evidence to show the recommended or requested health care service or treatment is more likely to be beneficial to the member than the usual and customary health care service or treatment, and that the adverse risks related to the recommended or requested health care service or treatment would not be significantly higher than those of the usual and customary health care services or treatments available;
- A description and analysis of the medical or scientific evidence considered to formulate the opinion;

- A description and analysis of any evidence-based standard considered to formulate the opinion; and
- Information as to whether the rationale behind the reviewer's opinion
- In the case of expedited external reviews, each clinical reviewer shall express their opinion, either verbally or in writing, to the independent review organization as soon as the member's condition or health problems require, but no later than five (5) days after being selected to perform the external review.
- If the clinical reviewer's opinion was initially formulated verbally, no later than two (2) days after providing their opinion, the clinical reviewer shall provide a written confirmation to the independent review organization, including the required information.

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

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

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

- The recommended or requested health care service or treatment has been approved by the Food and Drug Administration (FDA) for the member's condition; or
- There is medical or scientific evidence, or evidence-based standards, showing that the recommended or requested health care service or treatment is more likely to benefit the member than the usual and customary health care service or treatment available, and that the adverse risks of the recommended or requested health care service or treatment would not be significantly higher than those of the usual and customary health care services or treatments available.

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

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

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

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

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

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

If there is a tie among clinical reviewers as to whether the recommended or requested health care service or treatment should be covered or not, the independent review organization will obtain the opinion of an additional clinical reviewer so that a decision may be made based on majority opinion.

If there is a need to select an additional clinical reviewer, in accordance with the paragraph above, such additional clinical reviewer shall peruse the same information the other clinical reviewers had available when formulating their opinion.

The selection of an additional clinical reviewer will not delay the deadline for the independent review organization to make its determination based on the opinions of the selected clinical reviewers.

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

- A general description of the reason why an external review has been requested;
- The opinion of each clinical reviewer, including each one's advice as to whether the recommended or requested health care service or treatment should be covered or not, and the rationale for the reviewer's recommendation;
- The date when the independent review organization was appointed by the Commissioner to carry out the external review;
- The date the external review was performed;
- The date of determination;
- The primary reason(s) for its determination; and
- The reason or rationale for their determination.

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

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

Binding Nature of the External Review Determination

The external review determination binds Triple-S Salud, except when Triple-S Salud has any other recourse based on the applicable law in Puerto Rico.

The external review determination binds the member, except when the member has any other recourse based on the applicable Puerto Rico or federal law.

The member may not submit further requests for external review in regards to an adverse determination or final adverse determination for which there was already an external review in accordance with this Chapter.

Paying for the Costs of External Review

If Triple-S Salud receives a request for ordinary or expedited external review, they will be obligated to pay the independent review organization for the external review.

The Office of the Commissioner of Insurance shall notify Triple-S Salud, about the costs entailed of the process or any modification therein, at least 120 days in advance.

The member shall pay a nominal fee no greater than $25.00 per review. Furthermore, the fees for a single member may not exceed seventy-five dollars ($75.00) per policy year. The amount paid by the member will be reimbursed if the opinion is determined in their favor.

The external review processes at the Office of the Commissioner of Insurance regarding final adverse determinations1 will be conducted by the independent review organization “Maximus Federal Services, Inc.” In accordance with the aforementioned Article 28.170, the health insurance company or insurer subject of the request for external review will be required to cover the cost of the external review requests, which will be based on a fee of $575 for each ordinary review request or $670 for an expedited review request.

PROCEDURE FOR REIMBURSEMENTS

1. Reimbursement requests should be sent:

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

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

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

   d. You should include the following:
      - Full name (including both last names) and contract number of the member who received the service
      - Date of service
      - Diagnosis Code *(ICD-10)* and/or diagnosis description
      - Procedure code (effective as of the date of service) and/or service description
      - *National Provider Identifier* (*NPI*)
      - Official payment receipt including: provider's name, address, specialty, and license number
      - Amount paid for each service
      - Signature of provider or participant who rendered the services
      - Reason you are requesting a refund
      - For ambulance services, you must include information about the distance traveled, evidence of medical necessity, and the carrier's Incident Report
      - If the services required a precertification, copy of such precertification

      If you are requesting a reimbursement for medications, you must add:
      - Pharmacy’s official receipt
      - Name and contract number of the member who received the service
      - Name of medication
      - Daily dosage
      - Prescription number
      - Amount dispensed
      - National Drug Code (*NDC*)

- *National Provider Identifier* (*NPI*) of the pharmacy and the prescribing physician
- If you paid a participating pharmacy, state the reason.
- Include the charge for each medication.

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

- The service code, tooth number, and surfaces restored (if applicable)
- Amount paid for each service
- If the member pays more than one visit under a single a receipt, he/she must send the exact dates of service **(MONTH, DAY, YEAR)** for which he/she paid.
- If you receive dental prostheses and periodontology services, offered as an option for a corresponding additional premium, you must submit the X-rays.

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

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

2. You should issue a written claim notice to Triple-S Salud within twenty (20) days after the service occurred or, after such term, as soon as reasonably possible for the member, but no later than one (1) year after the date the service was rendered, unless evidence is submitted that it was impossible to submit the claim within the established time period.

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

4. Triple-S Salud will investigate, adjust, and resolve all claims in the shortest reasonable period, within 30 days after receiving the request. If Triple-S Salud cannot arrive at a resolution within the aforementioned period, it shall keep record of the documents that prove just cause to exceed such term. The Commissioner of Insurance has the authority to request an immediate resolution if it is understood that the process is being delayed unduly or unreasonably.

PRECERTIFICATIONS

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

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

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

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

Members and participating physicians and providers shall receive guidance about which hospital admissions need to be precertified or notified 72 hours in advance or as soon as reasonably possible. Certain studies and diagnostic or surgical procedures require precertification from Triple-S Salud. The member and the participating physicians and providers will receive guidance about which services should be precertified**. Services received in an Emergency Room as a result of a medical emergency do not require precertification by Triple-S Salud.**

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

- Bariatric and post-bariatric surgery (torso and abdomen)
- Orthognathic (jaw) surgery
- Lithotripsy
- PET CT Scan or PET Scan
- Reconstructive surgeries and procedures that could be performed on an outpatient basis but, for medical reasons, need another level of service (hospitalization or outpatient surgery center, if it can be performed at an office)
- Immunoprophylaxis for respiratory syncytial virus
- Durable medical equipment
- Skilled nursing facility
- Home health services
- Residential treatment
- Hospice
- Non-emergency services obtained in the United States
- General anesthesia and hospitalization services for dental procedures on minors and physically or mentally disabled people who require them.
- Genetic tests
- Insulin infusion pumps for members who have been diagnosed with Type 1 Diabetes Mellitus.
- Injectable drugs covered by the medical part and not related to cancer

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

You may submit your information request via fax or mail

Fax: (787) 774-4824

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

PROCEDURE FOR PRECERTIFICATIONS

Once the precertification request is received, Triple-S Salud will assess the request and notify the member, regardless of whether the benefit is certified or not, of their determination no later than 15 days after the date the request is received. This applies to prospective review determinations.

If the request is incomplete and does not meet the minimum requirements for evaluation, Triple-S Salud will provide verbal or written notice, no later than five (5) days after receiving the request, and confirm the information you should submit to complete the evaluation process. If you request to have the confirmation in writing, Triple-S Salud shall send the notification within the established time period. In such cases, you have up to 45 days from the receipt of the notification to furnish the requested information.

Prospective determinations are made no later than fifteen (15) days after the date the request is received. If a determination cannot be made within that time frame for reasons outside the control of the insurance company, the period may be extended for an additional fifteen (15) days. In such cases, Triple-S Salud will notify the member, before the end of the initial period of fifteen (15) days after receiving the precertification request, with a reason for the delay and the date when the determination is expected to be made.

PRECERTIFICATION FOR URGENT CASES

You may need Triple-S Salud to consider your precertification request urgently. This could be due to a health condition that, according to your attending physician, could put your life, health, or ability to regain maximum function at serious risk, or because submitting you to the regular terms to respond to the precertification request would expose you to suffering severe pain that cannot be handled properly without the treatment for which the precertification is being requested. In such cases, your attending physician must state the nature of the urgency. Once stated by the physician, Triple-S Salud will process the request urgently. Requests for these cases may be made orally or in writing. Triple-S Salud must notify you of its decision verbally or in writing, unless you request that it be done in writing, within 24 hours from receiving your request.

If Triple-S Salud needs additional information to furnish its determination, it must notify you verbally or in writing, unless you request it to be in writing within 24 hours after the request was received. You or your representative will have at least 48 hours from the notification to submit any additional information requested. After receiving the additional information, Triple-S Salud must answer the request within no more than 48 hours after whichever comes first between: the date of receipt of the additional information, or the established deadline to receive it. If Triple-S Salud does not receive the information requested by the aforementioned deadline, Triple-S Salud may deny the requested service certification.

The notification of the adverse determination shall state the following:

- Date of service, provider, claim amount, diagnosis and treatment codes, as well as their meanings, if applicable;
- Specific reasons for the adverse determination, including the denial code and its meaning, as well as a description of the standards, if any, used for the determination;
- Reference to the plan's specific provisions on which the determination is based;
- Description of all additional material or information needed to complete the request, including an explanation of why it is necessary;
- Description of the plan's internal procedures for grievances and expedited grievance reviews, including the applicable time limits for such procedures;
- If a rule, guideline, internal protocol, or other similar criteria was considered for the adverse determination, a copy will be provided free of charge to the member;
- If the adverse determination considered judgment of medical necessity, experimental or investigative nature, or similar exclusions or limits, we shall include an explanation of the scientific or clinical rationale that was considered for the determination when applying the health plan terms to the member's circumstances.

You have the right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health to request assistance at any time, and you have the right to sue before a competent court after concluding Triple-S Salud's internal grievance process. The Office of the Commissioner of Insurance is located at 361 Calle Calaf, World Plaza Building, 268 Muñoz Rivera Ave., San Juan, PR 00918, and you may call (787) 304-8686.

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

HEALTH COVERAGE

Some of the services in this Section are subject to applicable copayments, coinsurance, and/or deductibles. For details about your plan copayments, coinsurance, and deductibles, please refer to the Table of Deductibles, Copayments, and Coinsurance at the end of this policy.

MAXIMUM ANNUAL OUT-OF-POCKET

The maximum annual out-of-pocket for this coverage is $6,350 for individual contracts and $12,700 for couple or family contracts. Once the member reaches the applicable amount for his/her type of contract, he/she will not need to make any additional disbursements for the remaining policy year; Triple-S will pay 100% of the remaining health care expenses covered under this policy.

Triple-S Salud and its pharmacy benefit manager will include, as part of the calculation or requirement of the contribution or cost-sharing out-of-pocket maximum, any payment, discount, or item that forms part of a financial assistance program, discount plan, vouchers, or any contribution offered to the member by the manufacturer. These items will be considered for the patient's exclusive benefit when calculating their contribution, out-of-pocket expenses, copayments, coinsurances, deductible, or in their compliance with the cost-sharing requirements. These manufacturer contributions, discounts, and vouchers will be available and may be used with all health care providers, in accordance with the program requirements, regardless of the place of acquisition of the discount or voucher. The use of a benefit accumulator, maximizer, or any other similar program whose effect is to implement a restriction on the responsibility established in this section is prohibited.

Services provided by non-participating providers in and outside Puerto Rico, payments made by the member for non-covered services under this policy, alternative therapy services (Triple-S Natural), eyeglasses and contact lenses for members over 21 years old, and the monthly premium paid to Triple-S Salud for the plan are not considered eligible expenses for the accrual of the maximum out-of-pocket. The selected maximum out-of-pocket is in accordance with the amount allowed by the Office of the Commissioner of Insurance of Puerto Rico.

TELEMEDICINA

According to Law No. 68 of July 16, 2020, while the declared COVID-19 emergency remains active, the practice of Telemedicine and Telehealth in Puerto Rico is authorized without need for a certification. Besides, any member who received medical care through telemedicine or telehealth will be exempted from the fixed amount or copayment to be paid for this service during the emergency.

Article 13. - Emergency provisions.

The provisions included below concerning the practice of telemedicine and telehealth will apply due to the emergency declared by the Governor of Puerto Rico through Administrative Notice No. OE-2020-020 as a consequence of the SARS-CoV-2 coronavirus, known as COVID-19.

(1) The physicians and health care professionals covered under this Law may use telemedicine or telehealth technologies to see their patients without needing to have the corresponding certification from the Puerto Rico Board of Medical Licensure and Discipline or from their respective examiner boards or governing bodies.

(2) The examiner board or governing body of each health care profession covered under this Law must immediately establish basic guidelines to serve patients using telehealth technologies and notify the corresponding group of health care professionals so they may start using these methods. No health care professional authorized to practice in Puerto Rico may begin treating patients using their own telehealth

technology until their respective board or governing authority issues the corresponding guidelines, according to the nature of the declared emergency. This subsection shall not apply to physicians authorized to practice telemedicine, as established in Joint Resolution No. 19-2020.

(3) All services offered in accordance with the provisions in this Article will be subject and governed by the same standards of care, competence, and professional conduct that apply to the offering of these services in person. The recording of therapeutic consultations, sessions, or conversations is prohibited.

(4) The authorization described in this Article does not exempt physicians and health care professionals from complying with the requirements established by their respective licenses and/or ethical standards; therefore, they will be subject to the corresponding sanctions.

(5) Regardless of what is established in this Article, the patient's privacy shall always be maintained according to the provisions in the Health Insurance Portability Accountability Act of 1996 or in any other applicable state or federal act or regulation. Therefore, the Board of Licensure, as well as the examiner board or governing body, may adopt all measures deemed necessary, in accordance with any applicable federal laws or regulations, to ensure that health care providers will protect the privacy of their patients.

(6) All health insurance companies, insurers, health service organizations, pharmacy benefit administrators or managers, the Puerto Rico Health Insurance Administration (PRHIA), and similar entities contracted by these, will be required to include any existing or future medical diagnostic tests and/or treatments to manage COVID-19 under their basic coverage and cover them using state or federal funds, according to the prices established by the Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health & Human Services. Likewise, the PRHIA will adjust its requirements to eliminate the primary care physician's signature for prescriptions, referrals, and medical orders.

(7) As a measure to reduce personal contact and disease transmission, and to discourage citizens from visiting doctors' offices, pharmacies have been ordered to refill chronic medications even if the patient has no available refills or a new prescription. In order to do this, the patient must show an empty medication bottle whose label specifies the dose and the patient's identity. The aforementioned does not apply to medications classified as controlled under classifications II, III, IV, or V by state or federal laws or regulations, as well as to any narcotics regardless of their classification.

(8) Any permanent or temporary building set up in a service facility to treat patients with symptoms of this virus in isolation will be considered, for all pertinent legal purposes, an extension of the health service facility it is in.

(9) Insofar as the COVID-19 emergency is active, all physicians or health care professionals legally authorized to issue prescriptions, referrals, or medical orders, or to order treatments, tests, or exams for the patient, will be able to send in said prescription, referral, or order in picture format or using any other electronic method, and the receiving service provider will be required to accept it. The prescription must be sent directly by the physician or health care professional; prescriptions sent in picture format to the patient will not be accepted.

(10) Physicians and health care professionals herein authorized shall retain all the information necessary to document the services rendered. In order to avoid insurance fraud, the insurance companies, health service organizations, and the PRHIA may carry out the corresponding verifications to make sure that the services have been indeed rendered using telemedicine or telehealth methods.

(11) Physicians and health care professionals herein authorized must comply with the provisions on informed consent established in this Law.

(12) Billing:

(a) All physicians and health care professionals authorized to practice in Puerto Rico may bill for the services provided using telemedicine or telehealth technologies, and the health insurance companies,

insurers, health service organizations, pharmacy benefit administrators or managers, the PRHIA, and similar entities contracted by these will be required to pay these bills as if it had been an in-person consultation. To these purposes, these entities will need to provide physicians and health care professionals who request it the corresponding codes to bill for the health services rendered using telemedicine or telehealth technology. Health insurance companies, insurers, health service organizations, pharmacy benefit administrators or managers, the PRHIA, or similar entities may not refuse to pay for a rendered service that has been incorrectly coded if their guidelines and procedures allow for the creation of codes and/or procedures to adjust to the provisions in this Law. If physicians or health care professionals provide their services according to this Law, but such services are not duly coded by the PRHIA or a health insurance company, and there is a statute, policy, procedure, or regulation that prevents such codification, they may bill for the services rendered as they usually do for in-person consultations but must include a discount of ten percent (10%) from the bill total.

(b) If a physician or health care professional authorized through this Article provides their services through a health plan or health insurance, and the patient receives such services, the patient is exempted from paying the fixed amount or copayment they would usually pay for these services at an in-person consultation while the COVID-19 emergency declared by the Governor remains active.

The provisions included in this article will be valid up to (30) days after the COVID-19 emergency declared by the Governor ends. Once the emergency concludes, any physicians and health care professionals who did not have the Certification but were able to offer their services by virtue of this Article will need to make the corresponding arrangements with the Board of Licensure or their examiner board or governing body, as the case may be, to receive the corresponding Certification according to the provisions in this Law to be able to keep offering telemedicine or telehealth services.

TELECONSULTA MD®

Telemedicine service through virtual medical consultations. The **TeleConsulta MD®** service will allow you to receive medical attention from 6:00 a.m. to 10:00 p.m., from any place within Puerto Rico's geographical region, the 365 days of the year. You will have access to medical consultations by a participating provider, with licensed general practitioners, family physicians, internists, pediatricians, and psychologists, be it for minor medical conditions or less urgent cases. The conditions covered under this service are: allergies, bronchitis, nasal infection, stomachache, hypertension, sore throat, migraine, cold, nausea, ear pain, asthma, and muscle pain.

The provider must be certified to practice telemedicine, according to Act No. 168 of 2018, as amended by Act No. 68 of July 16, 2020. However, according to Joint Resolution No. 32-2020, while the declared COVID-19 emergency remains active, the practice of telemedicine and telehealth in Puerto Rico is authorized without need for a Certification. Additionally, in accordance with Section 1 of Joint Resolution No. 32-2020, patients who receive medical services via telemedicine or by phone will be exempted from paying the fixed amount or copayment due for these services, for the duration of the emergency.

You decide if you want to set up your own appointment time and choose your preferred provider. The provider can send prescriptions to participating pharmacies. You may also share test results with the doctor. Visit our website www.ssspr.com to download the smart phone application and contact us, or connect with us from your computer. Telemedicine services do not substitute the care provided by your doctor. If this is an emergency, please call 911 or visit the nearest emergency room.

PREVENTIVE CARE COVERAGE

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

PREVENTIVE CARE FOR ADULTS

Preventive Service	Indication
Abdominal aortic aneurysm (AAA)	One (1) service per ultrasonogram for abdominal aortic aneurysm (AAA) screening, for members 65 to 75 years of age who are smokers or were smokers at some point
Colorectal cancer	According to Administrative Order No. 334 of the Department of Health, one annual colorectal cancer screening via fecal occult blood test is covered for adults 40 years of age and older. If the person has a family history of colorectal cancer, the annual screening will be performed via colonoscopy instead of the fecal occult blood test. The USPSTF recommends colorectal cancer screenings to be performed via occult blood test, sigmoidoscopy, colonoscopy, or serological test, in adults 45 to 75 years old. The risks and benefits of these screening methods vary.
Depression screening for adults	Depression screening in adults, including for currently pregnant members and pots-partum. The screening must be done in an adequate system to guarantee an accurate diagnosis, an effective treatment, and adequate follow-up.
Hepatitis B screening: for adolescents and adults who are not pregnant	Hepatitis B screening for adults at high risk for infection.
Hepatitis C virus infection screening: adolescents and adults	Screening for hepatitis C (HCV) infections among adults who are 18 to 79 years old.
Hypertension screening for members who have not been diagnosed with the condition.	Hypertension screening for adults 18 years of age and older. Measures must be taken outside the clinical environment to confirm the diagnosis before starting treatment.

Preventive Service	Indication
Lung cancer screening	Annual lung cancer screening through computerized tomography, for adults aged 50 to 80 years old with a history of smoking twenty (20) packs a year, who are currently smoking or stopped smoking within the last 15 years. The screening will be discontinued once the person has stopped smoking for 15 consecutive years or develops a health problem that substantially limits their life expectancy or the likelihood of undergoing lung surgery to cure the disease.
Screening and counseling for obesity in adults	Doctors may offer or refer patients with a Body Mass Index (BMI) of 30 kg/m2 or more to intensive multi-component behavioral interventions.
Syphilis screening for non-pregnant members	Syphilis infection screening for all high-risk members.
Ceasing tobacco use and medications: adults who are not currently pregnant	The USPSTF recommends that physicians ask all adults about their tobacco use, discourage this habit, and offer behavioral interventions and smoking cessation drugs approved by the Food and Drug Administration (FDA). For those using products to cease tobacco use, this plan covers medications to cease smoking that are approved by the FDA for ninety (90) consecutive days in one single attempt, and up to two (2) attempts per year.
TB screening test: adults	Screening for tuberculosis infection in high-risk populations.
Harmful alcohol use: adults	Screening for harmful alcohol use at primary care facilities for adults over 18 years old, including pregnant members, by providing brief guidance behavioral counseling interventions to reduce harmful alcohol consumption in people who engage in dangerous or risky consumption.
Harmful drug use	Screening for harmful drug use in adults aged 18 and over, offering brief behavioral counseling interventions. The screening must be performed when the services for an accurate diagnosis, effective treatment, and adequate attention may be offered or referred.

Preventive Service	Indication
Screening for prediabetes and type 2 diabetes in asymptomatic adults aged 35 to 70 years old and who are overweight or obese.	The USPSTF recommends screenings for prediabetes and type 2 diabetes in adults aged 35 to 70 years old who are overweight or obese. Physicians must offer or refer patients with prediabetes to effective preventive interventions.
Healthy diet and physical activity as prevention for cardiovascular disease in adults at cardiovascular risk.	Offering and referring overweight or obese adults with additional risk factors for cardiovascular disease to intensive behavioral counseling interventions to promote a healthy diet and physical activity to prevent cardiovascular diseases.
Statins to prevent cardiovascular events in adults: Preventive Medication	For adults without a history of cardiovascular disease (for instance, symptomatic coronary arterial disease or ischemic stroke) to use low or moderate statin dosages to prevent cardiovascular events and death if all the following criteria are met: • ages between 40 and 75 years old • have one or more risk factors (dyslipidemia, diabetes, hypertension, or smoking), and • have a calculated 10-year risk for a cardiovascular event of 10% or more. Detecting dyslipidemia and calculating a 10-year risk for a cardiovascular event requires a genera lipid screening for adults between 40 and 75 years old.
Sexually transmitted diseases	Intensive behavioral counseling for sexually active adolescents and adults at high risk of sexually transmitted diseases.
Immunization	Vaccines. The recommended dosages, ages, and population vary: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza, MMR, Meningococcus, Pneumococcus, Tetanus, Diphtheria, Whooping Cough, and Chicken Pox. Catch-up vaccines are covered. COVID-19 vaccine for adolescents over 16 years old and adults, according to recommendations from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
Pre-exposure prophylaxis for HIV to prevent HIV infection	The USPSTF recommends doctors to offer pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to individuals at high risk of contracting HIV.

Preventive Service	Indication
Human Immunodeficiency Virus (HIV) screening test: adolescents and adults that are not currently pregnant	Human Immunodeficiency Virus (HIV) screening for adults 13 to 65 years old, as well as younger adolescents and older adults at a higher risk. As required by Law No. 45-2016, this includes one HIV test per year as part of the routine medical evaluation, except for pregnant members, to whom USPSTF requirements apply.
Prevention of obesity in middle-aged women.	Counseling middle-aged women aged 40 to 60 years old who have a normal or overweight body mass index (BMI) (18.5 – 29.9 kg/m2) to help them maintain their weight or limit their weight gain in order to prevent obesity. These counseling services may include a one-on-one discussion on healthy nutrition and physical activity.
Fall prevention in older adults: exercise or physical therapy	Exercises and physical therapy to prevent falls in adults over 65 years old who are at risk of suffering falls.

PREVENTIVE SERVICES FOR ADULTS, INCLUDING PREGNANCIES

Preventive Service	Indication
Folic acid	All insured members who may or are planning to get pregnant should take a daily folic acid supplement of 0.4 to 0.8 mg (400 – 800ug).
Counseling and screening for human immunodeficiency virus	Annual counseling and screening for human immunodeficiency virus infection for all sexually active women.
Screening for urine bacteria among pregnant individuals	The USPSTF recommends screening for asymptomatic bacteriuria through the use of urine cultures among pregnant individuals.
BRCA: Risk Assessment	Primary care providers must screen people who have had relatives with breast, ovarian, fallopian, or peritoneal cancer, with tools designed to identify family history that could be associated with an increase in risk for potentially harmful mutations in the breast cancer susceptibility genes (BRCA1 or BRCA2). Members whose tests come back positive must receive genetic counseling and, if prescribed as a result, the BRCA test.
Breast cancer: preventive drugs	USPSTF recommends that physicians involve their patients at high risk for breast cancer in the determination to use drugs to reduce the risk of developing the disease. The physician should offer to prescribe medications to reduce the risk of developing breast cancer, such as tamoxifen or raloxifene, for patients 35 years of age or older that are found to be at high risk of developing the disease (primary prevention) and that have a low risk of having adverse reactions to the medications.

Preventive Service	Indication
Breast cancer screening (Diagnosis and screening of breast cancer)	Pursuant to Law No. 10 of January 3, 2020, "Law on the Right to Effective Breast Cancer Screening," establishes that the following must be included among the preventive care benefits: • One mammography, for members who are thirty-five (35) to thirty-nine (39) years old. • One annual mammography for members who are forty (40) years old or over. • One annual mammography and follow-up treatment or supplementary diagnostic tests (MRI/sonomammograms), for members who are forty (40) years old or over whose breast tissue is classified as heterogeneously dense or extremely dense.
Cervical cancer screening	Cervical cancer screening for members who are 21 to 29 years old, with a Papanicolaou test, every three (3) years. For members from 30 to 65 years old, one test every three (3) years with cervical cytology, every five (5) years with the high-risk human papillomavirus test (hrHPV), or every five (5) years with the hrHPV test in combination with cytology.
Chlamydia screening	Chlamydia screening for all members who are pregnant or for members who are sexually active and under 24 years old or older if at a high risk of infection.
Screening for domestic violence: members of reproductive age	Screening for violence within the intimate relationships of members of reproductive age, such as domestic violence, and offering and referring people for whom the screening has turned out positive to intervention services.
Gestational diabetes mellitus	Gestational diabetes mellitus screening for pregnant people who show no symptoms after 24 weeks of gestation and for those identified as high-risk of developing gestational diabetes.
Gonorrhea screening	Gonorrhea screening for members who are sexually active and under 24 years old or older if at a high risk of infection.
Hepatitis B screening: pregnant members	For pregnant members, screening of Hepatitis B virus infection during the first prenatal visit.

Preventive Service	Indication
Human immunodeficiency virus (HIV) screening: Members during pregnancy	Physicians must screen all pregnant members for HIV, including those who are about to give birth and have not been tested and whose status is unknown. The following tests are covered at no copay for pregnant women: a. First HIV test during the first trimester of pregnancy or on the first prenatal visit, and b. Second test during the third trimester of pregnancy (between 28 and 34 weeks of pregnancy).
Osteoporosis screening: post-menopause members under 65 years old at a higher risk for osteoporosis.	Osteoporosis screening with bone densitometry test to prevent osteoporosis fractures in post-menopause members under 65 years old who are at a higher risk for osteoporosis, as determined through a formal clinical risk assessment tool.
Osteoporosis screening: members over 65 years old	Osteoporosis screening with bone densitometry test to prevent osteoporosis fractures in members over 65 years old.
Preeclampsia screening	Preeclampsia screening for pregnant members, with blood pressure monitoring throughout the pregnancy.
Rh(D) Incompatibility Screening	Testing for Rh(D) blood type and antibodies in all pregnant members during their first prenatal visit. Includes repeating the antibody test for pregnant members with non-sensitized Rh-negative blood type testing between 24 and 28 weeks of pregnancy, unless the biological father is Rh(D)-negative.
Diabetes mellitus screening after pregnancy	Screening for diabetes mellitus among women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and have not been previously diagnosed with type 2 diabetes mellitus. Ideally, initial tests must be performed within the first year postpartum and they may be done as soon as 4 to 6 weeks after delivery.
Syphilis screening during pregnancy	Syphilis screening for all members during pregnancy.
Perinatal depression: counseling and intervention	Clinical staff are advised to provide interventional counseling or refer pregnant members or members after birth who are at a risk for perinatal depression.

Preventive Service	Indication
Anxiety screening tests	The Women's Preventive Services Initiative recommends anxiety screening tests for adolescent and adult women, including those who are pregnant and postpartum. Optimal screening intervals are unknown, and clinical judgment should be used to determine assessment frequency. Given the high prevalence of anxiety disorders, lack of recognition in clinical practice, and multiple problems associated with untreated anxiety, physicians should consider screening women who have not been recently screened.
Urinary incontinence screening tests among women	The Women's Preventive Services Initiative recommends testing women to detect urinary incontinence as a preventive service. Factors associated with a higher risk of urinary incontinence include increasing parity, advancing age, and obesity; however, these factors should not be used to limit screening. Several screening tools demonstrate moderate to high accuracy in identifying urinary incontinence in women. Although the minimum screening intervals are unknown, given the prevalence of urinary incontinence, it is advisable that the screening be performed every year since many women do not exhibit symptoms, and the multiple risk factors associated with incontinence change frequently.
Breastfeeding	Support and counseling through a provider trained in breastfeeding during pregnancy and/or postpartum, as well as access to breastfeeding equipment and supplies, per pregnancy.
Contraceptive methods	FDA-approved contraceptive methods, sterilization procedures, counseling and education for members of reproductive age, as prescribed. It covers the insertion and removal of any device.
Weight management for pregnant members	Behavioral counseling interventions for adolescents and adults aimed at promoting a healthy weight gain and preventing an excessive increase during pregnancy.
Preeclampsia prevention: aspirin	Use of low-dose aspirin (81mg/d) as preventive medication after 12th week of pregnancy in members at high risk for preeclampsia.

Preventive Service	Indication
Tobacco use and smoking cessation for pregnant members	Physicians must ask all pregnant members about their tobacco use, advise them to stop, and provide behavioral interventions to help smoking members cease their tobacco consumption.
Preventive visits for members	Annual Preventive Visit (depending on the member's health needs and other risk factors) so that adult members can access the recommended preventive services that are adequate for their age, including essential prenatal care and services. Whenever appropriate, this preventive annual visit must include other listed preventive services. Should the physician determine that the patient requires additional visits, they will be covered without copayment.

PREVENTIVE SERVICES FOR MINORS

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

Preventive Service	**Indication**
Blood test	Screening for newborns.
Anemia / iron deficiency	Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP Pediatric Nutrition: Policy of the American Academy of Pediatrics (Iron chapter). Iron supplement for minors aged 4 months to 21 years old who are at a risk of anemia.
Topical application of fluoride varnish	Topical application of fluoride varnish for deciduous teeth in infants and minors from the onset of emergence of the primary teeth.
Hearing	Hearing screening for all newborns and for minors, once between 11 to 14 years old, once between 15 to 17 years old, and once between 18 to 21 years old.
Skin cancer: counseling	Counseling for minors, adolescents, and young adults with white skin, aged 6 months to 24 years old, to minimize their exposure to ultraviolet radiation and reduce their risk for skin cancer.
Bilirubin screening	Screening for newborns.
Autism screening	For minors between 18 and 24 months of age.
Depression screening for adolescents	Depression screening in adolescents between 12 and 18 years old. The screening must be done in an adequate system to guarantee an accurate diagnosis, an effective treatment, and adequate follow-up.
Developmental screening and monitoring	Screening for children under 3 years of age and monitoring throughout childhood.
Hematocrit or hemoglobin screening	Screening for all minors when there is a risk factor.
Screening for obesity in minors and adolescents	For minors aged 6 and older as well as adolescents, intensive comprehensive behavioral interventions to promote a healthy weight in minors.
Vision screening: minors	Vision screening test, at least once (1) for all minors between 3 and 5 years old to detect amblyopia or risk factors.
Phenylketonuria (PKU) screening for newborns	Phenylketonuria (PKU) in newborns.
Growth in terms of height, weight, and body mass index	Screening for minors. Ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years.

Preventive Service	Indication
Cervical displacement	Screening for sexually active members.
Postpartum depression	Screening for mothers of newborns at their 1-, 2-, 4-, and 6-month follow-up visits.
Dyslipidemia	Screening for minors, once between 9 to 11 years of age, and once between 17 to 21 years of age. Screening for minors at risk for lipids disorders. Ages: 1-4 years, 5-10 years, 11-14 years, 15-17 years.
Sickle cell disease (hemoglobinopathy)	Screening for sickle cell disease in newborns.
Behavioral health evaluation	Assessment for minors of all ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years.
Hypothyroidism	Congenital hypothyroidism screening for newborns.
Medical history	For any minor during development, from 0 to 21 years old.
Lead	Screening for minors between 1 and 6 years old with a high blood lead concentration, those who are at an average or high risk, and for pregnant members who show no symptoms.
Blood pressure	Screening for minors: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years.
Eye prophylaxis for gonorrhea: preventive medication	Topical eye medication to prevent gonorrhea in newborns.
Oral health	Risk assessment for minors from 0 to 11 months old, from 1 to 4 years old, and from 5 to 10 years old.
Oral fluoride supplements	Fluoride oral supplements from the age of 6 months old, for minors whose water supply is fluoride-deficient.
Tuberculosis	Test for minors at high risk for tuberculosis. Ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-21 years.
Tobacco use in minors and adolescents	Interventions, including education and counseling, for minors and adolescents to prevent the start of tobacco use.
Tobacco, alcohol, and drug use	Screening for minors aged 11 to 21 years old.
Vaccines	Recommended vaccines from birth to 21 years old. Recommended dosages, ages, and population vary: Diphtheria, Tetanus, Whooping Cough, Haemophilus, Influenza B, Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Inactive poliovirus, Influenza, MMR, Meningococcus, Pneumococcus, Rotavirus, and Chickenpox. Catch-up vaccines are covered. HPV screening starts at the age of 9 for minors with a history of sexual abuse or assault, who

Preventive Service	Indication
	have not started or completed the 3 dosages (recommended by the Advisory Committee on Immunization Practices [ACIP]) COVID-19 vaccine for adolescents over 16 years old and adults, according to recommendations from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

STANDARD VACCINE COVERAGE FOR MINORS, ADOLESCENTS, AND ADULTS

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

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

Covered vaccines with $0 copayment

- ***Hib-HepB*** *(90748)*
- ***ROTA-*** *Rotavirus Vaccine (90680)*
- ***ROTA-*** *Rotavirus Vaccine, human – Rotarix (90681)*
- ***IPV-*** *Inactivated Poliovirus Vaccine – injectable (90713)*
- ***Hib-*** *Haemophilus Influenza B Vaccine (90647, 90648)*
- ***Menomune-*** *Meningococcal Polysaccharide Vaccine 90733)*
- ***MCV-*** *Meningococcal Conjugate Vaccine – Menactra and Menveo (90734)*
- ***PPV-*** *Pneumococcal Polysaccharide Vaccine (90732)*
- ***FLU-*** *Influenza Virus Vaccine (90630, 90653, 90654, 90655, 90656, 90657, 90658, 90661, 90662, 90673, 90674, 90685, 90686, 90687, 90688)*
- ***PCV-*** *Pneumococcal Conjugate Vaccine - Prevnar 13 (90670)*
- ***DTaP-*** *Diphtheria, Tetanus Toxoid and Acellular Pertussis Vaccine (90700)*
- ***DT-*** *Diphtheria, Tetanus Toxoid (90702)*
- ***HPV*-*** *Human Papilloma Virus (Gardasil (90649), Cervarix (90650), 9vHPV (90651))*
- ***Tdap-*** *Tetanus, Diphtheria and Acellular Pertussis (90715)*
- ***Zoster-*** *Shingrix (90750)*
- ***MMR-*** *Measles, Mumps and Rubella Vaccine (90707)*
- ***VAR-*** *Varicella Virus Vaccine (90716)*
- ***HEP A*** *Hepatitis A Vaccine (90632, 90633, 90634)*
- ***HEP A-HEP B*** *Hepatitis A and Hepatitis B Vaccine (90636)*
- ***Td-*** *Tetanus and Diphtheria Toxoid Adsorbed (90714)*
- ***HEP B-*** *Hepatitis B Vaccine (90740, 90743, 90744, 90746, 90747)*
- ***Meningococcal B*** *(90620, 90621)*
- ***Pentacel*** *(90698)*
- ***DtaP-IPV-HEP B*** *(Pediarix, 90723)*
- ***Kinrix*** *(90696)*

Covered vaccine with coinsurance. The member will be responsible for paying the coinsurance established in the Table of Deductibles, Copayments, and Coinsurance at the end of this policy.

Immunoprophylaxis for respiratory syncytial virus (Synagis, Palivizumab 90378**) – Requires precertification** following the protocol established by Triple-S Salud**.**

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

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

OUTPATIENT MEDICAL-SURGICAL AND DIAGNOSTIC SERVICES

(Services available when the member is not admitted to the hospital)

The member will be responsible for paying the plan's copayment or coinsurance directly to the participating provider. Please refer to the Table of Copayments and Coinsurance included in the policy.

Diagnostic and treatment services

- Visits to PCP
- Visits to specialists
- Visits to subspecialists
- Visits to audiologists
- Visits to optometrists
- Visits to podiatrists, including routine foot care
- Annual preventive visits
- Medical services provided in the member's home by physicians who provide this service
- Intra-articular injections, up to two (2) daily injections and up to a maximum of twelve (12) injections per member, per policy year
- Cryosurgery of the uterine cervix
- Vasectomy

Note: The supplies used by medical offices to perform covered diagnostic gynecological tests are included in the visit copayment.

Allergy Care

- Allergy tests, up to fifty (50) tests per policy year, per member

Lab tests, X-rays, diagnostic tests, and specialized diagnostic tests

Through the Preferred *Selective* Network of clinical laboratories and radiology/images. For a list of participating facilities, please refer to the Preferred Network section in the Triple-S Salud Participants and Providers Directory. Laboratory tests, X-rays, diagnostic tests, and specialized diagnostic tests are provided through the *Selective* Preferred Network.

- Clinical laboratory, genetic tests **require precertification**
- X-Rays
- *PET Scan* and *PET CT.* **Requires precertification.**
- Non-invasive cardiovascular tests
- Non-invasive vascular tests
- Electrocardiograms and echocardiograms
- Nuclear medicine tests
- Computerized tomography (CT), up to one (1) per anatomic region, per member, per policy year
- *Single Photon Emission Computerized Tomography (SPECT)*
- Sonograms
- Magnetic resonance angiography (MRA) study
- Magnetic resonance imaging (MRI) study, up to one (1) per anatomic region, per member, per policy year.
- Electromyograms, up to two (2) per anatomic region, per member, per policy year
- Color Doppler Flow
- Nerve Conduction Velocity Test, up to two (2) tests of each, per member, per policy year
- Gastrointestinal endoscopies
- Electroencephalograms
- Polysomnography diagnostic test (study of sleep disorders), one (1) test per policy year, per member

- Tympanometry, one (1) test per member, per policy year
- Bone densitometry when it is not conducted as a preventive test as provided by federal law, but as a follow-up to a diagnosis or treatment of a condition
- Mammograms, digital mammograms, or sonomammograms if they are not rendered as preventive tests as provided by federal law, but as a follow-up to a diagnosis or treatment of a condition
- Neurological tests and procedures
- Other audiological tests, such as vestibular function tests, audiological function tests, and special diagnostic procedures

- **Surgeries** provided on an outpatient basis. **Requires precertification** when it is medically necessary to change the level of service (hospitalization or outpatient surgery center)

Treatment therapies

- Dialysis and Hemodialysis: All services related to any type of dialysis or hemodialysis, as well as any complications that may arise and the hospital or medical-surgical services that may be needed to treat these complications, will be covered for the first 90 days from:

  a. the date the member first becomes eligible to this policy; or
  b. the date the first dialysis or hemodialysis is performed.

  This will apply if the subsequent dialyses or hemodialyses are related to the same clinical condition.

Respiratory Therapy (administered in the physician's office)

- Respiratory therapy (provided by physicians specialized in allergy, pediatric allergy, anesthesia, pneumology, pediatric pneumology), two (2) therapy sessions per day, up to a maximum of 20 sessions per member, per policy year.

Durable medical equipment

Requires precertification:
- Purchase or rental of oxygen and the necessary equipment for its administration
- Purchase or rental of wheelchairs or adjustable beds
- Purchase or rental of respirators and other equipment to treat respiratory paralysis

- The following services are covered for members diagnosed with type 1 diabetes mellitus, as required by Act No. 19 of January 12, 2020, to amend the Title and Articles 1, 2, and 4 of Act No. 177 of 2016:

FDA-approved glucometers, up to one per policy year. If the endocrinologist orders a specific glucometer for the member's treatment, the endocrinologist must submit a justification. In this case, the glucometer brand ordered by the endocrinologist will be covered, along with its accessories, for patients exhibiting a clinical pattern of susceptibility or a greater number of risk factors for developing Type 1 Diabetes Mellitus, as established in the second paragraph of Article 1 of Act No. 177.

- Lancets, up to 150 for 30 days
- Strips, up to 150 for 30 days
- Insulin infusion pump and supplies ordered by the endocrinologist for members diagnosed with Type 1 Diabetes Mellitus. The endocrinologist will determine the brand of insulin infusion pumps based on the level of physical activity, knowledge of the condition, and age of the member or caretaker. **Requires precertification.**

- The provision of a Glucagon injection and replacement of said injection in case it is used or expires (covered under pharmacy coverage).

Mechanical ventilator

- Coverage comprises the necessary medical services, tests, and equipment for underage members who, even after turning 21 years old, require the use of technological equipment to stay alive, a minimum of one (1) daily session of eight (8) hours per patient, of services provided by skilled nurses specialized in respiratory therapy or respiratory therapist specialists with nursing skills, or of emergency medical technician - paramedics (EMT-P) duly licensed with approved and validated courses/certifications and training or with the skills and knowledge requirements established via regulation by their respective examining boards regarding the care and management of such patients and their medical equipment, as authorized in Law No. 69 of December 27, 2021. It also includes coverage for the supplies involved in the management of the technological equipment and physical and occupational therapy required for the motor development of these patients, as well as prescription drugs, which must be dispensed by a participating pharmacy that has been freely selected by the member and authorized by the laws of Puerto Rico (under the pharmacy benefit). The coverage provides for each member to have annual access to the appropriate laboratory tests and immunizations based on their age and physical condition.
- These services will be covered, provided that the member or his/her representative submits proof of the medical justification and the member's inscription in the registry designed by the Health Department for such purposes. It also includes the necessary supplies to manage the Mechanical Ventilator technological equipment.
- The mechanical ventilator services and the services provided by skilled nurses with knowledge in respiratory therapy or by respiratory therapy specialists with knowledge in nursing, supplies related to the management of technological equipment, and physical and occupational therapy will be covered as established in the Table of Deductibles, Copayments, and Coinsurance. For the copayments and coinsurance for medical services, treatments, diagnostic tests, and medications, please refer to the Table of Deductibles, Copayments, and Coinsurance at the end of this policy.

Nutrition services

- Triple-S Salud will cover these services if they are medically necessary and are provided in Puerto Rico by physicians specialized in nutrition or metabolic diseases. Visits are limited to a maximum of 4 visits per policy year.

Injectable medications

- All injectable medications not under the pharmacy coverage but covered by the medical part are subject to preauthorization and the Plan's payment policies and medical policies, except for cancer medications, which should not involve experimental use.
- **Medications administered on an outpatient basis:** outpatient medications are covered with no copayment or coinsurance**, up to a maximum of ten-thousand dollars ($10,000).** After this amount is reached, the member shall pay the entirety of the costs for these medications, except for chemotherapy, radiotherapy, and medications used in the preparation of chemotherapy, in which case the corresponding coinsurance applies.

Medications administered on an outpatient basis: outpatient medications are covered with no copayment or coinsurance, **up to a maximum of ten-thousand dollars ($10,000).** After this amount is reached, the member shall pay the entirety of the costs for these medications, except for chemotherapy, radiotherapy, and medications
used in the preparation of chemotherapy, in which case the corresponding coinsurance applies.

Coverage in case of declared emergencies

Legally mandated services will be covered in the event of an emergency or disaster.

In compliance with Act No. 43 of April 16, 2020 (Law to Address COVID-19), Triple-S Salud will require no copayment, coinsurance, deductible, preauthorization, or referral from the patient for medical services, tests, analyses, diagnoses, and treatments of COVID-19, including hospitalization, as long as these services are provided in Puerto Rico.

Chiropractors

- Visits to the chiropractor

Manipulations and Physical Therapy (Habilitation/Rehabilitation)

- Manipulations performed by chiropractors
- Physical therapies provided by chiropractors or physiatrists (or under their supervision and billed by such professionals)

They are covered up to a maximum of twenty (20) sessions overall per member, per policy year.

Visual Care

- Ophthalmology diagnostics tests
- Refraction examination, one (1) exam per member, per policy year, if the examination is conducted by a specialist in ophthalmology or optometry.
- Eyeglasses for members up to 21 years of age, one (1) pair per policy year, within the contracted collection, including low-vision eyeglasses, for members with significant vision loss but not total blindness. It also covers one (1) visual aids device per year (prescribed magnifying glasses, single or double lens telescopes), for members up to 21 years of age with significant vision loss but not total blindness. Available through the network of optical stores exclusively contracted to provide this benefit to the pediatric population.

- Eyeglasses or contact lenses for members over 21 years old, up to the amount established in the Table of Deductibles, Copayments, and Coinsurance at the end of this policy. Please refer to the Triple-S Salud Participants and Providers Directory for a list of participating providers. If you visit a non-participating provider, the service is covered by reimbursement up to the maximum amount established in the Table of Copayments and Coinsurance at the end of the policy.

Alternative therapies (Triple-S Natural)

The program is only available through participating providers. For a list of participating providers, please refer to the Triple-S Salud Provider and Participant Directory. Up to 6 services per year, per member, including the following types of therapy:

- Medical acupuncture
- Therapeutic massage
- Clinical nutrition
- Naturopathic medicine
- Reflexology
- Music therapy

- Chiropractic care

Services to treat Disorders within the Autism Continuum

In compliance with the Act for the Welfare, Integration, and Development of Persons with Autism (known as the BIDA Act), this policy covers all services aimed at diagnosing and treating people with disorders within the Autism Continuum. These services will be offered without limits to all the insured people who have been diagnosed with any of the conditions within the Autism Continuum, subject to the copayments or coinsurance as established in the section Outpatient Medical-Surgical and Diagnostic Services.

- Neurological exams
- Immunology
- Genetic testing and laboratory tests for autism
- Gastroenterology services
- Nutrition services
- Physical, occupational, and speech/language therapy
- Visits to the psychiatrist, psychologist (with a master's or doctoral degree and a current license issued by the Puerto Rico Board of Psychologist Examiners), or social worker.

Note: **Genetic tests require precertification.**

In compliance with the Law for the Hyperbaric Oxygenation Treatment of Individuals with Autism Spectrum Disorders, we cover therapeutic hyperbaric oxygenation treatments for individuals with autism when it is recommended by a medical practitioner and the treatment is allowed by federal law and regulations, as well as for other related purposes.

Phenylalanine-free Amino Acid Formula

This policy covers the phenylalanine-free amino acid formula for patients who have been diagnosed with the genetic disorder known as phenylketonuria (PKU), with no exceptions as to the member’s age.

MEDICAL-SURGICAL SERVICES DURING HOSPITALIZATION

During hospitalization periods, the member shall have the right to receive medical-surgical services, including:

Medical-surgical services

- Surgeries
- Corneal transplants, skin and bone graft, includes care before and after the procedure.
- Bariatric surgery: the first treatment must be changes in diet and lifestyle. The doctor must document the failed attempts at supervised weight loss. This policy only covers gastric bypass surgery to treat morbid obesity, up to one surgery per lifetime, per member, provided the services are available in Puerto Rico. The health facility where the surgery will be performed must be accredited by the Joint Commission and one of the following two entities: the American College of Surgeons or the American Society for Metabolic and Bariatric Surgery. Surgeries to remove excess skin will be covered, if the physician certifies it is necessary to remove the excess skin because it affects the functions of any body part. These surgical procedures require precertification from Triple-S Salud. Salud, as defined.
- Orthognathic (jaw) surgery; **requires precertification**
- Diagnostic services
- Treatments
- Anesthesia administration
- Consultation with specialists
- Gastrointestinal endoscopies
- Audiological evaluations, including the Neonatal Hearing Screening Test
- Invasive cardiovascular tests
- Lithotripsy **(***ESWL***)**; **requires precertification**

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

- Triple-S Salud promises to pay for the services contracted with the corresponding hospital institution during the member's hospitalization, during the eligible person's term of insurance, provided that such hospitalization is ordered in writing by the attending physician and that it is medically necessary.

Hospitalizations

- Semi-private or isolation room, up to a maximum of three hundred and sixty-five (365) days for regular admissions

  When a member uses a private room at a participating hospital, Triple-S Salud will cover what it would have paid for a semi-private room. The hospital may charge the patient for the difference between the normal cost of the private room and the fee established by Triple-S Salud for a semi-private room, except in cases where it is medically necessary and with prior notification to Triple-S Salud. The member's other hospitalization costs covered by this policy are included in the contract between the participating hospital and Triple-S Salud, hence no other difference may be charged to the member. Please check the Table of Deductibles, Copayments, and Coinsurance for any copayment or coinsurance amounts additional to the hospital admission.

- Meals and special diets
- Use of telemetry service
- Use of recovery room
- Use of Intermediate Care Unit for infants (Step-down Unit)
- Use of Intensive Care, Coronary Care, Pediatric Intensive Care, and Neonatal Intensive Care Units
- General nursing service
- Administration of anesthesia by non-medical personnel

- Clinical laboratory services
- Medications, biological products, healing supplies, hyperalimentation products, and anesthesia supplies
- Production of electrocardiograms
- Production of radiological studies
- Physical therapy services (habilitation and rehabilitation)
- Use of services provided by physicians in training, interns, and hospital residents authorized to provide medical services to patients
- Respiratory therapy services
- Use of emergency room if the member is admitted to the hospital
- Use of other facilities, services, equipment, and supplies, as ordered by the primary physician, that the hospital usually provides and that have not been expressly excluded from the contract with the hospital
- Blood for transfusions

Note: These services are included in the copayment you pay for hospital admission.

- Chemotherapy treatment in its various methods of administration (oral, injectable, intravenous, and intrathecal) and radiotherapy

- Hemodialysis facilities Services related to any type of dialysis or hemodialysis, as well as any complications related to these treatments and their corresponding hospital or medical-surgical services, will be covered during the first 90 days from:

  a. the date the member first becomes eligible to this policy; or
  b. the date the first dialysis or hemodialysis is performed.

  This will apply if the subsequent dialyses or hemodialyses are related to the same clinical condition.

- Lithotripsy procedure (ESWL); **requires precertification**

- Outpatient Surgery Center

POST-HOSPITALIZATION SERVICES THROUGH A HOME HEALTH CARE AGENCY

Triple-S Salud covers these services if they begin within 14 days after the member's date of discharge after a hospitalization of at least three (3) days, and if they are provided due to or in relation to the same condition for which he/she was hospitalized. It covers the following services rendered and supplies delivered at the patient's home by a Home Health Care Agency certified by the Puerto Rico Department of Health. **Requires precertification.**

- **Nursing Services** - partial or intermittent services provided by or under the supervision of a graduate nurse.
- **Home Health Services Assistant** - partial or intermittent services provided primarily for the care of the patient.
- **Physical, Occupational and Speech Therapies (habilitation and rehabilitation)** - up to a maximum of 40 visits, combined, per member, per policy year.

Note: These services must be supervised by a licensed physician.

SKILLED NURSING SERVICES

The plan covers these services if they begin within 14 days after the date the member was discharged after a hospitalization of at least three (3) days, and if they are provided due to or in relation to the same condition for which he/she was hospitalized. **Requires precertification.**

- They are covered up to a maximum of 120 days per member, per policy year.

Note: These services must be supervised by a licensed physician or a registered nurse (RN) dedicated full-time to such supervision, and their **medical necessity must be certified in writing.**

EMERGENCY ROOM/URGENT CARE SERVICES

Emergency room/urgent care services: Supplies and medications included in the suture tray contracted with Triple-S Salud. In addition to those included in the suture tray, it also covers any medications and supplies provided in the emergency/urgent care room due to an accident or illness. Copayment or coinsurance for illnesses and accidents applies, as per the Table of Deductibles, Copayments, and Coinsurance.

If a member requires treatment to address an urgent condition, Triple-S Salud offers a lower copayment if they visit an urgent care center in our provider network instead of an emergency room.

If a member requires treatment for an emergency condition, they should seek immediate assistance at a hospital emergency room or the nearest emergency facility, or call the 9-1-1 System. Emergency services do not require precertification and are not subject to waiting periods. However, we only cover the emergency services provided in an emergency room in order to treat an emergency condition, and these are covered regardless of whether they were rendered by a participating provider.

If the member receives emergency services from a non-participating provider, such services will be paid directly to the provider based on the contracted fee that would have been paid to a participating provider, after subtracting the applicable copayment and/or coinsurance, as established in the policy. The non-participating provider is obligated to accept payment for an amount no less than the amount contracted for the same services as rendered by participating providers. If the patient receives emergency services

from a provider not contracted by Triple-S, the patient will not be responsible for paying for the services more than what the applicable amount would have been if they had received the services from a provider contracted by Triple-S.

If the member receives health care services after receiving post-stabilization or emergency services, which would be covered under the health plan except for the fact that they were rendered by a non-participating provider, Triple-S Salud will compensate the member based on what is lower between the cost incurred and the fee that would have been paid to a participating provider, after deducting the applicable copayment and/or coinsurance, as provided in the policy, as long as there is a compelling medical reason why the patient cannot be transferred to a participating provider.

If the member calling Teleconsulta is advised to go to the emergency room with a registration number, a lower copayment/coinsurance may apply for the use of such facilities.

Psychiatric emergencies are covered according to Act No. 183 of August 6, 2008. Psychiatric emergencies will be covered, as well as transportation between institutions providing health services, including ambulances certified by the Public Service Commission and the Department of Health, as established in the last paragraph of article 4.20 (b) of Act No. 183 of August 6, 2008, and as described in the Ambulance Benefit under the section Services Provided by a Hospital or Another Facility and Ambulance Services.

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

Hospital admissions: If a member was admitted to the hospital as part of an emergency, they do not have to notify the plan about the admission, except if it happened outside Puerto Rico. In these cases, the member or anyone else must notify the plan at the telephone number that appears on the back of the identification card, within forty-eight (48) hours after the admission or as soon as reasonably possible.

Urgent care/emergency services in the United States

Members are entitled to urgent care/emergency service coverage when they are in the United States.

Triple-S Salud will cover urgent care/emergency services based on the contracted fees by *Blue Cross Blue Shield* Plan in the area, as long as the provider rendering the services is a participant of the *Blue Cross Blue Shield* Plan network.

The member will be responsible for paying the coinsurance established in the Expanded Coverage in the Unites States, under the Table of Deductibles, Copayments and Coinsurance at the end of this policy.

AMBULANCE SERVICES

In accordance with Act No. 129 of August 1, 2019, if the service is used through the 9-1-1 System in emergency cases, Triple-S Salud shall pay the provider directly.

This benefit is covered if the patient was transported:

a) from the residence or place of the emergency to the hospital or Skilled Nursing Facilities
b) from a hospital to another hospital or Skilled Nursing Facility – in cases where the institution initiating the transfer or authorizing the discharge is not adequate to provide the covered service
c) from the hospital to the residence, if the discharged patient's condition requires it
d) Between health care institutions, in case of psychiatric emergencies, by ambulances certified by the Public Service Commission and the Health Department.

In non-emergency cases, this benefit is covered by reimbursement. The member shall pay the total cost and send the claim to Triple-S Salud with the medical report including the diagnosis. Triple-S Salud will reimburse up to a maximum of $80.00 per case.

- Air ambulance service in Puerto Rico, subject to medical necessity.

CANCER SERVICES

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

This policy covers pelvic exams and all types of Pap smear that may be required, by instructions of a physician, to detect, diagnose, and treat early stages of abnormalities that could lead to cervical cancer.

Outpatient cancer treatment services, such as radiotherapy and cobalt.

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

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

Triple-S Salud shall not reject or deny any treatment that is agreed upon and/or included in the terms and conditions of the health care contract signed between the parties to any patient who has been diagnosed with cancer or has survived cancer, when there is a medical recommendation for such purposes. This includes the treatments, medications, and diagnostic tests listed in the National Comprehensive Cancer

Network (NCCN) Guidelines and/or approved by the Food and Drug Administration (FDA), as well as those necessary to address and minimize harmful effects, subject to the provisions of this Law. The “Local Coverage Determinations-LCD from First Coast Service Options, INC”, “Medicare Approved Compendia List”, “National Coverage Determinations Alphabetical Index”, “Milliman Care Guidelines”, and the internal guidelines of the PRHIA will also be used.

The rights established in this Law are in addition to those provided by Law No. 275-2012, as amended, known as the “Bill of Rights of Cancer Patients and Survivors,” and have the scope and are governed in accordance with the requirements and procedures established by Public Law No. 111-148, known as the “Patient Protection and Affordable Care Act,” Public Law No. 111-152, known as the “Health Care and Education Reconciliation Act,” as well as any federal and local regulations adopted under it and any other successive or applicable law or regulation.

All members are entitled to receive the treatment recommended by their physician without the insurers posing any limitations for the patient to receive the most effective and advanced treatment available in the market, in accordance with the coverage and the protocols established in the guidelines listed in the previous subsection and established by the Advisory Board on the Care and Treatment of Cancer Patients and Survivors.

This policy does not establish that the final interpretation of the contract terms is subject to the insurer's discretion, neither does it contain rules for their review or interpretation in contravention of the provisions of this Law.

If a primary care physician (PCP) is selected, in the case of cancer patients, they are allowed to select a physician specialized in oncology as their PCP, as long as the health care professional consents to such designation.

Triple-S Salud shall send its approval or denial for treatment medications and diagnostic tests listed in the NCCN Guidelines or approved by the FDA within a term of 24 to 72 hours after receiving the request, or within 24 hours in cases marked as urgent or expedited. If a determination is not issued within such terms, the medications, treatments, and/or diagnostic tests will be deemed to be approved.

MATERNITY SERVICES

(Applies to members, spouses, and direct dependents)

Outpatient Maternity Care

- Medical visits
- Sonograms; up to three (3) in normal pregnancies, according to clinical protocol
- Biophysical profile
- Preventive Well-Baby Care visits according to age and coverage recommended by the United States Preventive Services Task Force (USPSTF)

Hospital Maternity Care

Hospitalization services will be extended in case of maternity or secondary, pregnancy-related conditions, only if the member is entitled to the maternity benefit. As provided by Act No. 248 of August 15, 1999, Act to Guarantee Adequate Care for Mothers and their Newborns during the Post-Partum Period, hospital admissions in the event of delivery will be covered for a minimum of 48 hours in the event of natural childbirth, and 96 hours for cesarean deliveries, unless the physician, after consulting with the mother, authorizes the hospital discharge for the mother and/or newborn. If the mother and the newborn are discharged after a period shorter than the time established, Triple-S Salud will cover a follow-up visit within the next 48 hours. Services will include, but will not be limited to: assistance and physical care for the

minor, education on child care for both parents, breastfeeding assistance and training, guidance about home support, and medical treatments and tests for both the mother and the infant.

- Semi-private or isolation room, assistance and physical care for the minor, education on child care for both parents, breastfeeding assistance or training, counseling about home support, and medical treatments and tests for both the infant and the parents.
- Obstetric services
- Use of delivery room
- Production and interpretation of Fetal Monitoring
- Use of Newborns Room (Well-Baby Nursery)

Note: These services are included in the copayment you pay for hospital admission.

HOSPICE

Services provided through hospice for members who have been diagnosed with a life expectancy of six (6) months or less as a result of a terminal health condition.

Note: These **services require precertification** from Triple-S Salud and shall be evaluated by your Individual Case Management Program for coordination through network participating providers.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This policy covers mental health and controlled substance abuse services as provided under state and federal laws, Act No. 183 of August 6, 2008, and the Mental Health Parity and Addiction Equity Act of 2008, which promotes equity in the care of mental health and substance abuse disorders. This policy does not have any major restrictions in terms of limits to medical-surgical benefits, such as limited days or visits, limits to mental health benefits/substance abuse applied to medical-surgical benefits. Copayments have no major restrictions on the medical-surgical benefits.

Participating hospitals in the Triple-S Salud network have been grouped as preferred and non-preferred hospitals. You will benefit from using preferred hospitals as your first option, since their copayments/coinsurance is lower than those of non-preferred hospitals.

Hospitalization

Hospitalizations for mental conditions

- Regular hospitalizations
- Partial hospitalizations
- Electro-convulsive therapy for mental conditions, covered based on justified medical necessity and the standards of the American Psychiatric Association (APA).

Outpatient Services

- Patient visits to the office of the psychiatrist or psychologist (with a master's or doctoral degree and a current license issued by the Puerto Rico Board of Psychologist Examiners).
- Collateral visits (immediate family), including marriage counseling provided by a psychiatrist or psychologist (with a master's or doctoral degree and a current license issued by the Puerto Rico Board of Psychologist Examiners).
- Group therapy visits

Other psychological evaluations

- Psychological evaluation
- Psychological tests: The psychological tests required by Act No. 296 of September 1, 2000, known as the Children and Adolescents Health Conservation Act of Puerto Rico.

Substance Abuse (Drug Addiction and Alcoholism)

- Regular hospitalizations, including detoxification services
- Partial hospitalizations
- Visits to the office of the psychiatrist or psychologist (with master's or doctoral degree and a current license issued by the Puerto Rico Board of Psychologist Examiners).
- Collateral visits (immediate family), including marriage counseling provided by a psychiatrist or psychologist (with a master's or doctoral degree and a current license issued by the Puerto Rico Board of Psychologist Examiners).
- Group therapy visits

- Home Care Treatment**:** Covers home care treatment, provided there is medical justification and the facility is duly accredited and has personnel to offer the service. **Requires precertification**

EXTENDED COVERAGE IN THE UNITED STATES

The benefits provided in this coverage will be available to the policyholder and his/her dependents.

Triple-S Salud will cover any medical and hospital services in this policy that have been rendered in the United States of America, only in cases of medical emergency or when the required equipment, treatment, and facilities are not available in Puerto Rico.

To receive services under this coverage in cases that require equipment, treatment, and facilities not available in Puerto Rico, it is required to obtain precertification from Triple-S Salud before they are provided. In cases of medical emergency, precertification is not required, but they will be subject to corroboration from Triple-S Salud regarding their medical necessity.

Triple-S Salud will cover services under this policy based on the fees Triple-S Salud received from the *Blue Cross Blue Shield* Plan in the area, if the provider rendering the services is a participant of the *Blue Cross Blue Shield* Plan network.

If the member uses a non-participating provider in the local Blue Cross Blue Shield network, they will have to pay the total cost of the services and will not be eligible for reimbursement, except in case of an emergency. In such cases, Triple-S Salud shall pay:

- The fee percentage established for non-participating providers established by the local Blue Cross Blue Shield Association plan, or

- The greatest of the following three amounts (adjusted to cost-sharing from the participating provider network): the fee negotiated with participating providers, the amount of the usual, customary, and reasonable (UCR) charge, or the amount paid by Medicare.

In either case, the member will be responsible for paying the coinsurance established in the Table of Deductibles, Copayments, and Coinsurance at the end of the policy for the services received under this coverage.

The member may request an Assignment of Benefits if the services to be received are not provided in Puerto Rico, subject to a benefit precertification from Triple-S Salud. By accepting the Assignment of Benefits, the non-participating *Blue Cross Blue Shield Association (BCBSA)* physician, hospital, or facility may bill through the local plan for the services provided to the member.

If the service is provided in the United States and it is not an emergency or is available in Puerto Rico, Triple-S Salud shall reimburse the member for the amount equivalent to the fee established in Puerto Rico, as established in this policy under the Member Compensation section.

MEMBER COMPENSATION

If any person entitled to benefits, as per this policy, receives covered services from non-participating professionals or facilities outside Puerto Rico, except if otherwise provided in this policy or for services paid based on compensation, Triple-S Salud will issue direct payment to the member for the expenses incurred, up to the amount that it would have paid to a participating professional or facility, or up to the corresponding amount according to what is specified in the benefit. If the service is provided in the United States and it is not an emergency or it is available in Puerto Rico, Triple-S Salud will pay the amount equivalent to the fee established in Puerto Rico. The member must submit all the reports and evidence of statutory payments required in such cases to Triple-S Salud.

- Pharmacy coverage will be subject to the terms and conditions of the coverage for hospitalizations and medical-surgical and outpatient services that are not in conflict with the benefits and conditions described in this section, and in such cases, what is established in the pharmacy coverage provisions shall prevail.

- **Generic medications are dispensed as a first choice, except for brand-name medications included in the Drug List for this coverage for which there is no generic version. If the member chooses or the physician prescribes a brand-name drug when there is a generic version in the market, the member will pay the copayment for the generic drug and the difference in cost between the brand-name and the generic drug.**

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

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

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

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

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

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

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

This pharmacy coverage has the following characteristics:

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

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

a) new medications are included, after being evaluated, within no more than 90 days after being approved by the FDA.
b) medications are changed from a higher copayment/coinsurance level to a lower copayment/coinsurance level.
c) changes are made for security reasons, if the manufacturer of the prescription drug cannot supply it or it has been pulled from the market, or if the change entails including new prescription drugs in the Drug List.

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

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

Description of the Pharmacy Benefit

- A doctor's prescription is required to dispense drugs.

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

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

- Contraceptive methods – We will only cover the drugs included in the contraceptive list of the Drug List, which includes at least one medication for each of the categories defined in the Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA). Generic drugs will be covered as the only option except in categories where there is no generic version in the market. Contraceptive methods not listed in the drug formulary of this policy will be evaluated using the process of medical exception.
- Folic acid supplements (400 mcg and 800 mcg) for members who are planning or able to become pregnant.

- Oral fluoride supplements for preschool-age children, six (6) months old to five (5) years old, whose drinking water sources do not include fluoride.
- For those using the products to stop tobacco use, this plan covers the dispensing of *nicotine nasal spray, nicotine inhaler*, and *bupropion HCl* (smoking deterrent) for ninety (90) consecutive days per attempt, and up to two (2) attempts per year. The generic drug will be covered as the only option, except where there is no generic version in the market. This does not apply to OTC (Over-the-Counter) products.
- Preventive drugs for patients at high risk of developing breast cancer, the generic version of *tamoxifen* or *raloxifene* in tablet form, for patients who are at high risk of developing the disease and at low risk for adverse reactions to the drugs.
- Certain oral iron supplements for minors aged 4 months to 21 years old who are at risk of anemia.
- Statins to prevent cardiovascular events: low or moderate dose of statins for adults aged 40 to 75 years old with no history of cardiovascular disease, who exhibit one or more risk factors (dyslipidemia, diabetes, hypertension, or smoking) and a calculated risk of 10% or more for a cardiovascular event within 10 years. We cover the generic versions of simvastatin 5, 10, 20 and 40 mg; atorvastatin 10 and 20 mg, pravastatin 10, 20, 40 and 80 mg, Rosuvastatin 5 and 10 mg; Lovastatin 10, 20 and 40 mg, and Fluvastatin 20 and 40 mg.
- Colorectal cancer prevention – gastroenterologist prescriptions for bowel preparations for colonoscopy procedures in adults over 50 years old, only the following prescription drugs will be covered: Suprep and PEG (polyethylene glycol).
- Medications for Human Immunodeficiency Virus Pre-Exposure Prophylaxis (HIV PrEP), Emtricitabine/Tenofovir Disoproxil Fumarate 200 mg/300 mg, requires preauthorization to validate the diagnosis. Only the generic bioequivalent tablet will be covered.

- For more information about the preventive medications to which these law provisions apply, you may access the following link: http://www.healthcare.gov/center/regulations/prevention.html.
- This plan covers prescription drugs to comply with the federal Act for the Welfare, Integration, and Development of Persons with Autism (known as the BIDA Act), subject to the copayments and coinsurance established in this policy.
- Buprenorphine
- The amount of medications provided for an original prescription is limited to a 15-day supply for acute drugs and a 30-day supply for maintenance drugs.
- The amount of maintenance drugs is provided based on the original prescription and up to five (5) refills, each one with a 30-day supply, within one year from the date of the original prescription. The doctor's prescription must include the amount of refills.
- Ninety (90)-day supplies apply to certain maintenance drugs, such as medications for Hypertension, Diabetes (Insulin and Oral Tablets), Thyroid, Cholesterol, Epilepsy (Anticonvulsants), Estrogen, Alzheimer's (patches not included), Parkinson's, Osteoporosis, Prostate, Aromatase Inhibitors, Antiestrogens, Asthma (tablets and liquid; excludes inhalers and nebulizers), and Blood Thinners (warfarin not included), filled through the Mail-Order Pharmacy or 90-day Drug Supply programs at pharmacies. This does not apply to Tier 4 and 5 Specialized Products.

- This pharmacy benefit may be subject to an annual deductible (i.e. $75 individual). Please refer to the Table of Deductibles, Copayments and Coinsurance at the end of this policy. **The "annual deductible"** is the amount the member must pay for medications before our plan begins to pay its share. When a member receives their first dispensed medication in the policy year, they will pay the total cost of the medications until they reach the established amount (e.g. $75 individual).

  Pharmacy coverages may have a first tier of coverage (e.g. $800 per individual contract, and $2,100 per family contract). This means that:

  a. If the pharmacy coverage has an annual deductible, the first tier of coverage begins when the member has reached the deductible and until the plan pays the established amount (e.g. $800 per individual contract, and $2,100 per family contract).

  b. If the pharmacy coverage does not have an annual deductible, the first tier of coverage begins when the member receives their first dispensed medication in the policy year, up until the plan pays the established amount (e.g. $800 per individual contract, and $2,100 per family contract).

  c. In both cases, whenever the member begins the first tier of coverage, they will be responsible for the copayments and coinsurance, based on the drug tier, up until the plan pays the established amount (e.g. $800 per individual contract, and $2,100 per family contract).

  d. Once the amount established in the first tier of coverage has been accrued (e.g. $800 for individual contracts and $2,100 for family contracts), the member must pay a coinsurance for all covered medications for the rest of the policy year, as established in the Table of Deductibles, Copayments, and Coinsurance at the end of this policy.

  e. These deductibles, copayments, and coinsurance do not apply to Preventive Services with $0 copayment, as required by the federal *Patient Protection and Affordable Care Act* and the *Healthcare and Education Act*, and as established by the *United States Preventive Services Task Force*. Please refer to the Table of Deductibles, Copayments, and Coinsurance at the end of this policy.

- A $0 copay applies for tier 1 generic drugs during the first policy year if the member changes from a brand-name drug to a Tier 1 generic drug in the following therapeutic categories: Anticonvulsant, High blood pressure drugs, Anti-psychotics, Anti-diabetic, Antidepressants, Lipid (Cholesterol)-lowering agents, Platelet-modifying agents, and Antianginal medications.

MANAGEMENT PROCEDURES

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

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

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

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

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

c. **Medical specialization limits (SL)**: Some medications have a specialization limit based on the specialist who is treating the condition. For example, for a liver condition, only a gastroenterologist or infectious disease specialist may prescribe the medication *Ribavirin*. These specialization limits are established according to current medical literature.

d. **Age limits (AL)**: There are medications in the Drug List that include the initials AL. AL means these medications have an age limit. For example, the drug *Ritalin* (*methylphenidate*) may only be dispensed to members up to 18 years of age.

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

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

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

Among the services included in the program are the following:

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

- Clinical interventions that include, among others:

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

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

Structure of Pharmacy and Drug Dispensing Benefit

Please refer to the Table of Deductibles, Copayments, and Coinsurance at the end of this policy to see the copayments and coinsurance corresponding to your plan.

30-day Supply

- Tier 1 – Generic Drugs
- Tier 2 – Preferred Brand-Name Prescription Drugs
- Tier 3 – Non-Preferred Brand-Name Prescription Drugs
- Tier 4 – Preferred Specialty Products
- Tier 5 – Non-Preferred Specialty Products
- Oral chemotherapy
- Over-the-Counter Drug Program
- Medications required by federal law, including all FDA-approved contraceptives with a physician's prescription, limited to those available in the island

Note: In some cases, a copay or coinsurance may apply up to the maximum established per medication, or a coinsurance may apply after the member spends a specific amount.

90-Day Programs for the Extended Supply of Maintenance Prescription Drugs

Triple-S Salud offers programs that provide 90-day supplies of certain maintenance drugs. Maintenance drugs apply for the following conditions: Hypertension, Diabetes (insulin and oral tablets), Thyroid, Cholesterol, Epilepsy (Anticonvulsant), Estrogen, Alzheimer's (not applicable to patches), Parkinson's, Osteoporosis, Prostate Aromatase Inhibitors, Antiestrogens, Asthma (tablets and liquid; excludes inhalers and nebulizers), and Blood Thinners (warfarin not included). Does not apply to specialized products. Triple-S Salud members will be able to select their preferred option to receive certain maintenance medications, either through participating pharmacies or from the comfort of their own home, by registering in the Triple-S Salud Pharmacy Program (Mail Order).

90-Day Prescription Drug Dispensing Program: This extended supply program allows members to obtain a 90-day supply of certain maintenance drugs through participating pharmacies. The Program has

a network of pharmacies located throughout the Island, including chain pharmacies and independent community pharmacies.

Mail order pharmacy program: Under this program, members will receive a 90-day supply of their maintenance prescription drugs at home or any other place of preference, and may order medication refills by mail or phone. The shipment for drugs is free of charge, and members will save in their copayments. To receive information and register in the Mail Order Pharmacy Program, please call 1-866-560-5881.

90-day Supply

- Tier 1 – Generic Drugs
- Tier 2 – Preferred Brand-Name Prescription Drugs
- Tier 3 – Non-Preferred Brand-Name Prescription Drugs

Oral chemotherapy drugs medically indicated for an extended 90-day supply*

Over-the-Counter Drug Program (Not Applicable)

Medications required by federal law, including all contraceptives approved by the FDA with a physician's prescription

* Please refer to the Drug List

PREAUTHORIZATIONS FOR PRESCRIPTION DRUGS

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

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

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

PROCEDURE FOR MEDICATION PREAUTHORIZATIONS

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

1. Evaluate the documentation received.
2. If the required clinical information is not received, it will be requested from the physician, the member, or the pharmacy.
3. Notify you of our determination.

Upon receiving a drug preauthorization request from a pharmacy, physician, or member, Triple-S Salud evaluates all the documentation received. If any clinical information is needed from the member, pharmacy,

or physician, Triple-S Salud will send a notification to said member, pharmacy, or physician stating they have five (5) calendar days to provide the missing clinical information."

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

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

PROCESS FOR EXCEPTIONS TO THE DRUG LIST

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

Types of exception

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

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

How to make a request

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

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

Information required to approve your exception request

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

- Name of the patient
- Contract number
- Primary diagnosis
- Reason why you cannot use any prescription medication in the Drug List that would be a clinically acceptable alternative to treat the member's disease or medical condition.
- The alternative prescription medication included in the Drug List or required according to the step therapy:
    - Has been ineffective in treating the disease or medical condition; or, based on clinical, medical, and scientific evidence, the member's known relevant physical and mental features, and the known features of the prescription medication regime, it is very likely that it will be ineffective, or that the efficiency of the prescription medication or the patient's adherence will be affected.
    - Has caused or, according to clinical, medical and scientific evidence, is very likely to cause an adverse reaction or other harm to the member.
    - The member was already at a more advanced step therapy level under another health plan, so it would be unreasonable to require that they begin again at a lower step therapy level.
    - The available dosage, according to the prescription's dosage limitation, has been ineffective in treating the member's disease or medical condition; or, based on clinical, medical and scientific evidence, the member's known relevant physical and mental features, and the known features of the prescription medication regime, it is very likely that it will be ineffective, or that the efficiency of the prescription medication or the patient's adherence will be affected.

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

1. When a request for medical exception is received, Triple-S Salud will make sure it is reviewed by appropriate health care providers, based on the health condition for which the exception has been requested. These providers, in making their determination for the request, shall consider the specific facts and circumstances that apply to the member for whom the request has been submitted, using documented clinical review criteria that:
    - That are based on sound clinical, medical, and scientific evidence, as well as the corresponding practice guidelines, in tune with the respective regulations and state and federal laws, as long as the service provided is recognized by the generally accepted standards of medical practice and health care, in light of the latest communication and learning methods.
2. The health care providers appointed by Triple-S Salud to review the medical exception requests shall make sure that the determinations made correspond to the benefits and exclusions provided in the

member's health plan. These providers must have experience in the administration of medications. The aforementioned determinations must include a report stating the qualifications of the health care providers who made the determination.

3. Triple-S Salud will make a determination on the submitted request and notify the member, or their personal representative as promptly as required by the medical condition, but not later than 48 hours after receiving the information required, the request, or the prescribing physician's message, whichever date is later. This period shall not exceed 24 hours for controlled medications.

    - In order to evaluate your request, Triple-S Salud will ask the physician or the pharmacy for the required clinical information by phone, fax, or any other electronic means.
    - If the member submitted the request, and additional clinical information is required to complete the evaluation of the drug, the member will receive a phone call where they will obtain instructions on which additional clinical information needs to be provided by the physician in order to evaluate the case, the deadline to receive it, and the fax number to send it.
    - If the required clinical information is not received within 48 hours, we will proceed to close the request and will immediately notify the member and, if applicable, their personal representative and the prescribing physician. The notice will include details about the missing clinical information. Closing the request does not mean the member may not submit the claim again.

    - The exception request form is available free of charge at **www.ssspr.com**. You may find the medical request form under the section Tools for You, which is located at the bottom of the main page, under Member Forms, as well as in the Drug List.

    - Triple-S will be required to offer immediate temporary coverage for an initial fill of the prescribed medication during the medical exception request process and until its final determination is notified in writing, if the prescribing physician or health care professional provides a written statement that the prescribed medication is medically necessary to treat the member's illness or condition, even if said prescribed medication is excluded from the drug formulary in the member's health plan or is subject to a prescription drug handling procedure.

4. If Triple-S Salud fails to make a determination regarding the medical exception request or to notify it within the aforementioned time period:

    - For 30 days, the member will be entitled to a supply of the prescription drug involved in the request, according to how the drug was requested or prescribed, or in the case of step therapy, for the term provided in the coverage.

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

5. If Triple-S Salud does not make a determination regarding the medical exception request or notify it before the member finishes their medication supply, the coverage should be continued under the same terms, provided that the medication continues being prescribed to the member and is considered safe to treat the member’s illness or health condition, unless the applicable benefit limits have been exhausted.

6. If Triple-S Salud approves the medical exception request, it will cover the medication and will not require the member to request approval for refills or new prescriptions in order to continue taking this medication, provided that:

- the medication is prescribed for the same illness or medical condition; and
- the medication is considered safe for the current policy year.

7. Triple-S Salud has not established a copay or coinsurance level applicable only to medications approved via exception requests. If your exception request is approved, the **Tier 5** coinsurance will apply.

8. All exception request denials:

   - Will be notified to the member or, if applicable, to their personal representative in writing, or by electronic means if the member has agreed to receive information that way.

   - Will be notified to the prescriber by electronic means or, at their request, in writing.

   - This decision may be appealed. In the denial notice, we will inform the member of his/her right to file a request to appeal the denial, as established in this policy in the section Appeals for Adverse Benefit Determinations.

9. Process to notify the coverage determination:

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

   1) The specific reasons for the denial;
   2) References to the evidence or documentation, which include the clinical review criteria and the practice guidelines, as well as clinical, medical, and scientific evidence, considered to deny the request;
   3) Instructions on how to request a written statement of the clinical, medical, or scientific reasons for the denial;
   4) Description of the process and procedures to file a request to appeal the denial.

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

DENTAL BENEFITS

The dental benefit is designed to provide essential dental services in compliance with the law.

In compliance with Act No. 352 of December 22, 1999, this policy covers the general anesthesia and hospitalization services required for certain cases of covered dental procedures for minors, adolescents, or people with physical or mental impairments, according to the criteria established in this law:

- If a pediatric dentist or maxillofacial or oral surgeon from a hospital medical faculty, licensed by the Commonwealth of Puerto Rico, according to Act No. 75 of August 8, 1925, as amended, determines that the patient's condition or ailment is considerably complex, according to the criteria established by the American Academy of Pediatric Dentistry;

- If the patient, due to his/her age, impairment, or disability, is unable to withstand or tolerate pain, or to cooperate with the indicated treatment for dental procedures;

- If an infant, minor, adolescent, or member with a physical or mental disability has a medical condition where it is essential to perform dental treatments under general anesthesia at an outpatient surgical center or hospital, because it would otherwise pose a significant risk to the patient's health;

- If local anesthesia would be ineffective or contraindicated due to acute infection, anatomical variations, or allergic conditions;

- If the patient is an infant, minor, adolescent, or has a mental or physical disability, and is in a state of fear or anxiety that would impede conducting any dental treatment under traditional procedure for dental treatments, and his/her condition is such that postponing or deviating from the treatment would result in pain, infection, dental loss, or dental morbidity;

- If a patient has suffered severe or extensive dental trauma, where the use of local anesthesia would compromise the quality of service or be ineffective in managing pain and apprehension.

Predetermination is required for this service, and the copayments and coinsurance corresponding to your coverage will apply. The following documents must be sent to Triple-S Salud for the corresponding evaluation:

- Member's diagnosis
- Member's medical condition
- Reasons to justify the member receiving general anesthesia to undergo dental treatment, according to the previously established criteria.

Triple-S Salud will have up to two (2) business days from the date they receive the documents to approve or deny the request.

$0 copayments apply for the following services:

Diagnostic and Preventive Services

1. Initial comprehensive evaluation (initial evaluation for new patients), up to one (1) every three (3) years. (Per dentist / office of the same specialization.)
2. Routine periodic exam (follow-up evaluation), emergency exams, and dental prophylaxis (cleaning), up to two (2) per policy year, per member, at intervals of no less than six (6) months from the last date of service.
3. Individual periapical X-rays are covered, up to six (6) per policy year, per member.
4. "Bitewings" radiographic imaging (one; two) up to one (1) per policy year, per member.
5. Fluoride varnish application (topical) to children under 5 years of age, up to two (2) per policy year, at intervals of no less than every six (6) months. (Either fluoride varnish or topical fluoride, not both.)
6. Fluoride application (topical) to children under nineteen (19) years of age, up to two (2) per policy year, at intervals of no less than every six (6) months.
7. Fluoride applications (topical) only for adults with special conditions, up to two (2) per policy year at an interval of no less than six (6) months.

SERVICE PREDETERMINATION

- When the member receives services from participating dentists, the latter will be responsible for requesting the predetermination from Triple-S Salud before providing the aforementioned services.

BASIC COVERAGE EXCLUSIONS

This policy does not cover the following expenses or services:

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

2. Services that can be received according to workers' compensation laws (SIF), the member's responsibility, private workers' compensation plans, automobile accidents (ACAA), and services available as per state or federal law, which the member is not legally required to pay. Also, such services shall be excluded if they are denied by the corresponding governmental agencies, due to breach or infringement on the requirements or provisions of the aforementioned laws, even if said breach or infringement does not constitute a crime.

3. Treatment services that may arise as a result of the member committing a crime or not complying with the laws of the Commonwealth of Puerto Rico or another country, except for injuries resulting from an act of domestic violence or a medical condition.

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

5. Expenses or services for personal convenience, such as telephone, television, custodial care services, rest house, convalescence home, or home care, except for post-hospital services provided through a Home Health Care Agency.

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

7. Reimbursement of the expenses incurred in payments issued by the member to any participating physician or provider, without being required by this policy to do so.

8. Expenses for services provided by non-participating physicians, hospitals, laboratories, and other providers in Puerto Rico, except for eyeglasses or contact lenses for members over 21 years old and in emergency cases that will be covered as established in this policy.

9. Expenses for covered services received without precertification from Triple-S Salud, if such precertification is required, as established in this policy, except for emergency cases.

10. Services that are not medically necessary, services deemed to be experimental or investigative, according to the criteria of the Food and Drug Administration (FDA), the Department of Human and Health Services (DHHS), the Puerto Rico Department of Health, or as per the medical policies of Triple-S.

11. Expenses or services for new medical procedures and new equipment, or new medications not considered experimental or investigative, high-cost drugs, except as required by state or federal law.

12. Not covered are the expenses for clinical research studies or treatments (i.e., clinical trials), devices, experimental or investigative medications administered to be used as part of these studies, services or products provided to obtain data and analysis and not for the direct management of the patient, and items or services at no cost to the member that are usually offered by the research sponsor. This applies even if the member enrolls in the study to treat a life-threatening disease for which there is no effective treatment, and obtains the physician's approval for participation in the trial because it offers potential benefits. In these cases, Triple-S Salud will cover the patient's routine medical expenses, according to the terms and conditions established in this policy. Routine medical expenses are any medically necessary expenses

required for the study (clinical trials) that are normally available to members under this plan, whether or not they are participating in a clinical trial, as well as services to diagnose and treat any complications resulting from the study, according to the coverage established in this policy.

13. Expenses for cosmetic surgeries or treatments to correct defects in physical appearance (except for care and treatment of congenital abnormalities and defects in newborns, newly adopted children, or those placed for adoption), septoplasties, rhinoseptoplasties, mammoplasties or breast plastic surgery reconstruction to reduce or increase size (except for mammoplasty and reconstruction after a mastectomy due to breast cancer), mammoplasties for gynecomastia, liposuction treatments, abdominoplasties, abdominal and facial rhytidectomies, blepharoplasties, hair implants, autoplasties, rhinoplasties, and sclerotherapy injections for varicose veins in legs. Hospital and medical-surgical services, and the complications associated to these, are excluded, regardless of whether there is medical justification for the procedure.

14. Surgical interventions and medical treatments with the purpose of controlling obesity (except for the treatment of morbid obesity or metabolic syndrome, including bariatric surgery, as defined by Law No. 212 of August 9, 2008 in Puerto Rico and in the Definitions section of this policy).

15. Expenses for orthopedic or orthotics devices, prostheses, or implants (except for prosthesis after mastectomy), and other artificial devices. We cover any hospital and medical/surgical services necessary for their implementation.

16. Expenses for the member's contraceptive methods; except those listed as covered under this policy.

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

18. Expenses for scalenotomy services - division of the anterior scalene muscle (*scalenus anterior*) without resection of the cervical rib.

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

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

21. Analgesia services, intravenous and by gas inhalation administered at the oral surgeon’s or dentist’s office.

22. Dental services to treat temporomandibular joint (jaw joint) dysfunction, either through the application of prosthetic devices or any other method.

23. Services needed to correct the vertical size or occlusion.

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

25. Expenses for allergy immunotherapy.

26. Services rendered for an induced abortion.

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

28. Hospitalizations due to services or procedures that may be conducted in an outpatient setting. (except in cases where, due to the patient's reasons or conditions, their health could be at risk if the service or procedure is not performed in a hospital environment).

29. Expenses related to the management of the employer's drug screening program, such as coordination, sampling, administration of screening tests (even if provided by a participating provider), and coordination of employee services to be provided by the employer or the entity responsible for managing the program, among others. We exclude expenses for care, supplies, treatment and/or services that the member obtains from the employer at no cost, and the services provided by the employer's Employee Assistance Program as part of the employer's drug screening program. We will cover mental health and substance abuse services after the member completes the employer's Drug Screening Program, regardless of whether the condition was detected through this program.

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

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

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

33. Expenses for services rendered by water ambulance. Also, expenses for services rendered by air ambulance, except when the transfer is made within Puerto Rico.

34. Expenses for the removal of skin tags, ptosis repair, and injections in tendons/trigger points.

35. Expenses for heavy metals laboratory tests, doping, *HLA Typing*, and paternity tests.

36. Expenses for special nurse services.

37. Services provided by residential treatment facilities outside Puerto Rico, with no medical justification or precertification for the treatment.

38. Expenses originated by organ and tissue transplants (except for cornea and bone or skin grafts), as well as hospitalizations, complications, chemotherapy, and immunosuppressive agents related to the transplant.

39. Expenses for orthopedic or orthotics devices, prostheses, or implants (except for prosthesis after mastectomy), and other artificial devices. We cover any hospital and medical/surgical services necessary for their implementation.

40. Expenses in excess of the first 30 days for newborns of the policyholder's direct dependents after delivery, except if it meets the definition of direct dependent as established in this policy.

41. Expenses for occupational and speech/language therapy, except those offered under post-hospital services, mechanical ventilators, and autism (BIDA Act) and Down Syndrome.

42. Preventive services rendered by providers outside Puerto Rico.

43. Growth hormones and all related treatments.

44. New diagnostic or therapeutic services or procedures approved by the FDA, and equipment and devices that become available after the effective date of this policy unless they are required by federal or local law.

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

46. Expenses or services performed with new medical technologies available in the market during the policy year and not covered by Triple-S Salud, except for cases of cancer, in accordance with Law No. 79 of August 1, 2020, or when required by federal or local law or ordered by the Office of the Commissioner of Insurance of Puerto Rico.
47. Complications related to body piercings or tattoos and any other related procedures.
48. New benefits required by the local law that have been enacted during the calendar year the policy is in effect or after the approval of the rates for said coverage, unless explicitly required by the Commissioner of Insurance or the local law itself.
49. Any service related to anti-aging or aesthetic treatment.
50. Gene therapy: Any FDA-approved treatment, medication, or device whose purpose or condition for which it has been approved involves the alteration of the body's genes, genetic editing, or gene expression.
51. Charges for drugs or medications provided during medical appointments not covered under this policy.
52. Charges for exceeding the limits established in this policy.
53. Chimeric antigen receptor T-cell (CAR-T) therapy: Any treatment or therapy where the patient's own immune cells (T cells) are modified to express a receptor on their surface that will recognize structures (antigens) on the surface of malignant cells.
54. Medications administered by a provider at their facility which are not dispatched by a retail pharmacy, except for chemotherapy, radiotherapy, and drugs used for chemotherapy compounding.
55. Robot-assisted surgery.
56. Computer-assisted surgical navigation in orthopedic procedures.
57. Services or treatments not explicitly described as a covered benefit, except for services and benefits that, in accordance with newly enacted laws, are required to be offered in the health care coverage.

PHARMACY BENEFIT EXCLUSIONS

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

1. Drugs not containing a script, except those included in the Triple-S Salud OTC Program.
2. Charges for artificial instruments, hypodermic needles, syringes, lancets, strips, urine or blood glucose meters, and similar instruments, even if they are used for therapeutic purposes.
3. The following medications are excluded from the pharmacy coverage in all their forms and methods of administration, regardless of whether they include the federal script:

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

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

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

e. Pain medications Nubain® and Stadol®.

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

g. Dietary products (Foltx®, Metanx®, Folbalin Plus®, and Cerefolin®)

h. Medications to treat infertility (follitropin, clomiphene, menotropins, urofollitropin, ganirelix, cetrorelix acetate, progesterone vaginal insert, leuprolide acetate inj kit 5 mg/ml [1mg/0.2ml]), and fertility.

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

j. Implants (goserelin, mometasone furoate nasal implant, buprenorphine HCl subdermal implant, dexamethasone intravitreal implant, fluocinolone acetonide intravitreal implant, autologous cultured chondrocytes for implantation, testosterone, estradiol, fluocinolone acetonide intravitreal, etonogestrel subdermal implant). Additionally, any other drug approved by the FDA.

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

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

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

n. Medications used in tests for diagnostic purposes (thyrotropin, dipyridamole IV 5mg/ml, gonadorelin HCL, cosyntropin, glucagon Diagnostic Injection Kit 1 MG (this does not apply to patients diagnosed with type 1 diabetes mellitus), barium sulfate, diatrizoate, iohexol, iopamidol, iopromide, iodixanol, iothalamate, ioversol, mannitol, technetium gadoterate, gadopentetate, gadodiamide, trichophyton, tropicamide, tuberculin, antigens, and leuprolide acetate inj kit 5 mg/ml (1mg / 0.2ml)).

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

p. Products used as vitamins and nutritional supplements for oral use (dextrose, Liposyn, fructose, Alanicem, L-carnitine, tryptophan, CardioVid Plus, glutamine), except some folic acid doses for members, in compliance with the regulation Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act.

q. Oral vitamins (niacin, ascorbic acid, thiamine, riboflavin, vitamin E, pyridoxine, dihydrotachysterol, multi-vitamins with minerals, multi-vitamins with iron, multi-vitamins with calcium, complex of vitamin B - biotin - vitamin D - folic acid, complex of vitamin B with vitamin C, flavonoids, and bioflavonoids), except for prenatal vitamins, covered folic acid supplements, and injectables.

r. Growth hormones *(somatropin, somatrem, tesamorelin acetate*)

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

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

u. Sclerosants (intrapleural talc, ethanolamine, polidocanol, sodium tetradecyl)

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

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

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

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

7. Refills ordered by a dentist or podiatrist.

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

9. Triple-S Salud reserves the right to select new drugs available in the market to include them in its Drug List or Formulary. No expense for new drugs shall be covered until that drug is evaluated by Triple-S Salud's Pharmacy and Therapeutics Committee, following the guidelines established in Chapter 4 of the Health Insurance Code of Puerto Rico. This Chapter requires that the Pharmacy and Therapeutics Committee conduct an evaluation of new FDA-approved prescription drugs within no more than 90 days from the date they were approved by the FDA. Triple-S Salud will issue its determination within that time regarding whether or not the new drug will be included in the Drug List. Any new medication included in the excluded therapeutic classifications (categories) will also be considered an exclusion.

10. All the forms and methods of administration of the following medications will also be excluded: Trypan Blue solution (azoic dye used in histological stains to help differentiate between living cells and dead cells), intravenous lacosamide Vimpat® (medication to treat seizures), degarelix acetate, sodium tetradecyl, morrhuate sodium (solution for peritoneal dialysis), viaspan (cold storage solution to preserve organs before a transplant), sodium tetradecyl sulfate (improves the appearance of varicose veins), polidocanol (treatment of varicose veins), sodium morrhuate (treatment for hemangiomas), intrapleural talc (prevents malignant pleural effusion - accumulation of fluids in the chest cavity of people with cancer or other serious illnesses in people who already have this condition), solution for peritoneal dialysis (to correct the imbalance of electrolytes, fluid overload, and elimination of metabolites in patients with severe renal insufficiency), and homeopathic products in all their presentations (natural products used to treat different conditions on an

individual basis). The following medications (brand-name and generic) are excluded: Xuriden (treatment for hereditary orotic aciduria and antidote for fluorouracil and capecitabine), Signifor (treatment for acromegaly and Cushing's disease), Cuprimine (treatment for rheumatoid arthritis, Wilson's disease, and cystinuria), Austedo (treatment for Chorea-Huntington's disease), Lucentis intravitreal (treatment for eye diseases), Orkambi (treatment for cystic fibrosis), Keveyis (treatment for glaucoma and periodic paralysis), Uptravi (treatment for pulmonary hypertension), Impavido (treatment against the Leishmaniasis parasite), Emflaza (treatment for muscular dystrophy), Dupixent (treatment for atopic dermatitis), HP-Acthar (treatment for infantile spasm, multiple sclerosis, gout, sarcoidosis, and amyotrophic lateral sclerosis), Tepezza (treatment for thyroid eye disease), Givlaari (treatment for acute hepatic porphyria), Zokinvy (treatment for Hutchinson-Gilford syndrome), Oxlumo (treatment for primary hyperoxaluria, type I), Danyelza (treatment for neuroblastoma), Evkeeza (familial hypercholesterolemia), Nulibry (combined molybdoflavoprotein enzyme deficiency, type A), Rebif (treatment for multiple sclerosis), Ilaris (systemic juvenile idiopathic arthritis), Isturisa (treatment for Cushing's disease), Elaprase (treatment for type II mucopolysaccharidosis), Xyrem (treatment for narcolepsy), Ponvory (treatment for multiple sclerosis) , Lupkynis (treatment for lupus nephritis), Aduhelm (treatment for Alzheimer's disease), Bylvay (treatment for pruritus with progressive familial intrahepatic cholestasis), Nexviazyme (for treatment for Pompe disease), Leqvio (low-density hypercholesterolemia [LDL-C]), sabatolimab HR-MDS (myelodysplastic syndrome), Ligelizumab (chronic urticaria), pegunigalsidase (treatment for Fabry disease), roxadustat (for anemia in patients with non-dialysis dependent chronic kidney disease [NDD-CKD] and patients on dialysis), Cibinqo (atopic dermatitis), Opzelura (topical version to treat atopic dermatitis), Saphnelo (anifrolumab) (systemic lupus erythematosus), gefapixant (chronic cough), Korsuva (moderate to severe pruritus associated with chronic kidney disease in certain populations), Skytrofa (short height due to inadequate secretion of endogenous growth hormone), Tezspire (severe uncontrolled asthma), Qulipta (migraine), Livmarli (cholestatic pruritus associated with Alagille syndrome), Sotatercept (pulmonary hypertension), Rezurock (graft-versus-host disease), Recarbrio (infection treatment), Scenesse (erythropoietic protoporphyria), Krystexxa (gout), artesunate (malaria), Uplizna and Enspryng (neuromyelitis optica), Oxbryta (sickle cell anemia), Cosentyx (treatment for plaque psoriasis/arthritis), Vuity (treatment for presbyopia), Rethymic (treatment for congenital athymia), Livmarli (treatment for cholestatic pruritus), Ryplazim (treatment for plasminogen deficiency), Vyvgart (treatment for generalized myasthenia gravis), Cortrophin Gel (treatment for infantile spasms, multiple sclerosis, gout, sarcoidosis, polymyositis, nephrotic syndrome, arthritis, ankylosing spondylitis, vision disorders, and amyotrophic lateral sclerosis), Addyi (treatment for premenopausal women to treat acquired, generalized hypoactive sexual desire disorder), Vyleesi (treatment for premenopausal women to treat acquired, generalized hypoactive sexual desire disorder), Entereg (treatment of post-operative ileus), Zynrelef (treatment for post-operative somatic pain), Pyrukynd (treatment for hemolytic anemia), Vabysmo (treatment of macular edema and macular degeneration), Enjaymo (treatment for autoimmune heomlytic anemia), Mozobil (to mobilize hematopoietic stem cells), Somryst (digital treatment for chronic insomnia), Remicade (treatment for Chron's disease and ulcerative colitis; only applies to brand-name drug), Simponi (treatment for rheumatoid arthritis, psoriatic arthritis, and ulcerative colitis), and Tremfya (treatment for plaque psoriasis and psoriatic arthritis).

11. Products used to treat idiopathic thrombocytopenic purpura (Promacta, Nplate, Tavalisse).

12. Products used to treat amyloidosis (Vyndamax).

13. Products used to treat amyotrophic lateral sclerosis (Radicava).

14. Products used to treat idiopathic pulmonary fibrosis (Ofev, Esbriet).

15. Products used to treat paroxysmal nocturnal hemoglobinuria (Soliris, Ultomiris, Empaveli)

16. Products used to treat primary biliary cirrhosis (Ocaliva).

17. Products used to treat spinal muscular atrophy (Spinraza, Zolgensma, Evrysdi).

18. Products used to treat Duchenne muscular dystrophy (Exondys 51, Vyondys 53, Viltepso, Amondys 45).

19. Products used to treat hereditary angioedema (Takhzyro, Cinryze, Firazyr, Orladeyo, Kalbitor, Ruconest, Berinert, Haegarda).

20. Antihemophilic agents (Hemlibra, Advate, Adynovate, Afstyla, Alphanate/VWF Complex/Human, AlphaNine SD, Alprolix, Bebulin, BeneFIX, Coagadex, Corifact, Eloctate, Feiba, Fibryga, Helixate FS, Hemofil-M, Humate-P, Idelvion, Ixinity, Kcentra, Koate, Koate-DVI, Kogenate FS, Kogenate FS Bio-Set, Kovaltry, Monoclate-P, Mononine, Novoeight, NovoSeven RT, Nuwiq, Obizur, Profilnine, Profilnine SD, Rebinyn, Recombinate, Refacto, RiaSTAP, Rixubis, SevenFact, Tretten, Wilate, Xyntha, Xyntha Solofuse).

21. Products used to treat Gaucher disease (Vpriv, Zavesca [miglustat], Cerezyme, Elelyso, Ceredase, Cerdelga).

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

23. Products used in the treatment to abstain from smoking (varenicline). This is a categorical exclusion, except as required by the federal Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA), and the Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152 (HCERA).

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

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

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

27. Gene therapy: Any treatment, drug, or device that alters the body's genes, genetic correction, or gene expression (Abecma, Breyanzi, Imlygic, Luxturna, Tecartus, Yescarta, Zolgensma, Carvykti [ciltacabtagene autoleucel]).

28. Cellular therapy: Any treatment involving the transfer of live, intact cells into a patient to help relieve or cure a disease. The cells may originate from the patient themself (autologous cells) or from a donor (allogeneic cells) (Allocord, Clevecord, Ducord, Gintuit, Hemacord, Kymriah, Laviv, Maci, Provenge, Ryplazim, StrataGraft).

29. Chimeric antigen receptor T-cell (CAR-T) therapy: Any treatment or therapy where the patient's own immune cells (T cells) are modified to express a receptor on their surface that will recognize structures (antigens) on the surface of malignant cells (Carvykti [ciltacabtagene autoleucel]).

30. New specialty drugs approved by the FDA. Except for oral chemotherapies and as required by federal or local law or by the Office of the Commissioner of Insurance.

DENTAL COVERAGE EXCLUSIONS

The policy exclusions for hospitalizations and medical/surgical and outpatient services apply to this coverage, except for services specifically listed as covered services.

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

1. Any service not included as a covered service in the description of this coverage

2. Full-mouth reconstruction services

3. Restorative, surgical, and prosthetics dental services, endodontic treatment, periodontology, and orthodontics

4. Expenses for device replacements or repairs

5. Fluoride varnish treatment is mutually exclusive with topical fluoride treatment (it may be either one or the other, not both)

6. Services provided by non-participating dentists in Puerto Rico, except in emergency cases

7. Dental services rendered outside Puerto Rico

8. Dental services provided for aesthetic or purely cosmetic reasons.

9. Dental services provided in mobile units will not be acknowledged for payment. Mobile units are vehicles, such as buses and trucks, that are equipped to offer basic health care services and move to different locations.

10. Treatments necessary in connection with an auto accident.

NOTICE OF PRIVACY PRACTICES

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

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

OUR LEGAL RESPONSIBILITY

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

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

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

Triple-S Salud is required to abide by the terms in this Notice. However, we reserve the right to change our privacy practices and the terms of this notice. Before we make any significant changes to our privacy practices, we will amend this notice and send it to all our active enrollees by the date the change becomes effective. **This notice shall be effective as of September 1, 2021.**

SUMMARY OF PRIVACY PRACTICES

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

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

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

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

LAWS AND REGULATIONS

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

HITECH: Refers to the act called “Health Information Technology for Economic and Clinical Health Act of 2009” (HITECH). This law promotes the adoption and significant use of health information technology. It also regulates the privacy and safety in electronic transmissions of health information, partly through several provisions that reinforce the civil and criminal enforcement of HIPAA Guidelines.

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

ORGANIZATIONS COVERED UNDER THIS NOTICE

Triple-S Salud, Inc.

USE AND DISCLOSURE OF HEALTH INFORMATION

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

Triple-S may use and disclose PHI for:

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

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

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

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

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

We may use or disclose your health information to another insurer or to a health care provider, subject to the federal or local regulations on confidentiality, while said insurer or provider holds a relationship with you.

Affiliated covered entities: As part of our functions as insurance or benefit administrators, we may use and disclose PHI to the following entity: Triple-S Salud, Inc.

Business partners: Triple-S Salud may share information with our business partners, who provide services on behalf of Triple-S Salud, Inc. and partake from the operations to manage your insurance or coordinate your benefits.

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

For research purposes: We may use or disclose your PHI to researchers, if an institutional review board or ethics committee has reviewed the research proposal and established protocols to guarantee your information's privacy and has approved the trial as part of a limited data set.

As required by law: We may use or disclose PHI as required by federal, state, or local law. In this Notice, the term "as required by law" is defined as provided by the HIPAA Act Privacy Rule. Your authorization, or the opportunity to approve or object, will not be required for these purposes. The information shall be disclosed in compliance with the safeguards established and required by law.

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

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

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

Relief in case of disasters or emergencies; governmental benefit programs: We may disclose your PHI to any public or private entity authorized by Law or its statutes to participate in relief efforts in case of a disaster. This way, your family may be notified about your health condition and location in case of a disaster or any other emergency.

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

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

- Public health activities, including the statistic reports on diseases and vital information and specialized government functions, among others;
- Monitoring by regulatory agencies and fraud prevention;
- Reporting domestic violence, abuse, or negligence against children or adults;
- Carrying out regulatory agency activities;
- Responding to judicial or administrative orders;
- Providing information to law enforcement or national security officers;

- Preventing an imminent threat to public health or safety;
- Storing or transplanting organs, eyes, or tissue;
- For statistic investigations;
- For purposes related to descendants;
- As required or permitted by the applicable laws.

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

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

With your authorization: You may authorize us, in writing, to use or disclose your information to other people for any purpose. Your authorization is required for activities such as the marketing of non-health-related products or the sale of health information. In these cases, the insurance policies and their benefits will not be affected if you deny authorization.

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

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

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

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

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

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

YOU HAVE THE FOLLOWING RIGHTS OVER YOUR PHI

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

- Request additional time
- Provide the information requested, or allow you to examine the information during working hours

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

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

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

Restrictions: You have the right to ask us to implement additional restrictions in the way we manage your health information.

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

Confidential communications: You have the right to request that our communications to you regarding your health information be made through alternative methods or addressed to alternative addresses. You must submit your request in writing. We may agree to your request if it is reasonable and provides alternative methods or addresses.

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

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

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

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

QUESTIONS AND COMPLAINTS

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

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

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

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

U.S. Department of Health and Human Services
Mailing Address: 200 Independence Avenue, S.W. Room 509F HHH Bldg. Washington, D.C. 20201.
Email: OCRComplaint@hhs.gov
Customer Response Center: (800) 368-1019 Fax: (202) 619-3818 TDD: (800) 537-7697

We support your right to the privacy of your health information. We will not take any kind of retaliation if you decide to file a complaint with us or with the OCR.

If you would like to receive an English version of this notice, please contact us at the address above or visit our website at https://salud.grupotriples.com/en/privacy-policy/.

Date of Review of Notice on Privacy Practices: May 2021

Triple-S Salud, Inc. is an independent licensee of Blue Cross Blue Shield Association.

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

Triple-S Salud, Inc. cumple con las leyes federales aplicables de derechos civiles y no discrimina a base de raza, color, origen de nacionalidad, edad, discapacidad o sexo. Triple-S Salud, Inc. complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 787-774-6060, (TTY/TDD), 787-792-1370 or 1-866-215-1919. Free of charge 1-800-981-3241. If you are a federal employee or retiree call 787-774-6081, Toll free 1-800-716-6081; (TTY/TDD) 787-792-1370; Toll free 1-866-215-1999. ATENCIÓN: si hablas español, tienes a tu disposición servicios gratuitos de asistencia lingüística. Llama al 787-774-6060, Libre de costo 1-800-981-3241. (TTY/TDD) al 787-792-1370 o 1-866-215-1919. Si es empleado o retirado federal llame al 787-774-6081, libre de costo 1-800-716-6081; (TTY/TDD) 787-792-1370; libre de costo 1-866-215-1999. Independent licensee of BlueCross BlueShield Association.

TABLE OF DEDUCTIBLES, COPAYMENTS, AND COINSURANCE

Pocket by Triple-S (POS)	PCP	With PCP Consultation / Preferred Network	Triple-S Salud Participants and Providers Network
Visits to primary care physicians (PCP)	$0	N/A	N/A
Visits to specialists	N/A	$0	$20
Visits to subspecialists	N/A	$0	$25
Visits to audiologists	N/A	$0	$20
Visits to optometrists	N/A	$0	$20
Visits to podiatrists, including routine care	N/A	$0	$20
TeleConsulta MD® (Telemedicine)	$0	$0	
Preventive services covered by local or federal law, including annual preventive visits, bone densitometry, mammograms, digital mammograms, and sonomammograms. You may access these services through participating Preventive Centers or participating providers included in the Directory.	$0		
Medical services provided in the member's home by physicians who provide this service	$10	$10	N/A
Intra-articular injections	$0		
Emergency Room:			
- illness or accident	N/A	$100	
Pocket by Triple-S (POS)	**PCP**	**With PCP Consultation / Preferred Network**	**Triple-S Salud Participants and Providers Network**
- Teleconsulta	N/A	$75	
Urgent care center	N/A	$15	
Cervical cryosurgery	$50	$50	30%

Sterilization services for women	$0		
Vasectomy	N/A	$50	30%
Preventive vaccines	$0		
Immunoprophylaxis for respiratory syncytial virus (Synagis; palivizumab)	N/A	30%	50%
Clinical laboratory	N/A	35%	N/A
X-rays	N/A	35%	N/A
Diagnostic Tests	N/A	25%	50%
Specialized Diagnostic Tests- PET Scan, CT Scan, MRI or PET CT	N/A	35%	N/A
Color Doppler Flow	N/A	25%	50%
Pelvic exams and Pap smears (cervical cancer screening, diagnosis)	N/A	$0	
Surgeries provided on an outpatient basis	$50		30%
Biophysical profile	N/A	30%	50%
Well-baby care preventive visits	$0		
Allergy tests	N/A	$0	
Pocket de Triple-S (POS)	**PCP**	**Con Consulta PCP/ Redes Preferidas**	**Red de Participantes y Proveedores de Triple-S Salud.**
Chemotherapy in its various methods of administration (injectable, oral, intravenous, or intrathecal), radiotherapy, and cobalt	N/A	10%	
Dialysis and hemodialysis	N/A	20%	50%
Respiratory therapy (administered in the physician's office)	N/A	$0	50%
Durable medical equipment, including glucometer, strips, lancets, insulin infusion pumps, and supplies	N/A	50%	

for members diagnosed with type 1 diabetes mellitus			
Mechanical ventilator, supplies, and therapies (respiratory, physical, and occupational)	N/A	50%	
POST-HOSPITALIZATION SERVICES THROUGH A HOME HEALTH CARE AGENCY	N/A	20%	50%
Nutrition services	N/A	$0	$20
Visits to the chiropractor	N/A	$10	50%
Manipulations	N/A	$10	$18
Physical Therapy	N/A	$10	$18
Ophthalmology diagnostics tests	N/A	25%	50%
Refraction test	N/A	$0	
Eyeglasses for members up to 21 years old	N/A	$0 espejuelos para menores de 21 años	
Pocket de Triple-S (POS)	**PCP**	**Con Consulta PCP/ Redes Preferidas**	**Red de Participantes y Proveedores de Triple-S Salud.**
Eyeglasses or contact lenses for members over 21 years old	N/A	Hasta un beneficio máximo de $75.00 por año póliza.	
Alternative therapies (Triple-S Natural)	N/A	$15	
Medical screenings and screening tests to detect the condition of autism, as part of preventive services	$0		
Services to Treat Disorders within the Autism Continuum			
· Neurological Exams	N/A	25%	50%

· Immunology	N/A	35%	N/A
· Genetic testing and laboratory tests for autism	N/A	35%	N/A
· Gastroenterology Services	N/A	25%	50%
· Nutrition Services	N/A	$0	$20
· Physical, occupational, and speech/language therapy	N/A	$10	$18
· Visits to psychiatrists or social workers	N/A	$0	$20
· Visits to psychologists	N/A	$0	$20
· Psychological screening and evaluation	N/A	$0	$20
Pocket de Triple-S (POS)	**PCP**	**Con Consulta PCP/ Redes Preferidas**	**Red de Participantes y Proveedores de Triple-S Salud.**
MEDICAL-SURGICAL SERVICES DURING HOSPITALIZATION			
Surgeries	N/A	$50	$50
Diagnostic services	N/A	$0	
Treatments	N/A	$0	
Anesthesia administration	N/A	$0	
Consultation with specialists	N/A	$0	
Gastrointestinal endoscopies	N/A	$0	
Audiological evaluations, including the neonatal hearing screening test	N/A	$0	

Chemotherapy in its various methods of administration (injectable, oral, intravenous, or intrathecal), radiotherapy, and cobalt	N/A	10%	
Corneal transplants and skin and bone grafts	N/A	$50	
Mastectomy (related surgeries, reconstructions, and prostheses)	N/A	$50	
Bariatric surgery	N/A	$50	50%
Invasive cardiovascular tests	N/A	25%	50%
Lithotripsy (ESWL)	N/A	25%	50%
Pocket de Triple-S (POS)	**PCP**	**Con Consulta PCP/ Redes Preferidas**	**Red de Participantes y Proveedores de Triple-S Salud.**
AMBULANCE SERVICES AND SERVICES IN HOSPITALS AND OTHER FACILITIES			
Semi-private or isolation room	N/A	$50	$300
Meals and services	N/A	$0	
Dialysis or hemodialysis	N/A	20%	50%
Lithotripsy procedure (ESWL)	N/A	25%	50%
Outpatient surgery center	N/A	$50	50%
Maternity: Semi-private room	N/A	$50	$300
Obstetric services	N/A	$0	
Use of delivery room	N/A	$0	
Fetal monitoring production and interpretation	N/A	$0	
Use of Newborns Room (Well-Baby Nursery)	N/A	$0	
Post-hospitalization services through a Skilled Nursing Facility (SNF)	N/A	$100	50%

Pocket de Triple-S (POS)	PCP	Con Consulta PCP/ Redes Preferidas	Red de Participantes y Proveedores de Triple-S Salud.
Ground ambulance	N/A	$0 en casos de emergencia. En casos que no sean emergencia, la persona asegurada paga el costo total y Triple-S Salud le reembolsará, hasta un máximo de $80.00 por caso	
Air ambulance service in Puerto Rico, subject to medical necessity.	N/A	$0	
MENTAL HEALTH AND SUBSTANCE ABUSE			
Regular hospitalizations, including detoxification services	N/A	$50	$300
Partial hospitalizations	N/A	$50	$100
Electroconvulsive therapies for mental health conditions	N/A	$0	
Visits to the psychiatrist office	N/A	$0	$20
Visits to the psychologist office	N/A	$0	$20
Pocket de Triple-S (POS)	**PCP**	**Con Consulta PCP/ Redes Preferidas**	**Red de Participantes y Proveedores de Triple-S Salud.**
Collateral visits (immediate relatives)	N/A	$0	$20
Group therapy visits	N/A	$0	$20
Psychological evaluation	N/A	$0	$20
Psychological tests	N/A	$0	$20
Residential treatment	N/A	$100	50%
EXTENDED COVERAGE IN THE UNITED STATES			
EXTENDED Coverage in the Unites States	N/A	60%	
Extended Coverage in the Unites States: Sanitas	N/A	$50	
PHARMACY – Through the Pharmacy Network			

Drug List Applies			
Initial deductible; does not apply to medications classified as preventive under federal law	$50		
1st-tier coverage per member	$500 per person		
Copayments or coinsurances for 30-day supply at first-tier level of coverage			
Tier 1 – Generic Drugs	$5		
Tier 2 – Preferred Brand-Name Prescription Drugs	40%		
Tier 3 – Non-Preferred Brand-Name Prescription Drugs	50%		
Tier 4 – Preferred Specialty Products	60%		
Tier 5 – Non-Preferred Specialty Products	60%		
Pocket de Triple-S (POS)	**PCP**	**Con Consulta PCP/ Redes Preferidas**	**Red de Participantes y Proveedores de Triple-S Salud.**
Oral chemotherapy	10%		
Medications required by federal law (including all contraceptives approved by the FDA with a physician's prescription)	$0		
Over-the-Counter Drug Program (OTC)	$0		
Coinsurance after first-tier level of coverage	95%		
Mail-Order Pharmacy Program			
Tier 1 – Generic Drugs	$10		
Tier 2 – Preferred Brand-Name Prescription Drugs	30%		
Tier 3 – Non-Preferred Brand-Name Prescription Drugs	38%		
Tier 4 – Preferred Specialty Products	N/A		
Tier 5 – Non-Preferred Specialty Products	N/A		
Some oral chemotherapies*	10%		

Medications required by federal law (including all contraceptives approved by the FDA with a physician's prescription)	$0		
Over-the-Counter Drug Program (OTC)	N/A		
Coinsurance after first-tier level of coverage	95%		
Pocket de Triple-S (POS)	**PCP**	**Con Consulta PCP/ Redes Preferidas**	**Red de Participantes y Proveedores de Triple-S Salud.**
Beneficios Dentales			
Diagnostic and Preventive Services	$0		

787.774.6060

Toll free: 1-800-981-3241

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Monday to Friday	7:30 a.m. - 8:00 p.m.
Saturday	9:00 a.m. - 6:00 p.m.
Sunday	11:00 a.m. - 5:00 p.m.

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