Triple-S Directo
Policy

2024

GOLD

TRIPLE-S SALUD

BlueCross BlueShield of Puerto Rico

Triple-S Salud
1441 Ave. Roosevelt, San Juan, Puerto Rico
Independent Licensee of Blue Cross Blue Shield Association

INTRODUCTION

TRIPLE-S DIRECTO POLICY

METAL PLAN GOLD

Triple-S Salud, Inc., (hereinafter referred to as Triple-S Salud) insures you and your eligible dependents in accordance with the provisions of this policy, the medical policy, and the payment policy established by Triple-S Salud, against expenses for medically necessary medical-surgical and hospitalization services, as well as pharmacy and dental services, rendered while the policy is in force due to injuries or diseases contracted by any of the members, as provided below. This policy is your evidence of coverage and has been issued in consideration of the statements included in your enrollment application and the advance 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, 2024. You may keep this policy in force as long as you pay the premiums on time, as stipulated in the General Provisions chapter, Subsection 18 - PREMIUM PAYMENT. The benefits of this policy are not cumulative; they do not roll over from one year to the next.

Triple-S Salud renews this policy, upon request from the member and in accordance with the applicable local and federal laws and regulations, except as provided in the General Provisions Section, Subsections 4 - INDIVIDUAL CANCELLATION and 29 - TERMINATION, with prior written notice to you. Moreover, it does not renew a dependent's coverage after they reach the age limit for coverage, as stipulated in this policy. All the terms of coverage begin and end at 12:01 a.m., local time of Puerto Rico.

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.

THIS POLICY IS NOT A MEDICARE SUPPLEMENTAL POLICY OR CONTRACT. If you are eligible for Medicare, please refer to the Health Insurance Guide for People with Medicare available with the company.

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

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

Justice Thurman
President of Triple-S Salud

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

Table of Contents

CHAPTER 1: How to Contact Your Plan

SECTION 1 Phone Numbers and Contact Information

Section 1.01 Customer service and other contacts

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

Customer Service Phone Number	787-774-6060 or 1-800-981-3241 (toll-free) TTY users call TTY 787-792-1370 or 1-866-215-1999 (toll-free)
Call Center Business Hours:	• Monday to Friday: 7:30 a.m. - 8:00 p.m. (AST) • Saturday: 9:00 a.m. - 6:00 p.m. (AST) • Sunday: 11:00 a.m. - 5:00 p.m. (AST)
Fax – Customer Service	787-706-2833
TeleConsulta	1-800-255-4375 (24/7)
BlueCard	1-800-810-2583 www.bcbs.com
Mailing Address Customer Service	Triple-S Salud, Inc. Customer Service Department PO Box 363628 San Juan, PR 00936-3628
Email Address:	servicioalcliente@ssspr.com
Precertifications	Triple-S Salud, Inc. Precertifications Department PO Box 363628 San Juan, PR 00936-3628 Fax: (787) 774-4824
Case Management Program	787-706-2552 TTY users: Call 787-792-1370 or 1-866-215-1999 Fax: 787-744-4824
Programs for the Management of Chronic Conditions, such as: • **asthma** • **diabetes** • **heart failure** • **prenatal care** • **hypertension** • **COPD (Chronic Obstructive Pulmonary Disease)** • **Smoking Cessation**	Monday to Friday, 8:00 a.m. to 4:30 p.m. Saturday: 8:00 a.m. – 4:30 p.m. (AST) Fax: 787-744-4824 commercialclinicalmanagement@ssspr.com

Service Centers

Plaza Las Américas (second level entrance from North Parking Lot) Monday to Saturday: 9:00 a.m. – 6:00 p.m. (AST)	**Plaza Carolina** (second level, next to the Post Office) Monday to 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 Monday to Friday: 8:00 a.m. – 5:00 p.m. (AST)	**Arecibo** Caribbean Cinemas Building, Suite 101 Road #2, Km. 81.0 Monday to Friday: 8:00 a.m. – 5:00 p.m. (AST)
Ponce 2760 Maruca Ave. 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)

Other Available Services	
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 and format. If you also need help reading or understanding a document, we can help. Written materials may be available in other formats. For telephone services for hearing-impaired (TTY), call 787-792-1370 or 1-866-215-1999 (toll free) in the following business hours: • Monday to Friday: 7:30 a.m. – 8:00 p.m. (AST) • Saturday: 9:00 a.m. – 6:00 p.m. (AST) • Sunday: 11:00 a.m. – 5:00 p.m. (AST)
People with Special Needs	Call Customer Service if you need help in another language or format. If you would like to speak in another language or need help reading or understanding a document, we can help you. Printed materials may be available in other formats, including Braille. To learn more, please review Chapter 4, Section 4 Benefits Covered by Law. 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 Members may register in our website, where they will be able to, among other things: • Get information about their benefits • Access information about health • Obtain a Certificate of Coverage • Request ID card duplicates • Change address information • Check reimbursement status • Obtain a student certification letter • Review their service history

Mobile Application, Mi Triple-S	Download our mobile app to get access to important information about your health plan coverage. With Mi Triple-S, you will be able to: • View your plan card and email it to your doctors so you can get care even if you don't have the physical card. • View your health plan coverage and benefits. • Pay your health plan. • View the healthcare services you have received. This feature can help you keep a log of the health services you and your family have received. • Find the nearest health care provider. • Have quick access to Triple-S Salud's contact information, such as phone numbers, office locations, and email addresses. Go to: https://salud.grupotriples.com/mi-triple-s/ IMPORTANT: The Mi Triple-S application is only available to the members of the Triple-S Salud health plan and their dependents who are over 18 years of age.
Telexpreso	This automated line helps solve health plan issues at any time. You just need to call (787) 774-6060 or 1-800-981-3241 (toll free) to quickly settle any issues with your health plan. The Telexpreso system lets you: • Pay your health plan • Check your eligibility and that of your dependents • Check the status of a reimbursement • Obtain guidance for some processes, such as submitting a reimbursement claim, requesting card duplicates, and certifications, among others
Teleconsulta MD®	Virtual interactive consultation with a physician from any place within the Puerto Rico region. Visit our website to access the service through a mobile device or computer. You may consult with general practitioners, family physicians, internists, pediatricians, or licensed psychologists, among other specialists, during the following hours: Monday to Sunday: 6:00 a.m. – 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.

CHAPTER 2: Definitions

1. **ACUTE DRUGS:** Medications prescribed to treat a non-recurring illness, such as antibiotics. These drugs do not have refills.
2. **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.
3. **ASSIGNMENT OF BENEFITS:** Process through which non-participating physicians, hospitals, and facilities agree to provide the necessary covered services (in Puerto Rico and United States) for insured members, while billing Triple-S Salud for said services based on participating provider rates.
4. **BARIATRIC SURGERY:** A surgical procedure for obesity control that can be performed via four techniques: gastric bypass, lap band, intragastric balloon, or sleeve gastrectomy. Triple-S Salud will only cover, as required by law, the gastric bypass, subject to precertification.
5. **BLUE CROSS BLUE SHIELD PLAN:** Independent insurer that, through a contract with the Blue Cross Blue Shield Association, acquires the license to belong to the association of independent plans and to use its trademarks.
6. **BLUECARD PROGRAM:** The program that allows the processing of claims for covered services outside the geographic area of Puerto Rico, which are paid based on the fees negotiated by the Blue Cross or Blue Shield Plan in the area.

7. **BONA FIDE RESIDENT:** Natural person with permanent residence in Puerto Rico.

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

9. **CLINICAL REVIEW CRITERIA:** The written procedures for screenings, decision summaries, clinical protocols, and practice guidelines used by the health insurance company or insurer to determine the medical necessity and appropriateness of the health care service.

10. **COINSURANCE:** The percentage of the fee the member has to pay to participating providers or physicians or to any other providers when receiving covered services, 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.

11. **COLLATERAL VISITS:** Interviews held with the member's immediate relatives at the office of a psychiatrist or psychologist who has a master's or doctorate degree and a current license issued by the Puerto Rico Board of Psychologist Examiners.

12. **COMMISSIONER:** Puerto Rico Office of the Commissioner of Insurance ("OCI").

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

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

15. **COPAYMENT:** The predetermined fixed amount that the member must 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 notified to the participating physician or provider. This amount is not refundable by Triple-S Salud.

16. **COSMETIC SURGERY:** Surgery whose sole purpose is to improve the individual's appearance, not to restore functionality or correct deformities. Cosmetic surgery does not qualify as reconstructive surgery if performed purely for psychiatric or psychological reasons.

17. **CREDITABLE COVERAGE:** Health coverage the primary policyholder has before enrolling in this plan under a group plan, provided that the person has not experienced a substantial interruption in their coverage (period of 63 consecutive days during which they did not have creditable coverage, not including the waiting period or the enrollment period). The certificate of creditable coverage is provided:

    a. When the person stops being covered by the health plan or acquires coverage as provided by the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) regarding continuation of coverage;

    b. In the case of members insured in accordance with COBRA's provisions regarding continuation of coverage, when the person stops being covered pursuant to said provision;

    c. When requested on behalf of a person, if the request is submitted up to twenty-four (24) months after the date of termination of the coverage described in subsection (1) or (2), whichever date is later.

    It is the health coverage the primary policyholder has under a group plan before enrolling in this plan, provided that the person has not experienced a substantial interruption in coverage.

18. **CUSTODIAL CARE:** Personal care or assistance provided to a person on an ongoing basis to help in their daily activities, such as bathing, dressing, eating, getting in and out of bed or a chair, moving around, using the bathroom, preparing, and eating meals, and medication management. Custodial care does not require the ongoing presence of medical personnel.

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

20. **DEDUCTIBLE:** It is the amount the member must pay every year for eligible medical or pharmacy services before the plan begins to pay the cost of covered services. It does not apply to preventive services or vaccines.

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

    a. The primary policyholder's spouse (person with whom they are married after having performed all the ceremonies and formalities required by law), included in a family contract while this policy is in force, provided that the policyholder lives with said spouse. In the case of domestic partners, the primary policyholder must prepare an Affidavit of Domestic Partnership for their inclusion, following the template provided by the Commissioner of Insurance, and submit it to Triple-S Salud as proof.

    b. Biological or adopted children of the primary policyholder or their spouse or domestic partner, as defined in the prior subsection, until they reach twenty-six (26) years of age. The following are not eligible under this plan: the spouse of the primary policyholder's child, the children of the primary policyholder's child, except those included in subsection (d) below, or the children of the spouse of the primary policyholder's child.

    c. Minors placed in the member's home pending adoption by the member. The primary policyholder must provide evidence of the placement for adoption by submitting any documents requested by Triple-S Salud.

    d. A non-emancipated minor who is the primary policyholder's grandchild or blood relative is eligible as a direct dependent, as long as the member holds permanent custody of the minor awarded by final and unappealable judgment; this direct dependent may remain in the plan until they reach twenty-six (26) years of age. The policyholder's grandchildren or blood relatives of legal age are also eligible as direct dependents if the person has been declared incompetent by a final and unappealable judgment and guardianship has been granted to the member by the court. In either case, if a primary policyholder wishes to enroll a grandchild or blood relative as a direct dependent under this clause, the Primary Policyholder must provide proof of custodial or guardianship status and submit the court's final and unappealable judgment awarding permanent custody or guardianship, as the case may be.

    e. The primary policyholder's foster children are eligible as direct dependents until they reach twenty-six (26) years of age. The primary policyholder may prove a foster child's status by submitting an affidavit to Triple-S Salud specifying when the relationship with the minor began and including a school certificate or a certification of income tax return for the last two years, among other supporting documentation. A foster child is understood to be a minor who, without being the primary policyholder's biological or adoptive child, has lived in the same home with the policyholder since childhood leading a typical parent-child relationship and receives support, as defined in article 142 of the Civil Code of Puerto Rico.

22. **DOMESTIC PARTNERSHIP:** Two single adults with full legal capacity who are not related by family ties within the fourth degree of consanguinity or second degree of kinship, who have voluntarily and continuously engaged in a public, stable and affective domestic partnership for no less than one (1) year, who live together without being married to each other, and who intend to continue living together indefinitely.

23. **DRUG FORMULARY:** Guide of the medications selected by the Triple-S Salud Pharmacy and Therapeutics Committee, which contains the therapies necessary for a high-quality treatment. Pharmacy coverage benefits are determined based on the medications included in the Drug Formulary. This selection is made based on the safety, effectiveness, and cost of the medications that ensure the quality of the therapy, while minimizing misuse, which could be detrimental to the patient's health.

24. **DURABLE MEDICAL EQUIPMENT:** Equipment whose primary use is to serve a medical purpose; its medical necessity must be certified. These include oxygen and the equipment needed for its administration, wheelchairs, hospital beds, and others required by law, as well as mechanical ventilators and other equipment to treat respiratory paralysis.

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

26. **ELIGIBLE PERSON:** Someone who resides in Puerto Rico and is not eligible to be insured under an employer-sponsored health plan. This term may include members, as well as their spouses, children, and domestic partners:

    a. Who had creditable coverage and who, as of the effective date, have accrued the periods of creditable coverage required by HIPAA (eighteen 18 months or more).

    b. Whose last creditable coverage has not lapsed for more than sixty-three (63) days before the effective date of this policy.

    c. Who are 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 said Act (Medicaid), or a successor program for these plans.

    d. Whose most recent coverage within the accrued periods of creditable coverage was not terminated due to fraud or to the non-payment of premiums.

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

28. **ESSENTIAL HEALTH BENEFITS:** Services identified as Essential Health Benefits, pursuant to section 1302(b) of Public Law 111-148, known as the Patient Protection and Affordable Care Act, as amended by Public Law 111-152, known as the Health Care and Education Reconciliation Act, and in accordance with the federal and local regulations adopted thereunder. The Health Insurance Code and the Affordable Care Act guarantee that, as of 2014, all unprotected or non-grandfathered health plans offered in individual markets include comprehensive service coverage, better known as essential health benefits. These essential benefits, which are defined by law and Puerto Rico's reference plan, are divided 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 illness management services; and pediatric services, including dental and vision care.

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

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

    b. do not have final approval from the corresponding regulatory agency (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, based on the available scientific evidence, in order to reach conclusions about the effect of the treatment or technology on the medical results obtained; or

    d. have insufficient reported positive results to acceptably offset the treatment’s negative results; or

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

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

30. **FAMILY CONTRACT:**

    a. The insurance that provides benefits for any eligible person, their spouse or domestic partner, and their direct dependents, as per the definition of Direct Dependent. In these cases, the appropriate premium will apply based on family composition.

    b. If a policyholder does not have an eligible spouse or domestic partner, as per the definition of Direct Dependent, but has one (1) or more eligible direct dependents, the policyholder may choose to have their contract considered as either a Family Contract or an Individual Contract with one (1) or more direct dependents.

31. **FDA:** United States Food and Drug Administration.

32. **FEES:** The fixed amount that Triple-S Salud pays its participating physicians or providers for covered services rendered to members when these are not compensated by any other method of payment.

33. **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 prior authorization or have limits by age, quantity, specialty, or step therapy.

34. **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. The counseling process considers family and medical history, including the condition's diagnosis and probable course, as well as available treatments.

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

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

    a. The availability, delivery, or quality of the 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

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

37. **HEALTH CARE PROFESSIONAL:** A physician or health care professional who has been duly licensed to practice in Puerto Rico, in accordance with the applicable laws and regulations, including but not limited to physicians, surgeons, podiatrists, naturopathic doctors, chiropractors, optometrists, psychologists, dentists, pharmacists, nurses, audiologists, and medical technicians, as authorized by the corresponding laws in Puerto Rico.

38. **HEALTH INFORMATION:** Information or data, verbal or otherwise recorded in the manner and medium that:

    a. it was created or received by the insurer or health care service organization.

    b. it relates to the past, present, or future physical, mental, or behavioral health conditions of the person or their dependent, the health services rendered to the person, or the past, present, or future payment for health services rendered to the person.

    c. the payment for health care services rendered to a person.

    d. the health information also includes demographic and genetic data, as well as information about financial exploitation or abuse.

39. **HEALTH PLAN:** An insurance contract, policy, certificate, or enrollment agreement with a health insurance company, health services organization, or any other insurer, furnished in consideration of 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 agrees to provide or pay for the provision of specified medical services, hospital services, major medical expenses, dental services, mental health care, or services related to the provision thereof.

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

41. **HIPAA (Health Insurance Portability and Accountability Act of 1996):** 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. The act includes provisions to combat fraud and abuse in health coverages and in the provision of health services, and it streamlines the administration of health plans. This law is applicable in our jurisdiction and supersedes the Health Insurance Code of Puerto Rico.

42. **HOME CARE:** Home assistance or care provided to an individual by a licensed heath care provider or professional caregiver to help them in their daily activities, such as bathing, dressing, eating,

getting in and out of bed or a chair, moving around, using the bathroom, preparing meals, and medication management.

43. **HOME HEALTH CARE AGENCY:** An agency or organization that provides a medical assistance program in the home 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:

    - 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.
    - It has a full-time administrator.
    - It keeps written records of the services provided to patients.
    - Its staff includes at least one registered nurse (RN).
    - Its employees are bonded, and it provides professional misconduct and malpractice liability insurance.

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

45. **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.

46. **HOSPITALIZATION SERVICES:** Services covered under this policy that the member received while admitted to a hospital as a hospital patient.

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

48. **ILLNESS:** Any non-occupational illness contracted by any member. In the case of diseases for which hospitals are prohibited by law or regulation from admitting a patient, once such a disease is diagnosed, it is not covered by this policy. Maternity and secondary conditions related to the pregnancy are considered illnesses under the coverage offered by this policy, subject to the following conditions:

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

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

49. **INCURRED EXPENSE:** Amount paid by the member for the total cost of a covered service that was received and not billed to the plan or processed through assignment of benefits.

50. **INDIVIDUAL CONTRACT:** The insurance that provides benefits to any eligible person, unmarried or married, without including the member's spouse or domestic partner as a direct dependent. This person has the option to include each eligible direct dependent, as defined in this policy, by paying the applicable additional premium.

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

52. **INJURIES:** Any accidental injury suffered by the member, other than a car or work-related accident, which requires medical treatment and hospital services.

53. **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, services, or care plans.

54. **INTENSIVE CARE UNIT:** A separate and clearly designated service area that is reserved for patients who are seriously ill and in critical condition and require constant audiovisual observation, as prescribed by their primary care physician. It provides rooms and nursing care services rendered by nurses who are primarily responsible for the care of intensive care patients, as well as special equipment or supplies readily available at any time for the patients admitted in this unit.

55. **IRO:** The Internal Review Organization (IRO) is an organization authorized to perform independent medical reviews. These reviews are carried out by an independent physician.

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

57. **MAINTENANCE DRUGS:** Medications that require prolonged therapy and are less likely have a low probability of suffering changes in the dosage or course of treatment due to side effects. Also, medications whose most frequent use is to treat a chronic illness when a therapeutic endpoint cannot be determined.

58. **MAXIMUM OUT-OF-POCKET:** The established maximum amount the individual will pay during the policy year. Before reaching the established maximum out-of-pocket limit, the member pays the deductibles, copayments, or coinsurances described in the chapter on **Covered Benefits** for the essential medical-surgical care, dental services, and medications received through the plan's participating providers. Once the member reaches the maximum out-of-pocket amount established in this policy, the plan pays one hundred percent (100%) of the medical expenses covered under this policy.

59. **MEDICAL EMERGENCY:** A medical condition that presents with sufficiently severe acute symptoms, including severe pain, that a prudent layperson with an average understanding of health and medicine would anticipate that lack of immediate medical attention could seriously threaten the person's health or result in serious impairment of a limb or organ; or, in the case of pregnant members, if the member is experiencing contractions and there is insufficient time to transfer the member to another facility before delivery, or if such transfer would pose a threat to the member's health or the health of the unborn child.

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

    a. is consistent with the generally accepted standards for medical practice, in view of modern methods of communication and education;

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

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

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

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

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

    a. Expert peer-reviewed papers, published or approved for publication in specialized medical journals that meet the nationally recognized criteria for scientific texts;

b. Peer-reviewed medical publications, including those related to therapies that have been evaluated and approved by institutional review boards, the biomedical compendia, and other medical journals that comply with the indexing criteria of the National Institutes of Health Medical Library, in the Medicus Index (Medline), and those of Elsevier Science Ltd. In Excerpta Medicus (EMBASE);

- Medical journals recognized by the Secretary of Health and Human Services of the United States, pursuant to the federal Social Security Act;
- The following guidelines:
    - The American Hospital Formulary Service-Drug Information
    - Drug Facts and Comparisons®
    - The American Dental Association Accepted Dental Therapeutics
    - The United States Pharmacopoeia (compendium of drug information)
- Findings, studies, or research conducted or sponsored by federal government agencies and federal research institutes recognized in the United States, including:
    - Agency for Health Care Research and Quality
    - National Institutes of Health
    - National Cancer Institute
    - National Academy of Sciences
    - Centers for Medicare and Medicaid Services (CMS)
    - Any national board recognized by the National Institutes of Health whose purpose is to assess the effectiveness of health care services
- Any additional medical or scientific evidence comparable to those described in the preceding paragraphs.
- Categorical exclusion: it means the provision expressly established by Triple-S to not cover a prescribed drug, identifying it by its scientific or commercial name.

62. **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 which are determined and provided in accordance with good medical practice standards.
63. **MEDICARE:** Federal law on Health Insurance for the Aged and Disabled, Title XVIII of the 1965 amendments to the Social Security Act, as constituted or subsequently amended.
64. **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.
65. **METABOLIC SYNDROME:** A combination of several diseases or risk factors in a single individual that increase their likelihood of developing a cardiovascular disease or diabetes mellitus. People with metabolic syndrome have at least three of the following risk factors: excessive abdominal fat; high blood pressure (hypertension); abnormal levels of blood fat (lipids), cholesterol, and triglycerides; and hyperglycemia (high level of blood sugar).
66. **MORBID OBESITY:** Excess of body fat, as determined by a body mass index (BMI) of 35 or more. This condition forms part of the metabolic syndrome and is a risk factor for the development of other conditions, such as high blood pressure, cardiac diseases, orthopedic problems, sleep apnea, skin problems, circulation problems, diabetes mellitus, heartburn, psychological problems, anxiety, infertility, and pulmonary embolism, among others. Studies suggest that this condition is caused by multiple factors, such as genetics, the environment, and psychological aspects, among others. This means that it can be caused by eating in excess, metabolic disorders, or hereditary factors.
67. **NEW DRUGS:** Drugs that have been recently introduced in the market.

68. **NEW MEDICAL TECHNOLOGY:** New procedures for the diagnosis and treatment of various illnesses, which have been approved by the FDA and are widely recognized by the medical community and available in the service area.

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

    a. are not listed as covered;

    b. are expressly excluded in the member's policy.

70. **NON-PARTICIPATING PROVIDER:** Health care professional or facility that does not have a contract with Triple-S Salud to offer the benefits covered by this policy.

71. **NON-PREFERRED BRAND-NAME DRUGS (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 drug, they must pay a higher price for the medication. Some drugs require prior authorization or have limits by age, quantity, specialty, or step therapy.

72. **NON-PREFERRED SPECIALTY PRODUCTS (Tier 5):** These are the medications or products in the Drug Formulary that are offered under the Special Care Pharmacy Program. Medications 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 prior authorization or have limits by age, quantity, specialty, or step therapy.

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

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

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

76. **OUTPATIENT SERVICES:** Services covered under this policy that the member receives while not admitted to a hospital as a patient.

77. **OUTPATIENT SURGERY CENTER:** A specialized facility 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, in cases where such facilities are not regulated by law, it meets the following requirements:

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

    b. It operates under the supervision of a licensed medical doctor (MD) who devotes a full-time schedule to such oversight tasks and allows surgical procedures to be performed only by qualified physicians who, at the time of such procedures, also performs the same procedures in at least one other hospital in the area.

    c. In every case, except those where only local anesthesia is needed, it requires a licensed anesthesiologist to administer the anesthesia and remain present throughout the entire surgical procedure.

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

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

    f. It keeps a written contract with at least one hospital in the area for the immediate admission of patients with complications or who require postoperative hospitalization.

    g. It keeps adequate medical records for every patient, which should include an admission diagnosis —comprising a preoperative examination report, medical history, laboratory tests and/or

radiographs, an operative report, and a discharge summary—for all patients, except those who undergo procedures with local anesthesia.

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

79. **PARTIAL HOSPITALIZATION:** Services provided for the care of patients with mental health conditions that require hospital care through daytime or nighttime programs, covering daily periods of fewer than twenty-four (24) hours.

80. **PARTICIPATING PROVIDER:** Healthcare services professional or facility that has a contract with Triple-S Salud to provide the benefits covered by this policy.

81. **PERIODONTOLOGY:** Branch of dentistry related to the diagnosis and treatment of diseases in the gums and other tissues that comprise the supporting structure for the teeth.

82. **PERSONAL REPRESENTATIVE:** Someone who has been specifically authorized in writing by the member to represent them for the purposes of the Puerto Rico Health Insurance Code, including:

    a. A person authorized by law to consent in lieu of the member;

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

    c. A health care professional, when the member's health plan requires a health care professional to request the benefit; or

    d. In case of urgent care requests, a health care professional that has knowledge about the member's medical condition.

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

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

    a. The adequate manner, from a clinical perspective, of prescribing, administering, and overseeing the use of prescription drugs for outpatients; and

    b. Reviewing and assessing the use of these drugs, as well as intervening with such usage.

    If the pharmacy and therapeutics committee include members who represent the pharmacy benefit manager or Triple-S Salud, these members may only raise operational or logistical concerns, but they do not have a vote on any decisions regarding the inclusion or exclusion of prescription drugs in the Drug Formulary.

85. **PHARMACY:** A health care services facility that is licensed and registered under the provisions of federal and state laws to engage in the provision of pharmaceutical services, which includes dispensing prescription drugs, over-the-counter drugs, supplies, and other products related to health and the delivery of pharmaceutical care.

86. **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.

87. **PRECERTIFICATION:** The prior authorization issued by Triple-S Salud for the payment of any of the benefits and coverage under this policy and its endorsements. Precertifications are reviewed based on the precertification policies established by Triple-S Salud from time to time.

88. **PREDETERMINATION OF SERVICES:** Evaluation of the treatment plan suggested by the dentist before providing services to determine the member's eligibility, the scope of covered benefits, limitations and exclusions, and the applicable coinsurance under the member's contract.

89. **PREEXISTING CONDITION:** A condition, regardless of its cause, for which treatment was recommended or diagnosis, care, or treatment was received for six (6) months immediately prior to

the health plan's enrollment date. This policy does not exclude or discriminate against members on the basis of preexisting conditions or genetic predisposition, regardless of the member's age.

90. **PREFERRED BRAND-NAME DRUGS (Tier 2):** There are certain brand-name drugs that have been selected by the Pharmacy and Therapeutics Committee as preferred agents after being evaluated for safety, efficacy, and cost. These are identified as Tier 2. In the case of therapeutic classes that have no generic equivalents available, we encourage members to choose medications identified as preferred as their first alternative. Some drugs require prior authorization or have limits by age, quantity, specialty, or step therapy.
91. **PREFERRED PCP NETWORK (PPN):** Network of top-quality physicians who meet the state requirements to practice medicine and are prepared to provide routine and preventive care, as well as basic medical services to treat an illness or injury. This network is constituted by general practitioners, family physicians, pediatricians, internists, and gynecologists.
92. **PREFERRED SPECIALTY PRODUCTS (Tier 4):** These are the medications or products in the Drug Formulary that are offered under the Special Care Pharmacy Program. Medications in this tier include generic, biosimilar (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 prior authorization or have limits by age, quantity, specialty, or step therapy.
93. **PREMIUM:** The specific amount of money paid to an insurer as a requirement to receive the benefits of a health plan, which includes fees and other costs associated with the health plan. The premium billed to a member may only be changed once within a period of twelve (12) months in order to reflect: (1) changes in the member's family composition; or (2) changes made to the health plan requested by the member.
94. **PRESCRIPTION DRUG:** Medications that have been approved or regulated for marketing and distribution by the Food and Drug Administration (FDA), and which are required by Puerto Rico or United States law to be dispensed by prescription.
95. **PRESCRIPTION DRUGS WITH REFILLS:** Prescription that includes the physician's written indications authorizing the pharmacy to dispense a medication more than once.
96. **PRESCRIPTION:** An order issued by a person who is licensed, certified, or legally authorized to prescribe medications, addressed to a pharmacist to fill a medication prescription.
97. **PRIMARY CARE PHYSICIAN (PCP):** A physician who meets the state requirements to practice medicine and is prepared to provide routine, preventive, and basic medical care to treat an illness or injury. The PCP provides health care to the member. This 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.
98. **PRIMARY POLICYHOLDER:** Person who maintains an insurance contract with Triple-S Salud for 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, as per the terms of the individual health plan.
99. **PRIOR AUTHORIZATION:** Process to obtain prior approval from Triple-S Salud, as required under the health plan terms of coverage, to dispense a prescription drug.
100. **PROSPECTIVE REVIEW:** Utilization review before a health care service or treatment is provided to the patient, as per the insurer's requirements to approve such service or treatment, in part or in whole, before it is rendered.
101. **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 ranging 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 stated in the Exclusions Section.

102. **PSYCHOLOGICAL EVALUATION:** An initial interview to obtain the member's personal and clinical history, as well as a description of their 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.

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

104. **PSYCHOLOGIST:** A 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 the training, knowledge, skills, and experience to provide services that include, but are not limited to behavioral prevention, description or diagnosis; psychological evaluations; therapeutic interventions 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.

105. **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.

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

107. **RECONSTRUCTIVE SURGERY:** Surgery that is performed on abnormal bodily structures with the intention of correcting functional impairments or physical defects that have resulted from congenital defects, diseases, or trauma.

108. **RESIDENTIAL TREATMENT:** High-intensity and restrictive care services for patients with mental health conditions, including drug addiction, alcoholism, and co-morbid conditions that are difficult to handle at home and within the community, who have not responded to other less restrictive levels of care. This treatment integrates clinical and therapeutic services coordinated and monitored 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 teachers must be accredited under Act No. 30. The facility must also have ASSMCA's pharmacy license for the administration and storage of medications, as well as an interdisciplinary staff (clinical personnel, psychiatrist, psychologist, and registered nurses).

109. **RETROSPECTIVE REVIEW:** Review of a benefit request conducted after the health care service has been provided. It does not include a claim review, which is only meant to evaluate the documentation's accuracy or correct code use.

110. **SECONDARY CONDITIONS:** A medical condition that is directly caused by another existing medical condition rather than arising on its own.

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

112. **SESSIONS:** Two or more treatment methods for physical or respiratory therapy.

113. **SKILLED NURSING FACILITY:** It is 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's provisions; or an institution that meets the following conditions:

    a. It operates in accordance with the applicable laws of the jurisdiction where it is located.

b. It is supervised by a licensed physician or registered nurse (RN) who devotes a full-time schedule to such oversight responsibilities.

c. It regularly provides rooms, meals, and ongoing skilled nursing services, 24 hours a day, to ill and injured people during the convalescence stage of an injury or illness.

d. It keeps a medical record for each patient being assisted by a duly qualified physician.

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

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

g. It is not a hospital.

114. **SPECIAL CONDITION:** A low-prevalence or rare condition.

115. **SPECIAL ENROLLMENT:** Instance in which 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.

116. **SPECIAL NURSES:** Nurses dedicated to the specialized care of a specific population of patients (e.g., nurse anesthetists).

117. **SPECIALTY PHARMACIES:** These pharmacies provide specialty drugs for the treatment and management of chronic and complex health conditions. Specialty pharmacies handle specialty medications and provide fully integrated clinical management of the condition.

118. **SPORTS MEDICINE:** Branch of medicine that deals with illnesses and injuries resulting from sports activities, including the preventive and preparatory phases necessary to stay in good physical and mental shape.

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

120. **STANDARD REFERENCE COMPENDIA:** It means references from *The American Hospital Formulary Service-Drug Information*, *The American Medical Association Drug Evaluation,* or *The United States Pharmacopoeia- Drug Information.*

121. **STEP THERAPY PROGRAM (ST):** Protocol that establishes the sequence in which prescription medications must be dispensed for certain medical conditions. In some cases, the member is required to use a medication first as treatment for their condition before other medications are covered for the same condition (also known as first step medications). For instance, if Drug A and Drug B are both used to treat your health condition, the member may be required to use Drug A first. If Drug A does not work for the member, then Drug B (the second step medication) would be covered.

122. **TELEMEDICINE:** It is the remote 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 supplementary and simultaneous to the care of a general practitioner or specialist; immediate diagnoses by a specialist in a given area or region; digital record services for X-rays, ultrasounds, medical emergencies, and others; in accordance with Law No. 168 of 2018 and Law No. 68 of July 16, 2020.

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

124. **THERMOGRAPHY:** This technology, also known as thermal imaging, uses a special infrared camera to measure the temperature of any part of the human body. It is also used to detect blood flow and patterns, among other applications.

125. **TOBACCO USE:** It is defined as the use of one or more tobacco products four or more times per week within a period not exceeding the past 6 months by legal tobacco users, and it includes all tobacco products.

126. **TREATMENT PLAN:** A detailed report on the procedures recommended by the physician to treat the patient's medical needs encountered in the physical examination performed by the same physician.

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

127. **TRIPLE-S SALUD PARTICIPANTS AND PROVIDERS NETWORK:** Network of physicians who meet the state requirements to practice medicine and are prepared to provide routine care, preventive care, and basic medical services for the treatment of an illness or injury. This is a provider network, in addition to the Preferred PCP Network, constituted by primary care physicians (PCP), specialists, subspecialists, and health care professionals.

128. **URGENT CARE REQUEST:** A request for a health care service or treatment where the established time period for non-urgent care determinations:

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

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

    When determining if the request will be treated as urgent, the person representing Triple-S Salud will exercise the prudent judgment of a layperson with an average knowledge of health care 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 (a), Triple-S Salud will treat the request as an urgent care request.

129. **URGENT CARE:** Care for a sudden illness that does not threaten the person's life or integrity and may be treated at a medical office or an after-hours clinic, and not exclusively in an emergency room, but that could become an emergency if it is not treated promptly and appropriately.

130. **USUAL CHARGE:** The usual charge is the fee most frequently charged by a particular physician or service provider to patients for a determined service.

131. **UTILIZATION REVIEW ORGANIZATION:** An entity contracted by a health insurance company or insurer to perform a utilization review when Triple-S Salud is not performing its own health plan review. This shall not be construed as a requirement for Triple-S Salud to subcontract an independent entity to perform its utilization review processes.

132. **UTILIZATION REVIEW:** Refers to a set of formal procedures to monitor health care services, procedures, or places where such services are provided, or to evaluate the medical necessity, appropriateness, efficacy, or efficiency of such services. These procedures may include a review of outpatient services, prospective reviews, second opinions, certifications, concurrent reviews, case management, discharge planning, or retrospective reviews.

133. **WAITING PERIOD:** 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, twelve (12) months for bariatric surgery, and ninety (90) days for all other covered services. However, emergency room and urgent care services do not entail a waiting period.

CHAPTER 3: Important Notices and Terms

SECTION 1 Notices

Section 1.01 Important notice about individual plan enrollment

Triple-S Salud provides coverage to anyone who requests an individual plan from those available in the individual health plan market, without performing risk assessments or requiring a waiting period for preexisting conditions.

If the person applying for the health plan fails to enroll within the established annual enrollment period, they may do so at a later date.

If the person had prior qualifying coverage with benefits that are not comparable or do not exceed those covered in the basic individual silver health plan, Triple-S Salud offers the basic individual bronze health plan to said person until the next annual enrollment period, at which time they may select the basic individual health plan they prefer.

For health plan renewals, if the member fails to renew the basic individual health plan within the established enrollment period, they may renew it, provided it is done within thirty (30) days after the end of the aforementioned enrollment period.

Triple-S Salud may ask the person applying for the individual health plan to complete a medical questionnaire to provide information about the conditions they suffer, prescription drugs they take, and the care they receive to manage their health condition, as well as information about the primary care physician that takes care of their condition. The information gathered through this questionnaire is used only and exclusively to enroll the member in the disease management programs established for these purposes.

SECTION 2 Enrollment

Section 2.01 Eligibility rules

Guaranteed enrollment in the health plans is provided within the established annual enrollment periods, which occur once per year for initial enrollments. This initial enrollment period extends from October 1, 2023, until December 31, 2023, with an effective date of January 1, 2024. Dependents may only be included when this policy is acquired or renewed, except in the case of a qualifying special event, as described in the following section.

Section 2.02 Enrollment changes due to special events

During the policy year, the member will only be able make changes to their enrollment due to any of the following qualifying events:

1. **Birth, adoption, placement for adoption, or award of custody:**

   When the member procreates a biological child, legally adopts a minor, has a minor placed in their home to be adopted by the member, or is awarded legal custody or guardianship of a minor, the member may include them under this policy. The event must be evidenced with an original Birth Certificate, a Court sentence or resolution, or the official document issued by the corresponding agency or governmental authority, as the case may be. The coverage for newborns, recently adopted minors, or minors placed for adoption includes health care services to treat injuries or illnesses, including the care and treatment of congenital defects and abnormalities diagnosed by a physician, and is not subject to exclusions for preexisting conditions.

   a. **Newborns who are the member's biological children** – the plan covers the newborn from the moment of birth. If Triple-S Salud does not receive an application to include a dependent in such cases, Triple-S Salud covers the newborn under the primary policyholder's health plan, in case of individual contracts, or under the health plan of the primary policyholder or of their spouse, in case of family contracts, for the first thirty (30) days after birth, while the enrollment process for the minor is completed. In the case of newborns:

      - If the payment of a premium or specific enrollment fee is required to provide coverage for a newborn, the plan may require the member to provide notice of the minor's birth, along with a request to include them as a dependent and their original Birth Certificate, and to pay the required premium or fees within thirty (30) days from the date of birth.
      - If the member fails to provide notice or pay the premium, the plan may opt to discontinue the coverage for the dependent minor after such thirty-day (30) period. However, if the member makes all payments due within four (4) months from the minor's date of birth, the coverage for the minor is reinstated.
      - If, on the other hand, the plan does not require a premium payment, it may request to be notified of the birth, but it cannot deny or refuse to continue providing coverage if the member fails to provide such notice.

   b. **Minors who have been recently adopted by members** – starting on the earliest of the following dates:

- The date the child is placed in the member's home for adoption and remains in the home under the same conditions as the rest of the member's dependents, unless the placement is interrupted before the legal adoption takes place and the minor is removed from the home where they had been placed;
- The date an order is issued to grant custody of the minor to the member that intends to adopt them; or
- The effective date of adoption.

In the case of newly adopted minors or minors placed for adoption, Triple-S Salud is required to provide member with reasonable notice about the following:

- If the payment of a premium or specific enrollment fee is required to provide coverage for a minor that has been recently adopted or placed for adoption, the plan may require the member to provide notice of the adoption or placement for adoption to pay the required premium or fees within thirty (30) days from the date the coverage is required to begin.
- If the member fails to provide notice or issue the payment described in the previous subsection within thirty (30) days, the plan may not treat the minor who has been adopted or placed for adoption less favorably than any dependents, other than newborns, for whom coverage is requested after the date when the dependent became eligible for coverage.

If the primary policyholder has a family contract, and the event of adoption or placement for adoption does not entail the payment of an additional premium, the member must notify the plan of the event within thirty (30) days from the date of adoption or placement for adoption and submit the corresponding evidence to confirm the minor's eligibility, 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 covers services for these minors from the date of birth, adoption, or placement for adoption.
- If a primary policyholder (noncustodial parent) with underage dependents in their policy or a member of legal age covered by the policy as an eligible dependent request compensation to be paid directly to themselves because they paid for the covered medical services being claimed, Triple-S Salud may issue a direct payment to the noncustodial parent or the adult member.

2. **Marriage:** If the primary policyholder gets married during the term of this policy, they may include their spouse in their insurance if the change request is submitted to Triple-S Salud within thirty (30) days after the date of the marriage, including the Marriage Certificate as supporting documentation. In this case, the insurance is effective as of the date of the event.
3. **Divorce of the primary policyholder:** The change request to terminate the insurance must be submitted within thirty (30) days after the date of the divorce, including the Divorce Decree and its corresponding Notification as supporting documentation. The change is effective as of the date of the event.
4. **Domestic partner:** the primary policyholder may include their partner in the insurance within thirty (30) days after the date they start living together. The primary policyholder must obtain an Affidavit of Domestic Partnership for their inclusion, following the template provided by the Commissioner of Insurance, and submit it to Triple-S Salud as supporting documentation. In this case, the insurance is effective as of the date of the event.
5. **Termination of primary policyholder's domestic relationship –** The change request to terminate the insurance must be submitted within thirty (30) days after the date the relationship ended. The primary policyholder must obtain an Affidavit for the Termination of Domestic Partner's Insurance and submit it to Triple-S Salud as supporting documentation.
6. **When a child, grandchild, blood relative, or foster child, as per the definition for direct dependent in this policy, ceases to be eligible as a direct dependent:** When direct dependents reach the age of twenty-six (26) years, their birthdate is used as the effective date for the termination of coverage. The termination is effective the first day of the month after their birthday.

7. **Conversion:** Triple-S Salud offers conversion policies all year round with its available basic individual health plans. This only applies to members who exercise their right to convert their Triple-S Salud group plan within no more than thirty-one (31) days.

8. **COBRA** – If the individual was eligible for coverage by virtue of the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), selected such coverage, and exhausted it.

9. **Death of any of the members:** The change request to terminate the insurance must be submitted within thirty (30) days after the date of death, including the Death Certificate as supporting documentation. The change is effective as of the date of the event.

10. **Other qualifying events according to the Health Insurance Code of Puerto Rico:**

- The eligible person enrolled or failed to enroll in a health plan unintentionally, inadvertently, or by mistake, as a result of the error, misrepresentation, or inaction of an official, authorized representative, or employee of Triple-S Salud, the Department of Health and Human Services (HHS), or their agencies, to be evaluated and determined. In such cases, Triple-S Salud takes the necessary measures to rectify or reverse the effects of said error, misrepresentation, or inaction.
- An eligible person or member requests a new health plan due to a change of residence.
- The member demonstrates that the health plan in which they enrolled materially violates the terms of the agreement with said person.
- The person becomes eligible for the first time or becomes eligible again. In cases where the existing coverage under an eligible employer group plan is no longer affordable and will not even provide a minimum value for the following year's employer health plan, eligible individuals are allowed to enroll on or before the end of their coverage under said employer plan.
- The eligible person or their dependent loses the minimum coverage with essential health benefits.
- The previous policy has not been canceled for non-payment or fraud by the member.
- If the person ceased to be eligible for the Puerto Rico Government Health Plan.
- Insured individuals who are transferring 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 person must have been enrolled for more than eighteen (18) months. During this time, the individual may have been enrolled in an individual or group plan.
- If the individual lost their group or individual coverage due to the bankruptcy, dissolution, or license revocation of the insurer with whom they had insurance, and they submit their application to the new insurance company within sixty-three (63) days after the old insurer files for bankruptcy, is dissolved, or has its license revoked.

All members must complete the enrollment application in its entirety and deliver or send it to the main Triple-S Salud office or their other Service Centers around the island. The same norm applies for any change request for the insurance, except for the changes due to age, which can be performed automatically by Triple-S Salud. In order to obtain the benefits provided by this policy, Triple-S Salud may verify the member's eligibility to meet the necessary requirements.

Section 2.03 Waiting periods

If the member enrolls in the plan outside of the **Annual Enrollment Period** or at a time that does not qualify as a special event for enrollment, the policy and any attached endorsements will entail a waiting period of thirty (30) days for preventive services, twelve (12) months for bariatric surgery, and ninety (90) calendar days from the policy's effective date for all other covered services, except for emergency/urgent cases, as provided by law.

CHAPTER 4: Covered Benefits

SECTION 1 Health Coverage

Some of the services in this Chapter are subject to deductibles, copayments, and/or coinsurances. Section 1.02 of this Chapter provides a description of the covered benefits and your financial responsibility in terms of deductibles, copayments, and/or coinsurances.

Section 1.01 Annual Maximum Out-of-Pocket Limit

This coverage has an Annual Maximum Out-of-Pocket (MOOP) for Essential Health Benefits, as defined in Puerto Rico's reference plan, of $6,350 for individual contracts and $12,700 for couples or family contracts. This maximum out-of-pocket is consistent with the amount established by the Office of the Commissioner of Insurance of Puerto Rico. Once the member reaches the amount corresponding to their type of contract, Triple-S Salud will pay one hundred percent (100%) of the covered medical expenses for essential health benefits.

Triple-S Salud and its pharmacy benefits manager, in accordance with Law no. 109 of August 31, 2023, will include in the calculation or requirement of the contribution or cost sharing ("cost sharing, out-of-pocket maximum"), any payment, discount or item that is part of a financial assistance program, discount plan, coupons, or any contribution offered to the insured person by the manufacturer. These items will be considered for the exclusive benefit of the patient in the calculation of their contribution, out-of-pocket expenses, copayments, coinsurance, deductible or in compliance with shared contribution requirements.

For the purposes of this policy, the member must continue paying their share of the cost for the following services, since these are in addition to the services designated as essential health benefits:

- Triple-S Natural
- Services rendered by non-participating providers in Puerto Rico, except for emergencies, air ambulance, and services rendered by non-participating providers at a participating facility when there is no consent from the member to receive said services
- Payments made by the member for services not covered under this policy
- Monthly premium paid to Triple-S Salud for the plan

Section 1.02 Description of covered health benefits and your financial responsibility

Benefit Description	What You Must Pay in GOLD
Annual Deductible	
Deductible for all medical services, except preventive care and vaccines.	No applicable deductible
Emergency Room and Urgent Care Services:	
Covers 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. If a member requires urgent care for a condition, Triple-S Salud offers a lower copayment if they visit an urgent care center in our provider network instead of an emergency room. To learn more, see the section on **Benefits Covered by Law**. The coinsurances and/or limits for the outpatient benefit, as defined in this policy, apply to diagnostic tests, other than laboratories and X-rays, performed in emergency rooms.	$40 accident $100 illness $15 urgent care center

Benefit Description	What You Must Pay in GOLD
Covered Medical-Surgical Services and Services Provided by Hospitals and Other Facilities:	
Triple-S Salud agrees to pay for the services contracted with the corresponding hospital institution during the member's hospitalization, within 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 private room, up to a maximum of three hundred and sixty-five (365) days for regular hospitalizations • 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, wound care supplies, hyperalimentation products, and anesthesia supplies • Production of electrocardiograms • Production of radiological imaging • 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 when the member is admitted to the hospital • Use of other facilities, services, equipment, and supplies ordered by the primary care physician that the hospital usually provides and that have not been expressly excluded from the contract with the hospital • Blood for transfusions • Diagnostic services • Treatments • Anesthesia administration • Consultation with specialists • Gastrointestinal endoscopies • Audiological evaluations, including the Newborn Hearing Screening test **Note:** These services are included in your copayment for hospital admission.	$150 preferred $600 non-preferred

Benefit Description	What You Must Pay in GOLD
Other Hospital Services	
• 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, are covered for the first ninety (90) days from: a. the date the member first becomes eligible for this policy; or b. the date the first dialysis or hemodialysis is performed. This applies when subsequent dialysis or hemodialysis treatments are related to the same clinical condition.	30%
Covered Medical-Surgical Hospital Services	
• Surgeries that require hospitalization • Corneal transplants; skin and bone graft includes care before and after the procedure. • Orthognathic (jaw) surgery; **requires precertification** • Mastectomy (related surgeries, reconstructions, and prostheses) • Reconstructive surgeries **Requires precertification.**	$0
• Bariatric surgery: This policy covers gastric bypass surgery to treat morbid obesity only, up to one surgery per lifetime, per member, provided the service is available in Puerto Rico. Surgeries to remove excess skin are covered if the physician certifies that it is necessary to remove the excess skin because it affects the functions of any body part. **Requires precertification.** To learn more, see this chapter's section on Benefits Covered by Law.	40%
• Surgical care	50%
• Invasive cardiovascular tests • Lithotripsy procedure (ESWL); **requires precertification**	35%
• Chemotherapy treatment in its various forms of administration (oral, injectable, intravenous, and intrathecal) and radiotherapy.	30%
Other Facilities	
Post-Hospitalization Services - Home Health Care Agency These services are covered if they begin within 14 days after the date the member was discharged after being hospitalized for at least three (3) days and they are provided in relation to or due to the same condition for which the member 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 registered nurse. • **Home Health Services Aide**: partial or intermittent services provided primarily for the patient's care. • **Physical, Occupational, and Speech-Language Therapies (habilitation and rehabilitation)**: up to a combined maximum of 40 visits per member, per policy year. **Note:** These services must be supervised by a licensed physician.	30%

Benefit Description	What You Must Pay in GOLD
Post-hospitalization Services - Skilled Nursing Services These services are covered if they begin within 14 days after the date the member was discharged after being hospitalized for at least three (3) days and they are provided in relation to or due to the same condition for which the member 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 licensed physicians or registered nurses (RN) who devote a full-time schedule to such oversight tasks, and their medical necessity must be certified in writing.	$150
Outpatient Surgery Center	$100
Outpatient Surgical-Medical and Diagnostic Services (rendered while the member is not admitted at a hospital)	
Diagnostic and treatment services	
• Visits to the Primary Care Physician	$0 preferred $5 non-preferred
• Visits to specialists, audiologists, optometrists, and podiatrists (including routine foot care)	$0 SALUS $12 PPO
• Visits to subspecialists	$0 SALUS $18 PPO
• Visits to Social Workers for Autism only, by reimbursement	$12
• Annual preventive visits	$0
• Medical services provided at the member's home by physicians who provide such service	$15
• Intra-articular injections, up to two (2) daily injections and up to a maximum of twelve (12) injections per member, per policy year	$0
• Cervical cryosurgery	35%
• Vasectomy	35%
• Sterilization services for women	$0
• Immunoprophylaxis for respiratory syncytial virus (Synagis; palivizumab) **Requires precertification**	30%
Note: The supplies used at medical offices for covered gynecological diagnostic tests are included in the visit's copayment.	
Allergy Care Allergy tests, up to fifty (50) tests per policy year, per member	$0
Laboratory tests	30%

Benefit Description	What You Must Pay in GOLD
Through the Preferred Selective Network of clinical laboratories. For a list of participating facilities, please see the Preferred Network section in the Triple-S Salud Provider and Participant Directory. • Clinical laboratory. Genetic tests **require precertification**.	
X-Rays Through the Preferred Selective Network of radiology/imaging providers. For a list of participating facilities, please see the Preferred Network section in the Triple-S Salud Provider and Participant Directory. • X-Rays	$0 SALUS / 30% PPO
Specialized Diagnostic Tests Through the Preferred Selective Network of radiology/imaging providers. For a list of participating facilities, please see the Preferred Network section in the Triple-S Salud Provider and Participant Directory. • PET Scan and PET CT. **Requires precertification.** • Non-invasive cardiovascular tests • Electrocardiograms and echocardiograms • Nuclear medicine tests • Computerized tomography (CT), up to one per anatomic region, per member, per policy year • Single Photon Emission Computerized Tomography (SPECT) • Sonograms • Magnetic resonance angiography (MRA) test • Magnetic resonance imaging (MRI) test, 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 (sleep disorder study), 1 test per lifetime, per member • Tympanometry, 1 test per member, per policy year • Bone densitometry when not performed as a preventive test as defined by federal law, but as a follow-up to a diagnosis or treatment of a condition • Mammograms, digital mammograms, or sonomammograms when not performed as a preventive test as defined 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.	40%
Outpatient Surgery	35%

Benefit Description	What You Must Pay in GOLD
It covers procedures that are performed on an outpatient basis and do not require hospitalization. **Requires precertification** if it is medically necessary to change the level of service (hospitalization or outpatient surgery center).	
Treatment therapies Chemotherapy treatments in their various forms of administration (oral, injectable, intravenous, and intrathecal), radiotherapy, and cobalt.	30%
Dialysis and Hemodialysis Services related to any type of dialysis or hemodialysis, as well as any complications that may arise and the hospital or medical-surgical services that may be needed to treat these complications, are covered during the first 90 days from: a) the date the member first becomes eligible for this policy; or b) the date the first dialysis or hemodialysis is performed. This applies when subsequent dialysis or hemodialysis treatments are related to the same clinical condition.	30%
Respiratory Therapy (administered at 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.	$10
Durable Medical Equipment (Requires precertification) • Purchase or rental of oxygen and the equipment required for its administration • Purchase or rental of wheelchairs or hospital 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: ○ FDA-approved glucometers, up to one (1) per policy year. ○ Lancets, up to 150 for 30 days ○ Strips, up to 150 for 30 days ○ Insulin infusion pumps and supplies ordered by an endocrinologist. **Requires precertification.** ○ The provision of a Glucagon Injection and its replacement in case it is used or it expires (Covered under the pharmacy coverage).	50%
Mechanical ventilator (Requires precertification) Coverage includes 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. It covers the supplies required for the operation of the technological equipment, physical and occupational therapy required for the motor development of these patients, and prescription drugs, which must be dispensed at a participating pharmacy that has been freely selected by the member and licensed under the laws of Puerto Rico (part of the pharmacy benefit). The coverage provides for every member to have	25%

Benefit Description	What You Must Pay in GOLD
access to the annual laboratory tests and immunizations that are appropriate for their age and physical condition. These services are covered, provided that the member or their representative submits proof of medical necessity and of the member's inscription in the registry designated by the Health Department for such purposes. To learn more, see the section on Benefits Covered by Law.	
Nutrition services Triple-S Salud covers these services when they are deemed medically necessary and are provided in Puerto Rico by physicians specialized in nutrition or metabolic diseases.	$0 SALUS $5 PPO
Chiropractors Visits to the chiropractor	$15
Manipulations and Physical therapy (Habilitation/Rehabilitation) • Manipulations performed by chiropractors and physical therapies provided by physiatrists (or under their supervision and billing) or chiropractors, are covered, up to a combined maximum of twenty (20) sessions per member, per policy year. • Unlimited physical, occupational, and speech therapies only for individuals who have been diagnosed with autism and Down syndrome, as required by applicable law. To learn more, see the section on Benefits Covered by Law.	$15
Vision Care	
• Ophthalmology diagnostics tests	40%
• Refraction test, one (1) exam per member, per policy year, provided that the test is performed by a specialist in ophthalmology or optometry.	$0
• 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) vision aid per year (prescription magnifiers, 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 offer this benefit for the pediatric population.	$0
• Eyeglasses or contact lenses per member over 21 years old, up to a maximum benefit of $75 per policy year. Please see the Triple-S Salud Provider and Participant Directory for a list of participating providers. If you visit a non-participating provider, the service is covered by reimbursement.	$0

Benefit Description	What You Must Pay in GOLD
Preparation of Phenylalanine-free Amino Acid Formula It is covered for patients who have been diagnosed with the genetic disorder known as phenylketonuria (PKU). To learn more, see the section on Benefits Covered by Law.	$0
Maternity Services (Applies to members, spouses, and direct dependents)	
Outpatient Maternity Care	
• Sonograms; up to three (3) for normal pregnancies, according to clinical protocol	40%
• Biophysical Profile	50%
• Preventive Well-Baby Care visits according to the age and coverage recommended by the United States Preventive Services Task Force (USPSTF)	$0
• Preventive prenatal and postnatal visits and services, as defined by the Health Resources and Services Administration (HRSA).	$0
Maternity Hospital Care Hospitalization services are extended in case of maternity or secondary conditions related to the pregnancy, only if the member is entitled to the maternity benefit. To learn more, see the section **on Benefits Covered by Law**. Semi-private or private room, physical care and assistance for the child's welfare, education on child care for both parents, breastfeeding assistance or training, orientation about in-home support, and medical treatments and tests for both the infant and the parents. • Obstetric services • Use of Delivery Room • Fetal Monitoring procedure and analysis • Use of Well-Baby Nursery (newborns' room) **Note:** These services are included in your copayment for hospital admission.	$150 preferred $600 non-preferred
Mental Health and Substance Abuse Services	
To learn more, see the section **on Benefits Covered by Law**. ***Hospitalizations for mental health conditions***	
• Regular Hospitalizations	$150 preferred $600 non-preferred
• Partial Hospitalizations	$50 preferred $100 non-preferred
• Electroconvulsive therapy for mental health conditions is covered based on substantiated medical necessity and in accordance with the standards of the American Psychiatric Association (APA).	$0

Benefit Description	What You Must Pay in GOLD
Outpatient Services • Patient visits to the office of the psychiatrist or psychologist (with a master's degree or doctorate and a current license issued by the Puerto Rico Board of Psychologist Examiners). • Collateral visits (immediate relatives), including marriage counseling provided by a psychiatrist or psychologist (with a master's degree or doctorate and a current license issued by the Puerto Rico Board of Psychologist Examiners) • Group therapy visits	Psychiatrist: $12 Psychologist: $0 SALUS / $12 PPO
Other Psychological Evaluations	
• Psychological evaluation	$10
• Psychological tests	$10
Substance Abuse (Drug Addiction and Alcoholism)	
• Regular hospitalizations, including detoxification services	$150 preferred $600 non-preferred
• Partial hospitalizations	$50 preferred $100 non-preferred
• Visits to the office of the psychiatrist or psychologist (with a master's degree or doctorate and a current license issued by the Puerto Rico Board of Psychologist Examiners)	Psychiatrist: $12 Psychologist: $0 SALUS / $12 PPO
• Collateral visits (immediate relatives), including marriage counseling provided by a psychiatrist or psychologist (with a master's degree or doctorate and a current license issued by the Puerto Rico Board of Psychologist Examiners)	$12
• Group therapy visits	$12
• Residential Treatment: This policy covers residential treatment as long as it is medically justified, it is performed in Puerto Rico, and the facilities have the required accreditations and personnel to offer the service. **Requires precertification**	$150

Ambulance Services	
Ground Ambulance Service in Puerto Rico This benefit is covered if the patient was transported: • from their residence or place of the emergency to the hospital or skilled nursing facility; • 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 for the covered service • from the hospital to their place of residence, if the discharged patient's condition requires it. • between health care provider 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 pays the total cost and must then send the claim to Triple-S Salud with the medical report including diagnosis. Triple-S Salud reimburses up to a maximum of $80.00 per case. Air ambulance service in Puerto Rico: Subject to its medical necessity. To learn more, see the section on Benefits Covered by Law.	$0
Additional Benefits to your Essential Coverage	
TeleConsulta MD® Telemedicine service through **TeleConsulta MD®.** You have access to medical consultations with a participating provider, such as licensed general practitioners, family physicians, internists, pediatricians, and psychologists, among other specialists, for minor ailments and concerns. Conditions that are addressed through this service include allergies, bronchitis, nasal infections, stomachaches, hypertension, sore throat, migraines, colds, nausea, earaches, asthma, and muscle aches, among others. You decide if you wish to schedule the time for your consultation and select your preferred physician. The provider must send the prescriptions to a participating pharmacy. You may also share test results with the physician. The telemedicine service does not substitute the care provided by your physician. In case of emergency, you must call 9-1-1. To learn more, see the section on Benefits Covered by Law.	$0
Alternative Therapies (Triple-S Natural) The program is only available through participating providers. For a list of participating providers, please see 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 • Naturopathic Medicine • Music Therapy	$15
International Travel Insurance subscribed by Triple-S Vida. By subscribing to Triple-S Directo 2024, each person insured by contract, who is between the ages of 6 months and 84 years, will be automatically subscribed to the International Travel Insurance policy by Triple-S Vida (TSV). The insured person will receive their policy and important materials with their welcome package. The Triple-S Vida International Insurance policy approved by the	Multi-trip benefit with a maximum of $10,000 per policy year

Office of Insurance Commissioner on September 28, 2023, established the terms and conditions of the insurance. This insurance has specialized travel assistance. The insured person must call the Assistance Center specialized in travel insurance contracted by Triple-S Vida, called: Continental Assist at +1 939 475-1760. Types of communications with the Assistance Center by electronic means (Only for International Travel Insurance matters): WhatsApp: +573185544699. Note: The phone numbers must be dialed as listed above. Likewise, the insured person may call through the international operator of the country where they are located, requesting said call by collect to the following telephone number in the United States of America: 1 786-613-7102. In any case, the insured person must indicate his or her name, Triple-S Vida policy number, effective date, the place where they are located, contract telephone number and the reason for requesting assistance. To file a claim, the insured person will need to submit directly to Triple-S Vida for processing under the terms of the International Travel Insurance policy.	
Emergencies or Precertified Services in the United States, coordinated by Triple-S Salud, that are unavailable in Puerto Rico	
Triple-S Salud only covers medical services provided in the United States in cases of medical emergency or when Triple-S confirms that the service is not available in Puerto Rico and coordinates the service with a provider in the United States. 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 the services are subject to corroboration from Triple-S Salud regarding their medical necessity. Triple-S Salud covers services under this policy based on the fees Triple-S Salud receives 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 does not obtain prior authorization from Triple-S Salud for services under this coverage in cases where equipment, treatment, or facilities not available in Puerto Rico are required, the member will be responsible for paying the full cost of the services and will not be entitled to any reimbursement, except in the case of a medical emergency. If the provider is not a participant of the Blue Cross Blue Shield network, they will not be able to bill for the excess amount, and the member will not be responsible for any service fees in excess of the applicable amount if the services had been rendered by a contracted provider. In such cases, Triple-S Salud pays: • The fee percentage for non-participating providers established by the local Blue Cross Blue Shield Association plan • The greater of the following three amounts (adjusted for participating provider network cost-sharing): the fee negotiated with participating	50% $50 at Sanitas Urgent Care Centers in Florida.

providers, the amount corresponding to the usual, customary, and reasonable (UCR) charge, or the amount paid by Medicare.

The member is responsible for paying the deductible, copayment, and/or coinsurance for the services received under this coverage.

The member may request an Assignment of Benefits when 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 physician, hospital, or facility not affiliated with the Blue Cross Blue Shield Association (BCBSA) may bill through the local plan for the services provided to the member.

Section 1.03 Preventive service coverage

This policy covers the preventive services required by the Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA); the Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152 (HCERA); the Health Resources & Services Administration, the CDC's Advisory Committee on Immunization Practices, the Department of Health, and as established by the United States Preventive Services Task Force (USPSTF). These services may be modified throughout the year. The preventive care services listed below are included in the basic coverage, have no deductible or copayment, and entail a $0 copayment or 0% coinsurance, as long as they are rendered by participating physicians and providers in Puerto Rico. For the updated list, as well as additional information about these services, please visit the following website:
https://www.healthcare.gov/coverage/preventive-care-benefits/.

Preventive Care for Adults

Preventive Service	Indication
Abdominal aortic aneurysm (AAA)	One (1) service per ultrasonogram for abdominal aortic aneurysm (AAA) screening, for members 65 to 75 years of age who currently are or were smokers at some point
Colorectal cancer	According to administrative order #334 of the Department of Health, one annual occult blood test for colorectal cancer screening is covered for adults 40 years of age and older. If the person has a family history of colorectal cancer, the annual screening is performed via colonoscopy instead of the occult blood test. The USPSTF recommends performing the colorectal cancer screening via occult blood test, sigmoidoscopy, colonoscopy, or serological test in adults 45 to 75 years old. The risks and benefits of these screening methods vary. The USPSTF also recommends performing a follow-up colonoscopy after a positive result on a non-invasive test. This is a screening test, and patients will not incur any out-of-pocket expenses.
Depression Screening for adults	Depression screening in adults, including members during pregnancy and post-partum. The screening must be performed using an adequate system to guarantee an accurate diagnosis, an effective treatment, and adequate follow-up.
Fall prevention in senior citizens: exercise or physical therapy	Exercises and physical therapy to prevent falls in adults over 65 years old who are at risk of falling.
Healthy diet and physical activity as a form of prevention for cardiovascular disease in adults at cardiovascular risk.	Offering and referring adults who are overweight or obese and who have additional risk factors for cardiovascular disease to intensive behavioral counseling interventions, to promote a healthy diet and physical activity to prevent cardiovascular diseases.
Hepatitis B virus screening	The USPSTF recommends screening for the Hepatitis B virus in adults at high risk for infection.
Hepatitis C virus screening:	Screening for hepatitis C (HCV) infections in adults from 18 to 79 years

Preventive Service	Indication
teenagers and adults	old.
Hypertension screening for members who have not been diagnosed with the condition	Hypertension screening for adults 18 years of age and older. Readings should be obtained outside the clinical setting to confirm the diagnosis before starting treatment.
Pre-exposure prophylaxis for HIV to prevent HIV infection	The USPSTF recommends physicians to offer pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to individuals at high risk of contracting HIV.
Human Immunodeficiency Virus (HIV) screening test: teenagers and adults that are not currently pregnant	Human Immunodeficiency Virus (HIV) screening for adults 13 to 65 years old, as well as younger teenagers and older adults with high risk. As required by 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.
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 16 years and older and adults as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
Lung cancer screening	Annual lung cancer screening through computerized tomography for adults from 50 to 80 years old with a history of smoking twenty (20) packs per year, who are currently smoking or stopped smoking within the last 15 years. The screening will be discontinued once the person has stopped smoking for 15 consecutive years or develops a health problem that substantially limits their life expectancy or the likelihood of undergoing lung surgery to cure the disease.
Obesity screening and counseling for adults	Physicians may offer or refer patients with a Body Mass Index (BMI) of 30 kg/m2 or more to intensive multi-component behavioral interventions.
Screening for prediabetes and type 2 diabetes in asymptomatic adults aged 35 to 70 years old and who are overweight or obese.	The USPSTF recommends screenings for prediabetes and type 2 diabetes in adults aged 35 to 70 years old who are overweight or obese. Physicians must offer or refer patients with prediabetes to effective preventive interventions.
Sexually transmitted diseases	Intensive behavioral counseling for sexually active teenagers and adults at high risk of contracting sexually transmitted diseases.
Statins to prevent cardiovascular events in adults: Preventive Medications	The USPSTF recommends prescribing a statin for the primary prevention of cardiovascular disease (CVD) for adults aged 40 to 75 years who have one (1) or more CVD risk factors (for example, dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year cardiovascular event risk of 10% or greater.
Syphilis screening tests in teenagers and adults who are not currently pregnant	The USPSTF recommends screening for syphilis infection in asymptomatic and nonpregnant teenagers and adults who are at increased risk for infection.
Tobacco use and drug use cessation: Adults who are not	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

Preventive Service	Indication
currently pregnant	Administration (FDA). For those using products to cease tobacco use, this plan covers the supply of FDA-approved smoking cessation medications for ninety (90) consecutive days in a single attempt and for up to two (2) attempts per year.
TB Screening Test: adults	Screening for tuberculosis infection in high-risk populations.
Harmful alcohol use: adults	Screening for harmful alcohol use at primary care facilities in adults over 18 years old, including pregnant members, by providing brief behavioral counseling interventions to reduce harmful alcohol consumption for people who engage in dangerous or risky consumption.
Harmful drug use	Screening for harmful drug use in adults 18 years of age or older by providing brief behavioral counseling interventions. The screening should be performed when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.

Preventive Services for Adults, including Pregnancies

Preventive Service	Indication
Screening for urine bacteria in pregnant individuals	The USPSTF recommends performing urine culture screening for asymptomatic bacteriuria in pregnant individuals.
BRCA: Risk Assessment	Primary care providers must screen people who have had relatives with breast, ovarian, fallopian, or peritoneal cancer, using tools designed to identify family history that could be associated with an increased risk for potentially harmful mutations in the breast cancer susceptibility genes (BRCA1 or BRCA2). Members whose tests suggest they might be at risk must receive genetic counseling and, if prescribed as a result, the BRCA test.
Breast cancer: preventive medications	The 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 must 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 found to be at high risk of developing the disease (primary prevention) and at low risk of having adverse reactions to the medications.
Breast cancer screening (Breast cancer diagnosis and detection)	Law No. 10 of January 3, 2020, “Law on the Right to Effective Breast Cancer Screening,” establishes that the following must be covered as part of preventive care benefits: • One (1) mammography, for members who are thirty-five (35) to thirty-nine (39) years old. • One (1) annual mammography for members who are forty (40) years or age or older. • One (1) annual mammography, follow-up treatment, or supplementary diagnostic tests (MRI/sonomammograms), for members who are forty (40) years of age or older whose breast tissue is considered to be heterogeneously dense or extremely dense. • One (1) annual mammography, follow-up treatment, or supplementary diagnostic tests, for women who are at high risk of developing breast cancer due to their family history, their own history as a cancer patient, the presence of high-risk markers in their genetic profile, or any other factor determined by their physician.

Preventive Service	Indication
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.
Cervical cancer screening	Cervical cancer screening for members who are 21 to 29 years old, with the Papanicolaou test every three (3) years. For members from 30 to 65 years old, one test every three (3) years with cervical cytology, every five (5) years with the high-risk human papillomavirus (hrHPV) test, or every five (5) years with the hrHPV test in combination with cytology.
Chlamydia screening	Screening for chlamydia for all members who are pregnant and for members who are sexually active and under 24 years old, or older if at a high risk for infection.
Contraceptive Methods	FDA-approved contraceptive methods, sterilization procedures, counseling, and education all for members of reproductive age, as prescribed. The insertion and removal of any device are covered.
Weight management for pregnant members	Behavioral counseling interventions for teenagers and adults to promote a healthy increase in weight and prevent excessive weight gain during pregnancy.
Screening for domestic violence: members of reproductive age	Screening for violence, such as domestic violence, in the intimate relationships of members of reproductive age, and offering and referring individuals who tested positive to the screening to intervention services.
Folic acid	All female members who are planning to become or may become pregnant should take a daily folic acid supplement of 0.4 to 0.8 mg (400 – 800ug).
Gestational Diabetes Mellitus	The Women's Preventive Services Initiative (WPSI) recommends screening pregnant women for gestational diabetes mellitus (GDM) after 24 weeks of gestation (preferably between 24 and 28 weeks of gestation) to prevent adverse birth outcomes. The WPSI suggests that pregnant women with risk factors for type 2 diabetes or GDM be screened before 24 weeks of gestation —ideally at the first prenatal visit.
Gonorrhea screening	Screening for gonorrhea in members who are sexually active and no more than 24 years old, or older if at a high risk for infection.
Hepatitis B screening: pregnant members	For pregnant members, screening for Hepatitis B virus infection during the first prenatal visit.
Screening test for human immunodeficiency virus (HIV): Pregnant members	Physicians must screen all pregnant members for HIV, including those who come in for delivery and have not been tested and whose HIV status is unknown. The following tests are covered at no copayment for pregnant individuals: a. First HIV test during the first trimester of gestation or on the first prenatal visit, and b. Second test during the third trimester of gestation (between 28 and 34 weeks of gestation).
Human Immunodeficiency Virus (HIV) screening test	• All adolescents and adult women (15 years and older) should be tested for HIV at least once in their lifetime. • Earlier or additional screening tests should be based on risk, and annual or more frequent retesting may be appropriate starting at age 13 for adolescents and adult women at increased risk of HIV infection.

Preventive Service	Indication
	• Risk assessment and HIV prevention education beginning at age 13 and continuing as determined by risk. • An HIV screening test is recommended for all pregnant women at the start of prenatal care, with retesting during the pregnancy based on risk factors. • Rapid HIV testing is recommended for pregnant women who have gone into active labor and whose HIV status is unknown. Screening during pregnancy can help prevent vertical transmission.
Prevention of obesity in middle-aged women.	Counseling middle-aged women (40 to 60 years old) who have a normal or overweight body mass index (BMI) (18.5 – 29.9 kg/m2) to help them maintain their weight or limit their weight gain in order to prevent obesity. These counseling services may include a one-on-one discussion on healthy nutrition and physical activity.
Counseling and Screening for Human Immunodeficiency Virus	Annual counseling and screening for human immunodeficiency virus infection for all sexually active women.
Osteoporosis screening: postmenopausal members under 65 years old at a higher risk for osteoporosis	Screening for osteoporosis with a bone densitometry test to prevent osteoporosis fractures in postmenopausal members under 65 years old who are at a higher risk for osteoporosis, as determined through a formal clinical risk assessment tool.
Osteoporosis screening: members over 65 years old	Screening for osteoporosis with a bone densitometry test to prevent osteoporosis fractures in members over 65 years old.
Perinatal Depression: counseling and intervention	Clinical staff are advised to provide interventional counseling or refer pregnant or postpartum members who are at a risk for perinatal depression.
Preeclampsia prevention: aspirin	Use of low-dose aspirin (81mg/d) as preventive medication after the 12th week of gestation in members at high risk for preeclampsia.
Preeclampsia screening	Screening for preeclampsia in pregnant members using blood pressure monitoring throughout the entire pregnancy.
Rh(D) Incompatibility Screening	Rh(D) blood type and antibody tests for all pregnant members during their pregnancy at the first prenatal visit. Includes repeating the antibody test for pregnant members who have Rh-negative blood but aren't Rh-sensitized, sometime between 24 and 28 weeks of gestation, unless the biological father is also Rh-negative.
Anxiety screening tests	The Women's Preventive Services Initiative recommends anxiety screening tests for teenage and adult women, including those who are pregnant or postpartum. The optimal intervals for screening are unknown, and clinical judgment should be used to determine the frequency for these assessments. Given the high prevalence of anxiety disorders, the lack of recognition in clinical practice, and the multiple problems associated with untreated anxiety, physicians should consider screening women who have not been recently screened.
Screening for diabetes mellitus after pregnancy	The Women's Preventive Services Initiative (WPSI) recommends screening for type 2 diabetes among women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and have not been previously diagnosed with type 2 diabetes . Ideally, initial tests must be performed within the first year postpartum and may be performed as soon as 4 to 6 weeks after delivery. For women who were not screened in the first year postpartum or whose initial result was negative, the postpartum screening test should be performed at least every 3 years for a minimum of 10 years after

Preventive Service	Indication
	pregnancy. For those who test positive for diabetes in the early postpartum period, the test should be repeated at least 6 months postpartum to confirm the diabetes diagnosis regardless of the initial test type (for example, fasting plasma glucose, hemoglobin A1C, glucose tolerance test). Repeat testing is also indicated for women tested with hemoglobin A1C in the first 6 months postpartum, regardless of whether the test results were positive or negative, because hemoglobin A1C testing is less accurate during the first 6 months postpartum. For women who were not screened in the first year postpartum or whose initial result was negative, the postpartum screening test should be performed at least every 3 years for a minimum of 10 years after pregnancy. For those who test positive for diabetes in the early postpartum period, the test should be repeated at least 6 months postpartum to confirm the diabetes diagnosis regardless of the initial test type (for example, fasting plasma glucose, hemoglobin A1C, glucose tolerance test). Repeat testing is also indicated for women tested with hemoglobin A1C in the first 6 months postpartum, regardless of whether the test results were positive or negative, because hemoglobin A1C testing is less accurate during the first 6 months postpartum.
Syphilis screening during pregnancy	Screening for syphilis in all members during pregnancy.
Urinary incontinence screening tests in women	The Women's Preventive Services Initiative recommends screening women to detect urinary incontinence as a preventive service. Factors associated with a higher risk for urinary incontinence include a higher parity, advancing age, and obesity; however, these factors should not be used to limit screening. Several screening tools have demonstrated moderate to high accuracy in identifying urinary incontinence in women. Although the minimum screening intervals are unknown, given the prevalence of urinary incontinence, it is advisable to perform the test annually since many women do not exhibit symptoms, and the multiple risk factors associated with incontinence change frequently.
Tobacco use and smoking cessation for pregnant members	Physicians must ask all pregnant members about their tobacco use, advise them to stop, and provide behavioral interventions to help smoking members cease their tobacco consumption.
Preventive visits for members	Annual preventive visit (depending on the member's health needs and other risk factors) so that adult members can access the recommended preventive services adequate for their age, including essential prenatal care and services. Whenever appropriate, this annual preventive visit must include other listed preventive services. Should the physician determine that the patient requires additional visits, these will be covered without copayment.

Preventive Services for Minors

Preventive Service	Indication
Anemia / Iron Deficiency	Perform risk assessments or screenings, as appropriate, per the recommendations in the current edition of AAP's Pediatric Nutrition: Policy of the American Academy of Pediatrics (chapter on Iron). Iron supplement for children from 4 months to 21 years of age who are at risk for anemia.

Preventive Service	Indication
Anxiety in children and teenagers: Screening: children and teenagers between 8 and 18 years old	The USPSTF recommends screening for anxiety in children and teenagers from 8 to 18 years old.
Autism Screening	For minors between 18 and 24 months of age.
Behavioral, social, and emotional screening	The American Academy of Pediatrics (AAP) recommends performing an annual assessment from birth to 21 years of age.
Bilirubin screening	Screening for newborns.
Blood pressure	Screening for minors: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years.
Blood test	Screening for newborns.
Cervical displacement	Screening for sexually active members.
Screening for depression and suicide risk in children and teenagers	The American Academy of Pediatrics (AAP) and the USPSTF recommend screening for major depressive disorder (MDD) in teenagers from 12 to 21 years old.
Developmental screening and monitoring	Screening for children under 3 years of age and monitoring throughout childhood.
Dyslipidemia	Screening for minors, once between 9 to 11 years of age, and once again between 17 to 21 years of age. Screening for minors at risk for lipid disorders. Ages: 1-4 years, 5-10 years, 11-14 years, 15-17 years.
Eye prophylaxis for gonorrhea: preventive medication	Topical eye medication to prevent gonorrhea in newborns.
Hearing	Hearing screening for all newborns and for minors, once between 11 to 14 years old, once between 15 to 17 years old, and once between 18 to 21 years old.
Growth in terms of height, weight, and body mass index	Screening for minors. Ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years.
Hematocrit or hemoglobin screening	Screening for all minors when there is a risk factor.
Sickle cell disease (hemoglobinopathy)	Screening for sickle cell disease in newborns.
Hepatitis B screening	The USPSTF and the American Academy of Pediatrics (AAP) recommend screening for hepatitis B virus (HBV) infection in newborns up to early adulthood (21 years old) who are at high risk for infection.
Hypothyroidism	Screening for congenital hypothyroidism in newborns.
Vaccines	Recommended vaccines from birth to 21 years old. The recommended dosages, ages, and population vary: Diphtheria, Tetanus, Whooping Cough, Haemophilus, Influenza B, Hepatitis A, Hepatitis B, Human Papilloma Virus (HPV), Inactive poliovirus, Influenza, MMR, Meningococcus, Pneumococcus, Rotavirus, and Chicken Pox. Catch-up vaccines are covered. HPV screening starts at the age of 9 for minors and teenagers with a history of sexual abuse or assault who have not started or completed all 3 doses (recommended by the Advisory Committee on Immunization Practices ACIP) COVID-19 vaccine for adolescents 16 years and older and adults as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

Preventive Service	Indication
Lead	Screening for minors from 1 to 6 years old with high levels of lead in their blood who are at a moderate-to-high risk, and for pregnant members exhibiting no symptoms.
Postpartum depression	Screening for mothers of newborns during their visits at 1, 2, 4 and 6 months.
Medical history	For any minor during development, from 0 to 21 years old.
Screening for obesity in minors and teenagers	For minors and teenagers (6 years old and up), intensive comprehensive behavioral interventions to promote an improvement in the child's weight.
Oral health	Risk assessment for minors from 0 to 11 months old, 1 to 4 years old, and 5 to 10 years old.
Phenylketonuria (PKU) screening for newborns	Screening for phenylketonuria (PKU) in newborns.
Prevention of tooth decay in children under 5 years of age: Screening and interventions: children under 5 years of age	The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. The American Academy of Pediatrics (AAP) also recommends considering adding an oral fluoride supplement if the main water source is fluoride-deficient. The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. Once the tooth is in place, apply fluoride varnish to all children between 3 to 6 months of age via primary care or at the dental office, based on risk for cavities.
Skin cancer: Counseling	Counseling for minors, teenagers, and young adults with white skin, aged 6 months to 24 years old, to minimize their exposure to ultraviolet radiation and reduce their risk for skin cancer.
Sudden cardiac arrest and sudden cardiac death	The American Academy of Pediatrics (AAP) recommends counseling on the risks of sudden cardiac arrest and sudden cardiac death, and this has been added for those 11 to 21 years of age (to account for the range in which risk counseling may take place) to be consistent with AAP's policy ("Sudden Death in the Young: Information for the Primary Care Provider"). Perform an assessment, as appropriate.
Tobacco use in minors and teenagers	Interventions, including education and counseling, for minors and teenagers, to prevent the start of tobacco use.
Tobacco, alcohol, and drug use	Screening for minors aged 11 to 21 years old.
Tuberculosis	Test for minors at high risk for tuberculosis. Ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-21 years.
Vision screening: minors	Vision screening test, at least once (1) for all minors between 3 and 5 years old to detect amblyopia or risk factors.
Behavioral health evaluation	Assessment for minors of all ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years.

A preventive health care visit for minors normally includes the following services: medical history, measurements, sensory screening, developmental/behavioral assessment, physical examination, anticipatory guidance (such as nutritional counseling), and dental referrals, among others. The following services are available to the minor, based on age and other established guidelines as indicated below:

Section 1.04 Standard Vaccine Coverage for Minors, Teenagers, and Adults

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

Vaccines, including catch-up immunizations, are covered based on the immunization schedule established by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices of the Puerto Rico Department of Health, and as established by the Commissioner of Insurance of Puerto Rico:

Covered vaccines with $0 copayment:

- Hib-HepB (90748)
- ROTA - Rotavirus vaccine (90680)
- ROTA - Rotavirus vaccine, human – Rotarix (90681)
- IPV - Poliovirus vaccine, inactivated – 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 papillomavirus (Gardasil (90649), Cervarix (90650), 9vHPV (90651))
- Tdap - Tetanus, diphtheria, and acellular pertussis (90715)
- Zoster - Shingrix (90750)
- MMR - Measles, mumps, and rubella vaccine (90707)
- VAR - Varicella virus vaccine (90716)
- HEP A Hepatitis A vaccine (90632, 90633, 90634)
- HEP A-HEP B Hepatitis A and hepatitis B vaccine (90636)
- Td - Tetanus and diphtheria toxoid adsorbed (90714)
- HEP B- Hepatitis B vaccine (90740, 90743, 90744, 90746, 90747)
- Meningococcal B (90620, 90621)
- Pentacel (90698)
- DtaP-IPV-HEP B (Pediarix, 90723)
- Kinrix (90696)
- Dengue**
- Prevnar 20 (90677)
- COVID

Covered vaccines with coinsurance The member is responsible for paying the coinsurance established in Section 1.02 of this Chapter.

- Immunoprophylaxis for respiratory syncytial virus (Synagis, Palivizumab 90378) – **Requires precertification** following the protocol established by Triple-S Salud.

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

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

Note: The codes of the vaccines included are shown as published in the latest revised version of the CPT Manual (Current Procedural Terminology Manual). The codes included could be changed in any subsequent updates. For an updated version, please contact our Customer Service Department.

SECTION 2 Pharmacy Benefit

Section 2.01 General information

The pharmacy coverage is subject to the terms and conditions for the coverage of hospitalization, medical-surgical, and outpatient services that are not in conflict with the benefits and conditions described in this section; and in such case, the pharmacy coverage provisions prevail.

Generic medications are dispensed as a first choice, except for the brand-name medications in the Drug Formulary that have no generic version. If the member chooses or the physician prescribes a brand-name drug when there is a generic version available, the member pays the copayment corresponding to the generic drug plus the difference in cost between the brand-name drug and its generic version.

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 guidelines cover dosage, medication equivalence, and therapeutic classification, among others.

This plan provides for the dispensation of covered drugs, regardless of the ailment, injury, condition, or disease for which they are prescribed, as long as the drug is approved by the FDA for at least one indication and is recognized for treatment of the ailment, injury, condition, or illness in one of the standard reference compendiums or in generally accepted peer-reviewed medical literature. However, this plan is not required to cover a drug if the FDA has determined that its use is contraindicated for the treatment for which it is prescribed. It also covers the medically necessary services associated with the administration of the drug.

You must present your Triple-S Salud plan card at any participating pharmacy when requesting benefits in order to be covered. When presented with the plan card and a prescription, the participating pharmacy dispenses the covered drugs included in the Drug Formulary as specified in the prescription and does not charge or collect any amount from the member in excess of what is listed in the Table of Deductibles, Copayments, and Coinsurances at the end of this section. Upon receiving the drugs, the member must sign for the services received and show a second photo identification.

If your physician prescribed a drug not included in your pharmacy benefit, they may issue a new prescription with a covered drug or request an exception pursuant to the “Process for Exceptions to the Drug Formulary” section in 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 based on 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 specify indications for use or drug amount may only be dispensed for a supply of forty-eight (48) hours. Example: when a physician writes the 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 dispatch, 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 the Select Drug Formulary, which is approved by the Pharmacy and Therapeutics Committee for this coverage. Our Pharmacy and Therapeutics Committee comprises physicians, clinical pharmacists, and other health care professionals who meet regularly to evaluate and select the drugs to be included in the Formulary by following a rigorous clinical evaluation process.

  The Pharmacy and Therapeutics Committee evaluates the Drug Formulary and approves changes when:

  a) Any new drug introduced into the market during the term of this policy will be evaluated within ninety (90) days after its approval by the FDA to determine if it is to be included in the Drug Formulary.

b) The changes are due to safety reasons, or if the prescription drug manufacturer cannot supply the drug or has withdrawn it from the market, or if the change involves the inclusion of new prescription drugs in the Drug Formulary.

- We will notify any changes no later than their effective date to:
  a) All members
  b) Participating pharmacies, for the inclusion of new drugs, 30 days in advance before the effective date

Pharmacy Benefit Description

This policy includes the Better Value 2024 Pharmacy Network and Select 2024 Drug Formulary and requires a prescription to dispense medications.

It covers generic drugs, preferred brand-name drugs, non-preferred brand-name drugs, preferred specialty products, and non-preferred specialty products included in the Drug Formulary and whose label contains the phrase *Caution: Federal law prohibits dispensing without prescription*. as well as insulin and certain over-the-counter (OTC) medications.

We cover preventive services according to the federal laws, the 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, and as established by the United States Preventive Services Task Force (USPSTF). We will only cover the preventive medications included in the Drug Formulary. Medications classified as preventive are covered with a **$0 copayment** if they are medically prescribed and filled by participating pharmacies in the Triple-S Salud network, as listed below:

- Contraceptive methods: we will only cover the medications included in the Contraceptive list of the Drug Formulary, which includes at least one medication for each of the categories defined in the Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA). The generic versions will be covered as the only option, except in categories where there is no generic version in the market. Contraceptive methods not listed in this policy's drug formulary 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 to five 5 years old) whose drinking water sources are fluoride-deficient.
- For those using tobacco cessation products, this plan covers nicotine nasal spray, nicotine inhaler, and bupropion hcl (smoking deterrent) for ninety (90) consecutive days per attempt, and up to two (2) attempts per year. The generic versions will be covered as the only option, except when there is no generic version in the market. This does not apply to over-the-counter (OTC) products.
- Preventive drugs for patients at high risk of developing breast cancer, the generic version of tamoxifen or raloxifene tablets for patients who are at high risk of developing the disease and at low risk for adverse reactions to the drugs.
- Certain oral iron supplements for minors ages 4 months to 21 years old who are at risk of anemia.
- Statins to prevent cardiovascular events: low or moderate dose of statins for adults aged 40 to 75 years old with no history of cardiovascular disease, who exhibit one or more risk factors (dyslipidemia, diabetes, hypertension, or smoking) and a calculated risk of 10% or more for a cardiovascular event within 10 years. We cover the generic versions of Simvastatin 5, 10, 20, and 40 mg; Atorvastatin 10 and 20 mg; Pravastatin 10, 20, 40, and 80 mg; Rosuvastatin 5 and 10 mg; Lovastatin 10, 20, and 40 mg; and Fluvastatin 20 and 40 mg.
- Colorectal cancer prevention: prescriptions from gastroenterologists for bowel preps 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 prior authorization to validate the diagnosis. Only the generic bioequivalent tablet is covered.

- To learn more about the preventive drugs to which these law provisions apply, you may access the following link: http://www.healthcare.gov/center/regulations/prevention.html.
- This plan covers federal legend 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 coinsurances established in this policy.
- Buprenorphine
- The amount of medication provided for an original prescription is limited to a 15-day supply for acute drugs and a 30-day supply for maintenance drugs.

The amount of maintenance drugs is provided based on the original prescription and up to five (5) refills, each with a 30-day supply, for a total supply of 180 days per prescription. The physician must state the number of refills in the prescription, and these may be filled for up to a year after the original date of the prescription.

Ninety (90)-day supplies apply to certain maintenance drugs, such as medications for Hypertension, Diabetes (Insulin and oral tablets), Thyroid, Cholesterol, Epilepsy (Anticonvulsants), Estrogen, Alzheimer's (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 Specialty Products.

This pharmacy benefit may be subject to an annual deductible. Please refer to the Table of Deductibles, Copayments, and Coinsurances at the end of this section. **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 medication dispatch in the policy year, they must pay the total cost for the medications until the established deductible amount is reached. Pharmacy coverages may have an initial coverage stage. This means that:

a. If the pharmacy coverage has an annual deductible, the initial coverage stage begins when the member reaches the deductible and ends when the plan has paid the established amount.

b. If the pharmacy coverage does not have an annual deductible, the initial coverage stage begins when the member fills their first medication prescription in the policy year and ends when the plan has paid the established amount.

c. In either case, once the member begins the initial coverage stage, they are responsible for the corresponding drug tier copayments and coinsurances, up until the plan has paid the established amount.

d. Once the amount established for the initial coverage stage is reached, 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 Coinsurances at the end of this section.

e. These deductibles, copayments, and coinsurances 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 Coinsurances at the end of this section.

Section 2.02 Management procedures

Reference Guidelines

Some prescription drugs are subject to management procedures. Triple-S Salud provides its members, and includes with the information in this policy, the Drug Formulary, which includes 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 prior authorization (PA):** Certain medications require prior authorization for the patient to be able to obtain them. These are identified in the Drug List as PA (requires prior authorization), in which case the pharmacy processes the prior authorization before dispensing the drug to the member. The pharmacy also contacts us to obtain authorization for dosage changes and when charges exceed $750 per filled prescription, in order to avoid billing errors.

Medications requiring prior authorization are usually those that present adverse effects, are candidates for misuse, or are associated with a higher cost.

Drugs that have been identified as requiring prior authorization must meet the clinical criteria established by the Pharmacy and Therapeutics Committee. These clinical criteria have been developed in accordance with current medical literature.

b. **Quantity limits (QL):** Certain medications have a limit on the amount that may be dispensed. These amounts are established based on the manufacturer's guidelines, such as the maximum recommended amount not associated with adverse effects, or which amount is effective in treating a condition.

c. **Medical specialty limits (SL):** Some medications have a specialty limit as to the specialist who is treating the condition. For example, only a gastroenterologist or infectious disease specialist may prescribe a medication to treat a liver condition. These specialty limits are established in accordance with current medical literature.

d. **Age limits (AL):** The Drug Formulary includes certain medications accompanied by the code AL. AL means that these medications have an age limit.

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 with chronic and high-risk conditions who require the administration of specialty drugs to receive fully integrated clinical management of the condition. Some medical conditions or drugs that require management through the Specialty Prescription Drug Management Program are:

- Cancer (oral treatment)
- Antihemophilic Factor
- Crohn's disease
- Erythropoietin (blood cell deficiency)
- Cystic Fibrosis
- Hepatitis C
- Rheumatoid Arthritis
- Multiple Sclerosis
- Gaucher Disease
- Pulmonary Hypertension
- Osteoporosis
- Osteoarthritis
- Psoriasis

Program services include the following:

- An assessment to identify particular needs that the patient may have regarding the use of their medication.
- Clinical interventions that include, among others:
  - Coordination of patient care with their physician
  - Personalized education for patients and caregivers, based on the condition
  - Management and coordination of prior authorizations for medications
  - Monitoring for signs and symptoms of the condition
  - Monitoring adherence to therapy
  - Proper use of medications
  - Dosage optimization
  - Drug-to-drug interactions
  - Management of side effects
  - Coordination of refills
  - Assistance by personnel specialized in the condition
  - Easy delivery of medications to the patient's preferred location
  - Access to pharmaceutical personnel 24 hours a day, 7 days a week
  - Educational material about the condition

To learn more about the participating pharmacies in the Specialty Pharmacy Network, please see the Triple-S Salud Provider Directory, visit our website at www.ssspr.com, or call Customer Service.

The plan may have additional requirements that could affect coverage for certain prescription drugs. Please refer to the section on Pharmacy Benefit Exclusions or the Drug Formulary for more information.

f. **Triple-S en Casa Program:** Triple-S en Casa is a delivery service of non-specialty prescription drugs offered exclusively to Triple-S Salud members who have the pharmacy benefit. This service is designed to improve the patient's experience while streamlining the management and dispatch of their prescription drugs. To access the Program, the patient must sign up for the service through the Triple-S en Casa mobile application. We accept electronic prescriptions sent by your physician or paper prescriptions sent through the application. You may have your medications delivered directly to your home, office, or any other address of your choice. The service delivers to all municipalities of Puerto Rico, except Vieques and Culebra. The Triple-S en Casa Program entails no additional cost. Your prescription drug copayment or coinsurance will be that of the corresponding pharmacy benefit.

Section 2.03 Structure of pharmacy and drug dispensing benefit

Please refer to the Table of Deductibles, Copayments, and Coinsurances at the end of this section to find out your financial responsibility under your plan.

30-day Supply:

- Tier 1 – Generic Drugs
- Tier 2 – Preferred Brand-Name Drugs
- Tier 3 – Non-Preferred Brand-Name Drugs
- Tier 4 – Preferred Specialty Products
- Tier 5 – Non-Preferred Specialty Products
- Oral chemotherapy
- Over-the-counter drug program

Medications required by federal law, including FDA-approved contraceptives prescribed by a physician limited to those listed in the Drug Formulary.

Note: In some cases, a copayment or coinsurance may apply, up to the maximum established per medication, or a coinsurance may apply after the member spends a specific amount.

Section 2.04 Programs for the extended supply of maintenance prescription drugs (90 days)

Triple-S Salud offers programs for 90-day supplies of certain maintenance drugs. Maintenance drugs apply for the following conditions: Hypertension, Diabetes (insulin and oral tablets), Thyroid, Cholesterol, Epilepsy (Anticonvulsants), Estrogen, Alzheimer's (not applicable to patches), Parkinson's, Osteoporosis, Prostate, Aromatase Inhibitors, Antiestrogens, Asthma (tablets and liquid, excluding inhalers and nebulizers), and Blood Thinners (excluding warfarin). Does not apply to specialty products. Triple-S Salud members are free to select their preferred option to receive certain maintenance drugs, either through participating pharmacies or from the comfort of their own home, by registering in the Triple-S Salud Pharmacy Program by mail.

90-Day Prescription Drug Dispensing Program This extended supply program allows members to obtain a 90-day supply of certain maintenance medications through participating pharmacies. The Program has a network of pharmacies across the entire island, including chain drugstores and independent community pharmacies.

Mail-Order Pharmacy Program: Members in this program receive a 90-day supply of their maintenance prescription drugs at home or in any other place of preference and may order medication refills by mail or phone. Drugs are shipped at no cost, and members save in their copayments. To learn more and register in the Mail-Order Pharmacy Program, call 1-866-560-5881.

90-day Supply

- Tier 1 – Generic Drugs
- Tier 2 – Preferred Brand-Name Drugs

- Tier 3 – Non-Preferred Brand-Name Drugs
- Medications required by federal law, including FDA-approved oral contraceptives prescribed by a physician.

* Please refer to the Select Drug Formulary

Section 2.05 Prior authorizations for medications

Certain drugs require the member to obtain prior authorization before obtaining them. Medications requiring prior authorization are usually those that present adverse effects, are candidates for misuse, or are associated with a higher cost.

Physicians and pharmacies have received guidance on which medications need prior authorization. The medications that require prior authorization are identified in the Drug Formulary with the acronym PA in the column to the right of the medication, in which case the pharmacy processes the prior authorization before dispensing the medication.

For prior authorizations, or if the member needs more information or has any questions regarding whether they should request a prior authorization for the medications they need, please contact our Customer Service Department at (787) 774-6060.

Section 2.06 Procedure to obtain prior authorizations for medications

Triple-S Salud has a maximum of 72 hours (3 days) after receiving all required drug documentation for 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 their determination

When Triple-S Salud receives a prior authorization request for a medication from a pharmacy, physician, or member, it proceeds to assess all the documentation received.
If any clinical information is required from the member, pharmacy, or physician, Triple-S Salud will send a notice to the member, pharmacy, or physician stating that they have five (5) calendar days to submit the missing clinical information.

If Triple-S Salud receives all the required information and fails both to make a determination on the prior authorization request and to notify this within the established time (72 hours; 36 hours for controlled drugs), the member is entitled to a thirty (30)-day drug supply of the medication that was requested, or in the case of step therapy, for the terms established in the coverage.

Triple-S Salud then makes a determination on the prior authorization request before the member's medication supply is depleted. If neither a determination nor notice is provided within this period, coverage is maintained on the same terms and on a continuing basis. This is provided that the drug continues being prescribed and considered a safe treatment, and until the limits of the applicable benefits have been exhausted.

Section 2.07 Process for exceptions to the drug formulary

The member may ask Triple-S Salud to make an exception to the coverage rules, provided that the drug is not an exclusion. There are drugs that are classified as a “categorical exclusion”. This means that the plan has established a specific provision for the non-coverage of a prescription drug, identifying it by its scientific or trade name.

Types of exception
There are several types of exceptions that the member may request:

- To have their medication covered even if it is not in our Drug Formulary, provided it is not an exclusion.
- To cover a medication that has been or will be discontinued from the Drug Formulary for reasons not related to health care or because the manufacturer cannot supply the drug or has withdrawn it from the market.
- A management exception, meaning that the prescription drug is not covered until the step-therapy requirements are met or because it has a limit on the amount allowed.

- 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 not approved by the Food and Drug Administration (FDA). These drugs are usually not covered, except for health conditions where there is medical or scientific evidence that the drug is effective for such other purposes, according to the reference books that include the medical categories of approval or denial.

Process to Apply for an Exception

The member, their authorized representative, or their physician may apply for an exception by:

- **Calling 787-749-4949:** Guidance is provided on the process to apply for an exception.
- **Sending a fax to the Pharmacy Department at 787-774-4832:** All documentation must be submitted to evaluate the request; remember to include the contract number.
- **Mailing it to:** Triple-S Salud PO Box 363628 San Juan, PR 00936-3628.

Information required to approve your exception application

In order for us to process your exception application, your physician must provide the following information:

- Patient's name
- Contract number
- Primary diagnosis
- Reason why none of the prescription medications listed in the Drug Formulary as clinically acceptable alternatives can be used to treat the member's illness or medical condition.
- The alternative prescription medication included in the Drug Formulary or required as part of step therapy:
    - Has been ineffective in treating the illness; or, based on clinical, medical, and scientific evidence, as well as the member's known relevant physical and mental characteristics and the known properties of the prescription drug regime, it is very likely that it will be ineffective or that the prescription drug's efficiency or the patient's adherence will be affected.
    - Has caused or, based on clinical, medical, and scientific evidence, is very likely to cause an adverse event or other harm to the member.
    - The member was already at a more advanced level of step therapy with another health plan, so it would be unreasonable to require that they start over again at a lower level of step therapy.
    - The dosage available according to the prescription drug dosage limitation has been ineffective in treating the member's illness or medical condition; or, based on clinical, medical, and scientific evidence, as well as the member's known relevant physical and mental characteristics and the known properties of the prescription drug regime, it is very likely that it will be ineffective or that the prescription drug's efficiency or the patient's adherence will be affected.

Processing of Exception Applications

1. Upon receiving a medical exception application, Triple-S Salud will ensure it is reviewed by appropriate health care professionals who, in making their determination, will consider the specific facts and circumstances that apply to the member for whom the application has been submitted, using proven clinical review criteria:
    - Based on sound clinical, medical, and scientific evidence, as well as the corresponding practice guidelines, in accordance with the corresponding 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 current communication and learning methods.
2. The health care professionals designated by Triple-S Salud to review medical exception applications will make sure that the determinations made are consistent with the benefits and exclusions set forth in the member's health plan. These professionals should have experience in drug management. The aforementioned determinations will be set out in a report, which will include the qualifications of the health care professionals who made the determination.
3. Triple-S Salud will make a determination on the request submitted and notify the member or their personal representative as promptly as required by the medical condition, but not later than 72 hours

after receiving all the required information, the request, or the prescribing physician's request or message, whichever date is later. For controlled medications, this period will not exceed 24 hours.

- In order to evaluate the request, Triple-S Salud requests the required clinical information from the physician or pharmacy by phone, fax, or any other electronic method.
- 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 with instructions on the clinical information that 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 72 hours, we proceed to close the request and immediately notify the member, and their personal representative if applicable, and the prescribing physician. The notice includes details about the missing clinical information. Closing the request does not mean that the member may not send a request again.
- The exception applications form is available free of charge at **www.ssspr.com**. You may find the application form for medical exception under the Tools for You section located at the bottom of the main page, under Member Forms. It is also included in the Drug Formulary.

4. If Triple-S Salud fails to make a determination on the medical exception application and does not notify this within the aforementioned period:

    - The member will be entitled, for a period of 30 days, to a supply of the prescription drug that has been requested, based on the requested or prescribed supply, or in the case of step-therapy, based on the terms provided in the coverage.
    - Triple-S Salud will make a determination on the medical exception application before the member's medication supply is depleted.

5. If Triple-S Salud fails to make a determination on the medical exception application and fails to notify this before the member's medication supply is depleted, coverage must be maintained on the same terms and on a continuing basis, as long as the drug continues being prescribed to the member and is considered safe to treat the member’s illness or health condition, unless the applicable benefit limits have been exhausted.
6. If Triple-S Salud approves an application for medical exception, the drug will be covered and the member will not be required to request an approval for refills or for new prescriptions to continue the same drug treatment, as long as:

    - the drug is being prescribed for the same illness or health condition; and
    - the drug is considered safe for the current policy year.

7. Triple-S Salud has not established a level of copayment or coinsurance that is applicable only to drugs approved via exception applications.
8. Any denial to an exception application:

    - Will be notified to the member, or to their personal representative if applicable, in writing or by electronic means if the member has agreed to receive information this way.
    - Will be notified to the prescriber by electronic means or, at their request, in writing.
    - May be appealed. The denial notice informs the member of their 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 provide notice of the coverage determination

    The process of notifying a denial in cases that do not meet the criteria established for off-Drug Formulary coverage, prior authorizations, step-therapy, amount limits, duplicate therapies, and use not approved by the FDA includes:

    a. The specific reasons for the denial;
    b. References to the evidence or documentation, including the clinical review criteria and practice guidelines, as well as any clinical, medical, and scientific evidence considered to deny the request;
    c. Instructions on how to request a written statement of the clinical, medical, or scientific reasons for the denial;

d. Description of the process and procedures to file an appeal request for the denial.

10. The Triple-S Salud Pharmacy Department has written or electronic files documenting the exception request process.

Section 2.08	Table of Deductibles, Copayments, and Coinsurances

PHARMACY – Through the Better Value Pharmacy Network	**What You Must Pay in GOLD**
The Select Drug Formulary applies	
The initial deductible does not apply to medications classified as preventive under federal law	$25 per person
1st coverage stage per member	$900 per person
Initial coverage stage copayments or coinsurances for 30 days	
Tier 1 – Generic Drugs	10%, minimum of $7
Tier 2 – Preferred Brand-Name Drugs	30%, minimum of $20
Tier 3 – Non-Preferred Brand-Name Drugs	30%, minimum of $30
Tier 4 – Preferred Specialty Products	75%
Tier 5 – Non-Preferred Specialty Products	75%
Oral chemotherapy	30%
Medications required by federal law (including all FDA-approved contraceptives with a physician's prescription)	$0
Over-the-Counter (OTC) Drug Program	$0
Coinsurance after initial coverage stage	90%
90-Day Retail or Mail-Order Pharmacy Program	
Tier 1 – Generic Drugs	8%, minimum of $14
Tier 2 – Preferred Brand-Name Drugs	23%, minimum of $40
Tier 3 – Non-Preferred Brand-Name Drugs	23%, minimum of $60
Tier 4 – Preferred Specialty Products	Not applicable
Tier 5 – Non-Preferred Specialty Products	Not applicable
Some oral chemotherapies*	30%
Medications required by federal law (including all FDA-approved contraceptives with a physician's prescription)	$0
Over-the-Counter (OTC) Drug Program	Not applicable
Coinsurance after initial coverage stage	90%

* For more information, please refer to the Drug Formulary.

SECTION 3 Dental Benefits

Section 3.01 General information

The dental benefit is designed to provide essential dental services in compliance with the law.

In compliance with Law 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, in accordance with Law No. 75 of August 8, 1925, as amended, determines that the patient's condition or ailment is considerably complex, based on the criteria established by the American Academy of Pediatric Dentistry;
- If the patient, due to their 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, teenager, 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, teenager, or has a mental or physical disability, and is in a state of fear or anxiety that would impede conducting any dental treatment using traditional dental treatment procedures, and their 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 coinsurances corresponding to your coverage apply. The following documents must be sent to Triple-S Salud for the corresponding evaluation:

- Member's diagnosis
- Member's medical condition
- Reasons for the member to receive general anesthesia to undergo dental treatment according to the previously established criteria.

Triple-S Salud has up to two (2) business days from the date these documents are received to approve or deny the request.

Section 3.02 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 specialty).
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-ray images are covered, up to six (6) per policy year, per member.
4. Bite X-ray images (bitewings) are covered (one or two), up to one (1) pair per policy year, per member.
5. Application of (topical) fluoride varnish for children under the age of 5, up to two (2) per policy year at intervals of no less than six (6) months (either fluoride varnish or topical fluoride, not both).
6. Application of (topical) fluoride varnish for minors under nineteen (19) years old, up to two (2) per policy year at intervals of no less than six (6) months.
7. Application of (topical) fluoride varnish for adults with special conditions, up to two (2) per policy year at intervals of no less than six (6) months.

Section 3.03 Predetermination of services

When a member receives services from a participating dentist, the provider is responsible for requesting a predetermination of services from Triple-S Salud before providing such services.

Section 3.04 Table of Deductibles, Copayments, and Coinsurances

Dental Benefits	
Diagnostic and Preventive Services	$0.00

Psychiatric emergencies	In accordance with Law No. 183 of August 6, 2008, psychiatric emergencies are covered, as well as the transportation service between health care service providers, including ambulances certified by the Public Service Commission and the Department of Health, as established in the last paragraph of Section 4.20 (b) of Law No. 183 of August 6, 2008.
Care for mothers and newborns during the post-partum period	In compliance with Law No. 248 of August 15, 1999, the Act to Ensure Adequate Treatment of Mothers and their Newborn During the Postpartum Period: a. Maternal or newborn stays resulting from childbirth are not limited to less than 48 hours in case of natural childbirth or less than 96 hours in case of cesarean deliveries. b. However, insurers may cover stays shorter than these periods if the physician, after consulting with the mother, orders the mother or newborn to be discharged before the end of the aforementioned terms. c. If the mother and newborn are discharged in a shorter period of time than what is established in subsection (a) of this section but, as per subsection (b), the coverage provides for a follow-up visit within the next forty-eight (48) hours. Services will include, but will not be limited to, physical care and assistance for the child's welfare, education on child care for both parents, breastfeeding assistance or training, orientation about in-home support, and medical treatments and tests for both the infant and the mother. d. Insurers do not design benefits or include copayments or coinsurances that result in unfavorable treatment during any 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 does not require this precertification.
Screening for minors	In accordance with Law No. 296 of September 1, 2000, known as the Children and Adolescents Health Conservation Act of Puerto Rico, preventive screening services are covered, depending on the age of the preschool child. 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 at the beginning of each school year. Said medical evaluation must include physical, mental, and oral health assessments, vision and hearing screening tests, and all other regular screenings recommended by the American Academy of Pediatrics.
Bariatric surgery	In accordance with Law No. 212 of August 9, 2008, this policy only covers gastric bypass surgery in Puerto Rico to treat morbid obesity, up to one surgery per lifetime, if the service is available in Puerto Rico. Initial treatment must be diet and lifestyle changes. The physician must document the failed attempts at supervised weight loss. 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 are 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.
Mechanical ventilator	In compliance with Law No. 125 of September 21, 2007, as amended by Law No. 62 of May 4, 2015, the coverage includes the necessary medical services, tests, and equipment for underage members who, even after turning 21 years old, still require the use of technological equipment to stay alive, a minimum of one (1) daily session of eight (8) hours per patient; services provided by skilled

	nurses specialized in respiratory therapy, or respiratory therapist specialists with nursing skills, or duly licensed emergency medical technician - paramedics (EMT-P) with approved and validated courses/certifications and training or with the skills and knowledge requirements established by regulation by the corresponding Examining Board regarding the care and management of such patients and their medical equipment, as authorized in Law No. 69 of December 27, 2021. It covers the supplies required for the operation of the technological equipment, physical and occupational therapy required for the motor development of these patients, and prescription drugs, which must be dispensed at a participating pharmacy that has been freely selected by the member and licensed under the laws of Puerto Rico (part of the pharmacy benefit). The coverage provides for every member to have access to the annual laboratory tests and immunizations that are appropriate for their age and physical condition. These services are covered, provided that the member or their representative submits proof of medical necessity and of the member's inscription in the registry designated by the Health Department for such purposes. It also includes the necessary supplies to manage the Mechanical Ventilator technological equipment.
Autism	In accordance with Law No. 220 of September 4, 2012 for the Welfare, Integration, and Development of Persons with Autism (known as the BIDA Act, for its Spanish acronym), this policy covers services aimed at diagnosing and treating people with Disorders within the Autism Continuum, including neurological exams, immunology, genetic tests with **precertification**, laboratory tests, gastroenterology, nutrition, physical, occupational and speech-language therapy, and visits to the psychiatrist, psychologist, or social worker. These services are offered without limitation to all members who have been diagnosed with any of the conditions within the Autism Continuum, subject to the deductibles, copayments, or coinsurances established in the policy for these services. In compliance with Law No. 63 of July 19, 2019, for the Hyperbaric Oxygen Therapy of Individuals with Autism Spectrum Disorder, therapeutic hyperbaric oxygen treatments are covered for individuals with autism if it is recommended by a medical practitioner and the treatment is allowed by federal law and regulations, and for other related purposes.
Down syndrome	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 **(requires precertification)**, 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 deductibles, copayments, and coinsurances established in the policy.
Albinism and Hermansky-Pudlak syndrome	In compliance with Law No. 109 of December 22, 2022, to establish the Public Policy of the Government of Puerto Rico regarding the population with albinism and Hermansky-Pudlak syndrome, the services to treat and manage these conditions are covered without need for a referral, provided that they are scientifically proven to be effective and recommended to diagnose and treat the genetic condition and disorders and that they meet the patient's specific needs. These services will be covered in accordance with the terms in this policy, including limits and the deductibles, copayments, and coinsurances established

	in the Table of Deductibles, Copayments, and Coinsurances found in the Outpatient Medical-Surgical and Diagnostic Services section. Coverage includes: a) Medically necessary follow-up services, tests and procedures by an ophthalmologist or a dermatologist for the management of the condition once the diagnosis is established; b) In cases of Hermansky-Pudlak and Chediak-Higashi Syndrome, the services, tests, and procedures offered by a hematologist will also be covered; c) Medications prescribed by an ophthalmologist or dermatologist and in cases of Hermansky-Pudlak, those prescribed by a hematologist, pulmonologists to treat conditions or complications in the management and prevention of complications in this population; d) Lenses and glasses specially prescribed for protection, prevention, and improvement of vision; e) Specific sun protection creams to prevent complications due to exposure to ultraviolet rays. These lotions of creams must offer at least an SPF sun protection factor of 50 or more and protect against ultraviolet A and B rays (UVA and UVB). Subject to Triple-S validation; and f) Any other service, treatment or medication that is deemed pertinent to be included by this law. • In addition, the cost of generic testing for HPS type 1 is covered for newborn patients that visibly have albinism.
Braille	In compliance with Law No. 162 of December 30, 2020, Triple-S Salud will provide blind members, upon request, with their evidence of coverage and identification card issued in Braille.
Preparation of Phenylalanine-free Amino Acid Formula	In compliance with Law No. 139 of August 8, 2016, this policy covers the preparation of 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.
Acquired Immunodeficiency Virus (AIDS/HIV)	In compliance with Law No. 349 of September 2, 2000, all the benefits offered in this policy are covered for those diagnosed with HIV or AIDS, including the benefits required by local or federal law.
Mental health and substance abuse	In compliance with state Law No, 183 of August 6, 2008, and the federal Mental Health Parity and Addiction Equity Act of 2008, this policy covers mental health and controlled substance abuse services, 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, or limits to the mental health/substance abuse benefits applied to medical-surgical benefits. Copayments have no major restrictions on medical-surgical benefits.
Bill of Rights of cancer patients and survivors	In compliance with Law No. 275 of September 27, 2012, this policy covers pelvic exams and all types of Pap smears that may be required under instruction of a physician to detect, diagnose, and treat the early stages of anomalies that could lead to cervical cancer. 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 who has survived cancer, when there is a medical recommendation for such purposes. It covers all preventive services and benefits mentioned under the federal ACA for the early detection of breast cancer, as well as breast cancer screening 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 removed breast, reconstruction of the other breast to achieve a symmetrical appearance, breast prostheses, treatment of 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.
Cancer diagnostic tests, treatments, and medications.	In compliance with Law No. 79 of August 1, 2020, also known as the "Special Law to Ensure Access to Care and Diagnosis for Cancer Patients in Puerto Rico," or the "Gabriela Nicole Correa Law," the following is established: Triple-S Salud shall not reject or deny any treatment that is agreed upon and/or included in the terms and conditions of the health care contract signed between the parties to any patient diagnosed with cancer or who has survived cancer, when there is a medical recommendation for such purposes. This includes the treatments, medications, and diagnostic tests included in the guidelines of the National Comprehensive Cancer Network ("NCCN Guidelines") and/or approved by the Food and Drug Administration (FDA), as well as those necessary to treat and minimize adverse effects, subject to the provisions in 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 will 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 most effective and advanced treatment available and recommended by their physician, in accordance with the coverage and the protocols established in the guidelines listed in the previous subsection and established by the Advisory Board on the Care and Treatment of Cancer Patients and Survivors. This policy does not establish that the final interpretation of the contract terms is subject to the insurer's discretion, nor 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, cancer patients are allowed to select a physician who specializes 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 the medications, treatments, 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 are considered to be approved. In accordance with the requirements of Law No. 107 of 2012, this policy establishes equality of coverage for chemotherapy treatment against cancer in its various forms of administration, 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.

Women's Health and Cancer Rights Act (WHCRA)	In accordance with the Women's Health and Cancer Rights Act of 1998, this policy provides coverage for breast reconstruction where a mastectomy was performed, as well as for the reconstruction of the other breast to produce a symmetrical appearance, prostheses, and any physical complications that arise at any stage of the mastectomy. These benefits are provided in consultation between the member and their physician and are subject to the coinsurances and copayments established in this policy.
Law on surprise billing	The purpose is to stop surprise charges in health plan bills and establish consumer protections, transparency, cost controls, and out-of-network accountability, as well as other related objectives. According to Law No. 134 of August 12, 2020, you are entitled to: • Receive a clear description of your health benefits outside the contracted provider network, including the methodology used by Triple-S Salud to determine the amount allowed for out-of-network services. Please refer to Chapter 5: How Your Plan Works, in the section on Services Outside the Contracted Provider Network in Puerto Rico. • Receive information about the allowed amount that Triple-S Salud will reimburse and the member's responsibility to pay the difference between the allowed amount and the charges billed by a provider outside the contracted provider network. Please refer to Chapter 5: How Your Plan Works, in the section on Services Outside the Contracted Provider Network in Puerto Rico. • Get examples of the expected costs for frequently billed services rendered outside the contracted provider network. For example, you may get billed more than $140 for a computerized tomography reading performed by a radiologist, or your bill may exceed $2,500 for robot-assisted surgery. These examples are for illustrative purposes, and the amount billed may differ from the amounts shown here since it is the non-participating provider who determines the service fee. • Receive information on whether a health or medical service provider is a member of the contracted provider network. • Access a direct phone line that will operate at least sixteen (16) hours a day, seven (7) days a week, to inquire about the status of the participating provider network and costs. Please refer to Chapter 5: How Your Plan Works, Section 1.07 Participating providers in our network. • Only pay the deductible, copayment, or coinsurance established in your policy for the services rendered by Triple-S Salud's participating providers. If you are authorized to receive a covered service with a participating provider, and the provider's status changes to non-participating before you receive the service, you will be notified as soon as possible. If you do not receive the notice at least 30 days before the authorized service is performed, your financial responsibility will be the same as if the provider had continued to be a participating provider. Inadvertent and involuntary charges by non-participating providers that are located in a contracted facility are not subject to collection or billing beyond the financial responsibility incurred under the terms of the in-network service contract (does not apply if you were notified of the cost and knowingly and voluntarily decided to receive the service). 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 provided by a non-participating provider: Office of the Commissioner of Insurance Investigations Division 361 Calle Calaf

	PO Box 195415 San Juan, PR 00919 World Plaza Building 268 Muñoz Rivera Ave San Juan, PR 00918 Phone: 787-304-8686 www.ocs.pr.gov
COVID	In compliance with Law No. 43 of April 16, 2020 (Law to fight COVID-19), Triple-S Salud will not require the member to provide any copayment, coinsurance, deductible, precertification, or referral for health care, tests, analyses, diagnostics, and treatment related to COVID-19, including hospitalization, as long as these services are provided in Puerto Rico. This also includes COVID virus testing or diagnosis.
Cybertherapy	In accordance with Law No. 48 of April 29, 2020, the Act to Regulate Cybertherapy in Puerto Rico, Triple-S Salud will cover, as a service rendered in person, the services provided by any licensed health care professional authorized to practice physical therapy, occupational therapy, speech-language therapy, psychology, counseling, social work, rehabilitation counseling, and educational therapy in Puerto Rico.
Ground ambulance for medical emergencies	In accordance with Law No. 129 of August 1, 2019, when a member obtains the service of a ground ambulance through the 9-1-1 system for a medical emergency, the provider will be paid directly.
Type 1 Diabetes Mellitus	In compliance with Law No. 177 of August 13, 2016, as amended by Law No. 19 of January 12, 2020, Triple-S Salud includes as part of its basic coverage for members with Type 1 Diabetes Mellitus one (1) glucose monitor per policy year, 150 strips and 150 lancets per month, the portable insulin infusion pump prescribed by a pediatric endocrinology specialist or endocrinologist who will determine the pump brand based on the age, level of physical activity, and knowledge of the condition of the member or caregiver, as long as they meet the qualifying criteria of a diabetic patient who requires use of said pump, and one (1) glucagon injection and its replacement in case it is used or expires. If the endocrinologist orders a specific glucometer for the member's treatment, the endocrinologist will submit a justification. In this case, the glucometer brand ordered by the endocrinologist will be covered, along with its accessories, for patients with a clinical predisposition or higher number of risk factors for developing Type 1 Diabetes Mellitus.
Bedridden minors under 21 years of age	In compliance with Law No. 40 of February 1, 2023, this policy covers bedridden minors under 21 years of age with complex physical or physiological diversities, with medical justification according to the criteria established in the Department of Health protocols and according to the home care plan, a minimum of one eight (8) hour daily nursing staff shift; or emergency medical technicians-paramedics (TEMP-P) duly licensed with approved and validated courses, certifications, and training or the skills and knowledge requirements established by regulation of their respective Examining Board related to the care and management of these patients and their medical teams as authorized in this law.
Hepatitis A, B y C	In compliance with Law No. 67 of June 12, 2023, this contract covers one Hepatitis A, B and C virus detection test per year, including one test per pregnancy, as well as the sequence of reactive antibody tests, as part of the routine studies of any medical evaluation. For insured members with recognized conditions or exposures, they will be covered according to the frequency established in the recommendations of the Center for Disease Control and

	Prevention (CDC). The type, sequence and frequency of testing will be as recommended by the CDC.

SECTION 5 Health Coverage Exclusions

The following services and related expenses are excluded from your coverage:

1. Services provided while the patient's insurance is not in force.
2. Services that may be received under the Laws of Compensation for Work-Related Accidents (SIFC), the member's liability, private workers' compensation plans for accident, illness or bodily injury, automobile accidents (ACAA), and services available as per state or federal law, which the member is not legally required to pay. These services are also excluded when they are denied by the corresponding governmental agencies due to a breach or infringement of the requirements or provisions in the aforementioned laws, even if said breach or infringement does not constitute a crime.
3. Treatment services resulting from the member's commission of a crime or failure to comply 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 or residential care services, nursing home or home care, services provided for personal convenience or comfort, except for post-hospital services provided through a Home Health Care Agency and described in this policy.
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 expenses incurred for payments that a member makes to any participating physician or provider without being required by this policy to make such payments.
8. Expenses for services provided by non-participating physicians, hospitals, laboratories, and other providers in Puerto Rico, except for the following services:
    a. eyeglasses or contact lenses for members over 21 years old
    b. emergencies that are covered according to the provisions of this policy
    c. air ambulance
    d. Non-emergency services provided by non-participating providers in participating facilities when there is no consent from the member.
9. Expenses for covered services received without a precertification from Triple-S Salud, when it is required, as established in this policy, except in cases of emergency.
10. Services that are not medically necessary, services deemed to be experimental or investigational, 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 Triple-S medical policies.
11. Expenses or services for new medical procedures and equipment or new medications not considered experimental or investigational, except as required by state or federal law.
12. Expenses for clinical trials and studies, devices, experimental or investigational drugs administered to be used as part of these studies, services or products supplied to obtain data and analyses and not for the patient's direct care, 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 to participate in the study because it offers the patient a potential benefit. In these cases, Triple-S Salud covers 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 clinical study which are normally available to members under this plan, whether or not they are participating in a clinical trial, as well as the 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, and acne treatments as a cosmetic procedure. Hospital and medical-surgical services and their associated complications are excluded, regardless of whether or not the procedure is medically justified.
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). To learn more, see the section on **Benefits Covered by Law**.
15. Contraceptive methods not approved by the FDA or through the medical exception process.
16. Treatment services for infertility, to conceive by artificial means, and to restore the ability to procreate (for example, in vitro fertilization, intracytoplasmic sperm injections, embryo transfers, donor fertilization). Hospital and medical-surgical services, and the complications associated with these, as well as drugs and hormones, are excluded. Lab tests ordered for infertility treatments will be covered, as long as they are conducted by a laboratory covered under this policy.
17. Expenses for scalenotomy services - division of anterior scalene muscle (*scalenus anticus*) without cervical rib resection.
18. Expenses for alternative therapy treatments, except those specified as covered in the Triple-S Natural Program and rendered by participating providers in this Program.
19. Expenses for sports medicine services, psychoanalysis, and cardiac rehabilitation.
20. Analgesia services, administered intravenously or by inhaled gas at the oral surgeon's or dentist's office.
21. Services related to temporomandibular joint syndrome (jaw joint) either through the application of prosthetic devices or any other method.
22. Services required to correct vertical dimension of occlusion.
23. Expenses for implants related to orthognathic surgery (mandibular or maxillary osteotomy - Le Fort).
24. Expenses for allergy immunotherapy.
25. Services rendered for induced abortion.
26. Services provided in Outpatient Surgery Centers for procedures that can be performed at the physician's office.
27. Hospitalizations due to services or procedures that can be performed on an outpatient basis (except in cases where, due to reasons or conditions affecting the patient, their health would be at risk if the service or procedure is not performed in a hospital environment).
28. Expenses related to the administration of an employer's drug screening program, such as coordination, sample collection and administration of screening tests (even when performed by a participating provider), coordination of employee services that must be performed by the employer or party responsible for managing the program, among others. We exclude expenses for care, supplies, treatment, and/or services that the member obtains from the employer free of charge and the services performed by the employer's Employee Assistance Program as part of their 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.
29. 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 claims recovery from the Veterans Administration.
30. Laboratory tests that are not coded in the Laboratory Manual, as well as those considered experimental or investigational, will not be recognized for payment by Triple-S Salud.
31. Immunizations for the purpose of traveling or against occupational hazards and risks.
32. Expenses for water ambulance services. Additionally, expenses for air ambulance services, except for transportation within Puerto Rico.

33. Expenses for the removal of skin tags, ptosis repair, and injections in tendons/trigger points.
34. Expenses for heavy metal blood tests, doping tests, HLA typing, and paternity tests.
35. Expenses for special nursing services.
36. Services provided by Residential Treatment facilities outside Puerto Rico, with no medical justification or precertification for treatment.
37. Expenses related to organ and tissue transplants, except for cornea, skin and bone grafts, as well as hospitalizations, complications, chemotherapies, and immunosuppressive drugs related to the transplant.
38. Expenses for orthopedic or orthotics devices, prostheses or implants (except for prostheses after mastectomy), and other artificial devices. Hospital and medical-surgical services necessary for their placement are covered.
39. Expenses in excess of the first 30 days for newborns of the primary policyholder's direct dependents after delivery, except if the definition of direct dependent is met as set forth in this policy.
40. Expenses for occupational and speech-language therapy, except when offered under post-hospital services, mechanical ventilators, autism (BIDA Act), and Down syndrome.
41. Preventive services rendered by providers outside Puerto Rico.
42. Growth hormones and all related treatments.
43. New diagnostic or therapeutic services or procedures approved by the FDA, as well as equipment and devices that become available after the effective date of this policy, unless they are required by federal or local law.
44. Genetic tests performed in order to provide genetic counseling (offspring or family planning).
45. Expenses or services performed using new commercially available medical technologies during the policy year that are not covered by Triple-S Salud, except for cases of cancer, as per Law No. 79 of August 1, 2020, or when required by local or federal law or ordered by the Office of the Commissioner of Insurance of Puerto Rico.
46. Complications related to body piercings or tattoos and any other related procedures.
47. New legally required benefits enacted by local law during the calendar year the policy is effective or after the approval of the rates for said coverage, unless expressly required by the Commissioner of Insurance or by local law.
48. Any service related to anti-aging or aesthetic treatment.
49. Gene therapy: Any FDA-approved treatment, medication, or device whose intended purpose or the condition it was approved for is the alteration of genes in the body, genetic correction, or gene expression.
50. Expenses for drugs or medications supplied during medical appointments not covered under this policy.
51. Expenses in excess of the limits established in this policy.
52. Chimeric antigen receptor T-cell therapy (CAR-T): Any treatment or therapy in which the patient's own immune cells (T cells) are modified to express a receptor on their surface that recognizes structures (antigens) on the surface of malignant cells.
53. Expenses for drugs administered at an outpatient facility, including injectable drugs, except for chemotherapy, radiation therapy and drugs used to prepare chemotherapy, drugs for diagnostic purposes, vaccines mentioned as covered, and those required by federal or state regulation.
54. Robot-assisted surgery.
55. Computer-assisted surgical navigation in orthopedic procedures.
56. Services or treatments not explicitly described as covered benefits, except for services and benefits required by a new law to be offered as part of health coverage.
57. Expenses for hospice care.
58. Expenses for physical exams when required by the employer.
59. Acupuncture treatment services, except covered services provided through the Triple-S Natural program.

60. Surgeries to remove excess skin after bariatric surgery or gastric bypass will not be covered, except if the physician certifies it is necessary because it affects the functions of a body part. **Requires prior authorization.**
61. Services to correct erectile dysfunction and impotence, including diagnostic procedures, treatments, implants, and surgeries.
62. Surgeries and treatments, including tuboplasty with the purpose of restoring the ability to procreate.
63. Surrogate maternity care.
64. Diagnostic tests and procedures required for purposes related to social activities, travel of any kind, as required by educational institutions and by employers as a requirement for employment, when a pandemic is declared.
65. Expenses related to Medical Cannabis, including, but not limited to, prescription drugs containing Cannabis, related expenses, and purchases of Cannabis products, including edibles.
66. Services that are received free of charge, paid through donations, pro bono, or under a government plan.
67. Expenses for physical exams for the purpose of a medical certificate or other non-preventive purposes.
68. Subcutaneous mastectomy, including the reconstruction of the nipple and areola, except when performed due to breast cancer.
69. Expenses for thermography services offered or ordered by chiropractors or any other physician.
70. Hearing equipment even if there is medical justification.
71. Expenses for psychometric tests, except those required by the BIDA Act and for Down syndrome.
72. Expenses for services obtained at public health clinics offered and provided by an employer to its employees or by third parties.
73. Dialysis, hemodialysis, related services at hospitals and renal care centers, medical-surgical services, and related complications, after the ninety (90) covered in this policy have been exhausted.
74. Service of epidural anesthesia during childbirth.
75. Surgical assistance in outpatient surgeries.
76. Hyperbaric chamber, except for people diagnosed with Autism Spectrum Disorder, as required by law.
77. Durable medical equipment that is not expressly covered by this policy, including customized and tailor-made equipment and Optune equipment and service.
78. Amniocentesis services for genetic screening or checking for fetal maturity, fetal nonstress test, and fetal echocardiogram.
79. Expenses for services requested to be covered by reimbursement and which are not expressly listed in this policy as a reimbursable service.
80. Continuous positive airway pressure (CPAP) and bilevel positive airway pressure (BiPap) machines.
81. Services provided outside Puerto Rico and the United States.

SECTION 6 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. Triple-S Salud is not responsible for the expenses corresponding to the following benefits:

1. Medications that have not been prescribed, except those included in the Triple-S Salud OTC Program.
2. Expenses 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 carry the federal legend:
    a. Medications with cosmetics purposes or any related product with the same purpose (hydroquinone, minoxidil solution, eflornithine, finasteride, monobenzone, dihydroxyacetone, onabotulinum toxin A, botulinum toxin, and bimatoprost).
    b. Fluoride products for dental use (except for children between the ages of 6 months to 5 years)

c. Dermatological conditions – pediculicides and scabicides (lindane, permethrin, crotamiton, malathion, ivermectin, and spinosad), products to treat dandruff, including shampoo (pyrithione zinc 1%, glycolic acid, selenium sulfide, sulfacetamide sodium), lotions and soaps, alopecia (baldness) treatments like Rogaine® (topical minoxidil and finasteride), Olumiant.

d. Pain medications Nubain® and Stadol®.

e. Products for obesity control and other medications used in this treatment (benzphetamine, diethylpropion, lorcaserin, orlistat, liraglutide, phendimetrazine, phentermine, sibutramine, naltrexone-bupropion, mazindol, and semaglutide).

f. Dietary products (Foltx®, Metanx®, Folbalin Plus®, and Cerefolin®)

g. Medications for the treatment of infertility (follitropin, clomiphene, menotropins, urofollitropin, ganirelix, cetrorelix acetate progesterone vaginal insert, leuprolide acetate inj kit 5 mg/ml (1mg/0.2ml)), and fertility

h. Impotence (tadalafil, alprostadil, vardenafil, sildenafil, yohimbine, avanafil)

i. 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 product approved by the FDA.

j. Intracranial carmustine implant (to treat malignant gliomas and glioblastoma multiforme, a type of brain tumor) – the injectable version is included in the health coverage.

k. Intrathecal implants (nusinersen, poractant alfa, baclofen, indium pentetate, ziconotide, and calfactant)

l. Devices (sodium hyaluronate, hyaluronan, and hylan)

m. Medications used in tests for diagnostic purposes that are in the medical coverage, or that may be included in the payment of the diagnostic procedure or test, and that are administered by a health professional in a medical facility or office: (thyrotropin, dipyridamole IV 5 mg/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)), corticorelin ovine triflutate, adenosine, secretin acetate, dexamethasone diagnostic test oral kit, aminolevulinic acid, glucose tolerance test, intradermal histamine phosphate, indigotindisulfonate sodium, Cardio-Green injection, Lymphazurin, sincalide, regadenoson, macimorelin, metyrapone, histamine, benzylpenicilloyl polylysine, methacholine, arginine HCl, Geref Diagnostic, indocyanine green.

n. 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, Rh_o(D) immune globulin) and their combinations, as well as those used for allergy tests. Please refer to the section on Standard Vaccine Coverage for Minors, Teenagers, and Adults to learn more about the immunizations covered by your health care policy.

o. Vitamin and nutritional supplements for oral intake (dextrose, Liposyn, fructose, Alanicem, L-carnitine, tryptophan, CardioVid PLUS, glutamine), except some doses of folic acid for members, in compliance with the Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act.

p. Oral vitamins: (niacin, ascorbic acid, thiamine, riboflavin, vitamin E, pyridoxine, dihydrotachysterol, multivitamins with added minerals, multivitamins with added iron, multivitamins with added calcium, vitamin B complex - biotin - D - folic acid, vitamin B complex with vitamin C, flavonoids, and bioflavonoids), except for prenatal vitamins and folic acid, as well as injectable vitamins.

q. Growth hormones (somatropin, somatrem, tesamorelin acetate)

r. Wound care products (collagen, dressings, silver pads, balms, bismuth tribromophenate, wound cleansers or dressings, dimethicone-allantoin)

s. Ingredients that are used to make extemporaneous mixtures or formulations that are classified as categorical exclusions. For mixtures, only ingredients included in the drug formulary that are not part of a categorical exclusion will be covered with a prescription.

t. Sclerosing agents (intrapleural talc, ethanolamine, polidocanol, sodium tetradecyl)

u. Drugs classified as alternative medicine treatments (valerian root, European mistletoe, Glucosamine-Chondroitin-PABA-vitamin E and alpha lipoic acid, coenzyme).

4. Products considered experimental or investigational in the treatment of certain conditions for which the Food and Drug Administration has not authorized their use. We do not cover clinical research studies or treatments (i.e., clinical trials), devices, experimental or investigational drugs 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 to participate in the study because it offers the patient a potential benefit. In these cases, Triple-S Salud covers 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 trial) 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.
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 health 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 Formulary. No expenses for new drugs are covered until such drug is evaluated by the Triple-S Salud Pharmacy and Therapeutics Committee in accordance with the guidelines established in Chapter 4 of the Health Insurance Code of Puerto Rico. This Chapter requires the Pharmacy and Therapeutics Committee to conduct an evaluation of new FDA-approved prescription drugs within no more than 90 days from the date they were approved by the FDA. At this point, Triple-S Salud issues its determination regarding whether or not the new drug is to be included in the Drug Formulary. Furthermore, any new drug in the excluded therapeutic classifications (category) will also be considered an exclusion.
10. All the forms, methods of administration and any FDA-approved indication that occurs during the calendar year, except when required by state or federal law of the following medications are also excluded: trypan blue solution (azoic dye used in histological stains to help differentiate between living and dead cells), intravenous Vimpat® (medication to treat seizures) lacosamide, degarelix acetate inj, sodium tetradecyl, polidocanol, morrhuate sodium (solution for peritoneal dialysis), Viaspan (cold storage solution to preserve organs before a transplant), sodium tetradecyl sulfate (improves the appearance of varicose veins), polidocanol (treatment of varicose veins), sodium morrhuate (treatment of hemangiomas), intrapleural talc (prevent malignant pleural effusion), solution for peritoneal dialysis, and homeopathic products in all their forms (natural products used to treat different conditions individually). The following medications are excluded (both brand-name and generic): Xuriden (treatment of hereditary orotic aciduria and fluorouracil and capecitabine antidote), Signifor (treatment of acromegaly and Cushing's disease), Cuprimine (treatment of rheumatoid arthritis, Wilson's disease and cystinuria), Austedo (treatment of Chorea-Huntington's disease), Lucentis intravitreal (treatment of eye diseases), Orkambi (cystic fibrosis treatment), Keveyis, (treatment of glaucoma and periodic paralysis), Uptravi, (treatment of pulmonary hypertension), Impavido, (parasitic treatment of leishmaniasis), Emflaza, (treatment of muscular dystrophy), HP-Acthar, (treatment for ankylosing spondylitis, disorders of the eye, infantile spasm/epileptics, multiple sclerosis, nephrotic syndrome, polymyositis, psoriatic arthritis, rheumatoid arthritis, sarcoidosis, Steven-Johnson syndrome, lupus, gout, sarcoidosis, 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 enzyme molybdenum flavoprotein deficiency, Type A), Rebif, (treatment for multiple sclerosis), Ilaris, (systemic juvenile idiopathic arthritis), Isturisa, (treatment for Cushing's disease), Elaprase , (treatment for mucopolysaccharidosis type II), Xyrem,

(treatment for narcolepsy), Ponvory, (treatment for multiple sclerosis), Lupkynis, (treatment for lupus nephritis), Aduhelm, (treatment for Alzheimer's disease), Bylvay, (treatment pruritus with progressive familial intrahepatic cholestasis), Nexviazyme, (treatment for Pompe disease), Leqvio, (treatment for low-density hypercholesterolemia (LDL-C)), sabatolimab HR-MDS, (treatment for myelodysplastic syndrome), Ligelizumab, (treatment for chronic urticaria), Pegunigalsidase, (treatment of Fabry disease), Roxadustat, (treatment for anemia in patients with non-dependent CKD (NDD-CKD) and patients on dialysis), Cibinqo, (treatment for atopic dermatitis), Opzelura, (topical version for the treatment of atopic dermatitis), Saphnelo, (treatment for systemic lupus erythematosus), Gefapixant, (treatment for chronic cough), Korsuva, (treatment for moderate to severe pruritus associated with chronic kidney disease in certain populations), Skytrofa, (treatment for short stature due to inadequate secretion of growth hormone endogenous), Tezspire, (treatment for severe uncontrolled asthma), Qulipta, (treatment for migraine prevention), Livmarli, (treatment for cholestatic pruritus associated with Alagille syndrome), Sotatercept, (treatment for pulmonary hypertension), Rezurock, (treatment for graft versus host disease), Recarbio, (treatment of infections), Scenesse, (treatment for erythropoietic protoporphyria), Krystexxa, (treatment for prevention of gout condition), Artesunate, (treatment of malaria), Uplizna, (treatment of neuro optic myelitis), Enspryng, (treatment for neuromyelitis optica), Oxbryta, (treatment for sickle cell anemia), Cosentyx, (treatment for plaque psoriasis/arthritis, spondyloarthritis, ankylosing spondylitis), Vuity, (treatment for presbyopia), Rethymic, ~~Livmarli,~~ (treatment for congenital athymia), Ryplazim, (treatment for plasminogen deficiency), Vyvgart, (treatment for generalized myasthenia gravis), Cortrophin Gel, (treatment for ankylosing spondylitis, eye disorders, infantile/epileptic spasm, multiple sclerosis, nephrotic syndrome, polymyositis, psoriatic arthritis , rheumatoid arthritis, sarcoidosis, Steven-Johnson syndrome, lupus, gout, sarcoidosis, amyotrophic lateral sclerosis), Addyi, (treatment of premenopausal women with acquired diseases generalized hypoactive sexual desire disorder), Vyleesi, (treatment of premenopausal women with acquired diseases generalized hypoactive sexual desire disorder), Entereg, (post-operative treatment of ileus), Zynrelef, (treatment for post-operative somatic pain), Pyrukind, (treatment for hemolytic anemia), Vabysmo, (treatment for macular edema and macular degeneration), Enjaymo, (treatment for autoimmune hemolytic anemia), Mozobil, (hematopoietic stem cell mobilizer), Somryst, (digital treatment for chronic insomnia), Remicade (treatment for ankylosing spondylitis, Crohn's, plaque psoriasis, arthritic psoriasis, rheumatoid arthritis, ulcerative colitis, only applies to brand name medication), Simponi, (treatment for ankylosing spondylitis, rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, arthritic psoriasis and colitis ulcers), Tremfya, (treatment for plaque psoriasis and arthritic psoriasis), Zynteglo, (treatment for beta thalassemia, in patients who require periodic red blood cell transfusions), Amvuttra, (treatment for familial amyloid polyneuropathy), Onpattro, (treatment for familial amyloid polyneuropathy), Cablivi, (treatment for acquired thrombotic thrombocytopenic purpura), Tarpeyo, (treatment for primary IgA nephropathy), Terlivaz, (treatment for hepatorenal syndrome with acute kidney injury), Stelara (treatment for Crohn's, ulcerative colitis, psoriasis of plaque, arthritic psoriasis, only applies to brand name medication), Altuviiio, (treatment for hemophilia), Skyclarys, (treatment for Friedreich's Ataxia), Filspari, (treatment for primary IgA nephropathy), Syfovre intravitreal (treatment for non-exudative senile macular degeneration).

11. Products used to treat idiopathic thrombocytopenic purpura (Promacta, Nplate, Tavalisse, Doptelet)
12. Products used to treat amyloidosis (Vyndamax).
13. Products used to treat amyotrophic lateral sclerosis (Radicava, Relyvrio, Qalsody).
14. Products used 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 cholangitis (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 w 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. Drugs used for organ and tissue transplants (cyclosporine modified, tacrolimus, sirolimus, cyclosporine, mycophenolate sodium, everolimus, azathioprine, belatacept, and basiliximab).
23. Products used for smoking cessation treatment (varenicline). This is a categorical exclusion, except for the products 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 (6% hetastarch/nacl IV, Rheomacrodex IV, human albumin, and plasma protein fractions).
25. Any drug when the FDA has determined that its use is contraindicated for treatment of the indication for which it has been prescribed.
26. Treatment for symptoms of acute attacks of porphyria related to the menstrual cycle (hemin, Panhematin).
27. Gene therapy: Any treatment, medication, or device that alters the body's genes, genetic correction, or gene expression. (Abecma, Breyanzi, Imlygic, Luxturna, Tecartus, Yescarta, Zolgensma, Carvykti ciltacabtagene autoleucel).
28. Cell therapy: Any treatment where intact, live cells are transferred to a patient to help relieve or cure a disease. Cells can come from the patient (autologous cells) or from a donor (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 recognizes structures (antigens) on the surface of malignant cells (Carvykti ciltacabtagene autoleucel).
30. New specialty drugs approved by the FDA. Except for oral chemotherapies and when required by local or federal law or by the Office of the Commissioner of Insurance.
31. New FDA-approved drugs that become available after the effective date of this policy unless they are required by federal or local law.
32. Expenses for injectable agents that require administration by a health care professional. Agents related to cancer that need to be administered by a health care professional are covered by the health coverage.

SECTION 7 Dental Benefit Exclusions

The policy exclusions for hospitalizations and medical-surgical and outpatient services apply to this coverage, except for services specifically listed as covered.

Triple-S Salud will not cover the following expenses or services, except as otherwise stated:

1. Any service not included as a covered service in the description of this coverage.
2. Full mouth reconstruction services.
3. Restorative dental services, endodontic treatment, periodontal treatment, prostheses, surgical services, and orthodontics.
4. Expenses for appliance replacement or repair services.
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 case of emergency.
7. Dental services rendered outside Puerto Rico.
8. Dental services provided for aesthetic or purely cosmetic reasons.
9. Any dental services rendered in mobile units will not be considered for payment. Mobile units are defined as vehicles such as buses or vans that are equipped to provide basic health services and travel to different locations.

10. Necessary treatments related to an automobile accident.

CHAPTER 5: How Your Plan Works

SECTION 1 Description of Coverage

Section 1.01 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, application form and all other documents submitted when you enroll in 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 available to 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 following conditions.

The benefits provided by this policy are not cumulative. Furthermore, benefits are not subject to waiting periods when enrollment occurs within the fixed annual enrollment period or as a result of a qualifying event as established in Chapter 3, Section 2.

Section 1.02 Your Plan

You, as a Triple-S Salud member, are enrolled in a Free Choice plan. This means you have free access to your medical care within the Triple-S Salud Provider and Participant Network without needing a referral from a primary care physician or any other doctor.

Section 1.03 Members can access medical services in several ways

This product has a Preferred PCP Network and the Triple-S Provider and Participant Network. If the member visits a provider in the PCP Network or at the Salus Clinic, they don't have to pay anything for the visit. If they visit the Triple-S Provider and Participant Network, the corresponding copayment applies.

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

You should always visit physicians and providers who participate in the Triple-S Salud network to make sure your services are covered, except in cases of emergency or as required by law.

The Triple-S Salud plan also has certain rules that you must follow to ensure the services are covered, such as visiting certain providers to receive specific services, obtaining a precertification for services before receiving them, using the Drug Formulary, selecting generic drugs as a first option, and using network physicians and providers, among others.

Section 1.04 Medically necessary services

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

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

Section 1.05 Medical-surgical services during hospitalization

Triple-S Salud agrees to pay, according to the fees established for such purposes, for the services covered in this policy that are provided to the member during periods of hospitalization. We only cover physician services that are normally available at the hospital where the member is hospitalized.

Members insured by this policy who are hospitalized in semi-private or private hospital rooms are not 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 pays the medical fees directly to the participating physicians based on the rates established for such purposes.

Section 1.06 Hospitalization services

Participating hospitals in the Triple-S Salud Network have been grouped in two categories based on the quality of the hospital facilities. The first category is the Preferred Hospital network, where your admission copayment is lower. The second category is the Non-Preferred Hospital network, where your admission copayment is higher. To see which hospitals are preferred and non-preferred, go to the Preferred Networks section in the Triple-S Salud Provider and Participant Directory.

If a member requires hospitalization due to injury or illness, they must pay the established admission copayment to the hospital at the time of admission. The member is also responsible for paying any other services provided during hospitalization that entail a copayment or coinsurance, as defined in this policy. Copayments and coinsurances are non-refundable.

When calculating any hospitalization period, the day of admission is included, but not the day the patient is discharged by the attending physician. Triple-S Salud is not responsible for services received by any member if they remain in the hospital after being discharged by the attending physician. It is also not responsible for any day(s) of pass granted to the patient to leave the hospital during the same hospitalization period.

If a member is admitted to the hospital as an emergency, they do not need to notify the plan about the admission, except if it happens outside Puerto Rico. In these cases, the member or someone else must notify the plan at the phone number listed on the back of the identification card within forty-eight (48) hours after the admission or as soon as reasonably possible.

When a member uses a private room at a participating hospital, Triple-S Salud covers what it would have paid for a semi-private room. The hospital may charge the patient for the difference between the regular 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 notice 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, so no other difference may be billed to the member.

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, it will be considered a readmission, and the plan will merge it with the previous hospitalization.

Section 1.07 Participating providers in our network

We contract with physicians, facilities, and providers across the entire island so they can provide services to our members. It is essential for you to know and have access to our Provider and Participant Directory at any time so you can check if a provider is a participant before obtaining a service.

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

- Check your Triple-S Salud Network Provider and Participant Directory.
- To see an updated version, visit our website at: www.ssspr.com. The online provider directory is updated daily and lets you search by specialty and municipality.
- Access our Triple-S Salud mobile application for smartphones (Android or Apple). Once you complete the registration process, you will have access to the Provider Directory.
- For questions about a specific provider, call the Customer Service Department at 787-774-6060 (toll-free: 1-800-981-3241), available Monday to Sunday, 6:00 a.m. to 10:00 p.m. AST (Atlantic Standard Time). The Customer Service number is listed on the back of the plan card.

Section 1.08 Preferred networks in outpatient facilities

The plans available under this policy have Preferred Networks for medical visits, clinical laboratories, X-rays, radiology, and imaging services performed rendered on an outpatient basis. These Preferred Networks are identified as:

- SALUS Clinics: There are no copayments for medical visits (generalists, specialists, and subspecialists) and X-rays at the SALUS Clinics. You may visit other physicians within the Triple-S Salud participating provider network.
- Selective Network: Network of clinical laboratories, radiology, and imaging facilities. It's important that you visit providers from this network. Otherwise, the service will not be covered.

It is important to check the Triple-S Salud Provider and Participant Directory before receiving services to make sure that the provider rendering these services is a participant in the Preferred Networks.

Section 1.09 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's policies aim to ensure the proper management of these particular cases, so as to guarantee equal treatment for all members in similar conditions, while guaranteeing a cost-effective service. This policy is not construed as an elimination or reduction of the benefits covered under this policy.

Section 1.10 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 certifies them as eligible to receive services from the provider. The card will show the coverage the member is entitled to.

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

Section 1.11 Hired benefits administrators

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

You should refer to this policy to check your health plan coverage and whether there are any benefit limits. If you have any questions about your benefits, you may contact Customer Service through any of the service channels available in Chapter 1, How to Contact Your Plan.

Section 1.12 Services outside the contracted provider network in Puerto Rico

The services covered in this policy that are rendered by physicians or providers who are not Triple-S Salud participants are covered only in case of emergency, including air ambulance, as required by law, and are 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 established in the policy. The non-participating provider is required to accept payment for an amount that will be no less than the contracted fee with participating providers for the same services. If the emergency services are rendered by a provider not contracted by Triple-S Salud, the patient will not be responsible for a service payment in excess of what the applicable amount would have been if they had received the services from a provider contracted by Triple-S Salud.

If the member receives health care services after receiving post-stabilization or emergency services covered under the non-participating provider's health plan, Triple-S Salud reimburses 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, as long as there is a compelling medical reason why the patient cannot be transferred to a participating provider.

In compliance with the Consolidated Appropriations Act, 2021, when a member receives care or services from a non-participating provider at a participating facility, the participating facility is responsible for notifying the member—in writing via an official document, either printed or in electronic format (including electronic notifications), according to the member's selection—that the provider that is to render the service is not a participant. The notification must also include the costs of providing the service, a list of participating providers that offer the service at the participating facility, and language explaining that the member may opt to seek care and receive the service from a participating provider at the facility or from a participating provider at another participating facility. The member must give written consent and receive a signed copy of said consent. If the member gives their consent to proceed with the service, they will be responsible for the full cost of the services received from the non-participating provider. If the member was not notified in writing, the facility will be responsible for the full cost of the services the member received from the non-participating provider, minus the copayment or coinsurance applicable to the service if it had been performed by a participating provider.

Under any other circumstances, providers outside the network are not covered by this policy and you are financially liable for the full cost of the services.

Section 1.13 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 event of 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 later. If a patient is diagnosed with a terminal condition before the plan’s termination date and they continue receiving services for that condition before the plan’s termination date, the transition period will be extended for the remainder of the patient’s life.

Section 1.14 New members with ongoing treatment

If the member is receiving an ongoing treatment with a non-participating provider when this policy coverage becomes effective, the member may receive covered services for the ongoing treatment from the non-participating provider for a maximum of 60 days, starting on the effective date of Triple-S Salud coverage. This course of treatment must be for a life-threatening or a degenerative and debilitating condition or disease.

Members may also continue receiving care from a non-participating provider if the member is in the second or third trimester of pregnancy when the coverage of this policy becomes effective. Members may continue receiving health care up until the date of delivery and for any post-partum services directly related to it.

To continue receiving services from a non-participating provider under the aforementioned circumstances, the provider must accept our fees as payment for such services. The provider must also agree to provide the necessary medical information about the member’s health care and accept our policies and procedures, including those intended to ensure quality of care and access to a pre-certification and to a course of treatment approved by the Plan. If the provider agrees with these conditions, the member receives the covered services as if they were provided by a participating provider. The member is financially liable only for the copayments and coinsurances applicable to their coverage.

Section 1.15 Emergency services

Triple-S Salud covers emergency services to treat an emergency condition at a hospital or an independent emergency room. Members are provided coverage for emergency services received to treat an emergency condition, regardless of whether the provider is a participating provider. The plan only covers the emergency services and supplies that are medically necessary to treat or stabilize a member’s emergency condition at a hospital.

If a member requires treatment for an emergency condition, they should seek immediate attention at the nearest hospital emergency room or emergency room facility or call the 9-1-1 system, which is the response system for public security emergency calls, through the 9-1-1 number created by virtue of Law No. 144 of December 22, 1994, as amended, known as the "Act for the Speedy Attention of Public Safety Emergency Calls" or "9-1-1 Calls Act." Emergency services require no precertification and are not subject to wait periods. However, we only cover the emergency services provided at an emergency room in order to treat an emergency condition, and these are covered regardless of whether they were rendered by a participating provider.

Section 1.16 Urgent care

The Plan covers urgent care services. Our provider network includes urgent care centers where your copay is lower than it would be at an emergency room. Urgent care centers include the contracted Sanitas Medical Centers in Florida.

The Sanitas Medical Centers are part of our Preferred Provider Network and deliver 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 services provided by the Sanitas Medical Centers in Florida are part of our extended coverage in the United States.

Section 1.17 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 that are not emergencies. Visiting the emergency room in such cases could result in higher costs for the health plan and higher out-of-pocket expenses for you, compared to a medical visit. Observe the following examples:

Non-emergency services:	**Emergency**
You must call your doctor or visit a SALUS Clinic or an urgent care center • Mild sore throat • Earache • Minor cuts or scrapes • Minor sprains or tears • Fever below 103 ºF • Cold or flu	**Visit the closest emergency room or call the 9-1-1 System** • Broken bones or severe tears • Deep cuts or uncontrolled bleeding • Poisoning • Severe burns • Chest pain or sudden severe pain • Fever over 103 ºF • Coughing or vomiting blood • Sudden dizziness, weakness, loss of coordination or balance, or loss of consciousness • Numbness in the face, arm, or leg / Seizures • Difficulty breathing • Sudden blurred vision or sudden or unusual headache

Visit a general practitioner or primary care physician instead of visiting multiple medical specialists to properly diagnose and treat a condition. 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 coordinates 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 knows all about your health and keeps a record of your health condition. Remember that you do not need a referral to receive covered services from any provider in the Triple-S Salud network.

- Use generic medications as your first choice to treat your condition whenever they are available.
  - A generic medication is a copy of a brand-name medication whose patent has expired. A patent is what gives pharmaceutical companies the exclusive right to sell a medication while it is in force. When a patent expires, other companies may sell generic versions of the available brand-name medication.
  - A generic medication has the same use and works the same way on the body as the brand-name drug. It has the same active ingredient and it is equal in dosage, safety, and quality, as mandated by the Food and Drug Administration (FDA).
  - Generic medications can also mean savings for you since they cost much less than the brand-name versions. Copayments and/or coinsurances for generic medications are usually lower. Please note that, if you are using a brand-name medication for which there is a generic version available, you could be receiving the same benefits at a lower cost.
- Use OTC medications with a $0 copayment under the Triple-S Salud program. The list includes medications for stomach conditions, allergies, and eye drops that have demonstrated to be safe and effective, while also representing lower costs for the health plan. Please remember you need to submit a physician's prescription for the OTC medication.
- Discuss with your physician the medications included in our Drug Formulary that are part of your treatment. Use preferred drugs, which are cost-effective and already proven to treat conditions. In addition, they have been selected by the Pharmacy and Therapeutics Committee for their effectiveness. Your out-of-pocket expenses are higher when you use non-preferred medications. Check your description of coverage and the Table of Deductibles, Copayments, and Coinsurances in Chapter 4 to see how much your out-of-pocket expenses could be for copayments and coinsurances.
- Use your preventive service coverage to detect conditions early.

  Our plan offers all the preventive services required by law at no cost to you. This means that you pay nothing out-of-pocket for services such as annual physical checkups, preventive gynecological appointments, preventive mammograms and vaccines, among others. 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 in-network providers.
- Use the PCP Preferred Network with a $0 copayment. Likewise, use the SALUS Clinics and the Preferred Hospital Network, which offer lower copayments/coinsurances than the rest of the network.
- If you have an additional health insurance, notify Triple-S Salud and your other plan to coordinate benefits between them. Please refer to the section on Coordination of Benefits to learn more about the rules to determine which plan will be primary.

Section 1.18 TeleConsulta

Teleconsulta is a voluntary service offering telephone health care guidance, available 24 hours a day, 7 days a week, 365 days a year.

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 adequate treatment.

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

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

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

TeleConsulta is an exclusive service for Triple-S Salud members, managed by an independent contractor that provides health information and guidance hotline services.

Section 1.19 Service precertification / prior authorization for prescription drugs

There are certain services and medications that require prior approval from Triple-S Salud before the member can receive them. Some of the objectives of the precertification include assessing whether the service is medically necessary, evaluating the suitability of the site of service, verifying the member's eligibility for the requested service, and checking whether the service is available in Puerto Rico. Precertifications are reviewed based on the precertification policies established by Triple-S Salud from time to time. Either the member or the provider is responsible for requesting a service precertification. Please refer to the sections on Procedure to Obtain Precertifications and Prior Authorizations for Medications to obtain a detailed list of the services that require a service precertification or prior authorization for a medication and the process that the member or provider should follow to obtain the plan's precertification.

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

Section 1.20 Obtain an updated copy of the Drug Formulary

Your prescription drug coverage under this policy is subject to a Drug Formulary. This Drug Formulary is available on our website, www.ssspr.com. If you would like to obtain a copy of the Drug Formulary, please call Customer Service.

Section 1.21 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.

Section 1.22 Case management

The Case Management Program provides assistance in the coordination of services for members who have health care needs due to chronic health conditions such as:

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

The Case Management Program uses an individualized care plan to perform educational interventions with members who reflect a high utilization of health services, either because of the treatment required for their condition or for other reasons: Some of the diagnoses identified for the insured person to receive services from the Care Management Program are:

- Immunological disorders (such as HIV or AIDS)
- Cerebrovascular diseases
- Cystic fibrosis
- Degenerative diseases (such as multiple sclerosis, ALS)
- Skin lesions (stage 3 and 4 ulcers)
- Mental illness and substance abuse
- Strokes
- Pulmonary hypertension
- Cancer undergoing continuous chemotherapy treatment (head/neck, gastrointestinal, lung, ovary/uterus, brain, metastasis, or terminal phase)

Our Program is confidential and voluntary. It will also help participating members coordinate their benefits in order to meet their health care needs.

Members may be referred to the program by their physician, social worker, hospital, discharge planner, 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 in accordance with the individualized care plan.

If the member meets the program's criteria and agrees to participate, an interdisciplinary team with extensive clinical experience will evaluate the member's health needs and determine the available alternatives of care. After the member is admitted into the program, the case manager will create an individualized care plan and follow-up via phone calls and personal visits.

If you need additional information, please contact us at the phone numbers or email addresses listed in Chapter : How to Contact Your Plan.

Section 1.23 Clinical Management Program

The Clinical Management Program is designed to benefit the entire population by focusing on the needs identified by the prevalence of health conditions in our population. Adequate interventions are performed for individuals within a given population to reduce health risks and improve the quality of the services provided.

This program is intended to provide comprehensive care in order to optimize coordination and cover the health care needs of our (adult and pediatric) members and their families while providing preventive education and coordination of services.

The member can participate in the Programs through provider referral, self-referral, or by identification through the claims-based registry of chronic conditions.

This program serves as a specialized support unit whose personnel work collaboratively with providers to ensure optimal health care.

The Program consists of three levels of interventions for the population, including: Nurses, nutritionists, health educators, clinical clerks, and social workers. Each member participating in our clinical programs will have an individualized care plan, and follow-up will be provided until they reach their health care goals.

Program	Description
Diabetes Program	This program provides members with personalized guidance from a health care professional (nurse) who will identify members' specific risk factors and needs by conducting a comprehensive condition-related risk assessment. Members will be educated on the use and administration of medications, the prevention of future complications, reinforcing nutritional habits (if necessary, members 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 members' needs.
Asthma Program	This program is designed to provide guidance to our 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 specialized 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. Guidance is provided on the correct use of both maintenance and rescue inhalers. Assistance is provided in scheduling appointments.
Hypertension Program	Designed for members over 18 years old who suffer from hypertension (high or uncontrolled blood pressure) and may benefit from the educational activities offered by this program. The member learns what hypertension is, as well as its signs and symptoms, lifestyle changes, how to control blood

	pressure, and possible lifestyle modifications that may have an effect on their hypertension condition. Assistance is provided in scheduling appointments.
Heart Failure Program	Members affected by cardiac failure (heart disease that causes it to pump blood to the body in a way that is not normal). When the condition is severe, they receive educational materials at home and guidance from our Heart Failure Program nurses on how to take care of themselves and start feeling better. Members with less severe conditions are invited by health educators to attend educational activities. This helps them control their condition, prevent complications, and improve their quality of life.
COPD Program	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 review of medications and guidance on their proper use, and information on how to identify signs and symptoms of complications. The health care professional (nurse) will place emphasis on the importance of medical follow-up. 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 about the importance of early prenatal care and the risk factors to be aware of. Pregnant members receive educational brochures about pregnancy and baby care. They also receive phone guidance from a clinical management specialist in the prenatal area, as well as guidance at educational workshops offered by health educators. By enrolling and participating in the Program, the member will be eligible for the Postnatal In-Home Support service. If members do not enroll or participate in the program, the benefit will not be covered. The benefit consists of in-home support for everyday activities, such as light housekeeping (cleaning, laundry, washing dishes), preparing meals, help bathing and dressing, 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 delivering the baby. 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 arrange for the provision of a Zofran pump for members with hyperemesis gravidarum as well as injections to prevent preterm labor in high-risk pregnancies.
Smoking Cessation Program	This is an educational program that offers general information and education about the health effects of smoking and the benefits of modifying or overcoming this addiction. It is designed for people who have chronic conditions and those who would like to quit this addiction. The program is free of cost for members and is offered by phone. Members will coordinate with the education specialist offering the program to establish a convenient date and time. This program supports participating members who are in the process of quitting or reducing their smoking habit, thus helping reduce their health risks. To learn more, you may email servpreven@ssspr.com.
Contigo Mujer Program	Educational program focused on women's integral 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 & Healthy, Finances & Health, and Healthy for the Holidays.

If you need more information or would like to enroll in the program, please contact us at the phone numbers or email listed in Chapter 1 of this policy.

Section 1.24 Your coverage when you participate in a clinical trial

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

This applies when 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 a potential benefit.

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 that are usually covered regardless of whether or not the patient is participating in a clinical trial. This includes services to diagnose and treat complications resulting from the trial.

Our plan does not cover:

- Expenses for clinical research studies or treatments
- Experimental or research devices or medications administered to be used as part of these trials
- Services or products provided for data collection and analysis, and not for the patient's direct management
- Items or services at no cost to the member that are commonly offered by the research sponsor.

Section 1.25 Preventive Care Centers

Triple-S Salud has Preventive Care Centers that are available to adults over 21 years of age. These centers integrate a comprehensive medical evaluation with preventive tests, following the clinical guidelines of the US Preventive Services Task Force. One of the advantages of these centers is that you can get all your annual preventive check-ups in a single place, aside from receiving 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 a list of participating Preventive Care Centers, please refer to the Triple-S Salud Provider and Participant Directory.

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

Section 1.26 Triple-S Natural

Triple-S Natural is a program that allows you to receive certain medical services using an alternative medicine model. The member is responsible for paying the established copayment listed in Chapter 4.

This program combines the fields of conventional and alternative medicine to provide up to 6 services per policy year, per member, including 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 in certain areas of the skin. These areas 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 the energy, nutrients, and wellbeing that ensure a person's optimal state of health. Hands, elbows, and some auxiliary tools are used in a combination of specialized techniques to help activate the flow of blood and energy needed for the patient's recovery.
- **Naturopathic Medicine:** This is the health care system practiced by Doctors 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. Specialty 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 health conditions, addictions, depression, and hyper or hypoactivity, among others.

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

Section 1.27 Tool for Health Risk Assessment (HRA)

The Health Risk Assessment (HRA) tool helps evaluate lifestyles, risk factors, and existing conditions. This tool helps 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 learn 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 gain greater awareness to prevent future health problems. **Register today in our website Error! Hyperlink reference not valid.and complete your questionnaire. Stay active, stay healthy!**

Section 1.28 Educational materials on our website

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

Section 1.29 Satisfaction surveys

The opinion of our members matters.

Triple-S Salud periodically conducts surveys of 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 ongoing efforts to improve members' overall experience with the health plan, including the service experience and quality of care.

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

Section 1.30 Benefits not covered by the plan

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

We recommend that you check the sections on Health Coverage Exclusions, Pharmacy Benefit Exclusions, and Dental Benefit Exclusions in Chapter 4 before receiving the medical service, treatment, or medication, as well as any attached endorsements, to confirm whether it is covered or not. We also recommend that you talk with your physician or service provider about the treatment alternatives that are covered by the plan so you can reduce your payments, or about coverage options through programs in other organizations that may provide additional help.

Section 1.31 Advance directives or instructions

Advance directives or instructions 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 the event of a health condition that would prevent them from communicating during such treatment. This document offers you greater control over crucial matters regarding your quality of life, offering family members, friends, and physicians the basic information they need to take care of you. Physicians and other health care professionals are legally required to follow your advance directives. In accordance with the provisions of law, you cannot be denied care or be discriminated based on whether you have signed or not an advance directive.

If an illness renders you unable to communicate, the decisions regarding your health will be taken by someone else and not always in accordance to what you would have wished.

According to Puerto Rico law, the declarant's 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.

To learn more about Advance Directives, please visit our website, www.mitriples.com, or call Customer Service at the number listed on the back of the member card.

Section 1.32 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 care provider can help you both make informed decisions about your health and treatment. It is important to discuss your symptoms, condition, and concerns about your treatment openly. Here are some questions you should ask your physician to make sure 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 my treatment begin, and how long will it last?
- What are the benefits of this treatment, and what is its usual success rate?
- What are the risks and side effects associated with this treatment?
- Are there any foods, medications, or activities I should avoid while I am following the treatment plan?
- What medications will I take before, during, and after the treatment?

Ask for a cost estimate. After your physician gives you all the details about your condition and treatment options, contact Triple-S Salud to confirm what your out-of-pocket expenses will be to treat your condition.

Section 1.33 Coverage of services by local or federal law

This policy provides the member with all the benefits offered within, including the services required by local and federal law. To learn more, please refer to the sections on Preventive Service Coverage, Standard Vaccine Coverage, and Benefits Covered by Law, in the **Covered Benefits** chapter.

Section 1.34 You may request the following additional information to better understand your plan and learn about the company

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

Section 1.35 Acts of undue discrimination against victims of abuse

Undue discrimination is:

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

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

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

Discriminatory acts also include terminating the group coverage of an abuse victim because the coverage was originally issued in the name of the abuser, who has divorced, separated from, or lost custody of the victim, or because the abuser's coverage was otherwise terminated voluntarily or involuntarily. The provisions herein do not preclude Triple-S Salud from requiring the victim to pay the full premium for the health 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 apply equally to all current or potential members.

The occurrence of one or more of the following acts is considered abuse, be it committed by a member or former member of the victim's family, a resident in the victim's household, a romantic partner, or any other person in charge of the victim's care:

- Attempting to cause or intentionally or recklessly causing another person bodily injury, physical harm, severe emotional distress, psychological trauma, rape, sexual assault, or involuntary sexual intercourse;
- Knowingly engaging in a conduct of persecution against the victim, including following the victim, without due authorization, in circumstances where the victim could reasonably understand that their physical safety is at risk;
- Restricting the victim's freedom; or
- Knowingly or recklessly causing damage to property in order to intimidate or control the victim's behavior.

Section 1.36 How your coverage works

This plan helps pay for some of the costs incurred when you are ill or injured. It also pays for certain health care services to help you remain in optimal health and detect any conditions through preventive services. Aside from the monthly payment you make for your plan (called the “premium”), members also pay a share of the costs when they receive health care services covered by the plan. There are different types of costs that you must pay out of pocket: deductibles, copayments, and coinsurances, up to the maximum annual out-of-pocket corresponding to the coverage. For details about your plan's copayments, coinsurances, and deductibles, please see the chapter on Covered Benefits.

SECTION 2 Coordination of Benefits (COB)

When a member is covered by two or more plans, the rules to determine the order of benefit payments between the plans 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 when the member receives services from a provider outside the panel, except in cases involving emergency services or authorized referrals provided by the primary plan.

3) When there are multiple contracts providing coordinated coverage and these are treated as a single plan for the purpose of this rule, this section applies only to the overall plan. The coordination between the constituent contracts is governed by their respective terms. If more than one contractor pays or provides benefits under the plan, the contractor designated as primary payer in the plan will be responsible for the overall plan's compliance with this section.

4) If a person is insured by more than one secondary plan, these rules also apply to the order in which secondary plans pay benefits relative to each other. Each secondary plan takes into

account the benefits paid by the primary plan and the benefits paid by any other plan designated to pay first under these rules.

B. 1) Except for what is provided later in paragraph (2), a plan that has not established an order of coordination of benefits in a manner consistent with this section is considered to be a primary plan, unless the provisions for both plans, notwithstanding what is stated in this paragraph, specify that the plan providing an order of coordination of benefits is the primary plan.

2) A group coverage intended to supplement part of a basic benefit package may require that the supplemental coverage be the excess over any other constituting parts of the plan provided by the same contract or policy. Examples 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 when it is a secondary payer to such other plan pursuant to these rules.

D. Order of Determination of Benefits

Each plan determines its benefits using the first applicable rule below:

1) Non-dependent or dependent

a) Except for what is provided in subparagraph (b) of this paragraph, a plan that covers 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 a person as a dependent is the secondary plan.

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

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

(II) Primary to the plan covering the person as a non-dependent

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

2) Dependent child covered by more than one plan

Unless there is a court order to the contrary, the plans covering a dependent child pay their benefits in the following order:

a) In the case of a dependent child whose parents are married or living together but not married:

(i) The plan of the parent whose birthday occurs first in a calendar year is the primary plan; or

(ii) If both parents share the same birthdate, the plan that has covered a parent the longest is the primary plan.

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

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

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

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

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

I. The plan covering the custodial parent;

II. The plan covering the custodial parent's spouse;

III. The plan covering the non-custodial parent; and lastly

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

c) In the case of minors covered as dependents under more than one plan belonging to individuals who are not their parent, the order of benefits is determined in subsections (a) or (b) of this paragraph, as applicable, as if such individuals were the minors' parents.

d)

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

ii. In the case of coverage for minor dependent children under the spouse's plan which started on the same date as the coverage provided by one or both parents' plans, the order of benefits is determined by applying the birthday rule in paragraph (a) to the parent(s) of the minor dependent child(ren) and the dependent spouse.

3) Active, 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 covering a person as a former or retired employee or as a former or retired employee's dependent is the secondary plan.

b) If the other plan does not have this rule and, as a result, the plans do not agree on the order of payment of benefits, this rule is disregarded.

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

4) COBRA or state continuation coverage

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

b) If the other plan does not have this rule and the plans do not agree on the order of payment of benefits, this rule is disregarded.

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

5) Longest or shortest time of coverage

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

b) For the purpose of determining the amount of time a person has been covered by a plan, two successive plans are treated as one only if the person was eligible to participate in the second plan within a period of twenty-four (24) hours after the termination of the first plan.

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

i. A change in the amount or scope of plan benefits;

ii. A change in the entity that pays, provides, or manages the plan benefits; or

iii. A change in type of plan; for example, from a single-employer plan to a multi-employer plan.

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

6) If none of the previous rules determines the order of the benefits, the expenses are shared equally by the plans.

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

SECTION 3 Your Rights and Responsibilities as a Patient

Law No. 194 of August 25, 2000, as amended, known as the Bill of Rights and Responsibilities of the Patient, establishes the rights and responsibilities of the users of Puerto Rico's medical-hospital health system.

Section 3.01 Right to high-quality health services

Services consistent with the generally accepted principles of medical practice.

Section 3.02 Rights concerning the acquisition and disclosure of information

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

- Covered benefits, limitations, and exclusions
- Premiums, deductibles, coinsurances, and copayments due
- Provider Directory
- Access to specialists and emergency services
- Process for precertifications and grievances
- Education, licensing, and certifications of your health care providers

Section 3.03 Rights concerning plan and provider selection

Every individual has the right to:

- Select health care plans and providers that are appropriate and best fit their needs without being discriminated against based on socio-economic status, ability to pay, preexisting medical conditions, or medical history, regardless of age.
- A network of sufficient authorized providers to ensure that all the services covered by the plan are accessible and available without unreasonable delay and within reasonable geographical proximity to the members' homes and workplaces, including access to emergency services twenty-four (24) hours a day, seven (7) days a week. Every health care plan offering coverage for health services in Puerto Rico must allow patients to receive primary health care services from any participating primary care provider selected by the patient in accordance with the provisions of the health care plan.
- Allow members to receive the necessary or appropriate specialized health services to maintain their health, in accordance with the referral procedures established in the health care plan. This includes

access to qualified specialists for patients with special conditions or health care needs, to ensure that the members will have quick and direct access to the qualified providers or specialists of their choice from the plan's provider network. If special authorization is required by the plan to obtain such access to qualified providers or specialists, the plan guarantees an adequate number of visits to meet these members' health care needs.

Section 3.04 Right of the patient to continue health care services

If coverage from a provider or from the plan ceases, the member must be notified of such cancellation at least 30 days in advance. In the event of cancellation, and subject to payment of the premium, the member is 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 later. If a patient is diagnosed with a terminal condition before the plan's termination date and they continue receiving services for that condition before the plan's termination date, the transition period will be extended for the remainder of the patient's life.

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

Section 3.05 Rights concerning access to emergency services and facilities

- Free and unrestricted access to emergency services and facilities, whenever and wherever the need may arise, without the requirement of precertification or waiting periods, regardless of the patient's socioeconomic status and ability to pay. No health plan may deny payment or coverage for emergency medical-hospital health services, regardless of whether they are provided by a non-participating provider.
- Reliable and detailed information regarding the availability, location, and proper use of emergency facilities and services in their respective locations, as well as provisions regarding the payment of premiums and reimbursement of costs related to such services.
- If emergency services are rendered by a non-participating provider, the member will only pay the applicable copayment or coinsurance.
- If the member receives health care services after receiving emergency or post-stabilization services from a non-participating provider, they will be reimbursed based on the fees that would have been paid to a participating provider, as long as there is a compelling medical reason why the patient cannot be transferred to a participating provider.

Section 3.06 Rights concerning participation in decisions on treatment

- The right for you or for your parent, guardian, custodian, caretaker, spouse, relative, legal representative, proxy, or any person designated by court to such end, to fully participate in the decisions about your health care.
- Receive all the necessary information and available treatment options, as well as their associated costs, risks, and chances of success.
- The use of advance directives or instructions concerning your treatment, or appointing someone to act as your guardian if necessary to make decisions. Your health care service provider must respect and abide by your treatment decisions and preferences.
- No health care plan may impose gag clauses, penalties, or other provisions that interfere with patient-physician communications.
- Right to coverage of routine medical expenses, in the case of members with life-threatening conditions for which there is no effective treatment and which makes them eligible to participate in an authorized clinical therapy trial, provided that their participation offers a potential benefit and that the physician referring the member for participation in the trial believes such participation to be appropriate or that the covered person themselves presents evidence that their participation in the study is appropriate, or that the member submits their own evidence supporting that their participation in the trial is appropriate. "The patient's routine medical expenses" are not those related to the trial, or the tests

administered to be used as part of the trial, or the expenses that should reasonably be paid by the entity conducting the trial.

- All health care providers are required to provide you with your medical orders for laboratory tests, X-rays, or medications so you may choose the facility to receive these services.

Section 3.07 Rights concerning respect and equal treatment

- Right to receive 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, ability to pay, or form of payment.

Rights concerning the confidentiality of medical records and information

- Communicate freely, at ease, and in strict confidentiality with health care providers.
- Feel confident that your health records are kept under strict confidentiality and are not disclosed without your authorization, except for medical or treatment purposes, by court order, or as specifically authorized by law.
- Obtain receipts for expenses incurred for full or partial payments of copayments, or coinsurances. The receipt must specify the date of service, name, provider's license number and specialty, name of the patient and of the person paying for the services, breakdown of services, amount paid, and signature of the authorized officer.
- Access or obtain a copy of your medical record. Your physician must give you a copy of your medical record within 5 business days from the date you request it. Hospitals will have 15 business days to comply. They may charge 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 any outstanding debt with the health care provider.
- Receive a quarterly utilization report including, among other information, the member's name, service type and description, date of service, and the provider who rendered the service, as well as the amount paid for it. The member may access the quarterly utilization report showing a breakdown of the services paid for their and their dependents' benefit by registering as a member in Triple-S Salud's portal (www.ssspr.com).

Section 3.08 Rights concerning complaints and grievances

- Every health service provider or insurer has an established procedure to quickly and fairly resolve any complaint filed by a member, as well as appeal mechanisms for the reconsideration of determinations. Please refer to the section Appeals for Adverse Benefit Determinations.
- Receive a response to your concerns in your preferred language, be it English or Spanish.

Section 3.09 Your responsibilities as a patient are:

- Provide the necessary information about health plans and settlement of any bills. Know the rules for coordination of benefits and comply with the health plan's administrative processes.
- 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. Know the risks and limitations of medicine.
- Know the coverage, options and benefits, and other details pertaining to the health plan, such as internal procedures for resolving differences, limitations, and exclusions.
- Comply with your health plan's administrative procedures.
- Adopt a healthy lifestyle.
- Inform your physician about unexpected changes in your condition.
- Confirm that you clearly understand the course of action recommended by the health care professional.

- Provide a copy of your advance directives.
- Inform your physician if you foresee problems with the prescribed treatment.
- Acknowledge the provider's duty to be efficient and equitable in providing care to other patients.
- Be considerate so that your individual actions do not affect others.
- Resolve any differences through the procedures established by the insurer.

SECTION 4 Appeals for Adverse Benefit Determinations

Section 4.01 Right to request an appeal after an adverse determination

What is an adverse determination?

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

Section 4.02 Right to appeal an adverse determination

If you disagree with an Adverse Determination made by Triple-S Salud, either related to a request for reimbursement, a precertification request, or a denial of the benefits described in your policy, you may appeal Triple-S Salud's determination.

Section 4.03 Appeals procedure

1. <u>First-level review of grievances related to an adverse determination</u>

You or your authorized representative must submit your appeal in writing within **180 calendar days** from the date you received the first written notice of adverse determination in order to have it evaluated, regardless of whether it includes 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 due to an adverse determination related to a utilization review, we will appoint one or more clinical peer reviewers of the same or a similar specialty as the health care professionals who normally handle the case for which the adverse determination was made. These clinical peers must not have been involved in the initial adverse determination. If more than one clinical peer is appointed, they will have the appropriate expertise to evaluate your case.

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

The member or, if applicable, their personal representative is entitled to receive free access to and copies of all documents and records from Triple-S Salud, as well as information relevant to the grievance. You have the right to:

- Submit written statements, documents, records, and other items 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 information relevant to the grievance.

Documents, records, and any other information will be deemed relevant to the member's grievance filing if they:

- were used in the initial determination;
- were submitted, considered, or created in connection with the adverse determination, even if the benefit determination did not depend on these documents, records, or other information;
- prove that, in making the determination, Triple-S Salud consistently followed the same administrative procedures and guarantees followed with other members under similar circumstances; orconstitute statements regarding the plan's policy or guidelines on the denied health care service or treatment and the member's diagnosis, regardless of whether or not they were taken 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 an attorney of your choice (at your own expense).

To request assistance, please contact:

Office of the Commissioner of Insurance
Investigations Division
OCI mailing address
PO Box 195415
San Juan PR, 00919

361 Calle Calaf
World Plaza Building
268 Muñoz Rivera Ave
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 to the following mail address, email, or fax:

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

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

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

The periods for the 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 believes that the grievance does not contain all the information required to make a determination, it will provide the member or, if applicable, their personal representative with a clear explanation as to why it considers that the grievance cannot be processed, as well as a list of the documents or additional information that must be submitted.

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

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

This determination includes:

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

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

- The specific reasons for the 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 appeal review.
- If Triple-S Salud used a rule, internal protocol or guideline, or other similar criteria, in order to make its adverse determination, a copy of such rule, guideline, protocol, or similar criteria used as a basis for the adverse determination must be provided, 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 investigational nature, or on a similar exclusion or limitation, a written explanation of the scientific or clinical rationale employed to make the determination, or a statement to the effect that an explanation is made available to the member, or to their personal representative if applicable, free of charge upon request.
- If applicable, instructions must be included to request a copy of the rule, guideline, internal protocol, or similar criteria used as a basis for the determination or an explanation of the scientific or clinical rationale employed to make the determination.
- It must include a statement describing the process to obtain an additional voluntary review, as well as the deadlines for such review, in case the member wants 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 file a lawsuit before a competent court.

  If applicable, it must also include a statement indicating that Triple-S Salud and you may have other available options to voluntarily resolve disputes, such as mediation or arbitration, and your right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health for guidance, to learn about available options, and to request assistance, as well as the numbers to call in these cases.

2. <u>Ordinary reviews of grievances not related to adverse determinations</u>

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

Triple-S Salud informs you of your rights within three (3) business days from receipt of the grievance, and it appoints one or more individuals with no prior involvement in the issue raised by the grievance. Triple-S Salud will also give you, the member, or your personal representative if applicable, the name, address, and phone number of the people appointed to perform the ordinary grievance review. Triple-S Salud notifies you in writing of its determination no later than thirty (30) calendar days after receiving the grievance. The notice of Triple-S Salud's determination will include the names and titles of the officers or experts who evaluated your grievance, as well as a summary statement of the reviewers' evaluation of the grievance.

It must also include:

- the reviewers' determination in clear terms and the contractual basis or medical justification, so that you may respond to the claims;
- reference to the evidence or documentation used as grounds for the determination.
- If applicable:
  - a written statement describing the process to obtain an additional voluntary review in case the member wishes to request it
  - the procedure to follow and the deadlines for the review
  - a description of the process to obtain an independent external review, if the member decides not to request a voluntary review
  - the member's right to file a lawsuit before a competent court
  - Triple-S Salud and you may have other options for voluntary dispute resolution, such as mediation or arbitration. To learn more about the options available, contact the Commissioner of Insurance
  - a notice of the member's right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health for guidance and assistance, including the phone number and address of the Offices of the Commissioner of Insurance and 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 appeal 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's designation must contain all the elements described below:

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

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

The member or their authorized representative must notify Triple-S Salud in writing if the appointment is revoked before its expiration date.

The member is entitled to the benefits awarded, as determined, resulting from the appeal process.

3. Voluntary level of grievance reviews

If you are not satisfied with Triple-S Salud's response, you may submit a written request for voluntary review no later than fifteen (15) business days after receipt of the adverse determination. At the voluntary level, you may submit additional information to your case that was not provided at the previous level of internal review.

Upon receiving the request for additional voluntary review, Triple-S Salud acknowledges its receipt and notifies the member or personal representative about their right to:

- Request, within the specified time, an opportunity to appear in person before the review panel appointed by Triple-S Salud
- Obtain from Triple-S Salud copies of all the documents, records, and other non-sensitive and non-privileged information regarding the request for additional voluntary review
- Bring their case before the review panel
- Submit written remarks, documents, records, and other materials related to the request for additional voluntary review, for the panel's consideration both prior to and at the review meeting
- If applicable, ask questions to the review panel representatives
- Obtain assistance or representation from anyone, including an attorney

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

Once the member receives our acknowledgment of receipt of their request, they may submit a written request to appear in person before the review panel within 15 business days from its receipt.

In terms of requests for additional voluntary review of a determination rendered, Triple-S Salud appoints a review panel of Triple-S Salud employees or representatives to assess the request, before which you or your authorized representative may appear in person or by phone to explain your request. Individuals who participated in the first-level review may serve as panel members or appear before the panel solely to provide information or answer questions from the panel. Triple-S Salud will ensure that the individuals conducting the additional voluntary review are health professionals with the appropriate expertise, and that the personnel performing the additional voluntary review are not providers in the member's health plan and will have no financial stake in the review's outcome.

The panel has the legal authority to compel Triple-S Salud to abide by the panel's determination. If twenty (20) calendar days elapse without Triple-S Salud abiding by the review panel's determination, the panel is required to notify the Office of the Commissioner of Insurance.

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

In conducting the review, the appointed panel performs its evaluation and takes 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 submitted or considered in making the determination in previous (first-level) reviews.

When a member or their personal representative asks to appear in person before the panel, the procedures for the additional voluntary review will 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 additional voluntary review.

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

Triple-S Salud will 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 accessible to the member or, if applicable, to their personal representative.

When a face-to-face meeting is not feasible for reasons of geographical location, Triple-S Salud will offer the member, or their personal representative if applicable, the opportunity to contact the review panel by conference call, videoconference, or other suitable technology, at the expense of Triple-S Salud.

Triple-S Salud intends to be assisted by its legal counsel and will notify so to the member, or their personal representative if applicable, at least fifteen (15) calendar days prior to the date of the review meeting. It will also notify the member that they may be assisted by their own legal counsel.

The review panel will 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, the panel will issue their determination and notify it, in writing or electronically (if notices have been authorized in this manner,) no later than forty-five (45) calendar days after the first of the following dates:

- The date when the member or their personal representative notifies Triple-S Salud that they will not request the 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.

The written notice of Triple-S Salud's determination must include:

- The qualifications and credentials of the members of the review panel
- A statement of the review panel's evaluation of your request and all relevant facts.
- The supporting statement for the review panel's determination
- Reference to the evidence or documentation that the review panel considered and used as grounds for the determination

If the request for additional voluntary review is related to an adverse determination, it must include:

- The 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 process to obtain an independent external review of the adverse determination pursuant to the Health Insurance Code of Puerto Rico.

It will also include a notice of the member's right to contact the Office of the Commissioner of Insurance or the Office of the Advocate of Health for assistance at any time, including the phone number and address of the Offices of the Commissioner of Insurance and of the Advocate of Health. The contact information for these Offices is included in this section, under Right to assistance.

4. Expedited reviews of grievances related to adverse determinations

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

The procedures will allow the member, or their personal representative, to submit a verbal or written request to Triple-S Salud for an expedited review.

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

In an expedited review, all necessary information, including Triple-S Salud's determination, will be conveyed between Triple-S Salud and the member, or their personal representative if applicable, by phone, fax, or the most expeditious means available.

If your case is evaluated in an expedited manner, Triple-S Salud will notify the decision to you, or to your personal representative if applicable, by phone, fax, or in the most expeditious manner available, with the urgency required by your medical condition but no later than forty-eight (48) hours from the date the expedited review request is submitted with Triple-S Salud, regardless of whether the filing includes all the information required to make the determination. Urgent case appeals are appeal requests corresponding to medical services or treatments that, if held to the regular deadlines to respond to an appeal, would: (a) seriously jeopardize the member's life, health, or full recovery; or (b) in the opinion of a physician with full knowledge of the member's medical condition, subject the member to severe pain that cannot be adequately managed without the medical care or treatment that is the subject of the appeal.

This determination includes:

- The qualifications 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 its medical justification or contractual basis, to allow the member or their personal representative to respond to the claims;
- The evidence or documentation used as basis for the determination.

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

- The specific reasons for the 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 appeal review, including any rules, guidelines, internal protocols, or any other similar criteria used as a basis for the determination.
- If the adverse determination is based on medical necessity or the treatment's experimental or investigational nature, or on a similar exclusion or limitation, a written explanation of the scientific or clinical rationale employed to make the determination, or a statement to the effect that an explanation is made available to the member, or to their personal representative if applicable, free of charge upon request.
- If applicable, it should include instructions to request a copy of the rules, guidelines, internal protocols, or any other similar criteria used as ground for the determination, 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 specifying the member's right to file a lawsuit in a competent court of law.
- If applicable, it must 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 for guidance, to learn about available options, and to request assistance, as well as 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 will provide written or electronic notice no later than three (3) days after the verbal notice.
- Nothing herein will be construed to limit Triple-S Salud's ability to render an adverse determination null without following the procedure described herein.

To request assistance, please contact:

Office of the Commissioner of Insurance

Investigations Division
OCI mailing address
PO Box 195415
San Juan PR, 00919

361 Calle Calaf
World Plaza Building
268 Muñoz Rivera Ave
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 to the following mail address, email, or fax:

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

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

5. Procedures for utilization review and ordinary determination of benefits

Triple-S Salud will establish written procedures to perform utilization reviews and ordinary determinations of benefits on the claims submitted 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 an appropriate period of time according to the member's health condition but no later than fifteen (15) days from the date the request is received.
- If an adverse determination is issued, Triple-S Salud will notify such determination as established herein.

Triple-S Salud may extend or defer the period of fifteen (15) days to make the determination and notify the member once, for an additional period of fifteen (15) days, provided that Triple-S Salud meets the following requirements:

- The extension is determined to be necessary due to circumstances beyond Triple-S Salud's control; and
- The member is notified, before the first period of fifteen (15) days ends, of the circumstances warranting the extension and the date the determination is expected to be made.

If the extension is due to 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 provide an accurate description of the additional information required to complete the request; 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 request for prospective review that does not meet the requirements for filing benefit claims with Triple-S Salud, it will provide the member with a notice of this deficiency and include information about the process to be followed to file the claim correctly.

- The notice of insufficiency in the submission of the claim will be served as soon as possible but no later than five (5) days from the date of the insufficient submission.
- Triple-S Salud may provide notice of deficiency, either verbally or in writing, if so requested by the member.

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

- Any reduction or termination of treatment made by Triple-S Salud before the end of the previously certified time period or number of treatments will be considered an adverse determination, unless the reduction or termination is due to an amendment in the 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 period of time, but no later than thirty (30) days from the receipt of the request.
- If an adverse determination is issued, Triple-S Salud will notify such determination.

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

- The extension is determined to be necessary due to circumstances beyond Triple-S Salud's control; and
- The member is notified, before the initial period of thirty (30) calendar days ends, of the circumstances warranting the extension and the date the determination is expected to be made.

If the extension is due to 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 provide an accurate description of the additional information required to complete the request; 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 term for Triple-S Salud to make its determination will begin on the date Triple-S Salud receives the request, regardless of whether the filing includes all the information required to make the determination.

- If the term is extended because the member did not submit all the information necessary to make the determination, the applicable term will be interrupted as of the date that Triple-S Salud sends the extension notice to the member and until the earlier of the following occurs:
    - The date when the member responds to the request for specific additional information; or
    - The date by which the requested additional information should have been submitted.

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

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

- Sufficient information to help identify the benefit requested or claim made, including applicable data such as date of service, provider, amount of claim, and the diagnosis and treatment codes and their definitions;
- The specific reasons for the adverse determination, including the denial code and its definition, as well as a description of the criteria used, if any, in denying 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 request, 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 such procedures;
- If Triple-S Salud's 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 will be provided at no cost to the member;
- If the adverse determination resulted from an assessment of the medical necessity of the service or treatment, its experimental or investigational nature, or a similar exclusion or limitation, the notice will include an explanation of the scientific or clinical rationale used in making the determination and applying the health plan's terms to the member's circumstances; and
- An explanation of the member's right to contact, as appropriate, the Office of the Commissioner of Insurance or the Office of the Patient Advocate for assistance at any time, and of the right to file a lawsuit before a competent court after Triple-S Salud's internal grievance process is exhausted. The contact information for the Office of the Commissioner of Insurance and the Office of the Advocate of Health must be included.

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

6. Procedure for expedited utilization review and determination of benefits

Triple-S Salud establishes written procedures for the expedited utilization review and determination of benefits, and for notifying members of its determinations for urgent care requests. As per the procedures, if the member does not follow the filing procedures for urgent care requests, Triple-S Salud must notify them of the deficiency and the procedures to be followed in order to file the request correctly.

The member will be served the notice of deficiency in the filing of an urgent care request, either verbally or in writing, as soon as possible but no later than twenty-four (24) hours after receipt of the request.

In the case of urgent care requests, Triple-S Salud will promptly notify the member of its determination, be it adverse or not, taking into account the member's health condition, but never later than twenty-four (24) hours after the request is received, unless the member has not provided sufficient information for Triple-S Salud to determine whether the benefits claimed are covered and payable under this policy.

If the member has not provided sufficient information for Triple-S Salud to make a determination, Triple-S Salud will provide the member with notice of this deficiency, either verbally or—if the member so requests it—in writing, and specify the information required, as soon as possible but no later than twenty-four (24) hours after the request is received.

Triple-S Salud will give the member a reasonable deadline to submit the requested additional information, but this deadline may not be less than forty-eight (48) hours after the notice of deficiency.

Triple-S Salud will notify the member of its determination regarding the urgent care request 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 requested additional information, or the deadline for the member to submit the requested additional information.

If the member fails to submit the requested additional information by the established deadline, Triple-S Salud may deny certification of the requested benefit. If an adverse determination is issued, Triple-S Salud will notify such determination as explained in this section.

In the case of member requests for concurrent reviews to extend urgent care beyond the originally approved time period or number of treatments, if the request is made at least twenty-four (24) hours before the original term expires or after exhausting the amount of previously approved treatments, Triple-S Salud will make its determination on the request and notify the member as soon as possible, taking into account the member's health condition, but never later than twenty-four (24) hours from receipt of the request.

For the purpose of calculating the deadline for Triple-S Salud to make its determinations, the time period starts on the date Triple-S Salud receives the request in accordance with its established procedures to file such requests, regardless of whether the request includes all the information required to make the determination.

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

- Sufficient information to help identify the benefit requested or claim made, including applicable data such as date of service, provider, amount of claim, and the diagnosis and treatment codes and their definitions.
- The specific reasons for the adverse determination, the denial code and its definition, as well as a description of the criteria used, if any, in denying 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 request, including an explanation of why such material or information is necessary.
- A description of Triple-S Salud's internal grievance procedures, established in accordance with the Health Insurance Code of Puerto Rico, including the deadlines that apply to such procedures.
- A description of Triple-S Salud's internal procedures for expedited grievance reviews established in accordance with the Health Insurance Code of Puerto Rico, including the deadlines that apply to such procedures.
- If Triple-S Salud's 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 will be provided at no cost to the member.
- If the adverse determination resulted from an assessment of the medical necessity of the service or treatment, its experimental or investigational nature, or a similar exclusion or limitation, the modification will include an explanation of the scientific or clinical rationale used in making the determination and applying the policy terms to the member's circumstances.
- An explanation of the member's right to contact, as appropriate, the Office of the Commissioner of Insurance or the Office of the Advocate of Health for assistance at any time, of the right to file a lawsuit before a competent court after Triple-S Salud's internal grievance process is exhausted, and the contact information of the Offices of the Commissioner of Insurance and of the Advocate of Health.

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

7. Emergency services

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

Triple-S Salud will cover the emergency services required for screening and stabilizing the member, according to the following guidelines:

- 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 the 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 the 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 provided 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 above payment requirements if it pays for the emergency services rendered by a non-participating provider a fee no lower than the greater of the following amounts:

- The negotiated fee paid to 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 for determining payments to non-participating providers, and considering the copayments, coinsurances, and deductibles that apply 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.

Section 4.04 Notice of right to external review

Triple-S Salud will notify the member in writing of their right to request an external review. This notice will be provided when Triple-S Salud sends a written notice of any of the following:

- An adverse determination at the end of the utilization review process.
- A final adverse determination.
- Cases of coverage rescission.

The commissioner may prescribe the form and content of the required notification.

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 time required 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 before 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 a final adverse determination notice, a notice informing the member of the following, as applicable:

- If the member has a health condition where the time required 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 at 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 experimental or investigational in nature, the member may file a request for 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 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 processes, noting the provisions that offer the member an opportunity to submit additional information. It should also include the forms necessary, if any, to process the request for external review. Triple-S Salud will 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, 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 notice. The final adverse determination will include the forms for external review and 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 as follows:

- **Fax: 787-273-6082**
- **Mail:**
  Office of the Commissioner of Insurance
  Investigations Division
  OCI mailing address
  PO Box 195415 San Juan, PR 00919
  361 Calle Calaf, World Plaza Building, 268 Muñoz Rivera Ave., San Juan, PR 00918
  Phone: 787-304-8686
  www.ocs.pr.gov
- **Email:** investigaciones@ocs.pr.gov

Section 4.05	**Request for external review**

All requests for external review will be addressed to the Commissioner of Insurance. The Commissioner of Insurance may prescribe 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.

Section 4.06	**Requirement to exhaust the internal grievance process**

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

Triple-S Salud's internal grievance process will be considered exhausted if 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 member may not request an external review of an adverse determination arising from a retrospective review until the member has exhausted Triple-S Salud's internal grievance process.

Concurrently with the request for an expedited internal review of a grievance, the member may request an expedited external review based on any of the following:

- 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 leads to a denial of coverage based on a determination that the recommended or requested service or treatment is experimental or investigational 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 expedited external review, the independent review organization (IRO) appointed to conduct the external review will determine whether the member will be required to exhaust the expedited internal review process first.

If the independent review organization (IRO) determines that the member must first exhaust the expedited internal review process, it 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 exhausted.

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

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

Section 4.07 Ordinary external review

The member will have up to one-hundred and twenty (120) days after receiving a notice or final notice of adverse determination to submit a request for external review to the Commissioner of Insurance.

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

Triple-S Salud will have up to five (5) business days after receiving the copy of the request for external review to perform a preliminary review of the request and determine:

- Whether the claimant was insured when they requested the health care service or, in the case of retrospective reviews, whether they were a member of Triple-S Salud when the health care service was provided;
- Whether it could be reasonably understood that the health care service subject to the adverse determination or final adverse determination is covered by Triple-S-Salud, except when Triple-S Salud has determined it is not covered because it does not meet the criteria of medical necessity, appropriateness, the place where the health care service is provided, level of care, or effectiveness of care;
- Whether the member exhausted Triple-S Salud's internal grievance process, except when it is not required to exhaust such internal grievance process; and
- Whether the member has provided all the information and forms required by the Commissioner of Insurance 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 provide the Commissioner of Insurance and the member with written notice if:

- The request for external review is complete, and
- The request is eligible for external review.

If the request:

- Is not complete, Triple-S Salud will send a written notice of initial determination informing the member and the Commissioner of Insurance what information or documentation is required to complete the request, or
- Is not eligible for external review, Triple-S Salud will send a written notice of initial determination informing the member and the Commissioner of Insurance of the reasons for ineligibility.

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

- If, as a result of the preliminary review performed, Triple-S Salud determines that the request is not eligible for external review, the notice to such effect must advise the member that such

determination of ineligibility made by Triple-S Salud may be appealed before the Commissioner of Insurance.

The Commissioner of Insurance 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, following Triple-S Salud's initial determination to the contrary, must be made in accordance with the health plan's terms of coverage and will be subject to all applicable provisions.

No later than the next business day after the Commissioner of Insurance 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 appointed independent review organization will not be bound by any of the decisions or conclusions arising from Triple-S Salud's utilization review or internal grievance processes.

The notice sent by the Commissioner of Insurance to the member informing them that their request for external review has been accepted must also include language stating that they may submit, within five (5) business days of receiving the notice of acceptance and in writing, any additional information they believe should be considered by the independent review organization in the course of the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after the term of five (5) business days provided herein.

No later than five (5) days after receiving the notice regarding the appointed independent review organization, Triple-S Salud will release all the documents and information considered in rendering the adverse determination or final adverse determination subject to external review.

Any failure by Triple-S Salud to deliver the required documents and information within five (5) days should not delay the external review.

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

The independent review organization will notify the member, Triple-S Salud, and the Commissioner of insurance no later than the next business day after the decision is made to revoke the adverse determination or final adverse determination under review.

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, it shall, in turn, forward such information to Triple-S Salud no later than the next business day after receiving it.

On receipt of 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 delay or terminate the external review.

The external review may only be terminated if, after due reconsideration, Triple-S Salud agrees to 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 after the decision to revoke its adverse determination or final adverse determination, Triple-S Salud will provide written notice of such determination to the member, the independent review organization, and the Commissioner of Insurance.

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

In addition to the documents and information, the independent review organization, to the extent it deems appropriate and the information or documents are available, will consider the following in making its determination:

- The member's relevant health records;
- The recommendation of 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 treatment provider;
- The terms of coverage of the member's health plan;
- The most appropriate practice guidelines, which may 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 developed 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 within the independent review organization, after examining the documents.

The independent review organization must provide notice of its determination either to uphold or to revoke the adverse determination or final adverse determination subject to review no later than forty-five (45) days after receiving a request for external review. Written notice will be sent to:

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

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

- A brief description of the purpose of the request for external review;
- The date when the independent review organization received the referral from the Commissioner of Insurance to conduct the external review;
- The date the external review was performed;
- The date of its determination;
- The main reason or reasons for its determination, including which standards, if any, informed its determination;
- The rationale for its determination; and
- References to the evidence or documentation, including practice guidelines, taken into account in making the determination.

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

The Commissioner of Insurance will appoint the independent review organization to conduct an external review by randomly selecting one of 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.

Section 4.08 Expedited external review

The member may file a request for expedited external review before the Commissioner of Insurance upon receipt of 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 the expedited internal review of a grievance on 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 of Insurance must 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 Insurance of its determination as to whether the request is eligible for external review.

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

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

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

Upon receiving notice from Triple-S Salud that a request meets the criteria for review, the Commissioner of Insurance will immediately appoint an independent review organization to conduct the expedited external review. It will also notify Triple-S Salud which independent review organization was appointed and provide written notice to the member that their request is eligible and was accepted for expedited external review.

In making its determination, the appointed independent review organization will not be bound by any of the decisions or conclusions arising from Triple-S Salud's utilization review or internal grievance processes.

Upon receiving notice from the Commissioner of Insurance regarding the appointed independent review organization, Triple-S Salud will release, either electronically or by any other expedited means, all the documents and information considered in rendering the adverse determination or final adverse determination subject to expedited external review.

In addition to the documents and information, the independent review organization, to the extent it deems appropriate and the information or documents are available, will consider the following in making its determination:

- The member's relevant medical records;
- The recommendation of 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 may 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 developed 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 within 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 no 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 on whether to uphold 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 of Insurance.

If the independent review organization's notice of determination is not initially made in writing, within forty-eight (48) hours after the determination, the independent review organization will be required to:

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

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

The recourse of expedited external review will not be available if the adverse determination or final adverse determination was the result of a retrospective review.

The Commissioner of Insurance will appoint the independent review organization to conduct an expedited external review by randomly selecting one of 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.

Section 4.09	**External review for adverse determinations based on experimental or investigational treatment**

The member will have up to one-hundred and twenty (120) days to file a request for external review before the Commissioner of Insurance 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 investigational nature.

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 investigational nature, as long as 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 of Insurance 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 if the request meets the criteria for review and notify the member and the Commissioner of Insurance of its determination as to whether the request is eligible for external review.

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

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

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

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

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

Upon receiving notice from the Commissioner of Insurance regarding the appointed independent review organization, Triple-S Salud will release, either electronically or by any other expedited means, all the documents and information considered in rendering the adverse determination or final adverse determination subject to review.

Except in case of requests for expedited external review, the Commissioner of Insurance will send Triple-S Salud notice and a copy of any requests for external review of denials of recommended or requested health care services or treatments due to their experimental or investigational nature no later than the next business day after receiving such requests.

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

- The person is or was insured by the health plan when the health care service or treatment was requested or recommended or, in the case of retrospective reviews, the person had been insured by 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 by the member's health plan, but Triple-S Salud has determined that the treatment or service is of an experimental or investigational 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 applies:

- The usual and customary health care services or treatments have not been effective in improving 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 concerning which they certify, in writing, that they consider it is likely to be of more benefit to the member than the other usual or customary health care services or treatments available; or
- The member's attending physician, who is qualified to practice medicine in a field suitable for the treatment of the health condition in question, has provided written certification that there is scientifically valid research, conducted in accordance with the accepted protocols, that shows 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 when it is not required to exhaust such process; and

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

Triple-S Salud will provide written notice to the Commissioner of Insurance and the member no later than the next business day after completing the preliminary review:

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

If the request:

- Is not complete, Triple-S Salud will send a written notice informing the member and the Commissioner of Insurance what information or documentation is required to complete the request, or
- Is not eligible for external review, Triple-S Salud will send a written notice informing the member and the Commissioner of Insurance of the reasons for ineligibility.
- The Commissioner of Insurance may prescribe the form and content of the notice of initial determination.
- If, as a result of the preliminary review performed, Triple-S Salud determines that the request is not eligible for external review, the notice to such effect must advise the member that such determination of ineligibility made by Triple-S Salud may be appealed before the Commissioner of Insurance.

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

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

If Triple-S Salud determines that the request for external review is eligible for such purpose, it must inform the member and the Commissioner of Insurance.

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 of Insurance will be required to:

- 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 notice sent by the Commissioner of Insurance to the member informing them that their request for external review has been accepted must also include language stating that they may submit, within five (5) business days of receiving the notice of acceptance and in writing, any additional information they believe should be considered by the independent review organization in the course of the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after the term of five (5) business days provided herein.

The independent review organization must select, as appropriate, one or more clinical reviewers to conduct the external review, no later than the next business day after receiving the notice appointing it to conduct the external review.

In selecting clinical reviewers, the independent review organization will choose physicians or other health care professionals who meet the minimum requirements and who, due to their clinical experience over the past three (3) years, are experts in treating the member's condition, and who also have extensive knowledge of the recommended or requested health care service or treatment.

Neither the member nor Triple-S Salud will choose or control the way physicians or other health care providers are selected to serve as clinical reviewers.

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 bound by any of the decisions or conclusions arising from Triple-S Salud's utilization review or internal grievance processes.

No later than five (5) days after receiving the notice regarding the appointed independent review organization, Triple-S Salud will release all the documents and information considered in rendering the adverse determination or final adverse determination subject to review.

Any failure by Triple-S Salud to deliver the required documents and information within the five (5) days provided should not delay the external review.

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

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

Each clinical reviewer will examine 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 or to the member, it shall, in turn, forward such information to Triple-S Salud no later than the next business day after receiving it.

On receipt of 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 delay or terminate the external review.

The external review may only be terminated if, after due reconsideration, Triple-S Salud agrees to 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 decides to revoke its adverse determination or final adverse determination, it will immediately notify the member, the independent review organization, and the Commissioner of Insurance, in writing.

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

No later than twenty (20) days after being selected to conduct the external review, the clinical reviewer(s) will 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 indicators in the analysis to determine whether there is sufficient evidence to demonstrate that 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 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;
- A description and analysis of the medical or scientific evidence considered when rendering the opinion;
- A description and analysis of any evidence-based standard considered when rendering the opinion; and
- Information as to whether the rationale behind the reviewer's opinion
- In the case of expedited external reviews, each clinical reviewer will submit their opinion, verbally or in writing, to the independent review organization, with as much haste as the member's health

condition or circumstances require but no later than five (5) days after having been selected to conduct the external review.

- If the clinical reviewer's opinion was initially expressed verbally, the clinical reviewer will provide written confirmation to the independent review organization, including the required information, no later than two (2) days after having submitted their opinion.

Each clinical reviewer, to the extent deemed appropriate and as long as the information or documents are available, will consider the following in rendering their opinion:

- The member's relevant medical records;
- The recommendation of 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 treatment provider;
- The terms of coverage of the member's health plan;

Whichever alternative is applicable, if any, from the following:

- 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 that show 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 will make its determination and notify the following people in writing:

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

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

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

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 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 to uphold the adverse determination or final adverse determination under review.

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 secure the opinion of an additional clinical reviewer in order to make a determination based on a majority opinion.

Should the need arise to select an additional clinical reviewer as described in the paragraph above, the additional clinical reviewer, in rendering their opinion, will use the same information that was available to the other clinical reviewers.

The selection of an additional clinical reviewer will not extend the deadline for the independent review organization to make its determination based on the opinions of the selected clinical reviewers.
The independent review organization will include the following in its written notice of determination:

- A brief description of the reason for the request for external review;
- The written opinion of each of the clinical reviewers, including each reviewer's opinion as to whether or not the recommended or requested health care service or treatment should be covered and the rationale for said opinion;
- The date when the independent review organization was appointed by the Commissioner of Insurance to conduct the external review;
- The date the external review was performed;
- The date of its determination;
- The main reason(s) for its determination; and
- The supporting statement or rationale for its determination.

If the determination made by the independent review organization revokes the adverse determination or final adverse determination under review, Triple-S Salud will immediately approve coverage or payment for the health care service or treatment that was the subject of the review.

The Commissioner of Insurance will appoint the independent review organization to conduct an external review in accordance with this section by randomly selecting one of 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.

Section 4.10 Binding nature of the external review determination

The external review determination binds Triple-S Salud, except when Triple-S Salud has some other recourse under the applicable laws of Puerto Rico.

The external review determination binds the member, except when the member has some other recourse under applicable Puerto Rico or federal law.

The member may not submit further requests for external review in regard to an adverse determination or final adverse determination for which there was already an external review in accordance with this Chapter.

Section 4.11 Payment for the cost of the external review

If Triple-S Salud receives a request for ordinary or expedited external review, it will be required to pay the independent review organization for the external review.

The Office of the Commissioner of Insurance will notify Triple-S Salud of the costs incurred in the process or any modification thereof at least 120 days in advance.

The member will pay a nominal fee no greater than $25.00 per review, and the sum of such fees for any single member may not exceed seventy-five dollars ($75.00) per policy year. The amount paid by the member will be reimbursed if an opinion is determined in their favor.

The external review processes at the Office of the Commissioner of Insurance of Puerto Rico regarding final adverse determinations1 will be conducted through the independent review entity *Maximus Federal Services, Inc*. In accordance with Article 28.170, the health insurance company or insurer subject of the request for external review will be required to pay the cost of the requests for external review, based on a fee of $575 per request for ordinary review, or in the case of requests for expedited review, an applicable fee of $670 per request.

SECTION 5 Reimbursement Procedure

Section 5.01 Description of reimbursement procedure

1. Requests for reimbursement should be sent:

   a) Through our website, www.ssspr.com. Go to the Tools for You section at the bottom of the main page and click on the link to Member Forms. Here, you will find information on how to request a reimbursement online.

   b) By email. For **medical** services, please send 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) Your request 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 description of diagnosis
      - Procedure code (effective as of the date of service) and/or description of service
      - National Provider Identifier (NPI)
      - Official payment receipt including provider's name, address, specialty, and license number
      - Amount paid for each service
      - Signature of the provider or participant who rendered the services
      - Reason you are requesting a reimbursement
      - In the case of ambulance services, you should include information on the distance traveled, evidence of medical necessity, and the Incident Report for the ride
      - In the case of services requiring a precertification, a copy of such precertification

   If you request a reimbursement for medications, you must also include:

      - Official receipt from the pharmacy
      - 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 of the prescribing physician
      - If you paid a participating pharmacy, please specify the reason.
      - Include the charge for each medication.

   If you request a reimbursement for dental services, you must also include:

      - The service code, tooth number, and restored surfaces (if applicable)
      - Amount paid for each service
      - If the member pays for more than one visit on a bill, the exact dates of the services (**MONTH, DAY, YEAR**) they paid for should be submitted.
      - If your plan includes dental prosthesis and periodontics services, which are offered as an option for an additional premium, you must bring X-rays.

   If you request a reimbursement for Coordination of Benefits, you should also include:

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

2. You must provide written notice of the claim to Triple-S Salud within twenty (20) days after receiving the service or 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 provide acknowledgment of receipt after receiving the claim notice by mail. Notices delivered to a person appointed by the member are deemed to be notices given to the member, provided that the authorization is in effect and has not been revoked. If a person is not authorized and receives a notice on behalf of the member, they must report it within 7 days and provide the name and address of the intended recipient of the notice.
   If the claim notice is sent by email, the member will promptly receive a system confirmation of receipt. If the claim is submitted at a service center, a receipt is provided upon delivery of the document.
4. Triple-S Salud investigates, settles, and resolves any claim in the shortest reasonable period of time within 30 days after receiving the request. If Triple-S Salud cannot arrive at a resolution within the aforementioned period, it keeps 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 unduly or unreasonably delayed.
5. In compliance with Law 109 of December 22, 2022, Law to establish the Public Policy of the Government of Puerto Rico regarding the population with Albinism and Hermansky-Pudlak Syndrome, lenses and eyeglasses specially prescribed for protection, prevention and improvement of vision are covered through reimbursement.

SECTION 6 Procedure to Obtain Precertifications

In order for services to be considered covered, the member must obtain precertification for services that so require, as outlined in Chapter 4, Covered Benefits.

Upon receipt of the precertification request, Triple-S Salud will notify the member of its determination within no more than 15 days after receipt. This applies to prospective review determinations.

If the request is incomplete and does not meet the minimum evaluation criteria, Triple-S Salud will notify the member verbally or in writing —unless a request for written notices has been made— within no more than five (5) days after receipt and confirm the information the member should submit to complete the evaluation process. The member has up to 45 days after the date of notification to provide the information requested.

Prospective determinations are made within a term not exceeding fifteen (15) days from the date the request is received. Before the end of the initial period of fifteen (15) days after receipt of the request for precertification, Triple-S Salud provides notice to the member with a justification and the date a determination is expected to be made.

Physicians, doctors, facilities, and members have been apprised of which services need to be precertified. Precertifications for studies and procedures are processed by the attending physician, their appointed clinical personnel, or the facility where the patient is to be treated. They will need to call Triple-S Salud Precertifications, available Monday to Friday, 8:00 a.m. to 4:30 p.m. Providers can also verify the eligibility of studies and procedures using our website www.ssspr.com, available 24 hours a day, 7 days a week.

Members and participating physicians and providers receive guidance on hospital admissions requiring precertification or notice seventy-two (72) hours in advance or as soon as reasonably possible. **Services received in an emergency room as a result of a medical emergency do not require precertification.**

Precertifications for urgent cases

Urgent attention will be given to the request for precertification if the physician requests that it be addressed as a matter of urgency because, in their opinion, it could put the member's life, health, or ability to regain maximum function at serious risk, or because submitting the member to the regular deadlines for response to a request for precertification would expose them to suffering severe pain that cannot be handled properly without the treatment for which precertification is being requested. Requests for these cases may be made verbally or in writing. Triple-S Salud will notify its decision verbally or in writing, unless you request that it be done in writing, within twenty-four (24) hours from receipt of your request.

If more information is required, it will be notified verbally or in writing, unless the member requests that it be done in writing, within twenty-four (24) hours from receipt of the request. The member or their representative has at least forty-eight (48) hours from the notice to submit the additional information requested. After receiving the additional information, Triple-S Salud must answer the request within no more than forty-eight (48) hours after whichever occurs first between the date of receipt of the additional information or the established deadline to receive it. If the requested information is not received by the established deadline, Triple-S Salud may deny the certification of the service.

The notice of adverse determination will state the following, as applicable:

- 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 definition, as well as a description of the criteria used, if any, in making the determination;
- Reference to the plan's specific provisions on which the determination is based;
- Description of any 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 deadlines applicable to such procedures;
- If the adverse determination was made based on a rule, guideline, internal protocol, or other similar criteria, a copy will be provided at no cost to the member;
- If the adverse determination considered judgment of medical necessity, experimental or investigational 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.

For precertifications, or if you need additional information, please contact our Customer Service Department at (787) 774-6060.

You may submit the information requested of you by fax or mail

Fax: (787) 774-4824

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

You have the right to contact the Office of the Commissioner of Insurance or the Office or the Advocate of Health to request assistance at any time, as well as the right to file a lawsuit before a competent court after Triple-S Salud's internal grievance process is exhausted. 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.

CHAPTER 6: General Provisions

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

incurred in treating the member due to such acts of fault or negligence. Triple-S Salud will only claim the medical expenses paid in connection with the accident caused by the third party.

Subrogation is a legal process through which an insurer assumes the member's rights before a third party that has caused them damage. If the member suffers an accident caused by fault or negligence of a third party (for example, a school, a grocery store, or any other private or public establishment), they must fill out an Incident Report at the site of the accident. The member must provide a copy of this report to Triple-S Salud as soon as possible, including their name and contract number. This information may be sent by email to subrogation@ssspr.com or be delivered to your plan administrator, who will then forward these documents to Triple-S Salud.

This does not apply to automobile accident cases, which are handled by the Automobile Accident Compensation Administration (ACAA, by its Spanish acronym), or to cases of work-related accidents, where the insurer is the State Insurance Fund.

The member recognizes Triple-S Salud's right of subrogation and is responsible for notifying Triple-S of Salud of any actions initiated against said third party, providing that, were the member to act otherwise, they are responsible for repaying Triple-S Salud for said expenses.

2. **BILL OF RIGHTS AND RESPONSIBILITIES OF THE PATIENT:** Triple-S Salud requires its members, or—in the case of persons with disabilities or minors—their parents, guardians, custodians, or caretakers, to read and become familiar with the "Bill of Rights and Responsibilities of the Patient" or an adequate and reasonable summary thereof, as prepared or authorized by the Department of Health.

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

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

   Types of claims

   All types of claims are eligible for processing through Inter-Plan Arrangements, as described above, except for any dental care benefits, prescription drug benefits, or vision care benefits that could be processed by Triple-S Salud for the provision of services.

   a. **BlueCard® Program**

      Under the BlueCard® Program, when you receive covered services within a Host Blue service area, Triple-S Salud will continue being responsible for honoring our contractual agreements. However, the Host Blue is responsible for hiring and coordinating all 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 is determined as the lower value between:

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

   This "negotiated price" will often consist of a simple discount to determine a true rate that the Host Blue pays to its health care provider. Sometimes, it is an estimated price that factors in special arrangements with its supplier or specific group of suppliers, which may include settlements, incentive payments, and other credits or fees. Occasionally, it may be an average price, based on a discount that would yield

projected average savings for health care providers after taking into account the same kind of transactions that take place at an estimated price.

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

Host Blues decide if they will use a real price, an estimate, or an average. Host Blues using either estimated or average prices may prospectively increase or reduce such prices to correct previously understated or overstated prices (in other words, prospective adjustments may mean that the current price reflects additional amounts or credits for the claims that have been paid or are expected to be paid or received from providers). However, the BlueCard Program requires the sum paid by the member to be the final price. No future price adjustment will result in increases or reductions in the price determined for prior claims. Triple-S Salud takes into account the Host Blue's method of payment for claims when determining your premiums.

b. **Federal and state taxes / surcharges / fees**

In some cases, federal or state laws or regulations may levy a surcharge, tax, or any other applicable fee to member accounts. If applicable, Triple-S Salud will factor in any of these surcharges, taxes, or fees in determining the premium.

c. **Non-participating providers outside Triple-S Salud's service area**
When the covered services are rendered outside Triple-S Salud's service area by non-participating providers, the amount you pay for such services will usually be based on either the local rate payable to providers not participating with the Host Blue or the payment agreements required by the applicable state law. In these cases, you may be financially liable for the difference between the amount billed by the non-participating provider and the payment Triple-S Salud will make for the covered services, as established in this paragraph. Payments for out-of-network emergency services are governed by the applicable federal and state laws.

4. **CIVIL ACTIONS:** No civil action will 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 will be initiated after three (3) years have elapsed from the date written proof of service was required to be submitted.

5. **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 people or treat 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 can communicate effectively with us. We also offer free language services to people whose first language is not English.

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

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

   If the member receives services after receiving post-emergency or post-stabilization services that are covered under the health plan except for the fact that they were provided by a non-participating provider, Triple-S Salud will reimburse the member for that portion of the costs, as established in the policy.

   In order for Triple-S Salud to compensate or reimburse the member in these cases, the member should give a written notice of claim to Triple-S Salud within twenty (20) days after receiving the service or as

soon as reasonably possible, but no later than one (1) year from the date the service was rendered, unless evidence is submitted that it was impossible to submit the claim within the established time period.

7. **CONFIDENTIALITY:** Triple-S Salud protects the confidentiality of the member's health and claims information in accordance with the policies and practices set forth in the Notice of Privacy Practices contained in this policy.

8. **COVERAGE RENEWAL:** Triple-S Salud renews the individual health plan for the member or dependent, at the member's discretion and in accordance with the applicable federal laws and regulations, except in the following cases:

    a. A default on the payment of premiums or fees in accordance with the health plan terms, or if Triple-S Salud has not received the premium payment when due.

    b. The member or their representative has committed an act or engaged in a practice that constitutes fraud, or has intentionally made false representations as to material facts.

    c. Triple-S Salud has chosen to cease offering all the individual health plans it manages or issues in Puerto Rico and has notified its decision 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 the 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 is not in the best interests of the members or affects the insurer's ability to meet its contractual obligations.

    e. If the Commissioner of Insurance determines that the health plan's 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 not to 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 the 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 any other individual health plan currently offered by Triple-S Salud in Puerto Rico; and

        iv. In exercising the option to discontinue the obsolete product and offer the option of coverage under subsection (iii), Triple-S Salud is acting in a consistent manner, regardless of the member's claims experience or factors related to the health condition of the member or of dependents who may be eligible for coverage.

    If the plan is offered through a preferred network plan, and the member no longer resides, lives, or works in the established geographical service area, as long as the coverage is terminated in accordance with this subsection, regardless of the factors related to the member's health condition.

9. **COVERAGE RESCISSION:** Triple-S Salud reserves the right to rescind the coverage (invalidate retroactively to the original effective date) of any member in case of fraud or misrepresentation of a material fact. Triple-S Salud may rescind the coverage under this policy for the following reasons set forth in the Patient Protection and Affordable Care Act (PPACA) and article 2.050 of the Health Insurance Code of Puerto Rico:

    a. "A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to individuals or group of persons once the enrollee is covered under such plan, except in cases that involve fraud or an intentional misrepresentation of material fact by the enrollee or the person applying for health insurance on behalf of another person as prohibited by the terms of the plan or coverage. The health

insurance organization or issuer that wishes to rescind or cancel health plan coverage shall issue a notice, with at least thirty (30) days in advance, to every health plan subscriber, or primary subscriber in the case of individual health plans, who may be affected by the proposed rescission or cancellation of coverage."

b. In the event of a rescission of coverage, Triple-S Salud will send written notice at least thirty (30) days in advance to each health plan member who may be affected by the proposed coverage rescission.

10. **SUMMARY OF BENEFITS:** Triple-S Salud will give the policyholder a Summary of Benefits and Coverage (SBC), which outlines the copayment structure, the plan's limitations and exclusions, a list of participating physicians and providers, and the Drug Formulary.

11. **GRACE PERIOD:** A grace period of ten (10) calendar days is granted for each premium payment that expires after the first premium, during which the policy will remain in force.

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

    The member and their dependents agree and acknowledge that they have not acquired this policy based on representations from anyone other than Triple-S Salud, Inc. and that no person, entity, or organization other than Triple-S Salud, Inc. may be responsible for any obligations Triple-S Salud, Inc. has with the member arising from this policy.

    The foregoing does not create any additional obligations by Triple-S Salud, Inc. other than the obligations created by the provisions of this agreement.

13. **INDIVIDUAL CANCELLATION:** Triple-S Salud may cancel the insurance of any member at any time if the member commits fraudulent acts, misrepresents material facts, has submitted or made someone else submit a fraudulent claim or evidence to support such claim, to obtain payment for a claim pursuant to any Triple-S Salud policy, regardless of the date when such act was committed or the date and manner 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 by written notice, delivered or mailed to the most recent address according to Triple-S Salud's records, stating when the cancellation is effective, which cannot be less than thirty (30) days after the notice.

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

14. **LIABILITY WAIVER FOR MEMBERS:** Members are not financially liable for services where the participating provider failed to observe the eligibility procedures, health care policies, payment policies, or service protocols established by Triple-S Salud.

15. **MODEL FOR CLAIMS:** Upon receipt of a claim notice, Triple-S Salud provides the claimant with the models it regularly provides for the submission of proof of service. If these models are not provided within fifteen days after notice is given, it is 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—a written statement covering the incident and the nature and extent of the services for which the claim is being made.

16. **NOTICE OF CLAIM:** The member should issue a written notice of claim to Triple-S Salud within twenty (20) days after the service occurs or, after such term, as soon as reasonably possible for the member. A written notice provided by the member, on their own behalf, with sufficient information to identify them, to

Triple-S Salud, either at its main office in San Juan, Puerto Rico or at its Service Centers located around the island, or to any authorized Triple-S Salud representative is considered as notice given to Triple-S Salud.

17. **PERSONAL RIGHTS:** The rights and benefits of this policy are not transferable, and no member may assign, transfer, or convey any of the rights or benefits which they could claim under the policy in favor of third parties. Triple-S Salud reserves the right to recover all expenses incurred if the member, by express or implied consent, allows uninsured persons to use the plan ID card issued in their name by Triple-S Salud. Furthermore, the recovery of such expenses does not preclude Triple-S Salud from canceling the insurance contract upon learning of the illegal use of the card, nor will it prevent the initiation of a lawsuit to criminally prosecute the member or the person who illegally uses the card.

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

19. **PREMIUM PAYMENT:** The primary policyholder is liable for the payment of the policy premium, providing that such responsibility covers any premium due until the date of termination of the policy, in accordance with the clause on Termination. The primary policyholder remains liable in their personal capacity for the payment of the premiums, regardless of any arrangement made with a third party to handle or pay the premiums on their behalf.

    Triple-S Salud is entitled to collect the premium due or, if it so chooses, to recover the costs incurred in the payment of claims for services rendered to the member after the cancellation of the member's health plan, provided that the primary policyholder is responsible for the payment of any of the two amounts claimed by Triple-S Salud. Triple-S Salud may use the services of collection agencies to pursue payment of any debt owed to Triple-S Salud. Furthermore, the debtor is required to pay the costs, expenses, and attorney's fees, as well as any other additional amount or expense, unless the court determines otherwise.

    Triple-S Salud reserves the right to provide detailed notice to any credit agency, institution, or organization about the primary 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 service claim, written proof of such service must be provided to Triple-S Salud within ninety (90) days after receiving it. Failure to submit such proof within the required time will not nullify or reduce any claim if it was not reasonably possible to submit the proof within said time, as long as such proof is submitted as soon as reasonably possible but, except in the absence of legal capacity, no later than one (1) year from the date the proof is otherwise required. The primary policyholder consents and authorizes any professional or service provider to provide Triple-S Salud with reports, which are kept confidential, concerning the diagnosis and services supplied to the policyholder or to any insured dependent. These reports are used solely and exclusively to determine the rights and obligations contracted under the policy.

21. **RECOUPMENT OR RECOVERY OF PAYMENTS IN ERROR OR IN EXCESS:** 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 contacts the member as soon as it becomes aware that it has issued a payment in error or in excess. The member is required to notify Triple-S Salud when they realize they have received a payment in error or in excess.

22. **REINSTATEMENT:** If an overdue premium is not paid before the end of the grace period, the subsequent acceptance of a premium payment by Triple-S Salud or an authorized representative without requiring a reinstatement request will cause the policy to be reinstated. If Triple-S Salud or the authorized representative asks for a request, a conditional receipt will be provided for the premium payment. If the request is approved, this policy is reinstated as of the date of approval. In the absence of such approval, this policy will be reinstated on the forty-fifth (45) day after the date of the conditional receipt, unless written notice of denial has been provided.

The reinstated policy only covers claims arising from an injury sustained after the date of reinstatement, or from an illness commencing more than ten (10) days after the date of reinstatement. In all other respects, your rights and those of Triple-S Salud remain the same, subject to any provisions included or attached to the reinstated policy.

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

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

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

25. **MANDATORY COVERAGES:** This policy is subject to federal and local laws and regulations that may require, during its effective term, coverage for additional hospital or medical-surgical services that were included as covered services when the policy became effective. These mandatory coverages that come into effect at a later date after this policy is issued may have an impact on costs and premiums.

26. **SMOKER OR NON-SMOKER:** If Triple-S Salud becomes aware, through information on requested services, that a member has a tobacco dependency and is classified as a smoker, Triple-S Salud will notify them and change their premium retroactively to the effective date of the contract/policy year. If at the time of notice the member considers they should be classified as a non-smoker, they must submit an affidavit and a medical certificate stating that they have been a non-smoker for at least 6 months.

27. **IDENTIFICATION:** Triple-S Salud provides each member with a card that must be presented at any participating Triple-S Salud provider whose services are requested in order to have them covered by this policy. The member must also present a second photo identification.

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

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

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

    The transition period, given the circumstances described below, takes place as follows:

    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 is 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 date of termination of this policy and the provider has been offering medical treatment related to the pregnancy before the policy termination date, the transition period for such pregnancy-related services is extended until the

member's date of discharge from hospitalization for delivery or the newborn's date of discharge, whichever is later.

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 corresponding premium and may be denied or terminated if the member and/or the provider commit fraud against the insurance.

29. **TIME FOR CLAIM PAYMENTS:** Payments for services to be made pursuant to this policy are made immediately upon receipt of reliable written proof of such services.

30. **TOTAL PAYMENT FOR COVERED SERVICES IF THERE IS NO PROVIDER:** In cases where a member has medical need for a service that is covered by the plan but for which there is no contracted provider, and it is not stated in their coverage that the service is provided by reimbursement to the member, Triple-S Salud coordinates and establishes a special agreement with a non-participating provider for the delivery of such services to the member. This is subject to the terms and conditions of the member's policy and payment to the provider based on the fee established by Triple-S Salud for the services to be rendered.

CHAPTER 7: Notice on Privacy Practices and Discrimination

SECTION 1 Notice on 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.

Section 1.01 OUR LEGAL RESPONSIBILITY

Triple-S Salud, Inc. (hereinafter, Triple-S) is legally required to 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 protected health information (PHI). We will follow the privacy practices described in this notice while it remains in force.

This notice includes examples of the information we collect and describes the types of uses and disclosures we can make, as well as your rights.

This notice includes illustrative examples, which should not be considered a complete description of how we handle information.

Triple-S is required to abide by the terms in this Notice. However, we reserve the right to change our privacy practices and the terms contained herein. Before we make any significant changes to our privacy practices, we will amend this notice and send it to all our active enrollees as of the date of the change. This notice will be effective as of October 1, 2022.

Section 1.02 HOW WE PROTECT YOUR PHI

- Our employees are trained on our policies and procedures related to privacy and data protection.
- We use administrative, physical, and technological safeguards implemented to protect the integrity, confidentiality, privacy, and security of your protected health information.

- We have developed and implemented specific procedures and policies that restrict the use of your PHI by our employees to only those authorized to access this information, and only for purposes related to treatment, payment, or to perform certain health care transactions; and
- We have implemented proper procedures to monitor and ensure compliance with our Privacy and Security policies for protected health information.

SUMMARY OF PRIVACY PRACTICES

We are committed to limiting the information we collect to that which is strictly necessary to administer your insurance coverage or benefits. As part of our administration duties, we collect personal information from a variety of sources, including, but not limited to, the following:

- Information you provide in applications and other documents to obtain a product or service.
- Information originating from transactions performed with us or with 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 to request a service—that was created or received by a health care provider, health plan, intermediaries who process invoices for health care services, or business associates, and that is related to: (1) your past, present, or future physical or mental health or condition; (2) the provision of health care services to you; (3) past, present, or future payments for the provision of health care services. For the purpose of this Notice, this information will be referred to as PHI. This Notice has been created and amended in a manner that is consistent with the HIPAA Privacy Rule. Any term not defined in this Notice has the same meaning as the term as it appears in the HIPAA 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 for risk assessment or underwriting purposes.

Section 1.03 LAWS AND REGULATIONS

HIPAA: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 establishes rules for the use, storage, transmission, and disclosure of protected health information belonging to members in order to standardize communications and protect the privacy and security of the personal, financial, and health information.

HITECH: Abbreviation for the Health Information Technology for Economic and Clinical Health Act of 2009. This law promotes the adoption and meaningful use of health information technology. It also addresses the privacy and security issues associated with electronic transmissions of health information, partly through various provisions that bolster the civil and criminal enforcement of the HIPAA Rules.

Privacy and Security Rules: These are the privacy standards for an individual's identifiable information, as well as the security standards for safeguarding electronic protected information that are governed by 45 C.F.R. parts 160 and 164.

ORGANIZATIONS COVERED BY THIS NOTICE

Triple-S Salud, Inc.

Section 1.04 USE AND DISCLOSURE OF HEALTH INFORMATION

Triple-S will not disclose or use your information for any purpose other than as described 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 in effect. Triple-S will 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 claims 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.

We may use and disclose information without your authorization in the course of our duties as insurance or benefit administrators for activities related to your medical treatment, payment for medical services, and health care operations. For example:

Treatment: Disclosing information to a health care provider for treatment, provision, coordination, or oversight of your health care and related services. For example, the plan may disclose health information to your provider to coordinate treatment.

Payment: To pay for health care services provided to you; to determine your eligibility for services under your policy; to coordinate benefits; to collect premiums; 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 when you receive treatment.

Health care operations: For legal and auditing services, including fraud and abuse detection and compliance, as well as business planning and development, administrative and business management activities, patient safety activities, credentialing, disease management, and training for medical and 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 for as long as the insurer or provider maintains a relationship with you.

Affiliated Covered Entities: In our capacity as insurance or benefit administrator, we may use and disclose PHI with the following entity: Triple-S Salud, Inc.

Business Partners: Our use of PHI for the treatment, payment, or health care operations described above (or for other uses or disclosures described in this Notice) may involve disclosures of your PHI to certain other persons or entities we have contracted with to perform or provide certain services on our behalf (Business Partners). We may also allow our Business Partners to create, receive, maintain, or transmit your PHI on our behalf for the Business Partner to provide services to us, or for the Business Partner's proper management or administration, or to meet the Business Partner's legal responsibilities. These Business Partners include attorneys, accountants, consultants, claims processing companies, and other third parties. Our Business Partners may redisclose your PHI to contractors so that these contractors may provide services to the Business Partners. These contractors will be subject to the same restrictions and conditions that apply to our Business Partners. When such an arrangement with a Business Partner involves the use or disclosure of your PHI, we will execute a written contract with our Business Partner containing terms designed to protect the privacy of your PHI.

Your employer or organization sponsoring your group health insurance: We may disclose your health information to your employer or the organization sponsoring your group health plan in order to assist in its administration, such as enrollments and withdrawals from the health plan. We may also disclose summary health information. This includes claim history, claim or coverage expenses, or types of claims reported by plan participants.

For investigational 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 ensure the privacy of your information and has approved the research 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 Privacy Rule. Your authorization or the opportunity to approve or object will not be required for these purposes. The information will be disclosed in compliance with the safeguards established and required by Law.

Legal proceedings: We may use or disclose your PHI in the course of any judicial or administrative proceeding, in compliance with any order (to the extent such disclosure is expressly authorized), or in response to a subpoena, a request for discovery, or any other process authorized by Law.

Forensic pathologists, funeral directors, and organ donation cases: We may use or disclose your PHI to a Forensic Pathologist for the purpose of identifying a deceased person, determine cause of death, or perform other duties authorized by Law. We may also disclose information to funeral directors so they may perform 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 workers’ compensation laws and other similar programs established by law that provide benefits for work-related injuries or illnesses without regard to fault.

Disaster and emergency relief, government benefit programs: We may disclose your PHI to a public or private entity authorized by Law or its statutes that is involved in a disaster relief effort. 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 regulatory compliance, investigations, inspections, or licensing. 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 reporting disease statistics and vital information, specialized government functions, and others
- Regulatory agency monitoring and fraud prevention
- Reporting domestic violence or abuse or neglect of children or adults
- Activities of regulatory agencies
- Responding to judicial or administrative orders
- To law enforcement or national security officers
- To prevent an imminent threat to public health or safety
- For purposes of storage or transplantation of organs, eyes, or tissue
- For statistical research purposes
- For purposes relating 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. Also, to authorized officials performing

activities for national security, intelligence, counterintelligence, counterespionage, or other activities for the protection of the president and other authorities or heads of state.

Services related to your health: We may use your health information to tell you about benefits and services related to your health, or treatment alternatives that may be of interest to you. We will use your information to call you or write to you to remind you of your medical appointments or the preventive tests you need based on 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 marketing products unrelated to health or selling health information. In these cases, your insurance policies and benefits will not be affected if you deny authorization.

The authorization must be signed and dated by you, identify the person or entity authorized to receive the information, provide a brief description of the information to be disclosed, and include the expiration date of the authorization, which shall not exceed two years from the date the authorization is 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 twenty-four (24) months or until the request is denied, whichever occurs first
- To support or assist in the communication of ongoing treatment for a chronic condition or illness or rehabilitation from an injury.

Information disclosed pursuant to the authorization provided by you may be disclosed by the authorized recipient 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 in effect. We will keep a 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 family members or friends who are involved in your medical care or responsible for the payment of the medical services.

Before we disclose your health information to anyone involved in your health care or in the payment of your health care, we will provide you with an opportunity to object to such disclosure. If you are absent, incapacitated, or in an emergency situation, we will use our professional judgment in disclosing information in a way that we believe will be in your best interest.

Section 1.05 YOU HAVE THE FOLLOWING RIGHTS OVER YOUR PHI

Access: You have the right to examine and obtain an electronic or hard copy of your personal, financial, insurance, or health information related to enrollment or claims, within the limits and exceptions provided by law. To this end, you must provide us with your request in writing. 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 business 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, in part or in whole, because the information comes from a confidential source or was gathered in preparation for litigation or investigation by law enforcement officers, anti-fraud units, or quality assurance programs, or because its disclosure is prohibited by law. We will notify you in writing of 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 for matters not related to medical treatments, health service payments, health care operations, or as authorized by you. The report will 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 its disclosure. If you request this report more than once within twelve (12) months, we may charge you for the cost of processing the additional request(s). The report only covers the last six (6) years.

Restrictions: You have the right to request that we implement additional restrictions in how we handle your health information.

We do not have to agree with your request, but if we do agree, we will abide by it (except in case of an emergency). Your request and our agreement to implement additional restrictions in how we handle your health information must be put in writing.

Confidential communication: You have the right to request that our communications to you regarding your health information be sent to alternative addresses. You must submit a written request specifying the mailing address where you want Triple-S to send its communications to you.

Note: If you choose to have confidential communications sent to a new address, we will only respond to requests from you. If you receive services from health care providers, you are responsible for directly informing those providers of your new mailing address.

Amendment: You have the right to request amendments to your health information. Your request must be made in writing and contain an explanation or evidence to justify the amendment. We will respond to your request within sixty (60) days. If we need additional time, we will provide written notice before the original term expires.

We may deny your request if we did not originate the information you wish to amend and the party who originated it is available to receive your request, or for other reasons. If we deny your request, we will provide you with a written explanation. You may request to include a statement from you stating 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 the amendment in any future disclosures of such information.

Notice in case of a breach of Privacy and Security where your information is at risk: Triple-S is legally required to promptly notify you if an incident occurs that compromises the privacy, security, and confidentiality of your protected health information.

Notice by electronic means: If you received this notice through our website, www.salud.grupotriples.com, or by email, you are entitled to receive a hard copy of it.

QUESTIONS AND COMPLAINTS
If you have questions, concerns, or want to learn more about our privacy practices, please contact us. All forms to exercise your rights are available at www.salud.grupotriples.com.

If you believe that we or one of our business partners have violated your privacy rights, or if you disagree with a decision we made about access to your health information, you have the right to file a complaint at the address below:

Contact office: Compliance Department
Attention: Privacy Officer
Phone: (787) 620-1919
Fax: (787) 993-3260
Email: 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 take no retaliatory action if you choose to file a complaint with us or with OCR.

Si desea recibir una versión en español de este aviso, comuníquese con nosotros en la dirección arriba indicada o visite el sitio web de Triple-S Salud: www.salud.grupotriples.com.

Date of Review of Notice on Privacy Practices: August 2022
Triple-S Salud is an independent licensee of BlueCross BlueShield Association.

SECTION 2 NOTICE: TO INFORM INDIVIDUALS ABOUT NON-DISCRIMINATION AND ACCESS REQUIREMENTS, AND STATEMENT OF NON-DISCRIMINATION: DISCRIMINATION IS AGAINST THE LAW

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

- Provides free assistance and services to persons with disabilities so they can communicate effectively with us, such as:
    - Certified sign language interpreters
    - Information provided in other formats (large font, audio, and accessible electronic formats, among others).
- We offer free language services to people whose first language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, please contact a Customer Representative. If you consider that Triple-S Salud, Inc. has failed to provide you with these services or has discriminated in any other way on the basis of race, national origin, color, age, sex, or disability, please contact:

Service Representative
PO Box 363628, San Juan, PR 00936-3628
Phone: (787) 774-6060 or 1-800-981-3241
TTY: (787) 792-1370 or 1-866-215-1999
Fax: (787) 706-2833
Email: TSACompliance@sssadvantage.com

You may also submit your grievance by mail, fax, email, or in person. If you need help to submit your complaint, one of our Customer Representatives is available to help.

You may submit your civil rights complaint before the Office for Civil Rights of the U.S. Department of Health and Human Services through their website: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail, or by phone, to:

200 Independence Ave, SW Room 509F, HHH Bldg Washington, D.C. 20201
Phone: 1-800-368-1019, TDD: 1-800-537-7697

787.774.6060
787.792.1370
TTY (hearing impaired)

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.

www.ssspr.com