

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

An Independent Licensee of the Blue Cross and Blue Shield Association

MESSAGE FROM THE PRESIDENT

WELCOME TO TRIPLE-S SALUD, INC.

For 50 years we have provided the highest quality services and taken care of your health and the health of thousands of Puerto Ricans. Our priority has always been to serve you in every stage of your life. That is why we are constantly striving to develop initiatives to help us comply with this commitment.

Triple-S Salud, Inc. provides a wide range of comprehensive care services that ensure your TOTAL WELLNESS and help improve your quality of life. It also provides more and better services in our information room and by telephone with extended business hours and direct access through our service centers located throughout the island and 24-hour service every day through Teleconsulta, Telexpreso and our website at www.ssspr.com

This document informs you on the benefits and programs Triple-S Salud offers you and your family as insureds. These programs provide you with the tools you need to take charge of your health and make better decisions to maintain a good health condition.

We encourage you to read the document and keep it for future reference.

We wish that you continue to be a part of our family of insureds and let us take care of your most precious possession, your health.

THAT'S MY PLAN!



Pablo Almodóvar Scalley
President and CEO

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PHARMACY BENEFIT

DEFINITIONS

1. **BRAND-NAME DRUGS:** Medications that are offered to the public under a commercial name or manufacturing brand.
2. **COINSURANCE:** Percentage of the fee cost to be paid by the insured to the pharmacy at the moment services are received, which is the insured's contribution to the cost of the services received, as established in the contract and notified to the participating pharmacy. Triple-S Salud will not reimburse this amount.
3. **COPAY:** The predetermined fixed amount the insured pays to the pharmacy when receiving covered services, as his/her contribution to the cost of the services received, as established in the contract and notified to the participating pharmacy. Triple-S Salud will not reimburse this amount.
4. **DRUG:** (a) Any substance that bears on its label the following legend as required by federal law: "CAUTION: Federal law prohibits dispensing without prescription," and (b) Insulin.
5. **GENERIC DRUGS:** Chemical name or non-commercial name of those drugs that have the same active ingredients and are identical in their potency, doses, way of administration as their brand-name counterparts and are considered pharmaceutically equivalent to brand drug.
6. **MAIL ORDER PROGRAM:** Is a voluntary program that allows the insured to receive some maintenance drugs via the United States Postal Service.
7. **MAINTENANCE DRUGS:** These are drugs that require a prolonged therapy and have a low probability of changes in dose or therapy due to side effects. Other medications considered maintenance drugs are those whose most common use is to treat a chronic condition when a conclusion of therapy cannot be determined.
8. **NEW DRUGS:** Are those drugs that recently came out to market. These drugs are generally evaluated by the Pharmacy and Therapeutics Committee within 6 to 12 months after they have been available in market.
9. **NINETY (90) DAY DRUG SUPPLY PROGRAM THROUGH PHARMACIES:** Is a voluntary program that allows the insured to receive 90-day supplies for some maintenance drugs, through local pharmacies participating in this program.
10. **NON-PARTICIPATING PHARMACY:** Any pharmacy that has not subscribed a contract with Triple-S Salud to provide services to the plan members.
11. **OVER-THE-COUNTER DRUGS (OTC):** Are medications without a federal legend that can be sold to a customer without a physician's prescription. Triple-S Salud added some over-the-counter (OTC) drugs in most of its pharmacy coverages; with no

copayment. The Food and Drug Administration (FDA) approved these drugs in the same doses (mg by mg) previously identified by the FDA as drugs with a legend. This means that these drugs have proved to be safe and effective. Taking into account potential risks (subclinical therapy and inappropriate therapy), Triple-S Salud requires a prescription in order to dispense these drugs.

12. **PARTICIPATING PHARMACY:** Any pharmacy that has subscribed a contract with Triple-S Salud to provide services to its plan members.
13. **PHARMACY:** Any establishment legally authorized to supply drugs.
14. **PHARMACY AND THERAPEUTICS COMMITTEE:** It is a working committee composed of health professionals dedicated to evaluating the effectiveness of drugs and submitting utilization protocols and recommendations that result in a cost-effective management of therapies, as well as in the prevention of inappropriate use, according to medical practice standards, unnecessary medications, and fraud or abuse in their use. After the committee's evaluation, it determines the inclusion of prescription drugs in the pharmacy coverage. The Committee holds monthly meetings to share findings in utilization reports and new drugs that have been introduced in the market.
15. **PREAUTHORIZATION:** Medications that require preauthorization are usually those that must meet clinical criteria, for they have a potential for toxicity, are candidates for inappropriate use or are related to elevate costs.
16. **PRESCRIPTION:** Written request for medicines issued by a physician, dentist or podiatrist legally authorized to effect said request in the ordinary course of his/her practice.
17. **PRESCRIPTION DRUG WITH REFILL:** Prescription that has written instructions from the physician authorizing the pharmacy to dispense a prescription drug more than once.
18. **SPECIALTY PRODUCTS:** These are medications for the treatment of chronic and high-risk conditions. They require special administration and/or management, given their complex composition. These drugs are offered through the Medication Program for Special Conditions, which has a network of specialized pharmacies to ensure that these drugs are dispensed and administered correctly.
19. **STEP THERAPY PROGRAM:** In some cases, we require that the insured first try a specific drug as therapy for his/her condition before we cover another drug for that condition. This program requires the use of over-the-counter (OTC) or generic drugs before using other drugs for certain medical conditions. This results in accessibility to drugs with proven effectiveness and safety, lower copays or even zero copays for first-step drugs, as well as better compliance with the drug therapy.

Categories requiring an "OTC first" include proton pump inhibitors (PPI), non-sedating antihistamines, and ocular allergy agents. Categories requiring a "generic first" include cholesterol/statins, /oral bisphosphonates for osteoporosis and nasal corticosteroids for allergies. These drugs are also part of the Triple-S Salud Drug List.

This program will apply to insureds using the drug for the first time or if a period of six (6) months has passed since the last use of any of the drugs. The program's purpose is to determine when second-step drugs will be covered and not to interfere with the treatment recommendations of the patient's physician. The insured is free to discuss with his/her physician all the treatment alternatives available for his/her health condition, and to make informed decisions regarding his/her treatment.

For first-step drugs, the prescription will be processed and approved. In the case of second-step drugs, if the insured has used first-step drugs in the past six (6) months, these will be processed and approved. If he/she has not used first-step drugs, the pharmacy will notify the insured that first-step drugs he should use. After evaluating the insured's case, the physician must write a prescription with a first-step drug or request a preauthorization from Triple-S Salud for a second-step drug, including a medical justification for its approval.

If an insured with previous coverage under another Health Plan enrolls in Triple-S Salud and the insured used a second-step drug under said plan, the insured must provide evidence that he/she has been using the second-step drug. The pharmacy or insured must send Triple-S Salud, as soon as possible, a copy of one of the following documents: claims history or report of prior Health Plan utilization (explanation of benefits; EOB).

20. **THERAPEUTIC CLASSIFICATION:** Are categories used to classify and group medications on the Drug List by the conditions that they treat or for the effect they have in the human body.

BENEFITS

This coverage is issued in consideration of your employer payment in advance of the corresponding premiums and will be subject to the terms and conditions of the basic coverage that do not conflict with the benefits and conditions of this coverage.

This benefit is ruled by the Federal Food and Drug Administration (FDA) guidelines. These include dose, drug equivalence, and therapeutic classification, among others.

Dispensing of drugs is subject to the copays or coinsurances established in the Copays and Coinsurances Summary.

Generic drugs will be dispensed as the first option under this coverage, when a generic drug is available. In addition, it is not subject to a prescription drug list.

Generic or brand-name drugs, with the legend "Caution: Federal Law prohibits dispensing without prescription", and human insulin are covered. In addition, some over-the-counter (OTC) drugs are covered, as established in the Limitations section. Some maintenance drugs could be supplied through mail order or local participating pharmacies in the 90-day supply program.

Insureds under an individual plan, complementary coverage to Medicare Program (also known as Medigap) or a Medicare Advantage Plan will not be eligible to the benefits offered under this pharmacy coverage.

The benefits will be covered as follows:

1. Services Rendered by Participating Pharmacies:

If the drugs are supplied by a participating pharmacy, when showing the prescription and Triple-S Salud ID card, it shall not charge or collect from the insured any amount in excess of the copay or coinsurance established in the Copays and Coinsurances Summary at the end of this document.

2. Services Rendered by Non-Participating Pharmacies in the United States of America:

If the drugs are supplied by a non-participating pharmacy in the United States of America, the insured shall have the right to receive a reimbursement of the expenses incurred, as established in the Limitations section of this coverage, less any applicable copay or coinsurance, as established in the Copays and Coinsurances Summary. These services are covered only when provided in pharmacies located in the United States of America or its possessions, except in Puerto Rico, as established in the Exclusions section.

GENERAL PROVISIONS

1. It will be required to present the insured ID card to the Triple-S Salud participating pharmacy at the moment services are received, in order to obtain benefits under this coverage. When drugs are dispensed, the insured shall sign for the services rendered and present a second photo ID.
2. If your physician prescribed you a drug that is not covered under your pharmacy benefit, he can prescribe another drug covered by the Plan. This will apply when the therapeutic classification is covered and there are other treatment alternatives.
3. The continuous utilization of drugs to treat chronic conditions will not be interpreted as drug abuse, according to medical practice standards. Triple-S Salud reserves the right to cancel the contract or recover expenses paid to any insured when it identifies that the use of a drug is intended to maintain a condition considered an addiction or when the use of that same drug constitutes abuse of the medication, according to the accepted standards in medical practice, even when this drug has been prescribed by a physician, dentist, or podiatrist and agrees with the other terms of the coverage.
4. A pharmacy is not obliged to fill a prescription, if, for any reason, according to their professional judgment; such prescription should not be filled. This does not apply to the pharmacy decisions related to Triple-S Salud rates.

TYPE OF COVERAGE

This pharmacy coverage has the following main characteristics:

1. Dispensing of generic drugs as the first option.

SUPPLY

1. The amount of drugs supplied, as originally prescribed, shall be limited to supply for fifteen (15) consecutive days for those that are not maintenance drugs.
2. Supply for thirty (30) consecutive days for maintenance drugs and for tranquilizer drugs included in the benzodiazepines family. Refer to the Limitations section.
3. Ninety (90) day supply for some maintenance drugs supplied through Mail Order or local 90-Day Program participating pharmacies.
4. The amount of drug supplied, as originally prescribed, shall be limited to one (1) supply and up to five (5) refills for drugs with a thirty (30) day supply. The prescriptions must include a written notice from the physician authorizing the refills.
5. A drug with refills specifications shall not be repeated before 75% of the supply has passed from the day of the last dispensing, or after six (6) months from the date of the original prescription, unless otherwise established by the legislation regulating controlled substance dispensing.
6. Prescriptions issued by physicians with no instructions for use or amount of drug stated shall only be dispensed for a forty-eight (48) hour supply, for example, a physician writing the following instructions: "Use when necessary (PRN, Latin acronym)".

LIMITATIONS

1. Generic drugs will be dispensed as the first option, except when there is no generic available in market.
2. Drugs dispensed through Mail Order or local 90-Day Drug Supply Program participating pharmacies are limited to certain maintenance drugs. This does not apply to specialty products.
3. The insured receiving services rendered by non-participating pharmacies in the United States of America and its territories, except in Puerto Rico, shall have the right to receive reimbursement for drugs covered in an amount not exceeding seventy five per cent (75%) of the fee, as established in the Exclusions section, less any copay or coinsurance established in the Copays and Coinsurances Summary.

4. Drugs with a thirty (30) day supply are limited to: products for diabetes, including insulin, thyroid drugs and its derivatives, nitroglycerin, diuretics, digital preparations, hypotensors, blockers, anticoagulants, anticonvulsives, antiarthritics, hemorrheologics, sex hormones, vasodilators, oral medications for cancer, ulcers, and drugs for asthma, cholesterol, glaucoma, and Parkinson, among others. Medications for ulcers are limited to *Tagamet*[®], *Zantac*[®], *Pepcid*[®], *Axid*[®], and *Carafate*[®].
5. Tranquilizers included in the benzodiazepine family (e.g., *Valium*[®], *Xanax*[®], *Ativan*[®], *Tranxene*[®], and *Halcion*[®]) will only be covered when a psychiatrist prescribes them.
6. Psychotherapeutic drugs prescribed by psychiatrists or neurologists will be covered for a thirty (30)-day supply with refills. If prescribed by other physicians they will only be covered for fifteen (15) days with no refills.
7. Covered Over-the-Counter (OTC) drugs include: *Prilosec OTC*[®], *Claritin*[®] OTC, *Zyrtec*[®] OTC, *Zaditor*[®] OTC, and their generics; and any other OTC drug Triple-S Salud would like to include. In addition, some aspirin doses are covered for insureds over 18 years of age and prescription contraceptives with FDA approval. In order to receive the OTC through your pharmacy coverage, it is required to submit a physician's prescription for the selected OTC drug at the pharmacy. The other OTC medications remain excluded.
8. In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition (Step-Therapy). For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.

EXCLUSIONS

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

1. Drugs that do not have the legend: "Caution: Federal law prohibits dispensing without prescription" (Over-the-Counter [OTC]), except those specified in the Limitations section.
2. Charges for artificial instruments, syringes and hypodermic needles or similar instruments, whether or not used for therapeutic purposes.
3. The following drugs are not covered whether or not they bear the federal legend: "*Caution: Federal law prohibits dispensing without prescription*":
 - a. Cosmetic products or cosmetic drug mixtures for the same purpose.
 - b. Fluoride products for dental use (except for children between 6 months and 6 years of age) and dermatological conditions such as pediculosis or scabies; dandruff control products including shampoos, lotions and soaps; baldness control treatments (alopecia); painkillers (*Nubain*[®] and *Stadol*[®]); and *Rogaine*[®], *Retin-A*[®] and *Accutane*[®] products.

- c. Products to control and other obesity drugs used for this treatment.
 - d. Infertility, fertility, and impotence treatment or implants (i.e.: Norplant[®], Zoladex[®], etc.).
 - e. Drugs used in diagnostic tests and immunization drugs.
 - f. Products such as vitamins and oral nutritional supplements, except some folic acid dosages for women and some dosage forms of iron supplements for children between 6 months and 12 months old.
 - g. Smoking cessation products.
 - h. Growth hormones.
 - i. Drugs for organ and tissue transplants.
 - j. Drugs classified as alternative medicine treatment.
4. Products that are considered experimental or investigative for the treatment of certain conditions for which the Food and Drug Administration has not authorized its use. In addition, this contract does not cover medical or pharmacy expenses related to clinical trials or the tests and administered drugs as part of them, or the medical and pharmacy expenses that are to be paid by the entities conducting the clinical trials. This clause applies even when the insured has enrolled in a clinical trial to treat a life-threatening condition for which there is not effective treatment and has the approval of physician to approved to participate in said clinical trial because it offers the patient a potential benefit.
 5. Any expense for drugs that are part of the exclusions will not be covered under any circumstances.
 6. Services rendered by non-participating pharmacies in Puerto Rico.
 7. Refills ordered by a dentist or podiatrist.
 8. Expenses for injectable antineoplastic agents.
 9. Contraceptives not approved by the FDA. The plan will neither cover contraceptives approved by the FDA without a prescription from the physician.

PRECERTIFICATIONS

Certain drugs need a precertification to be dispensed to the insured. Drugs that require a precertification are usually those which may have adverse effects, may be misused, or have high costs. Besides, to verify the insured's eligibility for the service he/she is requesting.

The physician and pharmacies receive orientation on those services that must be preauthorized.

If you know a drug needs precertification, if you need a prescription drug and are not sure whether or not you should request a precertification or, if you need additional information, contact our Customer Service Department at (787) 774-6060.

PRECERTIFICATION PROCEDURE

1. Triple-S Salud has 15 days from the receipt of the precertification request for the following
 - a. Notify their determination; or
 - b. Request you additional information. You will have up to 45 days to provide the requested information.
 - c. Inform you that they need more time to make a decision. This extension may be of a maximum of 15 additional days.

PRECERTIFICATIONS IN URGENT CASES

You may need Triple-S Salud to consider your precertification request urgently, while not for emergency use. This may be due to a health condition which, according to the opinion of the attending physician, may jeopardize your life, health, or ability to regain maximum functions or because waiting for non-urgent precertification process would subject you to pain, that cannot be adequately managed without the care or treatment for which precertification is requested. In said cases, the attending physician must certify the urgency of the precertification. The request for these precertifications must be oral or in writing. Triple-S Salud must notify you their decision within 72 hours of the receipt of your request. If Triple-S Salud needs additional information, they must notify you within 24 hours of the receipt of your request. You or your representative will have up to 48 hours to submit the information requested from the date you received the notification. Once Triple-S Salud receives the additional information, they must give you an answer within a 48-hour period. If Triple-S Salud does not receive the additional information within the term required, they may make their determination with the information available at the moment. As with any other precertification request, Triple-S Salud will make their expedite determination on your urgent request based on the terms of this rider.

EXPEDITE (FAST) APPEALS OF PRECERTIFICATIONS DENIED IN URGENT CASES

If you do not agree with the initial determination on your urgent precertification request, you can request an expedite review. You or your appointed representative must present the arguments to support why you think your precertification must be granted under the terms of your contract and provide the additional documentary evidence Triple-S Salud may request or evidence on

which you base your argument. Triple-S Salud must notify their decision on your appeal within 72 hours from the receipt of your request.

APPEALS TO ADVERSE BENEFITS DETERMINATIONS

If you disagree with Triple-S Salud determination on a reimbursement request, a precertification request or any other denial of benefits, you may appeal Triple-S Salud's determination following the procedure outlined below:

You must request in writing a review of the determination within 180 days of the adverse determination notice. For your appeal to be considered, it must include the following:

- Name and contract number of the insured that received the services that are being appealed
- Date of service
- Number of services and description of the services received
- Original receipt for any amount paid by the appellant
- Invoices from the pharmacy
- Pharmacy's name and address
- Evidence of the precertification granted and/or the medical need certification, if any of these was required to receive the service
- A written statement explaining why you believe Triple-S Salud' decision on your reimbursement, precertification or benefit claim was incorrect.

You must also submit any additional written comments, documents, records, or information relating to your appeal. You must send your appeal request to: Triple-S Salud, Customer Service Division, PO BOX 363628, San Juan, PR 00936-3628.

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

If you do not agree with Triple-S Salud's decision on your first appeal, you have the right to request a second review within 60 days from the date Triple-S Salud notified their decision on your first appeal. With this second request for review, you must include a copy of all the documents relating to your first appeal and statement explaining why you believe Triple-S Salud's decision on your first appeal was incorrect. You may include additional evidence to support your allegation. Your second appeal will be evaluated by persons that did not intervene in the decision of the first appeal and are not subordinates of the persons who made the decision on your first appeal. Triple-S Salud' previous decision will not be considered. You

have the right to request Triple-S Salud to disclose the names and position of the officers that evaluated your second appeal, as well as an explanation of the criteria on which they based their decision.

In case of appeals to precertifications, Triple-S Salud must inform their decision on your second appeal within 15 days from the date they received your request for appeal. In other instances, Triple-S Salud must give their answer within 30 days from the date they received your request for appeal. If you are not satisfied with this second decision, you have the right to file suit in court under Section 502(a) of the Employee Retirement Income Security Act (ERISA). It is required that you make use of all the administrative procedures herein described before go to court with your claim. In the alternative, you could bring your case before the Office of the Insurance Commissioner for them to initiate an investigation of the case.

RIGHT TO APPOINT A REPRESENTATIVE

You have the right to appoint a representative to act on your behalf (e.g., requesting reimbursements, precertifications, etc.). The designation of a representative must meet all the following criteria:

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

The insured or beneficiary is responsible for notifying Triple-S Salud, in writing, if the designation is revoked before the expiration date.

SUMMARY OF COPAYS AND COINSURANCES

The insured will pay the following copays and/or coinsurances to the participating pharmacies.

<u>BENEFIT</u>	<u>COPAY</u>	<u>COINSURANCE</u>
▪ Level 1: Generic drugs	\$ 5.00	-----
▪ Level 2: Brand-name drugs	\$20.00	-----
▪ Level 3: New drugs	\$100.00 or	30%, whichever is lower
▪ Specialty products (generic or brand)	\$100.00 or	30%, whichever is lower

Over-the Counter medications (OTC), medications
Required by Federal Law, including Contraceptives
Approved by the FDA with the prescription of a physician \$0

Drugs supplied for **90 days**, through Mail Order or local 90-Day Program participating pharmacies:

▪ Level 1: Generic drugs	\$10.00	-----
▪ Level 2: Brand-name drugs	\$40.00	-----
▪ Level 3: New Drugs	\$300 or 30%,	whichever is lower
▪ Specialty products (generic or brand)	Not applicable	

Over-the Counter medications (OTC), medications
required by Federal Law, including Contraceptives
approved by the FDA with the prescription of a physician \$0

Generic drugs will be dispensed as the first option, except when there is no generic available in the market. If the insured chooses, or the physician prescribes, a brand-name for which a generic version exists in the market, the insured will pay the difference between the cost of the brand-name drug and the generic, in addition to the copay for the generic drug.

The Chairman of the Board of Directors and the President signs this rider in behalf of Triple-S Salud, Inc.



Ramón Ruíz Comas
President, Board of Directors



Pablo Almodóvar Scalley
President and CEO

This coverage becomes part of the policy to which it is attached. It is issued in consideration to the payment of the premiums, in advance, by the employer, and is subject to the terms and conditions of the policy that do not conflict with the benefits and conditions of this coverage.