MCS Global

P.O. Box 9023547
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Group Insurance between MCS Life Insurance Company and

WILLIAMS-SONOMA CORP.

Please read carefully.

This document is not a Medicare supplement policy or contract. If the employer has employees Medicare eligible, review the "Guide to Health Insurance for People with Medicare". MCS Life Insurance Company will be hereinafter referred to as "MCS Life".

DATA DISCLOSURE

IMPORTANT NOTICE FOR PEOPLE WITH MEDICARE

THIS INSURANCE DUPLICATES SOME *MEDICARE* BENEFITS

Instructions for the Use of Disclosure of Data in Health Insurance Policies Sold to Beneficiaries of *Medicare*:

- Federal law, P.L. 103-432 prohibits the sale of insurance policies (the term policy or policies includes certificates) that duplicate the benefits of *Medicare* unless it will also pay benefits without regard to other health care coverage and includes the prescribed disclosure of data in or together with the application.
- All types of health insurance policies that duplicate Medicare and includes in the application or together with the application an information disclosure will not be able change the attached statements with respect to language or format (font, size, proportional font spacing, bold character, line spacing and use of boxes throughout the text).
- State and federal law prohibit insurers from selling a Medicare supplement policy to a person that already has Medicare supplement except as a replacement.
- Property/Casualty and Life insurance policies are not considered health insurance.
- Disability policies (income) are not considered to provide benefits that duplicate *Medicare*.
- Federal laws do not preempt state laws that are more stringent than the federal requirements.
- Federal laws do not preempt existing state requirements for government form filing.

This is not Medicare Supplement insurance.

This insurance provides limited benefits if the insured meets the conditions detailed in the policy. It does not cover Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Benefits detailed in the policy and *Medicare* provides coverage for the same event.

***Medicare* generally pays for most or all of these expenses.**

***Medicare* pays extended benefits for medically necessary services regardless of the reasons for which the insured may need them. These include:**

- Hospitalization
- Medical services
- Hospice care
- Other approved items and services

Before you buy this insurance

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*. For a copy, you may contact Medicare Service Center at *Medicare* al 1-800-633-4227.

For help in understanding your health insurance, contact the Office of the Insurance Commissioner of Puerto Rico or an government insurance information program for the elderly.

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PART I: DEFINITIONS

Below are the definitions corresponding to the terms used in this policy. According to its use in this policy, the meaning of each term is limited to the accompanying definition.

Accelerated Review	When the covered or insured person suffers a health condition for which the time required for a first level review of the complaint could put his or her life, health or full recovery at risk. The decision of the accelerated review will be taken and the covered or insured person will be notified, or, if possible, his or her personal representative, with the promptness that the medical condition of the covered or insured person requires, but in no case more than forty-eight (48) hours from having received the accelerated review request.
Access	Availability of all health services included in the plan, in such a way that the medical necessities of the insureds can be met, in accordance with the policies and procedures established by MCS Life.
Accident	Situation arising from an external, violent, sudden or fortuitous event that is not under the control of the insured, and while the insured is covered under the effectiveness of this policy. Not considered are services for accidents covered under the Workers Accident Compensation Act (CFSE, by its Spanish acronym), that are the responsibility of the insured, that are covered under private worker accident compensation insurance plans, automobile accidents under the Automobile Accident Compensation Administration (ACAA) and other available services under state and federal laws.
Active Employee	An employee who: a. Carries out regular duties during a normal daily work shift in his or her usual location or at any other place where the employer's business may require his or her presence; b. Is capable of carrying out regular duties in a normal workday or holiday at the usual location or at any other place where the employer's business may require his or her presence.
Adverse Benefit Determination	An adverse benefit determination may be: 1. A determination made by a health insurance organization or insurer, or an utilization review organization, which denies, reduces or terminates a benefit or benefit is not paid, partially or in full, because when applying the utilization review techniques, based on the provided information, does not meet the requirements of medical necessity and appropriateness, nor for the site where the service is offered or the level or efficiency of care or if it is determined that it is experimental or investigational in nature; 2. The denial, reduction, termination or absence of payment of a benefit, either partially or in full, by the health insurance organization or the insurer or a utilization review organization, based on the determination of eligibility of the covered or insured person to participate in the health plan; or 3. The determination resulting from a prospective or retrospective review in which the benefit is denied, reduced, terminated or not paid, either partially or in full.

Affordable Care Act (ACA)	Federal health reform law enacted in March 2010. This law was enacted in two parts: Patient Protection and Affordable Care Act (PPACA), which became law in March 23, 2010, and was modified by the Health Care and Education Reconciliation Act on March 30, 2010, as amended. The name *Affordable Care Act* refers to the final version of the law.
Ambulance	Vehicle duly certified by government entities to operate as a vehicle for patient transportation.
Appeals	Request for revision of the results of an adverse determination of benefits or of the result of an investigation of a complaint.
Bariatric Surgery	Surgical procedure for the treatment of morbid obesity, including but not limited to, the following techniques: • *Gastric Bypass* – Bariatric surgery in which a small stomach pouch is created of fifteen (15) to thirty (30) ml, that is connected directly to the small intestine and food passes directly to it, reducing a great segment of the intestine and, thus, caloric absorption. • *Adjustable Gastric Band* – Bariatric surgery in which an inflatable band is placed around the upper portion of the stomach, creating a small stomach pouch (15cc) above the band, leaving a small passage to the rest of the stomach. • *Sleeve Gastrectomy* – Bariatric surgery that consists in removing vertically the left side of the stomach, especially the gastric fundus where an appetite-stimulating substance is produced.
Benchmark Plan	Coverage plan in which the state defines the essential health benefits that each insurer should include, in accordance with the provisions of federal PPACA.
Beneficiary	A person or entity on a life insurance policy that the main insured designates to receive benefits upon the loss of his or her life.
Case Management	A series of coordinated activities, established by the health insurance organization or the insurer for the individual care of patient conditions, either complex, prolonged or of any other type.
Claim	Statement of dissatisfaction submitted by an insured that may be solved with orientation, action, or brief intervention, as corresponding.
Clinical Laboratory	Facilities that have been legally authorized by the corresponding authorities to provide services in Puerto Rico.
Clinical Trials	Strictly controlled trial of a service or treatment in humans to determine if it is safe and/or effective for the management of a health condition.
Coinsurance	Percent amount of money that the insured has to pay at the time of receiving certain services. This amount of money varies according to the cost of services and rates contracted by MCS Life.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a law that requires that the employer provides the employee and/or spouse and direct dependents, the opportunity to continue receiving coverage. COBRA only applies to groups of twenty (20) employees or more.
Collateral Visits	Mental health treatment modality with the purpose of collecting information and implementing treatment objectives. Usually, a participant is the parent, spouse or siblings. Other people may also have rights to collateral visits; this applies to

	patients who are adults, children or adolescents, provided it is shown that the person is, in fact, an important person in the life of that patient.
Complaint	Written or verbal claim that entails an urgent request for care submitted by a covered person or on his or her behalf, regarding: 1. availability, offering, or quality of healthcare services, including complaints regarding an adverse determination resulting in a utilization review; 2. payment or management of a claim or reimbursement for healthcare services; 3. or issues regarding the contractual relationship between the covered person o insured and MCS Life.
Concurrent Reviews	A utilization review conducted during a patient stay at a healthcare facility or during treatment of the patient at the office of a healthcare professional or other place where healthcare services are offered to inpatients or outpatients.
Copayment	Fixed amount of money that the insured under this policy pays to the provider to receive certain services.
Consensual Couples	Couples formed by a man and a woman who sustain a stable couple relationship and live under the same household without being legally married. To the effects of this certificate of benefits, the following documentation is required as proof: • Sworn statement certifying the relationship of the couple and that they have been living together for at least one (1) year; • Sworn statement certifying that neither are legally married to someone else; • Authorization from the employer for the inclusion of the partner; • The benefit will be authorized to eligible active employees (depends on each group); • In case of separation, a sworn statement will be requested certifying the separation and, subsequently the other person will be withdrawn from the plan.
Consensual Couples of the Same Sex	Couples formed by two individuals of the same sex, who live under the same household as a stable couple. To the effects of this certificate of benefits, the following documentation is required as proof: • Sworn statement certifying the relationship of the couple and that they have been living together for at least one (1) year; • Sworn statement certifying that neither are legally married to someone else; • Authorization from the employer for the inclusion of the partner; • The benefit will be authorized to eligible active employees (depends on each group); • In case of separation, a sworn statement will be requested certifying the separation and, subsequently the other person will be withdrawn from the plan.
Convalescent Home	Home where various health services are provided designed to help people recuperate after a serious illness, surgery or injury. The services can consist of medical, nursing, skilled care or therapy. They can be provided in different settings, including, rehabilitation hospitals, outpatient treatment centers, skilled nursing facilities and the patient's home.

Covered Services	Assessments, procedures and treatments offered and delivered by a provider to the insured, subject to the specifications included in his or her coverage, and clauses and conditions under this policy.
Cosmetic Procedures (Aesthetic surgery)	Any procedure or medication solely to improve the appearance of a body part.
Credentialization	Initial process that verifies the documentation presented by the provider showing that he or she is qualified to practice in Puerto Rico, his or her hospital privileges, professional experience and any other relevant criteria established by MCS Life periodically. Related term: Provider
Custodial, Domiciliary or Residential Care	The type of care that does not require continued services by expert staff, physicians, or allied health personnel. Includes care mainly directed to help keep or maintain personal hygiene, nutrition or other means of self-care, provides socially necessary services through maintenance and requires adherence to a prescribed medication schedule. Custodial care usually is necessary for persons with physical illness who cannot take care of themselves, but who do not require the services of a licensed practical nurse o registered nurse.
Deductible	Amount paid by the insured before starting to receive services covered under this policy.
Devices (artefacts, apparatus, internal or external prosthesis)	An instrument, device, machine, internal or external implant, or any other similar device, or a related item that includes a part or an accessory: • Recognized by the U.S. Food and Drug Administration (FDA), whose intended use is for the diagnosis of diseases or other conditions or to cure, mitigate, treat or prevent an illness in a human being. • Whose use is intended to alter the structure or function of the human body that cannot achieve any of its purposes through a chemical action in the human body, and • That does not depend on metabolism to achieve any of its purposes.
Diagnostic	The process of identifying a disease by its common signs and symptoms, as determined by a physician or other healthcare professionals.
Direct Dependents	For this policy, direct dependents are defined as follows: • The spouse of the main insured included in the family plan or couple's plan, while the policy is in effect and provided the spouse lives permanently under the same household as the main insured. • Children until they turn twenty-six (26) years of age. These dependents are defined as biological children, foster children, adopted children, children placed under legal custody by the court and stepchildren. Factors such as financial dependence and living with the main insured, disability, changes in marital, student o work status or any combination of these factors, will not be used to determine plan eligibility. • Minors whose custody, parental authority or guardianship has been granted to the grandparents or any other relative who are the main insured under this policy, including those of legal age who have been declared disabled, in accordance with Law No. 15 of February 27, 2007, as amended. • Any child older than twenty-six (26) years of age who is physically or mentally disabled and has no Medicare benefits (Parts A, B or both).

	• Consensual Couples . • Same sex consensual couples . • Optional or collateral dependents: father or mother of the main insured, or spouses, even if not living in the same household .
Disability	Lack of a determined ability due to injuries, diseases or pregnancy that: • When referring to an insured, the insured, while under the regular care and attention of a participating physician, is unable to perform the duties associated with his or her regular occupation. However, after the insured has been disabled for fifty-two (52) consecutive weeks in any disability period, "total disability" will mean the inability of the insured, according to the opinion of, and while under the regular care and attention of a participating physician, to engage in any kind of businesses or occupation that the insured can reasonably perform, taking into consideration his or her education, training, and experience. • When referring to a direct dependent, the direct dependent is unable to perform the normal activities of a person of his/her own age and sex, according to the opinion of the participating physician, and while under his/her medical care and attention.
Disease	An abnormal process in which the aspects of the condition and social, physical, emotional or intellectual functions of a person are reduced or deteriorated compared to the prior condition of the person.
Drug, Medicine, or Medication	Any drug in an appropriate dosing form for the use of human beings.
Durable Medical Equipment	Equipment that due to medical reasons is ordered by a physician for the treatment of a medical condition or disease of a person. Additionally, is strong enough to withstand repeated use without damage. A person needs this type of equipment only when he or she is sick or injured. This equipment can be used in the home.
Effective Date	Date in which coverage comes into effect for receiving the services described under this policy.
Elective Hospitalization	Planned hospitalization for the treatment of a known (previously diagnosed) medical condition and is scheduled for a future date according to the provider's availability or patient convenience.
Elective Surgery	Surgical procedure that, while medically necessary and ordered by a physician, does not need to be performed immediately as there is no imminent risk to life, or risk of permanent damage to a vital organ or of suffering permanent disability.
Emergency Services	Healthcare services offered or required to treat an emergency health condition.
Employee	Employee who resides in Puerto Rico and has a full time job of thirty (30) hours per week, or a part time job of at least seventeen point five (17.5) hours per week in a regular work week for an employer in a *bona fide* employer-employee relationship that is not established with the purpose of buying health insurance.
Epidural Anesthesia	Administration of local anesthetic into the epidural space to block nerve endings where they exit the spine.

Expedited Appeal	Request for revision of the results of an adverse determination of benefits submitted by the insured or his or her physician when the regular procedure waiting time may put at risk the life, health or ability of the insured for maximum recovery.
Experimental or Investigational Services	Medical treatments: • that have not been approved by the corresponding regulatory agencies (For example: U.S. Food and Drug Administration (FDA), Department of Health and Human Services (DHHS), Department of Health of Puerto Rico); or that do not meet the medical policy criteria established by MCS Life for the specific indications and methods ordered; or • whose scientific evidence is inconclusive as to the effect of technology on the medical outcomes obtained; or • whose outcomes do not outweigh the negative side effects of the treatment; or • whose treatment does not outweigh other alternative treatments already established; or • whose improvement cannot be obtained outside the investigational phase.
External Appeal	Request for revision of an adverse determination of benefits or of an internal appeal before an external independent entity that meets the established requirements of the Insurance Commissioner of Puerto Rico and as provided in Sec. 1001 of the Patient Protection and Affordable Care Act, 75 Fed. Reg. 43330-43364 (July 23, 2010).
False representation or Fraud	A verbal statement or manifestation or conduct that does not represent the intentional fact, a statement a person makes knowing it is incorrect with fraudulent intent.
Family Plan	Any eligible person with more than two (2) direct dependents (as defined under this policy) constitutes a family plan.
Flexible Spending Accounts	Type of financial account that includes a tax benefit established through a cafeteria plan by an employer in the United States, as set forth in the Employee Retirement Income Security Act of 1974 (ERISA).
Foster Child	Minors who, even though they are not a biological or adopted child of the main insured, have lived in the same household since childhood in a normal father/mother/son/daughter relationship.
Full Hospitalization	Full hospitalization means from the first day in which the patient is admitted to a health facility up to the day of discharge.
Group Therapy	Method of psychiatric treatment focused on patients receiving treatment as a group. It is led by a licensed clinician, has an established treatment plan and certain particular improvement goals.
Habilitative Services	Refers to therapies (physical, speech, and occupational) offered with the purpose of correcting defects in the normal development of the patient.
Healthcare Coverage	Health services to which the insured is entitled, according to this policy.
Health and Human Services (HHS)	Department of Health and Human Services of the federal government responsible for the management of health and wellbeing related programs.

Health Professionals	Any professional duly admitted to practice in Puerto Rico, in accordance with the applicable laws and regulations, any of the health field and medical care professions, such as, but without limiting to, physicians, surgeons, podiatrists, naturopathic doctors, chiropractors, optometrists, clinical psychologists, dentists, pharmacists, nurses, and medical technologists, as authorized by the corresponding laws of Puerto Rico
Health Risk Assessment (HRA)	Health risks estimate is a questionnaire that facilitates that the insured gets a current profile of his or her health condition and knows of the risks associated with the development of chronic conditions. Through this health profile, MCS has the opportunity of: • Educating the insureds on how their lifestyles could affect their health and wellbeing • Designing health and wellbeing promotion interventions based on identified needs • Following-up on the progress of the members or groups to measure the effectiveness of an intervention It is also an essential tool to promote the participation in wellbeing programs and foster participants to take an active role on their health.
Home Health Care	Medical services and other types of related services that may include physical therapy, nursing care, counseling and social services offered by a provider in the home of the patient. Includes care and assistance in the home.
Clinical Peer	A physician or other healthcare provider with an unrestricted license from a state in the United States or Puerto Rico, of the same or similar specialty as physicians or healthcare providers that usually care for the condition, procedure or treatment that is reviewed by MCS Life on a claim or appeal.
Hospice Care	Special care provided to people with terminal conditions, with a life expectancy of six (6) months or less. This service includes physical care and counseling. Hospice applies to the period of time the doctor has determined that the insured qualifies and needs this type of care.
Hospital	Authorized and accredited institution that provides services to the community by offering treatment and medical and/or surgical diagnosis for diseases or injuries and/or obstetric care to hospitalized patients; including general and specialized hospitals.
Independent Review Organization	Entity that conducts an independent external review of an adverse determination or a final adverse determination, conducted by the health insurance organization or the insurer or the designated utilization review organization.
Individual Plan	Any eligible person, single or married, excluding the spouse (as defined under this policy) or any direct dependent. Premiums corresponding to individual plans will apply in these cases.
Injuries	Any accidental harm or trauma suffered by the insured that is not a result of a car or work accident, and requires medical treatment and hospital services.
Insured	Person enrolled and covered under this policy.
Insured Employee	Employee insured under this policy.

Insurer	The natural or legal person dedicated to contracting insurances, as defined in Article 1.050 of the Insurance Code of Puerto Rico, as amended, any reciprocal insurance association, a Lloyd's organization, a mutual association, any program created in virtue of Title XIX of the Social Security Act, health services organizations under Chapter XIX of the Insurance Code of Puerto Rico or any public or private, profit or non-profit entity dedicated to offering insurance contracts. For this policy, insurer refers to MCS Life Insurance Company.
Intensive Care Unit	Hospital unit required for patients with critical health conditions and who need life support of organic functions beside special medical supervision and constant monitoring.
Intensive Outpatient Programs (IOP)	Program that provides intensive treatment and support for the treatment of some conditions such as, depression and anxiety disorders, and substance dependence not requiring detoxification.
Internal Appeal	Request for revision of an adverse determination of benefits or of the result of the investigation of a complaint before the plan or insurer.
Main Insured	The employer's employee who subscribes a policy with the insurance company.
Maintenance Drugs	Maintenance drugs are those whose most common use is treating chronic diseases. Therapy with this medication is not considered curative. Maintenance drugs are administered continuously (for over ninety (90) days) instead of intermittently.
Marriage	Marriage is a civil institution that originates with a civil contract in which the contracting parties mutually agree to become spouses and follow the duties imposed by the law, as applicable, in the United States and its territories. It is valid only when it is contracted and solemnized according to the provisions of law, and may be dissolved before the death of any of the spouses only in cases as expressly provided by law.
Maximum Out-of-Pocket or MOOP	Maximum amount of money that an insured has to pay during a period of benefits in addition to the premium before the insurance company pays one-hundred percent (100%) of the services covered under this policy.
MCS Life Clinical Affairs	MCS Life department that groups the following units: Pre-authorization, Hospital Review, Education and Wellbeing, Managed Care and Care Transition.
Medical Emergency	Condition in which the symptoms presented are severe enough for a reasonable and prudent person with average health and medical knowledge to reasonably conclude that the absence of immediate medical care could result in: putting at risk the health of a person or the health of an unborn child, a serious impairment to body functions, or serious dysfunction of any body part or organ.
Medical necessity	Care, service or supply generally accepted by the medical community as effective, appropriate, and essential to diagnose and treat an illness or injury, and that: • Is based on generally accepted or recognized standards of care and that are appropriate for the symptoms, diagnosis and treatment of an injury, condition or illness, and for direct care of the patient who suffers any of the above, according to the interpretation of MCS Life Clinical Affairs;

	• Is provided according to the standards of good medical practice and is generally accepted by the medical community as effective, appropriate and essential for the diagnosis and treatment of an illness or injury; • Is not provided mainly for the convenience of the insured, physician or facility.
Medically Necessary Services	Services offered by a participating provider to maintain or restore the health of the insured, as per the standards of good medical practice.
Medicare	Federal Health Insurance Program for people sixty-five (65) years or older, people of any age with permanent renal problems and some people with disabilities, according to Title XVIII of the Social Security Act. Medicare has Parts A, B and C, and Part D for prescription drugs. Part A is the part that offers hospital insurance coverage and includes inpatient hospital care or skilled nursing facility, and certain follow-up care. Part B is the medical insurance and includes, among other things, health care services, medical supplies and related services. Part C came into effect on January 1, 1999. Under Medicare Part C, people eligible for Parts A and B can opt to obtain their Medicare benefits through various types of risks-based insurance plans, except people with end-stage renal disease. Medicare Part D came into effect on 2004 and offers prescription drug coverage.
Medicare Beneficiary	Any person sixty-five (65) years or older, or under 65 years with certain handicaps, or permanent renal failure, who requires dialysis or renal transplantation, and that is eligible under Medicare Parts A, B, C, or D.
Morbid Obesity	Is the excess of body fat, as determined by a Body Mass Index (BMI), greater than or equal to thirty-five (35).
Non-Covered or Excluded Services	Services that are: • expressly excluded from coverage in the insured's policy. • delivered by healthcare providers whose medical specialties do not include the corresponding specialized training required to offer such services. • considered experimental or investigational in nature, unless it is otherwise provided by law, and/or • not medically necessary
Partial Hospitalization (Mental Health)	Refers to organized services for patients with mental conditions and/or drug abuse, who require hospital care through day and/or night programs, and covers daily periods of less than 24 hours.
Participating Provider	Healthcare provider that has entered into a contract with MCS Life to provide services covered under this policy, such as, physicians, hospitals, participating pharmacies, laboratories, and radiology centers, among others.
Patient Protection and Affordable Care Act (PPACA)	Patient Protection and Affordable Care Act was signed into law on March of 2010. Related Term: Affordable Care Act.
Personal Representative	It may be: 1. A person to whom the covered or insured person has given written express consent to represent him or her when requesting a medical exemption, as set forth in the Puerto Rico Health Insurance Code;

	2. A person authorized by law to consent in place of the covered or insured person; 3. An immediate family member, family member up to second degree of consanguinity or affinity, such as, father, mother, child/children, and spouse of the covered or insured person or the healthcare professional in charge of his/her care, when the person is unable to give consent; 4. The healthcare professional who treats or administers medications to the covered or insured person, with the purpose of requesting a medical exemption on his or her behalf, as set for in the Puerto Rico Health Insurance Code.
Pharmacy	Health service facility authorized and registered in accordance with federal or state provisions dedicated to offering pharmaceutical services that includes: dispensing of prescription and non-prescription drugs, devices, and other health-related products, the offering of pharmaceutical care and other services within the functions of the pharmacist established by law.
Physician	Doctor of Medicine (MD) authorized to practice medicine in Puerto Rico. Should have updated licenses that allows him or her to offer benefits of the plan, including the prescription of drugs and controlled substances.
Plan Administrator	Employer o person designated by the employer to administrate this policy.
Plan for Couples	Any eligible person, single or married with a direct dependent (as defined under this policy).
Policyholder	Any employer to whom this insurance policy or contract is issued and, that in turn, assumes the obligations and responsibilities imposed by it, including but not limited to, payment of the corresponding premiums.
Policy Month	Monthly successive periods starting on the policy effective date.
Policy Year	The twelve (12) consecutive month period in which the insured acquires or renews his or her insurance with MCS Life.
Pre-authorization	Prior authorization issued by MCS Life Clinical Affairs Department to the insured to receive benefits subject to evaluation, as set forth in this policy.
Preferred Provider Organization (PPO)	Healthcare access services model which includes a group of hospitals, physicians and other providers that contract with the insurer, employer or other sponsor to provide medical care services to the insured.
Prescription	An order issued by a licensed, certified or legally authorized person to issue prescriptions of drugs, directed to a pharmacist for dispensing a prescription drug.
Prescription Drug	Those medications which, under the laws of Puerto Rico and the United States, require a prescription to be dispensed; and will be dispensed by a pharmacist at a duly authorized pharmacy.
Preventive Services	Preventive services (also known as prevention benefits) are services and examinations that are available to help the patient in the prevention and detection of diseases, as required by the Affordable Care Act (ACA).
Primary care physician	Primary healthcare providers. Offer basic care to the insured, refer them to specialists, and provide follow-up care. They are general practitioners, internal

	medicine physicians, family physicians, obstetrician/gynecologist, and pediatricians.
Prospective Review	Utilization review before healthcare service or patient treatment is offered, according to the requirement of aversion of health insurance or the insurer for the approval of such service or treatment, in part or in full, before it is offered.
Provider	Provider is a general term we use to refer to physicians, hospitals and other facilities that have been licensed or certified by the Commonwealth of Puerto Rico to provide healthcare services.
Provider Network	Any physician, hospital, skilled nursing facility or any other individual or entity that offers healthcare or ancillary services and who signs a contract and continues under a valid contract with MCS Life, to provide covered services to the insured, and who has been credentialed by MCS Life or its designee according to MCS Life credentialing policies.
Reconstructive Procedure	Procedure that may restore function and/or body structure.
Psychiatric Emergency	When a patient has a mental condition that can result in immediate harm to that person, other persons, or property.
Refills	Dispensing of drugs that are repeated with a written indication of a physician.
Rehabilitation Services	Rehabilitation is a process to restore the abilities of a person due to illness or body harm, allowing him or her to recover self-sufficiency and maximum function in a normal fashion or as close to normal as possible.
Renewal	MCS Life has the right to renew the policy and alter the premium at the beginning of the next term. The initial premium is guaranteed for a term of twelve (12) months.
Request for Urgent Care	A request for healthcare service or treatment in which the time period established for a non-urgent care determination: • Could put at risk the life or health of the covered or insured person or his or her full recovery; or • In the opinion of a physician, with knowledge on the medical condition of the covered or insured person, could expose the person to unmanageable pain without the requested the healthcare service or treatment. Upon determining if the request is to be treated as an urgent care request, the person representing the health insurance organization or insurer will exert the judgment of a lay prudent person with average knowledge in health and medicine. If a physician with knowledge on the medical condition of the covered or insured person determines to submit an urgent care request, the health insurance organization or insured will treat such request as urgent care.
Rescission	Invalidation of coverage retroactive to the effective date due to false or fraudulent representation of the material fact.
Residential Treatment	Treatment offered in a healthcare facility that provides therapy, and temporary living arrangements for patients with behavioral problems and/or substance abuse who require medication or continuous supervision or relief from environmental stress.

Rest Home	Residence where living, food, and personal care is provided to individuals who need assistance and supervision, and cannot live independently, but don't need nursing care.
Retrospective Review	Review of a request for benefit conducted after the healthcare service has been offered. "Retrospective review" does not include the review of a claim that is limited to evaluating the level of reimbursement, the truthfulness of the documentation or the use of the correct coding.
Semi-private Room	Standard room covered under hospital benefits in this policy
Service Area	Geographic area where the insured is expected to receive most of his or her medical and hospital services. The geographic area consists of the seventy-eight (78) municipalities of Puerto Rico.
Shared-cost	A portion of the cost for service that the insured has to pay upon receiving such service. Related terms: deductible, copayment and/or coinsurance.
Skilled Nursing Facility	Specially qualified institution with the appropriate staff and equipment to provide skilled-care nursing. It is an institution legally authorized to operate as such, and that works in accordance with the law, and is accredited to receive payment of benefits under the Medicare program or that meets the minimum requirements to receive such accreditation, if requested. Its main purpose is to provide skilled nursing services under the supervision of a licensed physician plus room and diet. This type of institution counts with nursing services to offer healthcare or with their supervision twenty-four (24) hours a day, as well as treatment and rehabilitation of people with injuries, illness or disability under the supervision of physicians. A health care record is kept daily of each patient; and it holds a contract for transferring people with injuries or illness with one or more hospitals.
Laboratory PPO Network	Laboratory network contracted to provide laboratory benefits as preferred network under this policy.
Surgical Assistance	Certified physician actively assisting the main surgeon while performing a covered surgical procedure, that due to its complexity, the need of assistance is justified.
Spouse	Person with whom the main insured has contracted a valid marriage in accordance with applicable laws.
Telemedicine	The diagnosis and treatment of patients at a distance by means of the use of telecommunication technologies.
Terminal Illness	An incurable or irreversible illness or condition diagnosed by a physician who, according to his/her professional judgment, will result in the patient's death within the next six (6) months.
Transplant	Transfer of an organ or tissue to an area of the same body or to another individual.
Treatment Plan	A detailed report of the procedures recommended by the physician or any other healthcare professional to treat the patient's health needs, according to the findings in a physical examination performed by the same physician.
Utilization Review	Group of formal techniques to supervise healthcare services, procedures, or places where such services are offered, or to evaluate their medical necessity, appropriateness, efficacy, or efficiency. Such techniques could include the review

	of ambulatory services, prospective reviews, second opinions, certifications, concurrent reviews, case managements, discharge plans, or retrospective reviews.
Utilization Review Organization	Entity contracted by a health insurance organization or the insurer to conduct a utilization review, when the health insurance organization or insurer is not the one that conducts the review of its own health insurance. It should not be interpreted that it is required for the health insurance organization or insurer to subcontract an independent entity to conduct utilization review processes.
Usual and Customary Charges	The usual cost of a specific medical service based on the geographic area where the insured receives service.
Waiting Period	Period that should elapse regarding the covered person or insured before becoming eligible to receive certain benefits under the terms of the health plan. In any case, the waiting period should not exceed ninety (90) days.

PART II: INSURANCE ELIGIBILITY, EFFECTIVE DATE AND CHANGES

Section 1: Eligibility

Large Group Enrollment

MCS Life meets the large group provision and definition established by the Office of the Insurance Commissioner on March 20, 2017. According to the definition, large groups are those businesses that employ fifty-one (51) or more eligible employees during at least fifty (50) percent of its work days of the previous natural year.

When determining the number of eligible employees, affiliated companies, or those eligible to file a combined tax return form for the purposes of filing in Puerto Rico, are considered only one employer. After having issued a health insurance plan and for the purpose of determining eligibility continuity, the size of such employer will be determined annually.

MCS Life requires the insureds to be *bona fide* residents in Puerto Rico for eligibility for this policy. MCS reserves the right to request from the insured proof of insurability showing that the insured meets the residence requirement under this policy. MCS may request proof showing the insured lives, physically and permanently, in Puerto Rico and *bona fide*, including but not limited to, proof of location of his or her main residence, place where he or she holds bank accounts, address where he or she receives mail, where he or she is registered to vote, among others.

MCS Life will not deny, exclude or limit benefits to people due to a pre-existing condition, regardless of age, in accordance with Article 2.050 (I) of the Puerto Rico Health Insurance Code.

Section 2: Employee

Employees are eligible to join the plan described in this policy if they are contracted as valid employees by the employer. The employer is responsible for coordinating the employee's eligibility requirements in accordance with applicable federal and state laws.

For participating in the plan, an "employee" is considered to be the person that is treated as or classified specifically as an employee in the employer's records for the purposes of income tax withholding.

Section 3: Direct Dependents

If the employee is eligible for the Plan and the Plan provides coverage for dependents, the spouse and his or her eligible dependents will also be eligible for coverage in accordance with the Puerto Rico Health Insurance Code. The Code provides that a dependent is considered to be any person that is or could be eligible to health insurance due to the relationship he or she has with the main insured, according to the conditions provided in the health plan. The following are considered dependents of the main insured:

- the spouse;
- a biologic child, adopted child or one placed for adoption who is under twenty-six (26) years of age;
- a biologic child, adopted child or one placed for adoption who, regardless of age, cannot sustain him or herself due to an existing mental or physical disability before turning twenty-six (26) years of age, in accordance with that provided in the Affordable Care Act and the regulations enacted under this Act;
- stepchildren;
- foster children who have lived since infancy under the same household with the main insured, in a relationship of father, mother and son or daughter, and that is and continue to be totally dependent on the family of the main insured for food, as set forth in Article 16.330 of the Insurance Code of Puerto Rico;
- non-emancipated minor whose custody has been adjudicated to the main insured;
- person of any age who has been legally declared disabled and whose tutoring has been adjudicated to the main insured;
- Consensual couples
- Consensual couples of the same sex
- optional or collateral dependents, as this term is commonly accepted and defined in the health insurance market, if the employer allows their inclusion in the health plan .

The employer may be required to submit documentation to his or her Human Resources Department representative as proof of eligibility of the dependent.

Eligibility when both spouses , or consensual couples work for the same employer

Both will be covered as employees under this plan instead of as a dependent under this plan. And, if both the employee and his or her spouse , or his or her consensual couple, work for the company or division or subsidiary of such participating employer, the family members will be considered dependents of only one employee and not of both.

Qualified Medical Child Support Order

A *Qualified Medical Child Support Order (*QMCSO) is a court or administrative order requiring support for the medical coverage of an insured's child. A common reason for a court or administrative agency to issue an order for a qualified medical support of a child is to protect the benefit of coverage of children in case of divorce.

The employee will be notified when the employer receives a QMCSO that affects him or her. If the employee receives a qualified medical support order for a child, he or she should contact the Human Resources Department representative. The Human Resources Department representative will follow the necessary

administrative procedures. Thus, ensuring compliance in the determination of the QMCSO status. The employee may request from the employer a copy of the QMCSO procedures, free of charge.

Section 4: Insurance Reinstatement

An employee whose insurance expired due to job termination and is re-hired within six (6) months from the date of such termination, will be eligible again for insurance when he or she returns to active work. However, if the employee is re-hired after six (6) months from the date of termination, such employee will only be eligible for insurance on the date in which he or she completes the applicable enrollment period.

Subject to the payment of the corresponding premium established by MCS Life, the insured will have the right to continue receiving medical insurance benefits for ninety (90) days after coverage termination. If the insured was hospitalized at the time of coverage termination, the ninety (90) day period will begin to count from the date of hospital discharge.

If an insured is on her second trimester of pregnancy on the date of coverage termination and has been under treatment for pregnancy before the date of coverage termination, the transition period regarding the related pregnancy services will be extended up to the date of hospital discharge of the mother due to labor or the date of discharge of the neonate, whichever comes last. In the case of insureds diagnosed with a terminal disease acquired before the date of coverage termination, and for which he or she has been receiving treatment before that date, the transition period will be extended during the remaining life time of the patient.

Section 5: Changes During Policy Year

If an insured is eligible for any change in the insurance and the information required by MCS Life for the change to take effect is received by MCS Life within thirty (30) days following the date of eligibility for such change (or within the time period indicated below), the change will become effective on the date of eligibility. The accepted changes are the following:

1. As part of an individual or family contract, MCS Life should be notified through a death certificate of the death of any insured within thirty (30) days following the date of death.
2. MCS Life should be notified of the divorce of a main insured within sixty (60) days from the date of divorce. MCS Life will make the change within thirty (30) days following the date in which the divorce became effective. In the case of consensual couples, the notification should be made through a dissolution statement of the consensual relationship within thirty (30) days following the dissolution.
3. The marriage of the main insured, provided the request for change is submitted to MCS Life within thirty (30) days following the date in which the marriage became effective.
4. In the case of consensual couples, the main insured and his or her partner should notify of their consensual relationship by means of a statement indicating that:
    a) The consensual relationship has been constituted for one (1) year or more, by two people who intend to stay as a couple for an indefinite period of time, that are not married to another person outside the relationship and of not having other consensual couples;
    b) It is a consensual couple composed by people who have no family relationship within the second degree of affinity or fourth degree of consanguinity;
    c) Have a common residence and have shared as a couple during the last consecutive year prior to the declaration, and have the intention to continue their cohabiting situation indefinitely;

d) Both are adults, mentally competent and with legal capacity to consent on the acquisition of the policy;

e) Their financial responsibilities and obligations are shared by both for their reciprocal wellbeing;

f) They understand that any false information offered on the declaration constitutes fraud, as well as the recovery by the employer or insurer, of any monetary amounts disbursed for health benefits received, including legal fees incurred as well as the referral of the case before local or federal authorities;

g) The insurer may conduct any actions deemed pertinent against the insured who offers false information constituting fraud against the health insurance;

h) They understand that the insurer can change the eligibility requirements at any time upon the expiration of the policy;

i) They acknowledge that the insurer may require an annual eligibility recertification;

j) The purpose of the declaration is to include the consensual couple in the health insurance of the insured.

4. In cases of controversy on the existence of a consensual relationship, MCS Life may request from the main insurer one of more of the following documents:

   a) mortgage or purchase deed;

   b) rental agreements granted jointly by the insured and his or her consensual couple;

   c) agreement on common property;

   d) joint bank accounts;

   e) utilities invoices of the place of living of the cohabiting couple; or

   f) any other method of proof of payment for the cohabitation of the consensual couple.

5. That the direct dependent children, as defined, stop being direct dependent when they turn twenty-six (26) years of age. Direct dependents that turn twenty-six (26) years of age will lose eligibility as dependents as established by PPACA. This change will become effective on the day of his or her twenty-six (26) birthday. The dependent will have the choice of enrolling into COBRA or to acquire his or her own individual coverage by means of the privilege of conversion or by a medical insurance from an employer.

6. By childbirth, adoption or adjudicated custody of a child. As provided in Chapter 54 of the Code of the Health Insurance of Puerto Rico (CSSPR):

   a) Newborn children of covered persons or insureds from the time of birth, or

   b) Recently adopted children of covered persons or insureds from the time of one of the following dates:

      i. The date in which they are placed in the household of a covered or insured person with the intention of adoption and remain in the home under the same conditions as those of other dependents of the covered person or insured unless that the placement is interrupted before the legal adoption and the child is transferred from the home where he or she was placed;

      ii. The date in which an order was issued providing custody of the child to the covered person or insured with the intention of adoption; or the date of effectiveness of the adoption.

   Coverage for newborns, recently adopted children or children placed for adoption should meet the following requirements:

a) Should include healthcare services for injuries or diseases, including care and treatment for congenital defects and abnormalities as diagnosed by a physician; and

b) Will not be subject to any exclusion due to pre-existing condition.

In the case of newborns, MCS Life will provide the insured a reasonable notification on the following:

a) If payment of the premium, or a specific enrollment charge is required in order to provide coverage for a newborn, MCS Life may require notification of the birth of the child and payment of the required charges or premiums no later than thirty (30) days from the birth of the child.

b) If the notification or payment described in the above item is not provided, MCS Life may decide to discontinue coverage for the child beyond a thirty (30) day period. However, if no later than four (4) months after the birth of the child the insured issues all due payments, the child's health coverage will be reinstated.

In cases involving newly adopted children or children placed for adoption, MCS Life will provide to the insured a reasonable notification on the following:

a) If payment of a premium or an enrollment charge is required in order to provide coverage to a newly adopted child or to a child placed for adoption, MCS Life can require the insured to notify the health insurance organization or insurer about the adoption or the placement of the child in the home for adoption and to provide payment of the premium or required charges, no later than thirty (30) days from the required coverage start date, as set forth in Article 54.050A(2) of the CSSPR.

b) If the covered or insured person does not provide notification or the payment described in the above item within a thirty (30) period, MCS Life will not be able to treat the adopted child or the child placed for adoption in a less favorable way than other dependents, except for newborns, for whom coverage is requested at a later date from the date in which the dependent became eligible for coverage.

7. That custody, parental authority or guardianship of minors or a disabled person be adjudicated to grandparents or other relatives who are main insureds in this policy, according to Law No. 15 of February 27, 2007 and Law No. 116 of July17, 2008.

Except otherwise provided above, changes will come into effect the first day of the month after the event mentioned in this section, provided all the enrollment requires are met and the corresponding premium for the new dependent is paid.

Section 6: Effective Date of Coverage

Employee coverage is effective once the eligibility criteria set forth by the employer are met.

Cost of Coverage

Both the employee and the employer share the cost of medical coverage; however, the company pays the largest portion of the total cost. The employee pays the cost corresponding to the portion for his/her coverage, that of spouse and/or his/her direct dependents covered through deductions from net salary. The cost of coverage will depend on the coverage chosen and will be shown on the Benefits Enrollment Form.

Section 7: Date of Coverage Termination

Coverage under the plan ends on the last day of the month in which:

1. Employment ends. (If coverage ends due to retirement or disability, the insured should contact the employer's Department of Human Resources representative for more information);
2. The employee no longer meets the plan's eligibility requirements;
3. The required payment is not done at its expiration date and according to that stated in the Grace Period Section in this policy;
4. Plan termination.

Coverage for a family member also ends on the last day of the month in which the dependent is no longer an eligible dependent.

If coverage ends, the expenses incurred by the insured will be paid, provided they occurred before plan termination, and as set forth in Article 7 of the Bill of Rights and Responsibilities of the Patient, Law No. 194 of August 25, 2000, as amended, and the insured should follow the procedures to submit the applicable reimbursement. When coverage ends, the employee and his or her direct covered dependents – except for consensual couples- can purchase continued health care coverage under the Federal Law known as COBRA. (See Part X: *COBRA*, for additional information) or may acquire an individual health plan.

In accordance with Article 7 of Law No. 194 of August 25, 2000, as amended, every patient, user or consumer of medical-hospital healthcare services in Puerto Rico, has a right to:

1. In the event of termination or cancelation of a health plan or termination or cancellation of a provider, MCS Life will notify the patient of said termination or cancelation, thirty (30) calendar days before the termination or cancelation date.
2. The insured has the right to remain with his or her current services provider for a period of ninety (90) days, beginning on the plan termination date and ending ninety (90) days after. However, in the following situations, the transition period may be extended:

    - If the insured has been hospitalized before the plan termination date and the date of hospital discharge has been scheduled before the termination date, the transition period will be extended from this date to ninety (90) days after the discharge.

    - If an insured is in the second trimester of pregnancy before the plan termination date, and her provider has been offering pregnancy-related medical treatment before the plan's termination date, the transition period in terms of pregnancy-related services will be extended up to the date the mother is discharged after delivery or the newborn is discharged, whichever comes last.

    - If the insured has been diagnosed with a terminal disease before the termination date and his/her healthcare provider has been offering treatment for said condition before that date, the transition period will be extended during the remaining life time. Once the transition period has ended, he or she should visit the healthcare provider from MCS Life Network of Contracted Providers. Following this process, will ensure the continuity of health services.

Section 8: Conversion of Coverage

If coverage of an insured under this policy ends due to job termination or of the condition as member of the eligible class or classes for coverage under the policy, he or she may be eligible to convert such insurance to an individual policy issued by MCS Life without the need to show proof or evidence of insurability, and subject to the payment of corresponding premiums within a time period not to exceed thirty-one (31) days from the qualifying event.

The benefits under the conversion policy not necessarily will be the same benefits of this policy but according to the individual conversion policy chosen by the insured. The conversion policy will be a reduced benefit plan.

In addition, the insurer is not obliged to issue an individual policy to cover a person with rights to receive similar benefits under any insurance coverage or under the Medicare program of the Social Security Act, as subsequently amended, if these benefits, jointly with those provided under the individual policy result in over-insurance, as per the insurer's norms.

Individuals Eligible for Conversion

An insured is eligible for insurance conversion if:

1. He or she is an employee whose insurance terminates for whichever reason;
2. Spouse , consensual couple and/or direct dependents of an employee whose insurance terminates due to the death of the employee or divorce or marriage annulment or for any reason that disqualifies the insured as a family member under the group policy even when the main insured continues to be under coverage.

If the group policy ceases or is amended in such a way that terminates the insurance in any insured category, any person included in such group policy at the date of termination and that has remained as such for at least three years before the date of such termination, will have the right to the issuance of an individual disability insurance policy by the insurer, subject to the same conditions and limitations provided in this Section.

If an employee is eligible for conversion insurance, he or she may also convert under the same policy any dependent insurance which could terminate at that time.

Request and Effective Date for Conversion

In order to convert, the eligible individual should request and pay the first premium within thirty-one (31) days from the date the insurance expires under this policy. The insured will receive notice thirty (30) days before the expiration date of the period to acquire a new coverage with a detail of the alternative services available and the cost of each plan at the time. If the insured does not receive notice, he or she will then have an additional period to exert his or her right, but this does not imply the continuation of the policy beyond the provided period.

The additional period will expire thirty (30) days after having notified the insured, but in no case will extend beyond sixty (60) days after the expiration date provided under this policy. Written notice presented to the insured or sent by mail to the policy holder or employer to the most recent known address of the insured or sent by the insurer to the last known address of the insured will be considered a notice to the effects of this paragraph.

If an additional period is granted to exert the right to convert, as provided herein, and the written request for such individual policy accompanied by the first premium occurs during the additional period, the effectiveness of the individual policy will be on the date of insurance termination under the group policy. Applications are available at the employer's offices or at MCS Life.

Premiums for the insurance conversion are based on:

1. the insurance benefit of the individual conversion policy chosen;
2. premiums in effect for this type of insurance;
3. and the age, at the effective date, of each insured.

The effective date of the conversion insurance will be on the date in which the insurance of the person in this policy has expired and will cover the spouse and direct dependents covered at the time of termination of the initial plan, provided the main insured does not opt for acquiring an individual policy for them.

It should be clear that if an insured under the group policy suffers a loss covered under the individual policy described on the first paragraph of this Section, during the period in which he or she would have qualified for the issuance the individual policy and before the effectiveness of such individual policy, the benefits to which he or she would be entitled under such individual policy will be payable as a claim under the group policy even when an individual policy has not been requested or even when the first premium has not been paid.

Section 9: Continuation Coverage in Special Cases

Please refer to Part IX of this policy: ERISA Provisions, for information on:

- Family and Medical Leave
- Military Leave
- *COBRA*

For more information about qualifying events for COBRA benefits, please refer to Part X: COBRA, of this policy.

A Federal Law known as the Consolidate Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that both employers and the insurer allow covered employees, their spouses, and direct dependents (referred as "qualified beneficiaries") to continue with the health plan coverage at the same costs when certain events occur. Under COBRA, they may continue for up to eighteen (18) or thirty-six (36) months, depending on the events that make the employee or his or her direct dependents eligible (referred as "qualifying events"), as provided below.

In the case of the employee

- Up to eighteen (18) months due to a reduction in work hours or job termination (for reasons other than misconduct).

In the case of a child or spouse

- Up to eighteen (18) months due to reduction in work hours or job termination (for reasons other than misconduct).
- Up to thirty-six (36) months due to death, divorce or legal separation of the employee or that the child is no longer a "dependent" under the terms of the plan, or due to Medicare rights of the employee.

In the case of direct dependents

- Up to eighteen (18) months due to reduction in work hours or job termination (for reasons other than misconduct).
- Up to thirty-six (36) months due to death, divorce or legal separation, to the right of insurance due to illness, or that the minor stops being a "dependent" under the terms of the plan. As a consideration, coverage may be continued for up to eighteen (18) months due to job termination or reduction in work hours, for reasons other than misconduct, of the main insured in case it occurs.
- Additional qualifying events may happen while COBRA coverage is in effect. These events can result in an extension period of eighteen (18) months and thirty-six (36) months, but such events cannot be covered beyond thirty-six (36) months.
- MCS Life will not incur in improper practices against victims of abuse. In accordance with that set forth in Article 72.040 of the Insurance Code of Puerto Rico, the following are considered discriminatory practices by health insurance plans. Notwithstanding, each insured is responsible for covering their corresponding monthly premium. The following are considered discriminatory:

1. Denying, refusing the issuance or renewing, cancelling or otherwise terminating or restricting coverage of a health plan, or setting an additional cost or increase the premium of a health plan because the covered person or the insured has been a victim of abuse; or
2. Excluding, limiting coverage or denying a claim because the covered person or the insured is a victim of abuse.
3. Voluntary or involuntary termination of group coverage to a victim of abuse because coverage was originally issued under the name of the batterer, and he or she has divorced or separated from the victim or has lost custody of the victim, or because coverage of the batterer has terminated in any other voluntary or involuntary manner. As provided here, this does not impede MCS Life to require that the victim of abuse pays complete coverage of the health plan, if requirements are equally applied to all people covered or insured, currently or potentially. MCS Life may terminate group coverage after continued coverage required here has been in effect during eighteen (18) months or thirty-six (36) months, if applicable, if it offers an equivalent conversion to an individual plan or if continued coverage may be satisfied with coverage provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

PART III: COVERED BENEFITS

The benefits included here will apply only when a person is insured under this policy. The insured must comply with the pre-authorization program for those procedures and services established in this policy. The insured will reimburse MCS Life for any claims paid by MCS Life as result of charges incurred after an insured has cancelled coverage.

The services will be covered as long as they are provided in Puerto Rico, by participating providers contracted with MCS Life. Also covered are services pre-authorized and coordinated by MCS Life Clinical Affairs to be performed in the United States, as well as emergency cases, in accordance with the Bill of Rights and Responsibilities of the Patient, Law No.194 of August 25, 2000 and its regulations, as amended.

Some health benefits require a maximum out of pocket (MOOP) expense or disbursement by the insured. The maximum applies to essential health benefits described in the Reference Plan of Puerto Rico. The MOOP amount will be confirmed annually by the Office of the Insurance Commissioner of Puerto Rico. Please refer to Part XII: Copayment, Coinsurance, and Deductible Table in this policy to learn about the corresponding MOOP for your coverage.

The maximum applicable to this policy will be equivalent to the maximum established by the Office of the Insurance Commissioner of Puerto Rico, for its effective year, and represents the sum of out-of-pocket expenses of the insured, that is, initial deductible, copayments and/or coinsurances established for medical coverage and prescription drugs (combined). When the insured reaches the maximum out-of-pocket expenses, as established by the Office of the Insurance Commissioner of Puerto Rico, MCS Life will cover one-hundred percent (100%) of the health essential benefits. For calendar year 2018, the maximum out-of-pocket amount established by the Office of the Insurance Commissioner of Puerto Rico is six-thousand three-hundred fifty dollars ($6,350) for individual and twelve-thousand seven-hundred dollars ($12,700) for families. The following services and their shared costs will not be included in the MOOP calculation:

- MCS Medilínea MD
- MCS Alivia
- Non-essential dental services
- Shared costs paid by a third party (for example: prescription drug discount programs).

In addition to MOOP, this plan requires the insured to pay an initial deductible amount for medical coverage. The insured should pay this amount before starting to receive services that contain an initial deductible.

Section 1: Health Benefits

Shared costs apply to some of these services, as described in Part XII of this policy.

1. Emergency Services

MCS Life will provide and cover, without a waiting period, the benefits of emergency services, including ground ambulance due to emergency. In such cases, the total cost of the service will be paid directly to the provider. In case of ground ambulance services that are not an emergency, the amount paid will be as set for in this policy through reimbursement, as described below in this policy. Said emergency services will be covered without pre-authorization from MCS Life, regardless if the provider of such emergency services is a participating provider or not.

In the case of non-participating providers in Puerto Rico, services will be covered in accordance with the Bill of Rights and Responsibilities of the Patient, Law No. 194 of August 25, 2000, as amended. MCS Life will compensate the provider that offers these services, and he or she/it is obliged to accept such compensation, for an amount that will not be less than the agreed fee with the contracted providers by MCS Life to offer these services. In addition, under these circumstances, said emergency services will be provided regardless of the terms of the corresponding health plan. All medical emergencies in which services are accessed through the **9-1-1 system will not require pre-authorization** and will be covered according to Law No. 383 of September 6, 2000.

MCS Life covers emergency room services and the insured will pay the corresponding copayment or coinsurance for emergency room for accident or illness. If the insured calls Medilínea and is recommended to visit the emergency room with a registry number, a lower copayment or coinsurance may apply for the use of such facilities.	• Medical services due to trauma and/or illness
	• Drugs, materials and equipment
	• Laboratories and X-rays
	• Unlimited respiratory therapy
	• Self-inflicted conditions (suicide attempts)
	• Specialized diagnostic tests

MCS Life covers services offered at an urgency center or facility and the insured will pay the corresponding copayment or coinsurance for urgency center or facility.	• Medical services due to trauma and/or illness.
	• Drugs, materials and equipment.
	• Unlimited respiratory therapy.
	• Self-inflicted conditions (suicide attempts).

2. Hospital Services

Hospitalization Services: All hospitalization services covered under this policy will be paid according	• Room and bed in a semi-private room when the insured is hospitalized. If the insured requests a private room, the insured will be responsible for paying the difference in cost between a semi-private and a private room, except when there is a medical

to the fees negotiated by MCS Life with the participating hospitals of the corresponding network in this coverage. Copayment or coinsurance for hospitalization applies. /Copayment or coinsurance for hospitalization applies, according to hospital classification Level I and Level 2. The hospital level is shown in the Providers Directory 1, 2, 3, 6 applicable to this policy.	necessity of isolation certified by the physician in charge of managing the insured during admission, as provided by the Office of the Insurance Commissioner of Puerto Rico in Ruling Letter No. N-AV-12-111-99 of December 20, 1999. In addition, except in the case of differences in room cost, the contracted provider will not charge for private rooms distinct amounts from those to which it is entitled to charge if the insured were hospitalized in a semi-private room. Elective admissions, elective surgeries and/or procedures that are regularly performed in outpatient facilities but that require to be performed in a hospital, will require pre-authorization from MCS Life Clinical Affairs Department. Initial deductible applies/No initial deductible applies.
	• Isolation room when medically necessary and ordered by admitting physician.
	• Intensive care units, cardiovascular care unit, pediatric intensive care and neonatal intensive care unit.
	• Universal Newborn Hearing Screening, in accordance with Law No. 311 of December 19, 2003, as amended, and hearing screenings by ENTs (ear, nose and throat specialists) and audiologists.
	• Screening for critical congenital cardiac defects by pulse oximetry, in accordance with Law No. 192 of December 20, 2014.
	• Telemetry services.
	• Nursing care and other allied-healthcare providers.
	• Nutrition services offered by the hospital, including parenteral feeding.
	• Clinical laboratories and radiology tests.
	• Diagnostic tests and studies.
	• Respiratory and physical therapies.
	• Blood, plasma and platelets.
	• Medical supplies and drugs.
	• Chemotherapy and radiotherapy (including cobalt) if the condition of the insured requires such treatments during hospitalization (according to that provided in Law No. 107 of 2012, as amended, MCS Life will cover anti-cancer drugs in its various dosing forms, that is, intravenous, orally, injectable or intrathecally, according to the medical order of a specialist or oncologist).
	• Dialysis and hemodialysis – services related to any type of dialysis and hemodialysis, including services for complications that may arise; and the corresponding hospital services or surgical services, will be covered during the first ninety (90) days from:

	– The date the insured became eligible for the policy (in the case of dialysis or hemodialysis, before the date of eligibility), or – The date the insured received the first dialysis or hemodialysis treatment. This applies when dialysis and hemodialysis services are related to the same clinical conditions.
	• Hospitalizations for mental conditions and substance abuse will be covered according to the mental health and substance abuse services, including behavioral health treatment. Electroconvulsive therapies require pre-authorization from MCS Life Clinical Affairs Department.
	• Elective admissions and/or procedures commonly performed at an outpatient facility but that require to be performed in a hospital. Requires pre-authorization from MCS Life Clinical Affairs Department.
	• Medical visits at the hospital
	• Other facilities, services, equipment and supplies usually provided by the hospital and ordered by the physician and that are not expressly excluded from the contract with the hospital.
	• Surgeries and hospital anesthesia – surgeries usually performed at an outpatient facility but need to be performed in the hospital require pre-authorization from MCS Life. This applies only when the procedure is the reason for admission; does not apply when the procedure is performed as treatment during admission.

Other Institutional Services	
Skilled Nursing Facilities	Covered. Corresponding copayment or coinsurance applies. Maximum of one-hundred twenty (120- 6,000) days per policy year. Requires pre-authorization from MCS Life Clinical Affairs. /Covered. Corresponding copayment or coinsurance applies. Requires pre-authorization from MCS Life Clinical Affairs. Services will be covered if they start within the following fourteen (14) days of the date in which the patient was discharged after a hospitalization of at least three (3) days and if offered for the same condition or for any event related to the health condition that caused the hospitalization. Initial deductible applies/No initial deductible applies.
Inpatient Anesthesia	Covered. Initial deductible applies/No initial deductible applies.
Inpatient Surgeries	Covered. Surgeries commonly performed at an outpatient facility but need to be performed in the hospital require pre-authorization from MCS Life Clinical Affairs. This applies only when the procedure is the reason for admission; it does not apply when the procedure is performed as treatment during an admission. Requires pre-authorization from MCS Life.

	Reconstructive surgery will only be offered as a reconstructive intervention to restore damaged tissue due to illness or body injury, an accident (post-trauma) or to correct a birth defect, including oral defects of the newborn, and not related to the Automobile Accident Compensation Administration (ACAA, by its Spanish acronym) or the Workers Accident Compensation Act (CFSE, by its Spanish acronym) occurring during the effectiveness of the policy. Copayment or coinsurance for procedure and facility applies. Initial deductible applies/No initial deductible applies.
Hospitalization due to mental health or controlled substance abuse and/or alcohol (partial and complete)	Covered. Copayment or coinsurance for hospitalization applies/ Copayment or coinsurance for hospitalization applies, according to the hospital classification Level I or Level 2. The hospital level is shown in the Providers Directory 1, 2, 3, 6 applicable to this policy. Electroconvulsive therapies require pre-authorization from MCS Life Clinical Affairs.
Inpatient Hospital Assistance	Covered. Corresponding copayment or coinsurance applies. Requires pre-authorization from MCS Life Clinical Affairs Department. Initial deductible applies/No initial deductible applies.

3. Outpatient Services

Visits to Physicians or Healthcare Professionals	Covered. Corresponding copayment or coinsurance applies to these services according to medical specialty / Corresponding copayment or coinsurance applies to these services according to medical specialty and the network used. There is a (VIP Network) and a (PPO Network) . Copayments and coinsurances will be according to the chosen network . Initial deductible applies/No initial deductible applies. The services of this policy include visits to: • General practitioners • Specialists • Subspecialists • Clinical psychologists • Podiatrists • Audiologists • Optometrists • Chiropractors; and • Naturopathic doctors • Nutritionists
Pediatricians	Covered. General practitioner copayment applies. Initial deductible applies. /No initial deductible applies.
Optometrist	Covered in accordance with Law No. 148 of August 9, 2002. Copayment or coinsurance for specialists applies. Initial deductible applies/No initial deductible applies.
Clinical psychologist	Covered in accordance with Law No. 148 of August 9, 2002, as amended, and in accordance with Act No 239 of 2012. Copayment

	for specialist applies. Initial deductible applies/No initial deductible applies.
Audiologist	Covered in accordance with Law No. 127 of September 27, 2007, as amended. Copayment for specialist applies. Initial deductible applies/No initial deductible applies.
Chiropractor	Covered. For the initial chiropractor visit, the insured will pay the corresponding amount for visit to a specialist. For subsequent visits, the amount corresponding to manipulations applies. Services will be covered by healthcare professionals who are authorized participants to provide said services in accordance with the Bill of Rights of the Patient, as amended under Law No. 150 of August 8, 2006, as amended. Initial deductible applies/No initial deductible applies.
Podiatric Services	MCS Life will cover routine foot care and podiatric surgical procedures performed by participating podiatrists, which will be considered as any other surgical procedure. The insured will be responsible for copayment or coinsurance for visits to a podiatrist. Services will be covered by authorized participating healthcare professionals in accordance with the Bill of Rights and Responsibilities of the Patient, as amended under Law No. 150 of August 8, 2006, as amended. Copayment for specialist applies. Initial deductible applies/No initial deductible applies.
Naturopathic Doctor	Covered in accordance with Law No. 210 of December 14, 2007. Copayment for specialist applies. Initial deductible applies/No initial deductible applies.
Nutritionist	Copayment and coinsurance for specialist applies. Initial deductible applies/No initial deductible applies.
Outpatient Facilities	The use of outpatient surgery facilities will be covered; the insured is responsible for copayment or coinsurance for the use of the facility. Procedures that are regularly performed in the medical office but need to be performed at an outpatient facility require pre-authorization from MCS Life Clinical Affairs Department. Intraocular lens: The cost of the intraocular lens will be included as part of the services contracted in ambulatory surgery facilities. Initial deductible applies/No initial deductible applies.
Pre-admission Examinations	Covered. Copayment or coinsurance for exams and labs in the corresponding network applies. Initial deductible applies/No initial deductible applies.
Diagnostic and Surgical Procedures performed in the medical office	Covered. copayment or coinsurance for diagnostic and surgical procedures in the medical office and copayment or coinsurance for medical visit applies. For molecular or genetic testing, refer to item 7. Laboratory and X-rays Services. Initial deductible applies/No initial deductible applies.
Diagnostic and Surgical Procedures Performed in an outpatient facility	Covered. The insured is responsible for the copayment or coinsurance for diagnostic and surgical procedures performed at an outpatient facility, plus copayment or coinsurance applicable for

	outpatient facility. Procedures generally performed at the medial office that require the use of an outpatient surgical center require pre-authorization from MCS Life Clinical Affairs Department. For molecular or genetic testing, refer to item 7. Laboratory and X-ray services Initial deductible applies/No initial deductible applies.
Intra-articular injection	Covered. Copayment or coinsurance for diagnostic and surgical procedures in the medical office and copayment or coinsurance for medical visits applies. Maximum of twelve (12-6000) injections per policy year. Initial deductible applies/No initial deductible applies.
Outpatient Respiratory Therapy	Covered up to twenty (20-6,000) therapies per policy year in the medical office or outpatient facility. Copayment for outpatient respiratory therapy applies. Respiratory therapy will be covered without limits at the emergency room and hospital, in case of a hospitalized patient. /Covered. Copayment for outpatient respiratory therapy applies. Respiratory therapy will be covered without limits at the emergency room and hospital, in case of a hospitalized patient. Initial deductible applies/No initial deductible applies.
Circumcision	Covered. Initial deductible applies/No initial deductible applies. • Outpatient facility: Copayment or coinsurance for outpatient facility applies. • Medical office: Copayment or coinsurance for diagnostic and surgical procedures in the medical office plus copayment or coinsurance for medical visit applies.
Vasectomy	MCS Life will cover one (1) vasectomy for life, per insured. In medical office: Copayment or coinsurance for diagnostic and surgical procedures in the medical office plus copayment or coinsurance for medical visit applies. In outpatient facility: Corresponding copayment or coinsurance applies. Requires pre-authorization from MCS Life Clinical Affairs Department. These services will only be covered through contracted facilities. The benefit is not available by reimbursement. Initial deductible applies/No initial deductible applies.
Endoscopy in the medical office	Copayment or coinsurance for diagnostic and surgical procedures in the medical office plus copayment or coinsurance for medical visit applies as applicable. Initial deductible applies/No initial deductible applies.

Endoscopy in outpatient facility	Copayment or coinsurance for endoscopy procedures and copayment or coinsurance for outpatient facility applies. Requires pre-authorization from MCS Life Clinical Affairs Department. Initial deductible applies/No initial deductible applies.
Chemotherapy and Radiotherapy (including cobalt)	According to the provisions in Law No. 107 of 2012, MCS Life will cover anti-cancer drugs in their different routes of administration: such as intravenous, oral, injectable or intrathecal; per the medical order from a specialist or oncologist. For chemotherapy administered at the medical office or ambulatory facility, copayment or coinsurance for chemotherapy and radiotherapy applies, including drugs used prior to chemotherapy. Initial deductible applies/No initial deductible applies.
Dialysis and hemodialysis	Covered. Initial deductible applies/No initial deductible applies. Corresponding copayment or coinsurance applies. Services related to any type of dialysis and hemodialysis including services for complications that may arise and corresponding hospital or surgical services will be covered for the first ninety (90) days from: 1.The date in which the insured became eligible for this policy (in case dialysis or hemodialysis began before the date of eligibility) or, 2. The date in which the insured received the first dialysis and hemodialysis treatment. This applies when dialysis and hemodialysis services are related to the same clinical conditions.
Lithotripsy	Copayment or coinsurance for outpatient facility applies. Initial deductible applies/No initial deductible applies. Requires pre-authorization from MCS Life Clinical Affairs Department.
Orthognathic Surgery	Requires pre-authorization from MCS Life Clinical Affairs Department. Initial deductible applies/No initial deductible applies. • In medical office: Copayment or coinsurance for diagnostic and surgical procedures in medical office, plus copayment or coinsurance for medical visit applies. • In outpatient facility: Copayment or coinsurance for outpatient facility applies.
Cervical cryosurgery	Covered. Initial deductible applies/No initial deductible applies. • Medical office: Copayment or coinsurance for diagnostic and surgical procedures in medical office, plus copayment or coinsurance for medical visit applies. • Outpatient facility: Copayment or coinsurance for outpatient facility applies. Requires pre-authorization from MCS Life Clinical Affairs Department.
Nerve conduction velocity test	Covered. Copayment or coinsurance for special network lab applies. Initial deductible applies/No initial deductible applies. Two (2-6,000) procedures per policy year per insured. / Covered. Copayment or coinsurance for laboratory applies.
Invasive and non-invasive cardiovascular tests and procedures	Copayment or coinsurance per corresponding test, plus copayment or coinsurance for medical office or outpatient facility where test is performed applies. For information on applicable copayment or

	coinsurance for each test, please refer to laboratory and X-ray services. Initial deductible applies/No initial deductible applies.
Septoplasty, Rhinoseptoplasty, and Rhinoplasty post-trauma or for medical necessity	Covered only post-trauma or for medical necessity. Not covered for cosmetic cases. Copayment or coinsurance for outpatient facility applies. Requires pre-authorization from MCS Life Clinical Affairs Department. Initial deductible applies/No initial deductible applies.
Neurological tests and procedures	Copayment or coinsurance for X-rays applies. Initial deductible applies/No initial deductible applies.
Scalenotomy	Copayment or coinsurance for outpatient facility applies. Initial deductible applies/No initial deductible applies.
Hearing tests	Covered for outpatient hearing tests that are not preventive services. One (1) tympanometry will be covered per policy year. Copayment or coinsurance for laboratory from special network applies. / Covered. Copayment or coinsurance for laboratory from special network applies. Initial deductible applies/No initial deductible applies.
Reconstructive Surgeries	Only offered for reconstructive interventions to restore damaged tissue due to illness or body injury, an accident (post-trauma) or to correct a birth defect, including oral defects of the newborn, and not related to the Automobile Accident Compensation Administration (ACAA, by its Spanish acronym) or the Workers Accident Compensation Act (CFSE, by its Spanish acronym) occurring during the effectiveness of the policy. Corresponding copayment or coinsurance for facility where the service is offered applies. Initial deductible applies/No Initial deductible applies.
Cardiac catheterization	Copayment or coinsurance for X-rays plus copayment or coinsurance for outpatient facility applies. Initial deductible applies/No initial deductible applies.
Drugs Administered in an Outpatient Level	For medications administered at the medical office or outpatient facility not dispensed by the pharmacy, copayment or coinsurance applies for outpatient-administered medications. Covered medications are described in Drug Formulary *Value* I/Preferred Drug List (PDL) corresponding to this policy. Initial deductible applies/No initial deductible applies.

4. Maternity and Newborn Care

Maternity and neonatal care services are available for the main insured, spouse, and direct dependents of the main insured.

Maternity Services (Prenatal)	Pre and postnatal care will be paid as any other visit. Corresponding copayment or coinsurance for general practitioner, specialist, or subspecialist applies. Initial deductible applies/No initial deductible applies.
Coverage for care within hospital facilities for the mother and her	Initial deductible applies/No initial deductible applies. Minimum forty-eight (48) hour coverage will be provided for care within hospital

newborn copayment or coinsurance applies according to the hospital classification Level I or Level 2. Hospital level is shown in the Providers Directory 1, 2, 3, 6 applicable to this policy./ Copayment or coinsurance for hospitalization applies.	facilities for the mother and the newborn for natural birth, and ninety-six (96) hours for Cesarean section, in accordance with Law No. 248 of August 15, 1999.
MCS Life will cover the following maternity services and the insured is responsible for applicable copayments or coinsurances	Initial deductible applies/No initial deductible applies. • Hospital and outpatient obstetric services. Corresponding copayment or coinsurance for facility or hospital applies. • Obstetric sonographies up to three (3-100) per pregnancy . Copayment or coinsurance for X-rays applies. • Biophysical profile, limited to one (1) per pregnancy, additional ones require pre-authorization from MCS Life Clinical Affairs Department. Copayment or coinsurance for X-rays applies • Fetal Non-Stress Test up to one (1-100) per pregnancy. Copayment or coinsurance for X-rays applies. • Fetal echocardiogram requires pre-authorization from MCS Life Clinical Affairs Department. Copayment or coinsurance for X-rays applies. • Amniocentesis (genetic) up to one (1-100) per pregnancy. No copayment or coinsurance applies. • Amniocentesis (fetal maturation). No copayment or coinsurance applies. Requires pre-authorization from MCS Life Clinical Affairs. • Hospital services. Copayment or coinsurance applies, according to hospital classification Level 1 or Level 2. Hospital level is shown in Providers Directory 1, 2, 3, 6 applicable to this policy. / Copayment or coinsurance for hospitalization applies. • Delivery room or for Cesarean section. Copayment or coinsurance applies, according to hospital classification Level 1 or Level 2 applies. Hospital level is shown in Providers Directory 1, 2, 3, 6 applicable to this policy. / Copayment or coinsurance for hospitalization applies. • Fetal monitoring for pregnancy (results and interpretation) in hospital. Copayment or coinsurance according to hospital classification Level 1 or Level 2 applies. Hospital level is shown in Providers Directory 1, 2, 3, 6 applicable to this policy./ Copayment or coinsurance for hospitalization applies.
Post-partum follow-up visit	Follow-up visit will include any treatment and medical tests required both for the infant as for the mother. Copayment or coinsurance for medical visit applies. Initial deductible applies/No Initial deductible applies.
Newborn care in the hospital (during stay for childbirth)	Initial deductible applies/No initial deductible applies. The following benefits are covered under this policy:

copayment or coinsurance applies, according to hospital classification Level 1 or Level 2 applies. Hospital level is shown in Providers Directory 1, 2, 3, 6 applicable to this policy. / Copayment or coinsurance for hospitalization applies.	• Healthcare services for injuries or diseases, including care and treatment for birth defects and abnormalities as diagnosed by a physician, in accordance with Article 54.050 (B) of the Health Insurance Code of Puerto Rico. • Medical care in the hospital and neonatal intensive care units (NICU) • Use of the Well Baby Nursery • Universal newborn hearing screening in the hospital • Screening for critical congenital cardiac defects by pulse oximetry, in accordance with Law No. 192 of November 20, 2014. • Charges for routine nursing care in the hospital • Circumcision of the newborn in the hospital.
Neonatal care (outpatient services)	Initial deductible applies/No initial deductible applies. • Routine visits for the baby (*Well Baby Care*). Corresponding copayment or coinsurance for primary physician, specialist or subspecialist applies. • Healthcare services for injuries or illnesses, including care and treatment for birth defects and abnormalities as diagnosed by a physician, in accordance with Article 54.050 (B) of the Health Insurance Code of Puerto Rico. • Universal newborn hearing screening
Newborn Screening Tests	Initial deductible applies/No initial deductible applies. Preventive tests required by PPACA and set forth by the Department of Health of Puerto Rico and according to Title XIX of the Medicaid Program, Title V of the Mother, Children and Adolescents Program and the American Academy of Pediatrics, as required under Law No. 296 of September 1, 2000, as amended. For information on applicable screenings, refer to item 9, Preventive, Wellness and Chronic Diseases Management Services.

5. Mental Health, Substance Abuse and Behavioral Health Treatment

MCS Life will cover services according to Law No. 408 of October 2, 2000, amended on October 3, 2008, and in accordance with Law No. 239 of 2012, and in accordance with the Mental Health Parity Act. Professionals who provide psychology services for MCS Life are duly licensed by the Examining Board of Psychologists of Puerto Rico (Junta Examinadora de Psicólogos de Puerto Rico).

Mental Health, Substance Abuse and Behavioral Treatment services are offered directly through the provider or by their voluntary participation in the programs MCS Solutions, offered twenty-four (24) hours a day, seven (7) days a week, with a coverage that integrates mental health and substance abuse care. The purpose of the program is to facilitate immediate access to the necessary services for your situation or condition with a hotline service provided by MCS Life. This coordination facilitates that the insured receives the most appropriate service at the least restrictive level possible, in accordance with Law No. 408 of October 2, 2000, known as Mental Health Act.

The insured can access the services directly according to his or her need. In the event of an emergency, the insured will have direct and immediate access service through an emergency room.

Mental health and substance abuse. Ambulatory treatment includes, but is not limited to:	• Unlimited visits to psychiatrists and clinical psychologists with corresponding applicable copayment. Initial deductible applies/No initial deductible applies.
	• Twenty-three (23) hour stabilization units, after twenty-four (24) hours it is considered a hospitalization. Initial deductible applies/No initial deductible applies.
	• Intensive Outpatient, IOP. Copayment or coinsurance applies, according to hospital classification Level 1 or Level 2. Hospital level is shown in Providers Directory 1, 2, 3, 6 applicable to this policy. / Copayment or coinsurance for hospitalization applies. Requires pre-authorization from MCS Life Clinical Affairs. Initial deductible applies/No initial deductible applies.
	• For partial hospitalization, copayment or coinsurance for partial hospitalization applies and requires pre-authorization from MCS Life Clinical Affairs Department. For full hospitalization, corresponding copayment or coinsurance applies. Partial hospitalizations require pre-authorization from MCS Life Clinical Affairs Department. Initial deductible applies/No initial deductible applies.
	• For group therapy visits and collateral visits, corresponding copayment applies. Initial deductible applies/No initial deductible applies.
	• Management of intensive cases with mental health case management intervention. Initial deductible applies/No initial deductible applies.
Substance abuse:	The following services are covered without limits for dependence disorders or controlled substance and/or alcohol abuse, in accordance with Law No. 408 of 2000, as amended, and in accordance with PPACA. Initial deductible applies/No initial deductible applies. : • Management of intensive cases • Psychiatrist • Clinical psychologists • Collateral visits • Group therapies (by clinical psychologists) • Ambulance transfers from one facility to another.
Residential treatment for dependence disorders or controlled substance and/or abuse alcohol	Covered. Initial deductible applies/No initial deductible applies. This benefit includes detoxification from controlled substance dependence or abuse at facilities available in Puerto Rico, in accordance with Law No. 408 of 2000, as amended. Requires pre-authorization from MCS Life Clinical Affairs.
Psychological tests	Covered. Initial deductible applies/No initial deductible applies. Copayment or coinsurance for laboratory applies. For people under twenty-one (21) years of age, psychological tests covered are those determined by the Department of Health in collaboration with the

	Department of Education, subject to the conditions and limitations set forth by the referred agencies and/or special applicable laws, in accordance with Law No. 296 of September 1, 2000, as amended.
Employee Assistance Program (PAE, by its Spanish acronym) with coordination required through MCS Solutions	Eight (8) visits per insured to a psychologist or social worker, without copayment for consultation, counseling and referrals. If the insured exceeds eight visits, copayment for specialists should be paid. • Legal advice • Financial advice • Crisis management • Marriage counseling.

6. Rehabilitation, Habilitation and Durable Medical Equipment Services

Rehabilitative and Habilitative Physical Therapy	Covered up to twenty (20-900) physical therapies per policy year per insured. Additional therapies require pre-authorization from MCS Life Clinical Affairs Department. These services will also be covered for the treatment of autism, as defined in the Diagnostic and Statistical Manual of Mental Disorders, in accordance with Law No. 220-2012 approved on September 4, 2012, better known as BIDA Act, (Spanish acronym for the Act for the Wellbeing, Integration, and Development of Persons with Autism). Corresponding copayment or coinsurance applies. In accordance with Law No. 220 of 2012 approved on September 4, 2012, better known as BIDA Act (Spanish acronym for the Act for the Wellbeing, Integration, and Development of Persons with Autism) , there are no limits for the treatment of autism disorders. Initial deductible applies/No initial deductible applies.
Occupational therapies (outpatient)	Covered up to twenty (20-900) occupational therapies per policy year per insured. Copayment or coinsurance for physical therapy applies. These outpatient services will also be covered for the treatment of autism disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, in accordance with Law No. 220-2012 approved on September 4, 2012, better known as BIDA Act (Spanish acronym for the Act for the Wellbeing, Integration, and Development of Persons with Autism) / These outpatient services are covered only for the treatment of autism disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, in accordance with Law No. 220-2012 approved on September 4, 2012, better known as BIDA Act (Spanish acronym for the Act for the Wellbeing, Integration, and Development of Persons with Autism). Copayment or coinsurance for physical therapy applies. Initial deductible applies/No initial deductible applies.
Speech and Language Therapy (outpatient)	Covered up to twenty (20-900) speech therapies per policy year per insured. Copayment or coinsurance for physical therapy applies. These outpatient services will also be covered

	for the treatment of autism disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, in accordance with Law No. 220-2012 approved on September 4, 2012, better known as BIDA Act (Spanish acronym for the Act for the Wellbeing, Integration, and Development of Persons with Autism). / These outpatient services will only be covered for the treatment of autism disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, in accordance with Law No. 220-2012 approved on September 4, 2012, better known as BIDA Act (Spanish acronym for the Act for the Wellbeing, Integration, and Development of Persons with Autism). Department Copaymentor coinsurance for physical therapy applies. Initial deductible applies/No initial deductible applies.
Chiropractor Manipulations	Covered up to twenty (20-900) manipulations per policy year per insured. Additional therapies require pre-authorization from MCS Life Clinical Affairs Department. Corresponding copayment or coinsurance applies, in accordance with Law No. 220-2012 approved on September 4, 2012, better known as BIDA Act (Spanish acronym for the Act for the Wellbeing, Integration, and Development of Persons with Autism), no limits will apply to treatments for autism disorders. Other chiropractor services are: Services offered by chiropractors and received by the insured may include radiology services and physical therapy, provided there is a contract with the participating provider. / These outpatient services will only be covered for the treatment of autism disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, in accordance with Law No. 220-2012 approved on September 4, 2012, better known as BIDA Act (Spanish acronym for the Act for the Wellbeing, Integration, and Development of Persons with Autism). Copayment or coinsurance for corresponding therapy applies. Services offered by chiropractors and received by the insured may include radiology services and physical therapy, provided there is a contract with the participating provider. Initial deductible applies/No initial deductible applies.
Durable Medical Equipment (DME)	Covered. Copayment or coinsurance for durable medical equipment applies through providers with a contract and requires pre-authorization from MCS Life Clinical Affairs. Covered services are: • Mattress • Respiratory equipment, including respiratory therapy equipment • Adjustable beds • Standard wheelchairs

	• Oxygen and the necessary equipment for its administration • Shoes for patients with diabetes • *brassier* required post-mastectomy Durable medical equipment not described in this policy is not covered, including custom made equipment. / Covered. Copayment or coinsurance for Durable Medical Equipment applies through providers with a contract and requires pre-authorization from MCS Life Clinical Affairs. Initial deductible applies/No initial deductible applies.
Glucometer, lancets and strips	Covered in accordance with Law No. 177 of August 13, 2016 only for people twenty-one (21) years of age with a diagnosis of type 1 Diabetes *Mellitus* by a pediatric endocrinologist or endocrinologist. • One (1) glucometer every three (3) years. Copayment or coinsurance for Durable Medical Equipment applies. Requires pre-authorization from MCS Life Clinical Affairs. • One-hundred fifty (150) test strips and one-hundred fifty (150) lancets per month. Requires medical prescription. Lancets and strips are covered through medical equipment providers with a contract with MCS Life, not covered under pharmacy. Copayment or coinsurance for Durable Medical Equipment applies. Requires pre-authorization from MCS Life Clinical Affairs. MCS Life will cover only those glucometers approved by the Food and Drug Administration (FDA). If an endocrinologist orders a specific glucometer because of the treatment being used by the patient, the endocrinologist will submit a justification. In such a case, the brand ordered by the endocrinologist will be covered. As per guidelines set forth by the Centers for Medicare and Medicaid Services, children up to twenty-one (21) years of age should receive the health care they need, including high quality supplies and treatment. Initial deductible applies/No initial deductible applies. / Covered. Copayment or coinsurance for Durable Medical Equipment applies through contracted providers and requires pre-authorization from MCS Life Clinical Affairs. Covered in accordance with Law No. 177 of August 13, 2016 only for people under twenty-one (21) years of age with a diagnosis of type 1 Diabetes Mellitus by a pediatric endocrinologist of endocrinologist. • One (1) glucometer every three (3) years. Copayment or coinsurance for Durable Medical Equipment applies. Requires pre-authorization from MCS Life Clinical Affairs. • One hundred-fifty (150) test strips and one-hundred fifty (150) lancets per month. Requires medical prescription. Lancets and strips are covered through providers of medical equipment with contract with MCS Life, not covered under pharmacy. Copayment or coinsurance for Durable Medical

	Equipment applies. Requires pre-authorization from MCS Life Clinical Affairs. MCS Life will cover only those glucometers approved by the Food and Drug Administration (FDA). If an endocrinologist orders a specific glucometer because of the treatment being used by the patient, the endocrinologist will submit a justification. In such a case, the brand ordered by the endocrinologist will be covered. As per guidelines set forth by the Centers for Medicare and Medicaid Services, children up to twenty-one (21) years of age should receive the health care they need, including high quality supplies and treatment. Initial deductible applies/No initial deductible applies.
Portable Insulin Infusion Pump	Covered, in accordance with Law No. 177 of August 13, 2016, is a portable infusion pump and its maintenance for people under twenty-one (21) years of age diagnosed with type 1 Diabetes Mellitus by a pediatric endocrinologist or endocrinologist. Copayment for Durable Medical Equipment applies. Requires pre-authorization from MCS Life Clinical Affairs. The portable insulin infusion pump covered by MCS Life must have been ordered by an endocrinologist. The endocrinologist chooses the portable infusion pump brand based on patient age, level of physical activity, and his or her knowledge or of their caregivers of the condition. Initial deductible applies/No initial deductible applies. / Covered. Copayment or coinsurance for Durable Medical Equipment applies through providers with a contract and requires pre-authorization from MCS Life Clinical Affairs. Initial deductible applies/No initial deductible applies. / Covered. Copayment for Durable Medical Equipment applies. Requires pre-authorization from MCS Life Clinical Affairs. Covered, also in accordance with Law No. 177 of August 13, 2016, is a portable infusion pump and its maintenance for people under twenty-one (21) years of age diagnosed with type 1 Diabetes Mellitus by a pediatric endocrinologist or endocrinologist. Copayment for Durable Medical Equipment applies. Requires pre-authorization from MCS Life Clinical Affairs. The portable insulin infusion pump covered by MCS Life must have been ordered by an endocrinologist. The endocrinologist chooses the portable infusion pump brand based on patient age, level of physical activity, and his or her knowledge or of their caregivers of the condition. / Covered. Copayment or coinsurance for Durable Medical Equipment applies through providers with contract and requires pre-authorization from MCS Life Clinical Affairs Initial deductible applies/No initial deductible applies.
Technological Equipment Services	Copayment or coinsurance for Durable Medical Equipment applies. Initial deductible applies/No initial deductible applies.

	Includes tests and equipment for insureds who require the use of a ventilator for life support. In addition, it covers an eight (8) hour daily shift of skilled nursing services or specialists in respiratory therapy with nursing knowledge for the prevention of death or greater degree of disability per insured. Also included are supplies needed for technical equipment management and physical and occupational therapy necessary for motor development of these patients, in accordance with Law No. 125 of September 21, 2007 and Law No. 62 of May 4, 2015. To the effects of Law No. 62 of May 4, 2015, a beneficiary is anyone who: • uses medical technology; as well as; • children that need a tracheostomy to breathe, and whose functioning relies on medical equipment, ventilators or supplemental oxygen; • those that started treatment as minors and reach twenty-one (21) years of age or have received medical services or received home care, and need to continue receiving these services after turning twenty-one (21) years of age.
Home Health Care	Covered up to sixty (60-6,000) combined days in the home, per policy year per insured. Corresponding copayment or coinsurance applies. Requires pre-authorization from MCS Life Clinical Affairs. Additional days require medical justification and pre-authorization from MCS Life Clinical Affairs. Initial deductible applies/No initial deductible applies. Charges made by a certified home care institution will be covered if ordered by a physician, under the following modalities: • if started within fourteen (14) days following discharge date after a hospital stay of at least three (3) days and if rendered for the same condition or related condition as for the hospitalization; • if provided as continuity of treatment for the same condition-related causes or admission diagnosis that prompted the hospital stay; • or as an alternative to hospitalization. Services offered under home health care are: • speech therapy (habilitative or rehabilitative) • physical therapy • occupational therapy • cardiovascular rehabilitative therapy • respiratory therapy.

7. Laboratory and X-rays Services

MCS Life will pay the negotiated and contracted amount in the MCS Life Providers Network for the production and interpretation of laboratory and X-ray procedures, when the insured incurs in laboratory tests or X-rays expenses that are:

- ordered by a physician;
- necessary for the diagnosis of an illness or injury;
- medically necessary; and
- practiced by a laboratory or radiologist

Laboratories	Covered with laboratory coinsurance. Initial deductible applies/No initial deductible applies.
X-Rays	Covered with X-ray coinsurance. Initial deductible applies/No initial deductible applies.
PET CT	Copayment or coinsurance for special tests applies. Also known as Pet Scan. Requires pre-authorization from MCS Life Clinical Affairs Department. / Copayment or coinsurance for special tests applies. Maximum of one (1-900) per policy year. Also known as *Pet Scan*. Requires pre-authorization from MCS Life Clinical Affairs Department. Initial deductible applies/No initial deductible applies.
Molecular and/or Genetic Tests	Initial deductible applies/No initial deductible applies. Covered as required under Law No. 220 of September 4, 2012, Act for the Wellbeing, Integration, and Development of Persons with Autism (BIDA, by its Spanish acronym), federal law (*Women's Health and Cancer Rights Act* of 1998) or as required by the Puerto Rico (*Health Benefit Benchmark Plan*) that includes required preventive services. Only covered with participating providers that hold contract with MCS Life. Coinsurance for molecular and/or genetic tests applies, except for tests required by law as preventive services. Requires pre-authorization from MCS Life Clinical Affairs. These tests will only be covered upon referral from the following specialties, as per medial policies set forth by MCS Life: • oncologist • hematologist-oncologist • urologist • geneticist • gynecologist • gastroenterologist. / Covered. Coinsurance for molecular and/or genetic tests applies. Coverage, in accordance with Law No. 220 of September 4, 2012, Act for the Wellbeing, Integration, and Development of Persons with Autism (BIDA, by its Spanish acronym), federal (*Women's Health and Cancer Rights Act* of 1998) or as required by Puerto Rico (*Essential Health Benefit Benchmark Plan*) that includes required preventive services. Only covered with participating providers that hold contract with MCS Life. Coinsurance for molecular and/or genetic tests applies, except for tests required by law as preventive services. Requires pre-authorization from MCS Life Clinical Affairs. These

	tests will only be covered upon referral from the following specialties, as per medial policies set forth by MCS Life: • oncologist • hematologist-oncologist • urologist • geneticist • gynecologist • gastroenterologist.
Nuclear Medicine	Covered. Coinsurance for X-rays applies. Initial deductible applies/No initial deductible applies.
Polysomnography Sleep study	Covered, one (1-900) study for life per insured. Coinsurance for X-rays applies. Requires pre-authorization from MCS Life Clinical Affairs. Initial deductible applies/No initial deductible applies.
CT Scan	Copayment or coinsurance for special tests applies. Requires pre-authorization from MCS Life Clinical Affairs. / Copayment or coinsurance for special tests applies. Maximum of One (1-900) per policy year. Requires pre-authorization from MCS Life Clinical Affairs. / Copayment or coinsurance for special tests applies. One (1-900) per anatomical region per policy year. Requires pre-authorization from MCS Life Clinical Affairs. Initial deductible applies/No initial deductible applies.
Bone densitometry	Covered. Coinsurance for X-rays applies. Initial deductible applies/No initial deductible applies.
Echocardiogram	Covered. Coinsurance for X-rays applies. Initial deductible applies/No initial deductible applies.
Electrocardiogram	Covered. Coinsurance for X-rays applies. Initial deductible applies/No initial deductible applies.
Electroencephalogram	Covered. Coinsurance for X-rays applies. Initial deductible applies/No Initial deductible applies.
Electromyogram	Covered, two (2-900) per policy year per insured. Copayment or coinsurance for X-rays applies. Initial deductible applies/No initial deductible applies.
Angiography	Covered. Coinsurance for X-rays applies. Initial deductible applies/No initial deductible applies.
Holter	Covered. Coinsurance for X-rays applies. Initial deductible applies/No initial deductible applies.
Non-invasive peripheral cerebrovascular tests	Covered. Coinsurance for X-rays applies. Initial deductible applies/No initial deductible applies.
Myelography	Covered. Coinsurance for X-rays applies. Initial deductible applies/No initial deductible applies.

MRA	Covered. Copayment or coinsurance for X-rays applies. Requires pre-authorization from MCS Life Clinical Affairs. / Covered. Maximum of one (1) per policy year. Copayment or coinsurance for X-rays applies. Requires pre-authorization from MCS Life Clinical Affairs. / Covered. One (1) per anatomical region per policy year. Copayment or coinsurance for X-rays applies. Requires pre-authorization from MCS Life Clinical Affairs. Initial deductible applies/No initial deductible applies.
MRI	Covered. Copayment or coinsurance for X-rays applies. Requires pre-authorization from MCS Life Clinical Affairs. / Covered. Maximum of one (1) per policy year. Copayment or coinsurance for X-rays applies. Requires pre-authorization from MCS Life Clinical Affairs. / Covered. One (1) per anatomical region per policy year. Copayment or coinsurance for X-rays applies. Requires pre-authorization from MCS Life Clinical Affairs. Initial deductible applies/No initial deductible applies.
Sonography	Covered. Coinsurance for X-rays applies. / Covered. One (1) per anatomical region per policy year. Coinsurance for X-rays applies. Initial deductible applies/No Initial deductible applies.
SPECT	Covered. Copayment or coinsurance for special tests applies. / Covered. One (1) per anatomical region per policy year. Copayment or coinsurance for special tests applies. Initial deductible applies/No Initial deductible applies.
Stress test)	Covered. Coinsurance for X-rays applies. Initial deductible applies/No initial deductible applies.
Stress Test with sestamibi, Persantine or Thallium	Covered. Coinsurance for X-rays applies. Initial deductible applies/No initial deductible applies.
Allergy test	Covered. Maximum of fifty (50) per policy year. • In medical office: Coinsurance for laboratory applies special network . • In laboratory: Coinsurance for laboratory applies of corresponding network. / Covered. • In medical office: Coinsurance for laboratory applies special network . • In laboratory: Coinsurance for laboratory applies of corresponding network. Initial deductible applies/No initial deductible applies.

8. Preventive, Wellbeing, and Management of Chronic Diseases Services

Preventive medicine services will be covered with zero ($0) copayment or zero (0%) coinsurance according to the insured's age and gender. Preventive care services to which these conditions apply are defined and included below and described in the following link: https://www.healthcare.gov/what-are-my-preventive-care-benefits .

Preventive services drugs will be covered as required by federal laws PPACA, Public Law No. 111-148 (PPACA) and Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152 (HCERA), as set forth by the United States Preventive Services Task Force (USPSTF) and the Puerto Rico Health Insurance Code (CSSPR,

by its Spanish acronym). In addition, this plan covers the dispensing of the drug buprenorphine for the treatment of opioid dependence, as provided in Law No. 140 of September 22, 2010.

MCS Life will cover the evaluation and/or tests described when performed as part of a preventive service. Preventive medicine service includes history and physical exams according to the insured's age and gender. Preventive medicine services include:

- Evaluation by a physician appropriate for the insured's age and gender;
- Counseling and treatment to identify and reduce identified risk factors.

Preventive Services in Children

Preventive medicine services for children usually include the recommendations of the American Academy of Pediatrics depending on age and gender:

- history
- measures
- sensory assessments
- development/behavioral assessment
- physical examination
- specific procedures for patients at risk
- anticipatory guidance (like nutritional counseling) and
- dental referrals.

Preventive Services	**Indication**
Use of tobacco, alcohol, and drugs	Evaluation to identify use in children eleven (11) – twenty-one (21) years of age.
Tobacco use	Physician's interventions to include education or brief counseling to prevent the initiation of tobacco use in children and teenagers.
Autism	Evaluation for children between twelve (12) and thirty-six (36) months.
Behavioral Health Assessment	Children of all ages: zero (0) to eleven (11) months, one (1) to four (4) years, five (5) to ten (10) years, eleven (11) to fourteen (14) years and fifteen (15) to seventeen (17) years.
Blood Pressure Screening	Screening for high blood pressure in adults eighteen (18) years or older. Obtain measurements beyond clinical scenario to confirm diagnosis before starting treatment.
Cervical Dysplasia	Screening for sexually active girls
Congenital Hypothyroidism	Screening for all newborns.
Depression	Screening for depression disorders in adolescents twelve (12) to eighteen (18) years to establish a system that can adequately diagnose and offer the necessary treatment, including psychotherapy and follow-up visits.

Developmental Screening	Screening for children under three (3) years of age and monitoring during childhood.
Dyslipidemia	Screening for children at risks of lipid disorders. Ages: one (1) – four (4) years, five (5) – ten (10) years, eleven (11) – fourteen (14) years, fifteen (15) – seventeen (17) years.
Prevention of Dental Caries and Fluoride Supplements	Covered for babies and children up to five (5) years of age. Fluoride application to primary teeth in all babies and children at start of primary teeth eruption in primary medical care practices. Oral fluoride supplements starting at 6 months of age in children with fluoride-deficient water supply.
Gonorrhea	Prophylactic topical eye medication for all newborn for the prevention of gonococcal ophthalmia neonatorum (Gonorrhea).
Hearing Screening	Universal Neonatal Hearing Screening.
Screening for Height, Weight and Body Mass Index	Evaluation for children ages zero (0) to eleven (11) months, one (1) to four (4) years, five (5) to ten (10) years, eleven (11) to fourteen (14) years and fifteen (15) to seventeen (17) years.
Hematocrit or hemoglobin	Screening for children.
Sickle Cell Disease	Neonatal screening.
Human Immunodeficiency Virus (HIV) Screening Test	HIV screening in teenagers and adults fifteen (15) and sixty-five (65) years. Younger adolescents and older adults who are at greater risk should also have screening tests.
Iron Supplementation	For children ages 6 (six) to twelve (12) months at risk of anemia.
Lead Screening	Screening for children with high lead blood levels ages one (1) to six (6) years with an average and higher risk, and in pregnant asymptomatic women.
Medical History	For all children throughout their development: zero (0) to twenty-one (21) years.
Obesity	Obesity screening for children six (6) years and over and comprehensive counseling, intensive behavioral interventions to promote improved weight.
Oral Health	Risk evaluation in children from birth up to ten (10) years of age.
Phenylketonuria (PKU)	Neonatal screening for genetic disorders.
Sexually Transmitted Disease	Preventive counseling and screening for adolescents at risk.
Tuberculin	Tuberculin test in children at greater risk of tuberculosis from zero (0) to eleven (11) months, one (1) to four (4) years, five (5) to ten (10) years, eleven (11) to fourteen (14) years, fifteen (15) to twenty-one (21) years.
Vision	Vision screening for all children.

Skin Cancer	Counseling for young adults, teenagers, children and parents of small children of the benefits of minimizing exposure to radiation from ultraviolet (UV) rays in people with fair skin from six (6) months up to twenty-four (24) years of age to reduce the risk of skin cancer.
Hepatitis B Virus (HBV) Infection	Evaluation for teenagers and adults at risk of infection.
Syphilis	Syphilis evaluation in high risk teenagers and adults.
Vision evaluation	Eye exam at least once in children three (3) to five (5) years to detect amblyopia or its risk factors.

Preventive Services in Adults

The physician will determine the medical preventive services for the adult, based on the insured's age and sex, including at least the following services:

Preventive Services	Indication
Abdominal Aortic Aneurysm (AAA) Screening	One (1) ultrasound service for AAA screening in men aged sixty-five (65) to seventy-five (75) who have smoked at any given time.
Alcohol Abuse	Screening for adults aged 18 or older for alcohol abuse and counseling on reducing the misuse of alcohol to people involved in risky or harmful alcohol drinking.
Counseling and Aspirin Supply for Cardiovascular Disease and Colorectal Cancer Risk Prevention	Low-dose aspirin use is recommended for the prevention of cardiovascular diseases and colorectal cancer in adults aged fifty (50) to fifty-nine (59) years with a 10% or greater cardiovascular risk at 10-years; who are not at increased risk for bleeding; have a life expectancy of at least 10 years; and are willing to take low-dose aspirin daily for at least 10 years.
High Blood Pressure (HBP) Screening	Hypertension screening for men and women aged eighteen (18) years or older.
Cholesterol Screening	Lipid disorders screening for men and women if at a higher risk of coronary heart disease, in accordance with Law No. 218 of August 30, 2012.
Colorectal Cancer Screening	Occult blood test, sigmoidoscopy or colonoscopy for colorectal cancer screening for men and women, in accordance with Law No. 218 of August 30, 2012. The risk and benefits of these screening methods vary.
Lung Cancer Screening	Annual lung cancer screening with low-dose computed tomography (CT) in adults fifty-five (55) to eighty (80) years old, with a history of smoking thirty (30) packs a year and: • currently smoke or • have stopped smoking in the last fifteen (15) years. Screening should be interrupted once the person has stopped smoking for fifteen (15) years or develops a health problem that

	considerably limits life expectancy or ability or willingness to undergo curative lung surgery.
Depression Screening	Depression screening. Applies to both men and women who think they are suffering from depression.
Type II Diabetes Screening	Covered for adults with hypertension and blood pressure greater than 135/80 mm/Hg. Includes counseling and tests to identify blood sugar levels.
Abnormal Blood Glucose and Type II Diabetes Mellitus Screening	Screening for abnormal blood glucose as part of cardiovascular risk assessment *in* adults aged forty (40) to seventy (70) years who are overweight or obese. Physicians should offer or refer patients with abnormal blood glucose levels to intensive behavioral counseling interventions to promote a healthy diet and physical activity.
Healthy Diet and Exercise for Cardiovascular Disease Prevention	Counseling and recommendations for overweight or obese adults with high risk factors for cardiovascular disease. Counseling includes healthy nutrition and physical activity for disease prevention.
Hepatitis B (VHB) Virus Infection	Screening for adults at risk of infection.
Fall Prevention and Recommendations for the use of Vitamin D	Counseling and recommendations on the use of vitamin D for fall prevention in adults over sixty-five (65) years old who are at a higher risk of falling.
Fall Prevention and Recommendations for exercising or physical therapy	Counseling and recommendations for exercising or receiving physical therapy to prevent falls in adults sixty-five (65) years and older who are at a higher risk of falling.
Hepatitis C Virus (HCV) Screening Test	Hepatitis C virus (HCV) screening for adults at higher risk of infection and one (1) test for adults born between 1945 and 1965.
Human Immunodeficiency Virus (HIV) Screening Test	Human immunodeficiency virus (HIV) screening test for teenagers and adults between fifteen (15) and sixty-five (65) years. Younger adolescents and older adults who are at a higher risk should also have screening tests.
Obesity	Counseling and screening for all adults. Physicians may provide or refer patients with a body mass index (BMI) of 30kg/m^2 or higher to intensive multicomponent behavioral interventions.
Sexually Transmitted Diseases	High-intensity behavioral counseling for sexually transmitted disease prevention for sexually active adolescents and adults at high risk of related disease.
Tuberculin	Tuberculin screening for adults at risk of latent tuberculosis infection *(*LTBI*)*.
Use of Statins for the Prevention of Cardiovascular Disease	Use of low or moderate dose statins to prevent cardiovascular disease (CVD) episodes, such as symptomatic coronary disease or cerebrovascular ischemic accidents, and mortality in adults without history of CVD, provided they meet the following criteria:

	• Age forty (40) to seventy-five (75) years of age; • One or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); • Calculated risk of 10% or more of a cardiovascular event at 10-years. Identification of dyslipidemia and calculated risk of a CVD event at 10-years requires full lipid panel test in adults forty (40) to seventy-five (75) years.
Tobacco Use and Medication	Adult screening and behavioral interventions for smoking cessation. For those using smoking cessation products, this plan covers the dispensing of U.S. Food and Drug Administration (FDA) approved smoking cessation drugs for ninety (90) consecutive days at one (1) attempt and up to two (2) attempts per year.
Syphilis	Syphilis screening for adults at high risk.

Preventive Services for Women, including Pregnant Women

Preventive Services	Indication
Anemia	Iron deficiency routine screening for pregnant women.
Bacteriuria (or urinary tract infection)	Screening for pregnant women not showing bacterial symptoms in urine culture at twelve (12) to sixteen (16) weeks of pregnancy or at the first prenatal visit, if after that term of pregnancy.
BRCA	Genetic testing, screening and counseling using tools to identify family history of breast cancer, ovarian cancer, Fallopian tubes cancer or peritoneal cancer. After being identified at high risk for a genetic mutation (BRCA1 and BRCA2), the provider will determine if the insured should have a BRCA test or not.
Preventive Medications for Breast Cancer	Clinical orientation for patients at high risk of developing breast cancer that will allow her to decide along with her physician if pharmacotherapy is adequate to reduce the risk of developing the disease. The physician may prescribe medications to reduce the risk of breast cancer, such as tamoxifen or raloxifene, for women at high risk of developing the disease and at low risk of adverse reactions to the medication.
Mammography for Breast Cancer Screening	Screening every one (1) to two (2) years in women older than 40. Screening every two (2) years for women aged fifty (50) to seventy-four (74) years.
Breast Cancer Preventive Medication Discussion	Counseling for women at high risk.
Breastfeeding	Support and counseling by a trained breastfeeding provider (pediatrician, obstetrician/gynecologist, family physician) during pregnancy and/or post-partum. The breastfeeding equipment is covered with a written order from the physician after the third trimester of pregnancy and up to a year after childbirth.

	Additional supplies for breastfeeding equipment are covered and equipment is available through contracted providers.
Cervical Cancer Screening	Screening for sexually active women. Women aged twenty-one (21) to sixty-five (65) years should have a PAP test every three (3) years or women thirty (30) to sixty-five (65) years old who wish to have less frequent testing combined with a human papillomavirus virus (HPV) test every five (5) years.
Chlamydia Screening	Chlamydia infection screening for women twenty-four (24) years of age or younger, and older pregnant women at high risk. Chlamydia infection screening for all women twenty-four (24) years or younger who are not pregnant and older women who are not pregnant who show high risk of infection.
Contraceptive Methods	Orientation, counseling and supplies of all FDA approved contraceptive methods, as required by law. No copayment ($0) or (0%) coinsurance applies to these medications. The following methods will be covered through your medical coverage as outpatient services, including insertion and removal of applicable devices: • Surgical sterilization • Implants surgical sterilization for women. • Rod implant • Intrauterine copper device • Intrauterine progesterone device • Injection • Diaphragm • Sponge • Cervical cap • Female condoms • Spermicide The following methods are covered under your pharmacy coverage. Please refer to Form Value/Preferred Drug List PDL applicable to this policy, for the list of contraceptives covered under this policy: • Oral contraceptives (combined oral contraceptive pill) • Oral contraceptives (progestins only) • Extended/continuous use oral contraceptives • Patches • Contraceptive vaginal ring • Emergency contraceptives (ulipristal acetate)
Evaluation and Counseling for Detecting Signs of Domestic and Interpersonal Violence	Screening for women of childbearing age to detect couple violence, such as domestic violence, and offer or refer women who are positive to intervention services. This recommendation applies to women with no signs or symptoms of abuse.

Folic Acid Supplements	Recommending the daily use of 0.4 – 0.8 mg (400 to 800 mcg) folic acid supplementation in women planning or with the ability to become pregnant. Requires medical order.
Gestational Diabetes Screening Tests	For pregnant women after twenty-four (24) weeks of gestation and on the first prenatal visit in women identified at high risk of diabetes.
Gonorrhea	Gonorrhea infection screening for sexually active women, including pregnant women with risk factors for infection (for example, if they are young or have other individual or community risks of infection).
Hepatitis B Virus	Screening for pregnant women.
Counseling and Screening for Human Immunodeficiency Virus (HIV) Test	Covered in all sexually active women. According to Administrative Order No. 307 of August 14, 2013 of the Health Department of Puerto Rico, the test will be performed to pregnant women as follows: • First HIV test during the first trimester of pregnancy or at first prenatal visit. • Second test during the third trimester of pregnancy between twenty-eight (28) and thirty-four (34) weeks of pregnancy.
High Risk Human Papillomavirus Test (DNA testing for human papilloma)	Applies to women with normal cytology results. This screening test should start at age thirty (30) and repeated every three (3) years.
Osteoporosis	Osteoporosis screening is covered with bone measurement tests in women sixty-five (65) years on. In addition, osteoporosis screening is covered with bone measurement tests for the prevention of fractures caused by osteoporosis in post-menopausal women under sixty-five (65) years with a high risk of osteoporosis, as determined by a formal clinical tool to evaluate the risk, in accordance with Law No. 218 of August 30, 2012 and the recommendations of the United States Preventive Service Task Force (USPSTF).
Blood Group Classification – Rh (D) Factor	Rh (D) blood type and antibodies screening for all pregnant women during their first prenatal visit. Similarly, the United States Preventive Service Task Force (USPSTF) recommends repeating antibodies testing in pregnant women Rh (D) negative or intolerant between pregnancy weeks 24 to 28, unless the biological father is known to be Rh (D) negative.
Tobacco Use	Screening and behavioral interventions for women who smoke and extensive interventions for pregnant women who use tobacco, this plan covers dispensing U.S. Food and Drug Administration (FDA) approved cessation drugs for ninety (90) consecutive days at one (1) attempt and for up to two (2) attempts per year.
Sexually Transmitted Diseases	Annual counseling for sexually active women.

Syphilis	Screening for all pregnant women or others at high risk.
Preventive Visits for Women, also known as Well Woman Visits	Annual preventive care (depending on the women's health status, their health needs, and other risk factors) for adult women so that they can obtain the recommended and appropriate preventive services, according to age and development, including care before conception, and the necessary prenatal care services. These visits include preventive services for women as mentioned in this policy. If the physician determines that the patient requires additional visits for other preventive services, these will be covered with zero ($0) copayment or zero (0%) coinsurance as applicable.
Aspirin Supplementation for Prevention of Preeclampsia	Screening, counseling and supplies of low-dose aspirin as a preventive medication for pregnant women at high risk of preeclampsia from the twelfth (12^{th}) week of pregnancy on.
Preeclampsia screening	In pregnant women with blood pressure measurement during pregnancy.

Immunizations

Immunization, counseling and administration of vaccines recommended by the United States Preventive Services Task Force and the Department of Health of Puerto Rico immunization Schedule, will be covered for children, adolescents under twenty-one (21) years and adults as set forth in the immunization schedule of the Department of Health of Puerto Rico and the Centers for Disease Control (CDC) and Prevention, including follow-up vaccines. Immunization will be covered with $0 copayment or 0% coinsurance. The insured will pay the corresponding amount for medical visit for outpatient service. The preventive care services to which these conditions apply are defined and described at the following link: https://www.healthcare.gov/what-are-my-preventive-care-benefits.

Immunization Schedule for Children According to the Schedule of the Department of Health of Puerto Rico	
Hepatitis (Hep B)	As shown in the Schedule of the Department of Health of Puerto Rico as of the effective date of this policy. The insured may request the current schedule by phone at MCS Customer Service Call Center at (787) 281-2800 .
Diphtheria, Tetanus and Pertussis (DTaP)	
Diphtheria and Tetanus Toxoid (Tdap)	
Rotavirus	
Inactivated Poliovirus (IPV)	
Haemophilus influenzae, Type B (Hib)	
Pneumococcus (PCV) and (PPV)	
Measles, Mumps and Rubella (MMR)	
Chickenpox	
Hepatitis A (Hep A)	
Meningococcus (MCV) and (MPS)**	

Influenza	
Human Papillomavirus (HPV)- Vaccine for Prevention of Cervical Cancer	

Centers for Disease Control and Prevention (CDC) Immunization Schedule for <u>Children, Adolescents</u> and <u>Adults</u>	
Tetanus, Diphtheria and Pertussis (Td/Tdap)	Centers for Disease Control (CDC) and Prevention vaccine schedule as of the effective date of this policy. The insured may request the current schedule by phone at MCS Customer Service Call Center at (787) 281-2800 .
Human Papillomavirus (HPV)- Vaccine for Prevention of Cervical Cancer	
Chickenpox	
Herpes Zoster	
Measles, Mumps and Rubella (MMR)	
Influenza	
Pneumococcus	
Hepatitis A	
Hepatitis B	
Meningococcus**	

<u>*VPH immunization will be covered for males and females ages nine (9) and on and for adolescents with a history of sexual abuse or rape who have not initiated or completed the series of three (3) doses, in accordance with Law No. 255 of September 15, 2012.</u>

** Meningitis immunization (MCV4) or meningococcal vaccine will be covered, as required by Ruling Letter CN-2011-131-AV of the Office of the Insurance Commissioner of Puerto Rico.

Additional Immunizations Requiring Copayment or Coinsurance

Respiratory Syncytial Virus (RSV) (known as Synagis®) Vaccine	This vaccine is covered in the suggested dose, in accordance with Law No. 165 of August 30, 2006. Requires pre-authorization from MCS Life Pharmacy Department. The insured will pay the corresponding amount for the vaccine and the medical visit for an outpatient service, in accordance with Part XII of this policy.
Rhogam Vaccine	Covered. The insured will pay the amount of twenty percent (20%- 99%) coinsurance corresponding to the vaccine and the medical visit for outpatient service, in accordance with Part XII of this policy.

9. Other Covered Services

Mastectomy and Reconstructive Mammoplasty	MCS Life will cover mastectomy-related services for both men and women, including all stages or reconstruction and surgery to achieve breast symmetry, prosthesis and complications that may arise from a mastectomy, including lymphedema, in accordance with the Women's Health and Cancer Rights Act of 1998. Requires pre-authorization from MCS Life. Lymphedema therapy requires pre-authorization from MCS Life Clinical Affairs, and copayment or coinsurance for physical therapy applies. Mammoplasties or plastic reconstruction for breast reduction or augmentation are not covered (except for reconstruction after mastectomy for breast cancer. Initial deductible applies/No initial deductible applies.
Annual Physical Exam	MCS Life will cover an annual physical exam, provided it is for preventive purposes. Excluded are physical exams and lab tests for medical certificates ordered by the employer or for other purpose that is not prevention, except as otherwise provided under Law No. 296 of September 1, 2000, known as the Children and Adolescents Health Conservation Act of Puerto Rico, as amended. A comprehensive annual health evaluation performed by health professionals may include diagnostic tests, among others, according to the insured's age, sex, and health status. Initial deductible applies/No initial deductible applies.
Acquired Immunodeficiency Syndrome (AIDS/HIV)	Covered as any other condition, in accordance with Law No. 349 of September 2, 2000, as amended. Initial deductible applies/No initial deductible applies.
Autism	According to Law No. 220-2012 approved on September 4, 2012, better known as BIDA Act (Spanish acronym for the Act for the Wellbeing, Integration, and Development of Persons with Autism), treatments for autism disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, will be covered without limits, after a medical necessity has been established under this policy. Covered services include, but are not limited to, genetics, neurology, immunology, gastroenterology, nutrition, speech and language therapies, psychological, occupational and physical services, and will include medical visits and medically necessary tests. Initial deductible applies/No initial deductible applies.
Down Syndrome	Services for insureds with Down Syndrome will be covered without limits, in accordance with Law No. 97 of May 15, 2018. Services include tests, without limiting to, genetics, neurology, immunology, gastroenterology and nutrition; in addition, medical visits and medically referred tests and therapeutic services.
Cancer Patients' and Cancer Survivors Bill of Rights	In compliance with Law No. 275 of September 27, 2012 for patients diagnosed with cancer and cancer survivors, MCS Life will not refuse or deny any contracted treatment, and/or within the terms and conditions of the health plan subscribed between the parties, to any patient diagnosed with cancer, as evidenced through a medical recommendation. It also covers all preventive services and benefits listed under federal ACA for early detection of breast cancer, as well as studies and monitoring tests for breast cancer, such as visits to specialists, breast clinical examinations,

	mammography, digital mammography, magnetic resonance mammography and sonomammography and treatments, included but not limited to, mastectomy, reconstructive surgery of the removed breast after mastectomy, reconstruction of the other breast to achieve symmetry, breast prosthesis, treatment for physical complications during all the stages of the mastectomy, including lymphedema (inflammation that sometimes occurs after breast cancer treatment), as well as any other reconstructive post-mastectomy surgery necessary for the physical and emotional recovery of the patient. Initial deductible applies/No initial deductible applies.
Air Ambulance Services in Puerto Rico	Covered, according to the medical necessity established at the time of the service, through contracted providers. Corresponding copayment or coinsurance applies.

10. Major Medical

Shared Costs	**A. Deductible** – The applicable deductible for Major Medical Expenses is one-hundred $100 per person, per policy year, and three-hundred $300 per family, per policy year. **B. Coinsurance** a. After paying the deductible applicable to Major Medical Expenses, every insured person is responsible of paying, the zero to one-hundred 0%-100% of coinsurance for the covered medical services up to a maximum out of pocket amount of two-thousand ($0-$ 10, 000,000) per policy year. When the insured reaches the established maximum out-of-pocket amount, MCS Life will cover one-hundred percent (100%) of the benefits . b. After paying the deductible applicable to Major Medical Expenses, every insured family is responsible of paying, the zero to one-hundred 0%-100% of coinsurance for the covered medical services up to a maximum out of pocket amount of four-thousand dollars ($4,000-$ 10,000,000) per policy year. When the insured reaches the established maximum out-of-pocket amount, MCS Life will cover one-hundred percent (100%) of the benefits . c. In case that an insured person or family have incurred in any expenses for benefits covered through reimbursement, as described in the Section IV of this endorsement, will be responsible of the difference between the incurred expenses and the rates established by MCS Life. MCS Life will only reimburse the percentage applicable to the service, based on the established rates for such benefits by MCS Life. The applicable amounts for the accumulation of the co-payment and twenty percent (20%) of covered medical expenses will be determined based on the rates established for covered medical expenses. This benefit is supplemental to any other group of employer health benefits. It will not pay

	any amount under this benefit for charges in excess of the amounts payable under the basic health benefits of this policy. MCS Life will pay benefits for eligible charges, provided those are incurred as a result of illness or injury medically necessary and practiced or ordered by a physician. Eligible charges will be considered based on the rates established by MCS Life for services in Puerto Rico and not having rates established, will be paid based on reasonable and customary charges. If an insured person incurs in charges for care, services or supplies described under eligible charges, which are not payable under a basic benefit or is given outside Puerto Rico, MCS Life will pay benefits for these charges in accordance with the rates established by MCS Life for such services or based on reasonable and customary charges that exceed any amount of copay or coinsurance.
Covered Benefits	**Hospice** Covered only for patients at end-stage, with a life expectancy of six (6) months or less. Correspondent coinsurance applies. Pre-authorization required from MCS Life Clinical Affairs.
	Allergy Vaccines MCS will cover allergy vaccines by reimbursing the insured less the coinsurance that applies for these services.
	Treatment for Mental Health and abuse of controlled substances and Alcohol out of Puerto Rico Services outside of Puerto Rico should be precertificated through MCS Solutions (integrated employee assistance program, for Mental Health and substance abuse)otherwise the person will not be covered. Mental health conditions and the patients in treatment of alcohol and controlled substances abuse are subject to the usual and customary charges that apply to the services incurred and require to be precertificated via MCS Solutions. Emergency services does not require pre-certification.
	Ambulance service for emergency out of Puerto Rico: ***Land ambulance:*** ▪ The service will be covered through reimbursement to the insured, or based on the assignment of benefits based on the customary and reasonable charges for the area where the service was rendered. ***Air ambulance*** ▪ This service is limited to one trip per year policy based on reasonable and customary charges in the area where the service was provided.

	Services received in the United States of America (USA) The benefits for charges incurred will be based on the customary and reasonable charges applicable to the area where the services were rendered, if the charges are incurred as a result of: ▪ An emergency that occurs in the U.S.A. ▪ Through a medical referral for treatment that is not available in Puerto Rico, which has been certified by the physician and has been preauthorized by the Individual Case Management Program of MCS Life prior to the beginning of treatment. If the charges for medical treatment are incurred in the United States, and such medical treatment was not approved in advance by the Individual Case Management Program, the eligible charges will be based on the applicable rates of MCS for Puerto Rico, minus the applicable copayment or coinsurance for a similar treatment for said injuries or illness. Charges in excess of the rates of MCS Life will be considered ineligible charges and will be the responsibility of the insured.
	Services received outside of the United States of America (USA) Services received outside of the U.S.A. will be paid based on the reasonable charge for the area where the service were provided, if the charges are incurred as a result of: ▪ An emergency or; ▪ Through a medical referral for treatment that is not available in Puerto Rico or the U.S.A., which has been certified by the physician and has been preauthorized by the Individual Case Management Program of MCS Life prior to the beginning of treatment.
	The Elective Services that are not emergencies or if such treatment was not approved in advance by the Individual Case Management Program of MCS Life will be excluded from coverage. In emergency situations, the services will be covered. You may access the service provider directory in the United States UnitedHealthcare through the following website, https://us1.welcometouhc.com/ or by calling at 1-877-563-9016.
	Dependent children who are students in the United States Will be covered only in negotiations with employers who have requested it, and when it has been considered in the process of establishing the rate for the particular group. If such a negotiation should arise, it shall be paid according to the provisions of "**Services received in the United States**."
Major Medical Exclusions	1. Excluded under the Basic Coverage Exclusions and Limitations, unless coverage includes such benefit. 2. Are a result of a disease or employment-related body injury of the insured. 3. Expenses occur due to war or armed international conflict.

	4. For services while admitted at an institution that serves as a school or other for training, resting place, elderly institution or particular healthcare institution. 5. For services from a social worker, including psychology or psychiatry social worker. 6. Marine ambulance. 7. For surgical assistance at an outpatient facility.

Section 2: Services Covered Through Reimbursement

Shared costs apply to some of these services, as described in Part XII of this policy.

A. Services eligible for reimbursement in this policy:

Social worker	These services will be reimbursed only for treatments related to autism disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, in accordance with Law No. 220 -2012 approved on September 4, 2012, known as BIDA Act (Spanish acronym for the Act for the Wellbeing, Integration, and Development of Persons with Autism). / Covered through reimbursement including treatments related to autism disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, in accordance with Law No. 220-2012 approved on September 4, 2012, known as BIDA Act (Spanish acronym for the Act for the Wellbeing, Integration, and Development of Persons with Autism).
Ground Ambulance Services in Puerto Rico and the United States	Ground ambulance service between hospital facilities is covered through reimbursement to the insured. The maximum amount for reimbursement is seventy five dollars ($75) per trip. The total cost of the ground ambulance services for an emergency, will be paid directly to the provider. This benefit will be covered if the entity providing services is duly authorized by the Public Service Commission of Puerto Rico or any other regulatory agency in the geographic area where the service is offered. The service will only be covered if the insured meets any of the following requirements: • The patient was transported by an ambulance service, as described in the Definitions in Part I under "Ambulance Services"; • The patient suffered an illness or injury for which other types of transportation are not recommended; • Psychiatric emergencies, in accordance with Law No. 183 of August 6, 2008; • The patient was transported;

	○ from the residence or place of the emergency to the hospital or skilled nursing facility (SNF); ○ between hospitals or to a skilled nursing facility when the transferring institution or institution authorizing discharge is not appropriate for the covered services; ○ from the hospital to the home, for patients whose health condition does not allow the use of other means of transportation; ○ or between healthcare institutions, including ambulances certified by the Public Service Commission of Puerto Rico and the Department of Health of Puerto Rico, in accordance with Law No. 183 of August 6, 2008, as amended. • Service reimbursement request includes medical certificate of the transport, place of pick up and destination; • Is not a case covered by the Automobile Accident Compensation Administration (ACAA, by its Spanish acronym), Workers Accident Compensation Act (CFSE, by its Spanish acronym) or any other liability insurance (*third-party liability*).
Emergencies outside the United States	Covered. A reimbursement of eighty percent (80%) based on usual and customary rates in the place of service.
Phenylalanine-free amino acid preparations	According to Law No. 139 of August 8, 2016, MCS Life will reimburse the total cost of phenylalanine-free amino acid preparations for patients with a diagnosis of a genetic disorder known as phenylketonuria (PKU), regardless of patient age and for other related purposes.

B. Process for Requesting Reimbursement

In order to receive reimbursement for the services described in this Section, the insured must complete and submit a reimbursement form within a period of one hundred eighty (180) days of receiving the service, subject to the terms described in Part VI of this policy. The insured may request a copy at MCS Life Customer Service Centers or by calling the Customer Service Department at 787-281-2800 (Metro area) or 1-888-758-1616 (toll free) from Monday to Friday, 8:00 AM to 8:00 PM; Saturdays from 8:00 AM to 4:30 PM.

The insured should submit the reimbursement form along with the original official receipt of the services for which reimbursement is requested. The receipt must include the following information and meet the requirements described below:

1. Original official receipt (receipt with the logo or stamp of the provider, which shall include the name, address, phone number and specialty)
2. National Provider Identifier (NPI) or one of the following numbers: Employer identification number or state license number.
3. Patient's full name and group/contract information.
4. Date of service (dd/mm/yyyy).

5. Description of service; if the receipt is for more than one service, each service must be identified.
6. Laboratory receipts must specify all the tests done.
7. Service and diagnosis codes for each service claimed.
8. Total cost of service and the amount paid by the patient. If the receipt is for more than one service, the cost of each service must be identified.
9. If reimbursement is for dental services, the tooth or oral structure and side must be indicated. Each surface has a separate rate.

Section 3: Bone, Skin, Cornea, Organs and Bone Marrow Transplants

Bone, skin and cornea transplant services

Bone, skin and cornea transplant services will be covered without waiting period; pre-authorization from MCS Life Clinical Affairs Department is required. This service is not available through reimbursement. One-hundred percent (100%) of this benefit will be covered at institutions or hospitals that belong to the network of providers or with a provider with whom MCS Life has coordinated the service for the particular patient, as per the terms and conditions set forth in the coverage. Includes care before and after the procedure, including immunosuppressant drugs, as ordered by a physician.

Organ and bone marrow transplants

This service is not available through reimbursement, only through MCS Life Clinical Affairs Department coordination. Organ and bone marrow transplants have a ninety (90) day waiting period from the date of effectiveness of the policy. The benefit is covered provided transplant procedures are performed in Puerto Rico (as first option) or in the United States, at institutions, hospitals or with a provider with which MCS Life Clinical Affairs Department has previously coordinated the service for the particular insured, as per the terms and conditions set forth in the coverage.

This benefit requires pre-authorization from MCS Life Clinical Affairs and is available for the main insured, spouse, and direct dependents of the insured, provided they are under sixty-five (65) years of age.

To begin the process, the medical provider should contact MCS Life Clinical Affairs Department to notify about the transplant process. Then, MCS Life Clinical Affairs Department, along with the provider, will complete the necessary documentation for the procedure.

The benefit period begins thirty (30) days before the transplant procedure.

Organ and bone marrow transplant services are covered as per the rates negotiated with the provider's network of Puerto Rico.

Expenses covered will be those directly related to the transplant procedure, preoperative and postoperative care and the treatment's immunosuppressive drugs. These expenses have limits that are detailed below:

Organ Transplant:

Services covered include heart heart-lung, lung (unilateral or bilateral), liver, pancreas, pancreas-kidney, kidney, and small intestine. Expenses for organ transplant procurement, preservation and transportation are covered, subject to the following limitations:

Organ	Amount
heart	$ 100,000

heart - lung	$ 125,000
lung	$ 75,000
liver	$ 75,000
small intestine	$ 35,000
pancreas	$ 50,000
kidney	$ 25,000
pancreas - kidney	$ 50,000
allogenic bone marrow	$ 100,000
autologous bone marrow	$ 100,000

Covered expenses of the recipient are limited to those directly related to the transplant procedure, including preoperative and postoperative care and the treatment's immunosuppressive drugs.

Expenses incurred by the transplant donor including surgery, storage and transportation directly related to the organs to be used in the procedure will be covered up to a maximum benefit of twenty thousand ($20,000) dollars per procedure.

A maximum amount of ten-thousand ($10,000) dollars per transplant will be covered for transportation expenses to and from the facility where the surgery will take place, for the insured and a companion. If the insured is under nineteen (19) years of age, transportation for two (2) companions will be covered, provided they are the parents or the persons holding the legal custody of the insured. The maximum benefit of covered expenses for meals and lodging is one-hundred ($100) dollars per day per person. The maximum established limit for meals and lodging is five-thousand ($5,000) dollars.

Bone Marrow Transplant:

Allogeneic and autologous bone marrow transplants, and germ or peripheral cells transplant are covered provided they are intended for the following conditions and illnesses for which they are considered accepted practices and not investigational, such as: leukemia, lymphoma, and cancer, among others.

Covered Services

- Bone marrow donation and storage. Bone marrow procurement will be subject to a maximum of one-hundred thousand ($100,000) dollars per transplant, regardless if in or outside of the Participating Provider Network .
- Chemotherapy or radiation therapy before the transplant procedure.
- Donor's surgery, storage and transportation expenses directly related to the organs to be used in the procedure. These services will be covered up to twenty-thousand ($20,000) dollars per procedure.
- Transportation expenses to and from the facility where the surgery will take place for the insured adult and one (1) companion. If the insured is under nineteen (19) years of age, transportation for two (2) companions will be covered, provided they are the parents or the persons holding the legal custody of the insured. Up to ten-thousand ($10,000) dollars will be covered per transplant for transportation expenses to and from the facility where the surgery will take place, incurred by the insured and one (1) companion.

- Up to one-hundred dollars ($100) per day per person for meals and lodging are covered. The maximum limit for meals and lodging is five-thousand ($5,000) dollars per transplant.

Section 4: Life Insurance Benefit

Life Insurance $10,000

If an employee dies while covered under this insurance benefit, MCS Life will pay the corresponding amount. Life insurance coverage applies only for purchase and coverage of the main insured over eighteen (18) years and under sixty-five (65) years.

Accidental Death and Dismemberment Insurance $10,000

Coverage for accidental death and dismemberment applies only for purchase and coverage of the main insured over eighteen (18) years and under sixty-five (65) years.

If while insured for this benefit, an employee suffers one of the losses listed below, MCS Life will pay a percentage of the principal sum for such loss, provided:

The loss occurs as a result of accidental bodily injury suffered without any other contributing factor, and the loss occurs within the following twelve (12) months from the date of the injury:

List of Losses and Benefits	
Loss	**Percentage Loss (Sum)**
Life	100%
Both hands	100%
Vision in both eyes	100%
One hand and one foot	100%
One hand and vision of one eye	100%
One foot and vision of one eye	100%
One hand or one foot	50%
Vision of one eye	50%
Both feet	100%

Note: Loss of a hand or a foot means amputation at or above the wrist or heel. Loss of vision should be complete and permanent.

Amount of Principal Sum

MCS Life will pay the stipulated amount for the loss, according to the insurance coverage and the List of Losses and Benefits in effect on the date of the injury.

MCS Life will pay up to one-hundred (100%) percent of the principal sum for all losses occurring to an employee as a result of an accident.

Beneficiary's Provisions, Death Income and Options

A. Naming a Beneficiary

An employee can name one (1) or more beneficiaries as recipients of the death benefits. Unless restricted by law, the beneficiary can be changed.

Naming or changing a beneficiary should be:

1. In writing;
2. Signed by the employee; and
3. Registered in MCS Life enrollment or change form.

Death Benefit

Unless determined otherwise by law, the death benefit of the employee will be paid as determined below:

A. If the employee has named one or more beneficiaries, MCS Life will pay the benefit to:

   1. Surviving beneficiary; or
   2. Surviving beneficiaries in equal amounts, unless otherwise stated by the employee

B. If the employee has not named a beneficiary, or if no named beneficiary survives the employee, MCS Life will pay the death benefit to the surviving person(s) in equal amounts, in the following order:

   1. Children
   2. Parents
   3. Spouse
   4. Other collateral family members
   5. Commonwealth of Puerto Rico (ELA, by its Spanish acronym)

C. To determine which person(s) will receive the benefit, MCS Life requires birth certificate, marriage or death certificate and/or copy of the declaration of heirs and/or identification document issued by a government entity demonstrating inheritance rights. If a written notice of a valid claim from another person is received before the benefit is paid, the payment based on such declaration will release MCS Life from liability for the amount paid.

D. However, at MCS Life's discretion, the Company may pay up to five-hundred ($500) dollars, or as permitted by law, to any person who has incurred in funeral or other expenses related to the terminal illness or death of the employee. The sum of five-hundred ($500.00) dollars will be deducted from the total benefit payable to the beneficiary upon the death of the insured.

E. If the death benefit is payable to a minor or to any other person who cannot legally sign a valid release, MCS Life can pay the death income to his or her legal guardian. The death benefit of any dependent will be paid to the employee.

Claims

The payable amount upon the death of the insured will be paid once MCS Life receives proof of valid claim. Proof of claims includes:

A. Certificate and/or valid document of the cause of death;
B. Proof of age;
C. Title of the claimant; and
D. Any other information that MCS Life deems necessary to establish the validity of the claim.

Policy Benefits Options

Instead of paying the amount under this policy in a lump sum:

- The employee may choose; or

- If the employee dies without choosing, the beneficiary can choose full or partial payment of the benefit under any of the deposit or annuity options available at that moment. Option details are available at MCS Life upon request.

    1. Certificate and/or valid document of the cause of death;
    2. Proof of age; and
    3. Any other information that MCS Life may require to establish the validity of the claim.

Section 5: Bariatric Surgery Benefit for Treatment of Morbid Obesity

Shared costs apply for some of these services, as described in Part XII of this Policy.

The benefit of morbid obesity treatment requires a waiting period of twelve (12) months from the time of effectiveness of the policy, unless a physician certifies that the life of the person is in imminent risk. Covered services include: gastric bypass surgery, adjustable band surgery or sleeve gastrectomy (open or closed procedures through laparoscopy). Other methods of bariatric surgery are excluded from this policy. The insured is responsible for the applicable coinsurance and for copayment for hospital admission.

Coverage is subject to pre-authorization of the procedure from MCS Life Clinical Affairs, and the procedure will be covered through providers contracted by MCS Life in Puerto Rico. Bariatric surgery is limited to one (1) procedure for life. To begin the authorization procedure, the insured must meet the minimum requirements described below:

- Body Mass Index (BMI) greater than or equal to thirty-five (35)
- Diet treatment regime during at least six (6) months, supervised by a physician or bariatric surgeon prior to the surgery. In addition, the physician should indicate the diet regime used and reason for failure.
- The physician should specify patient's underlying conditions that worsen with morbid obesity, for example: cardiovascular or cardiopulmonary diseases, severe diabetes, arthritis and sleep apnea, in accordance with Article 3(c) of Law No. 212 of August 9, 2008.
- Assessment by a mental health specialist (psychologist or psychiatrist) certifying that the insured understands and is willing to follow life style changes required for a successful bariatric procedure.

Surgeries for removing excessive skin (commonly known as flaps) are not covered, except if the physician certifies the need to remove excessive skin as it affects the functioning of a body part.

Section 6: Programs Included as Part of Your Benefits

Shared costs apply for some of these services, as described in Part XII of this Policy.

MCS Alivia	A model of alternative and complementary therapies and treatments integrated into conventional health systems. Some of the integrative medicine services available are: • Integrative and complementary health • Traditional Chinese medicine • Medical acupuncture • Therapeutic massage • Homeopathy offered by certified physicians • Bioenergetic medicine (Pranic Healing). To access these benefits and assure the appropriate coordination of all necessary services, the insured must call or make an appointment. The insured will be evaluated by MCS Alivia center's general practitioner who will determine the corresponding methods of treatment. A maximum of six (6) visits per policy year per insured are covered with a maximum of two (2) methods per visit. Corresponding copayment applies.
MCS Solutions	Program that integrates mental health care and treatment for abuse of controlled substances. All services are provided in a private and confidential manner, twenty-four (24) hours a day, seven (7) days a week. A program coordinator will provide counseling, health education, and referrals in a confidential manner to the insured and his or her family members. In emergency situations, the insured should go directly to the hospital and request the service. For additional information about these services, the insured can call 1-866-627-4327.
Wellness Programs and Initiatives	As part of MCS Life's commitment with the health of our insureds, we have developed a variety of innovative programs and initiatives to supplement the basic benefits of our coverage. These wellness programs and initiatives address areas that go from physical health to emotional health of our insureds and meet the expectations of a comprehensive health plan. It includes educational talks, exercise sessions, orientation clinics, among others. For additional information on available programs, the insured can contact our customer center call center at 787-281-2800 Metro area, or toll free 1-888-758-1616, Monday to Friday, 8:00 AM to 8:00 PM, Saturdays from 8:00 AM to 4:30 PM; the hearing impaired (TTY) can contact 1-866-627-8182.
MCS Medilínea MD	This is a program from MCS Medilínea MD. Corresponding copayment applies for Telemedicina. Maximum of four (4) consultations per year. Access to virtual visits with primary physicians, including family medicine, generalists, internists, and pediatricians, on the MCS Medilínea MD digital platform. Children under eighteen (18) years must be accompanied by an adult for consultation. Appropriate conditions for consulting the service are: • allergies • constipation

	• cough • diarrhea • ear problems • fever • cold • headache • insect bites • nausea • conjunctivitis • skin rash • sore throat • urinary problems/UTI • vomiting. Parents or guardians of children under thirty-six (36) months are required to complete a form as well as a medical history disclosure before an appointment or a consultation with a physician from the contracted telemedicine provider. Children under thirty-six (36) months who show fever should be referred to his or her pediatrician or to the emergency room. In acute cases in which the physician deems necessary the use of medications for treating the patient, the delivery of the prescription will be coordinated directly with the insureds preferred pharmacy. If the physician determines that the condition for which the patient requires the service cannot be taken care of by means of this platform, the insured will be referred to the emergency room or his or her primary physician. The patient has the responsibility of checking on his or her benefits descriptions documentation and/or the drug formulary to determine if MCS Life will cover certain prescriptions. The patient should pay the corresponding copayment for the visit each time he or she accesses this service platform. To register, the insured should visit www.mdlive.com/mcs.
MCS Care Clubs	This is a voluntary program that forms part of the basic coverage at no additional cost to the premium. It consists of two (2) visits with zero dollars ($0) copayment to the preferred MCS Care Club of the insured: • First visit: *a.* The insured should complete a *Health Risk Assessment* (HRA) and have an initial assessment. The purpose of the HRA is to identify possible medical conditions and be able to continue developing wellbeing programs for the population. *b.* The physician will recommend several preventive services available at the center based on the results of the HRA. Services will be recommended taking into consideration factors like age and gender, as established by the *United States Preventive Services Task Force*. • Second visit: The physician will discuss with the insured the tests performed, and the personalized profile report. If necessary, the physician will make additional recommendations or referrals to other specialists, as applicable.

	In case the insured needs additional tests due to his or her condition or clinical indication, the center will refer the insured as applicable. This program is available for all insureds eighteen (18) years and older.
MCS Balance	This is an incentives program for the wellbeing of the insured, based on voluntary participation and is part of the basic coverage at no additional cost to the premium. It consists on providing a ten dollar ($10) reimbursement per month for membership to a gym, as approved by the Department of Sports and Recreation of Puerto Rico, up to a maximum of six (6) months. To have access to this benefit, completing a *Health Risk Assessment* (HRA) is required, at the MCS Care Club center of the insureds convenience, in the first ninety (90) days from the effective date of the policy. This program is available for all insureds eighteen (18) years and older.

PART IV: COVERAGE EXCLUSIONS

Shared costs apply to some of these services, as described in "Part XII" of this Policy.

Section 1: Coverage exclusions

The following services are not covered under this policy:

1. Services offered while the insurance is not in effectiveness.
2. Services that are to be received or covered by the Workers Accident Compensation Act (CFSE), private insurances for workers accident compensation, car accidents (covered by ACAA) and other services available by state of federal laws. Also excluded are services when they are denied by pertinent government agencies due to non-compliance or violation of requirements or provisions of aforementioned laws, or of any other law, even if such non-compliance or violation does not constitute an offense.
3. Services covered by any other insurance or entity with primary liability (*third party liability*). MCS Life has the right to subrogation to recuperate medical claims paid when the main responsibility corresponds to another insurance or entity. Please refer to the subrogation clause under General Provisions Section of this policy.
4. Services for treatments resulting from the commission of a crime or attempt of assault or any other criminal offense, or non-compliance with the laws of the Commonwealth of Puerto Rico or any other country committed by the insured; services that are a result of war, declared or not, acts of terrorism or any incidental act of war or participation in riot or civil disturbance or in those cases in which services received are related to an injury suffered while the insured was active in the army (service connected) in which case MCS Life will recover expenses from the Veterans Administration.
5. Services received at no charge or defrayed through donations; or that the person receives or has a right to receive free of charge or under any other government plan.
6. Expenses or services for personal comfort, such as: private room, except in cases in which the service is required due to a medical necessity, as per this policy, telephone, television, custodial care, rest home, convalescent home (except for skilled nursing facilities that are covered under this policy) or care in the home, unless otherwise stipulated in your policy.
7. Services rendered by healthcare professionals who are not physicians, dentists or paramedics, except as set forth in the benefits coverage.
8. Services not listed in Part III of this policy or that are not part of the requirements provided in the Puerto Rico Health Insurance Code (CSSPR, by its Spanish acronym) or not required by the Office of the Insurance

Commissioner of Puerto Rico or of any other agency or entity that regulates the health insurance industry of Puerto Rico, or that are not required by federal or local law to cover the service.

9. Expenses incurred for physical examinations to obtain a medical certificate or for any other purpose other than preventive, except if otherwise provided in Law No. 296 of September 1, 2000, as amended.
10. Services that are not medically necessary, services considered experimental or investigational, as defined in the U.S. Food and Drug Administration (FDA), U.S. Department of Human and Health Services (DHHS), the Department of Health, or that are not in accordance with the medical policy established by authorized health entities for the specific indications and methods ordered.
11. Experimental medicines or treatments or drugs that carry the label "Caution: Limited by federal law to investigational use". Expenses or services for new medical procedures that are not considered experimental or investigational, except as required by a state or federal law. Regardless of that provided in above items 10 and 11, if the insured suffers from a life-threatening illness, for which there is no effective treatment approved by federal and state agencies, when the insured becomes eligible to participate in an authorized treatment study in accordance with the study protocol regarding such treatment, and as long as the participation in the study offers the insured a potential benefit, and the referring doctor understands that patient's participation is appropriate, or the patient provides MCS Life evidence showing that his or her participation is appropriate, MCS Life will cover the routine expenses of the patient. The expenses or study-related tests, or expenses that reasonably have to be paid by the entity conducting the study will not be considered routine medical expenses.
12. Expenses for cosmetic surgeries/procedures or beautification, treatments or care to correct physical appearance defects, except for reconstructive interventions to repair damaged tissue due to illness or physical injury caused by an accident, or surgery to correct a congenital anomaly, including oral defects in newborns; mammoplasties or plastic reconstruction for breast reduction or augmentation (except for reconstruction after breast mastectomy due to breast cancer, which is covered under this policy), surgical interventions that are not after a bariatric surgery, in accordance with Law No. 212 of August 9, 2008.
13. Also excluded are hospital services, medical surgical, and complications related to all services listed in Section I2, regardless if there is medical justification for the procedure, except as provided in Law No. 212 of August 9, 2008, known as the Breast Cancer Reconstruction Act.
14. Charges resulting from any illness or body injury during the performance of the insured's job duties.
15. Charges for the treatment of Temporomandibular Joint (TMJ) Syndrome.
16. Charges for drugs or medications supplied and administered in medical visits not covered under this policy.
17. Charges for thermography services offered or ordered by chiropractors and other specialists not contracted for this service.
18. Charges for the treatment of infertility or related to artificial conception methods, except laboratory tests for diagnostic purposes.
19. Charges for hearing equipment services and/or cochlear implants, regardless of medical justification.
20. Charges for orthoptic therapy services (vision therapies).
21. Charges for orthopedic insoles.
22. Charges for rendering elective abortions, including all the related services.
23. Charges for psychometric tests without clinical justification. Except for conditions under Law No. 220-2012 of September 4, 2012, better known as BIDA Act (Spanish acronym for the Act for the Wellbeing, Integration, and Development of Persons with Autism) and treatments for autism disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM), will be covered without limitations as provided in BIDA Act.
24. Any procedure whose purpose is to surgically reestablish the ability to father a child or any procedure not under infertility, if they are used to induce pregnancy, like *in vitro* fertilization.
25. Expenses for vaccines and related services required by the employer to obtain or keep an employment or insurance, or for travelling purposes.

26. Expenses for services provided in workplace health clinics offered and provided by the employer or a third party.
27. Home care services do not include residential or custodial care, services provided for personal convenience or comfort, for example, housework, childcare and food delivery services, regardless if recommended by a nutritionist or doctor.
28. Dialysis and hemodialysis services, services at hospitals or renal care facilities, medical-surgical services and related complications; after exhausting the maximum of ninety (90) day period set forth in this policy.
29. Fetal monitoring in medical offices (belts).
30. Oral surgeries additional to those described in this policy, except for those that result from an accident or that are covered by an optional dental coverage.
31. *Lasik* procedures and surgeries for correction of refractive defects.
32. Analgesia administered by the intravenous or inhalation routes by a physician or dentist, except anesthesia in accordance with Law No. 352 of December 22, 1999.
33. Excision of granulomas or radicular cysts from tooth pulp infection.
34. Surgical assistance services for outpatient surgeries.
35. Medical visits to the home that are not part of home health care or residential treatment, as described under this policy.
36. Services not pre-authorized and that require pre-authorization from MCS Life Clinical Affairs, as described in the benefits of this policy.
37. Services in the United States that are not an emergency or not available in Puerto Rico. Services not available in Puerto Rico require pre-authorization from MCS Life Clinical Affairs Department.
38. Expenses for contraceptive methods for men other than vasectomy, as established in this policy.
39. Complementary medicine services not offered by providers contracted by the MCS Alivia program.
40. Expenses following the first thirty (30) days for newborns of dependent daughters of the main insured after delivery.
41. Laboratory, molecular or genetic test, not codified in the Laboratory Manual, as well as those considered experimental or investigational or not required by state or federal laws.
42. Water ambulance.
43. Expenses for technology, procedures or new diagnostic tests in the market during the effective calendar year of this policy. MCS Life Clinical Affairs team will evaluate each new technology, procedure or tests available in the market and the correct rates will apply on the next calendar year, unless they are immediately required by a state or federal law or ordered by the Office of the Insurance Commissioner of Puerto Rico.
44. New benefits required by local state law enacted during the effective calendar year of the policy or after approval of the rates of such coverage, unless specifically required by the Office of the Insurance Commissioner of Puerto Rico or by local law.
45. Growth hormones.
46. Total maxillary or mandibular reconstructions, including removal of exostosis (mandibular o maxillary).
47. Non-outpatient surgical procedures for students in the United States, except for emergency cases or in case the service is not available in Puerto Rico.
48. Elective hospitalization for students in the United States or any other service in the United States not described in this policy.
49. Coverage to residents in the United States.
50. MCS Life reserves the right to choose those new drugs that are available on the market to include in the medical component under chemotherapy, radiotherapy, and intravenous drugs. Expenses for new drugs are not covered until said drug is evaluated by the MCS Life Insurance Pharmacy and Therapeutics Committee following the rules set forth in Chapter 4 of the CSSPR. This chapter requires that the Pharmacy and Therapeutics Committee conduct an evaluation of new prescription drugs approved by the Food and Drug Administration (FDA) within a term no greater than ninety (90) days from the date of FDA

approval. During this term, MCS Life will issue a determination regarding the inclusion of the new drug in the formulary. Even new drugs that are in the excluded therapeutic classifications (categories) will be considered excluded.

51. Paid expenses accrued by an assistance program or a third party for maximum out-of-pocket expenses (MOOP). No prescriptions will be issued for substances controlled by the Drug Enforcement Administration (DEA), non-therapeutic drugs or other drugs that can be harmful due to its potential for abuse through Telemedicine service.
52. Coverage excluded for optional or collateral dependents.
53. Neurologic tests and procedure services.
54. Scalenotomy services.
55. Occupational and speech outpatient therapies, and social worker, except for the treatment of autism disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, in accordance with Law No. 220-2012 approved on September 4, 2012, better known as BIDA Act (Act for the Wellbeing, Integration, and Development of Persons with Autism). Occupational and speech therapies covered under home care services.
56. Molecular and/or genetic tests not required by local or federal law.
57. Emergency services outside the United States.
58. Consultations to specialists or subspecialists through Telemedicine services, except for pediatricians, family medicine and internists.
59. No prescriptions for refills of existent drugs will be issued through the Telemedicine service.
60. No prescriptions will be issued for a supply longer than thirty (30) days through the Telemedicine service.
61. No prescriptions for maintenance drugs and/or refills will be issued through the Telemedicine service.
62. Telemedicine consultations for out-of-network or contracted platform through the Telemedicine service.
63. MCS Balance Program.

Section 2: Bone, Skin, Cornea, Organ and Bone Marrow Transplants Exclusions

The following services are excluded:

1. Any service, treatment or procedure rendered or incurred prior to policy agreement effective date and/or not pre-authorized by MCS Life Clinical Affairs.
2. Services, treatments or procedures for which Medicare is responsible.
3. Experimental or investigational transplants, or that have not been found to be medically effective.
4. Organ and tissue transplant-related expenses and services without pre-authorization from MCS Life.
5. Purchase of a car or other means of transportation.
6. Car rental services from a company not formally dedicated to this type of business. Gas, car maintenance and parking expenses.
7. Alcoholic beverages, cigarettes, recreational expenses and items other than food.
8. Personal articles and cleaning products.
9. Transportation, meals and lodging expenses, as mentioned in Part III", Section 4: Covered Services, without receipts for expenses and/or purchase specifying the date, place of purchase, name and price of articles bought.
10. Charges in excess of the established amounts for benefits, as described in Part III, Section 4 of this document.

Section 3: Exclusions and Limitations for Bariatric Surgery for the Treatment of Morbid Obesity

MCS Life will not pay for losses due to or that contributed to any of the following:

1. Surgery for the removal of excess skin (known as flaps) will not be covered except if certified by a physician as necessary because it affects a body part function.

2. Other techniques or methods of bariatric surgery other than gastric bypass, adjustable band surgery or sleeve gastrectomy are excluded from the benefit.
3. Bariatric surgery benefit is limited to the geographical area of Puerto Rico; bariatric surgeries performed outside Puerto Rico are excluded.
4. Bariatric surgery is limited to one (1) for life, regardless of the surgical technique used.
5. Bariatric surgery or bariatric surgery-related reconstructive procedures without MCS Life pre-authorization are excluded from the benefit.

Section 4: Exclusions and Limitations of the Life Insurance Benefit
MCS Life will not pay for losses due to or that contributed to any of the following:

1. If the insured, while sane or insane, commits suicide within the first year of the effective date of his or her individual policy, MCS Life's responsibility will be limited to returning the amount of premiums paid from the individual effective date up until the date of the death of the insured.
2. War or acts of war, declared or not.
3. Performing police or security guard duties; in case of accidental death or dismemberment benefit.
4. Performing duties in a military organization, either the Navy, Army or Armed Forces or any similar organization.
5. Traveling or flying in an aircraft; landing an aircraft, if the insured is a pilot or member of the flight crew or if flight is for instructional, testing or teaching purposes.
6. Wounds or bodily injuries suffered while the insured is driving a motor vehicle if: at the time of the wounds or injuries, a chemical, breath or blood test shows blood alcohol concentration of eight (8) one-hundredths of one (1) percent (0.08%) or more. For truck drivers, school bus driver, heavy motor public transportation vehicles or heavy motor vehicles, this provision will apply when the blood alcohol concentration is two (2) one-hundredths of one (1) percent (0.02%) or more; greater than 100 mg of alcohol per 100 mL of blood. Excluded are wounds or bodily injuries received while the insured was operating a motor vehicle, if when the wounds or injuries were received, it is shown that he or she was driving under the influence of prescription drugs or narcotics.
7. Losses that occur while the insurance is not in effect.
8. Death or accident resulting from the commission of a crime or attempt of assault or any other felony or criminal offense, as well as the non-compliance with laws of the Commonwealth of Puerto Rico or of any other country by the insured.

PART V: PRE-AUTHORIZATION OF SERVICES AND PROCEDURES

Pre-authorization requests should be conducted by your physician or provider. The request should be signed and sent by fax or medical order to MCS Life Clinical Affairs Department. This process applies to all procedures, studies, and services requiring pre-authorization. MCS Life is not responsible for the payment of services received or rendered without pre-authorization, except for cases of emergency, in accordance with that set forth in Law No.194 of August 25, 2000, as amended.

MCS Life fax telephone numbers available for pre-authorization requests are as follows: (787) 622-2436 or (787) 622-2434, or you can call the Customer Service Call Center at (787) 281-2800 .

It is suggested that pre-authorization for services or procedures planned in facilities (outpatient surgery or acute hospital admission) that are not an emergency, be conducted with a minimum of fifteen (15) days in advance to the admission or planned surgery.

Pre-authorization Procedure – Ordinary

Pre-authorization determination will be managed as early as possible and will never exceed fifteen (15) days. In case the initial request is incomplete, you will be notified as early as possible, but not more than five (5) days from the date the request was received. The fifteen (15) day period could be extended for fifteen (15) additional days provided the extension is for handling situations out of the control of MCS Life or there is insufficient information for the determination. In both circumstances, the insured will be notified or the provider who submits the request of the specific reason for the extension or the specific information needed for MCS Life to make a determination. The insured will have at least forty-five (45) days from the date of receipt of notification extension to provide the specified additional information. Extensions will be informed during the first fifteen (15) days from the date the request is received.

Accelerated Pre-authorization Procedure

Your provider may request an accelerated or urgent pre-authorization. MCS Life will treat the request as urgent care, provided it is required because the life, health or full recuperation of the insured is at risk or could expose the insured to unmanageable pain for not receiving the service or treatment requested. In case the submittal of a request and required documentation for the urgent or accelerated process is incomplete, MCS Life will notify of the lack of documentation as early as possible, but not later than twenty-four (24) hours from the time of receipt. Once the completed information is received, MCS Life will notify the determination no later than twenty-four (24) hours from the date in which the completed information is received.

In case of requests of a concurrent review for urgent care, in which the insured requests an extension of treatment, (at the office of a health professional or any other place where outpatient healthcare services are offered), beyond the original length of time approved or the amount of treatments previously approved, if the request is made at least twenty-four (24) hours before the original length of time lapses or of completing the amount of treatments previously approved, MCS will make a determination with respect to the request and notify the insured in twenty-four (24) hours from the date of receipt of the request.

If the submission is complete, but the clinical information submitted is insufficient for a determination, MCS Life will notify of the defficiency (verbally or in writing) in or before twenty-four (24) hours from the receipt of the request for pre-authorization, and the insured has fourteen (14) days from the date of receipt of the notification to submit additional clinical information. MCS Life will notify the determination on or before forty-eight (48) hours from the date of receipt of the additional information or the date in which the time period granted to submit the additional documentation lapses, whichever happens first. If the additional information is not received in a fourteen (14) day period, it will be denied due to lack of clinical information for a determination.

When the requested service meets all established criteria, the provider will be authorized and informed of the authorization number. In addition, an approval letter will be sent both to the provider requesting the pre-authorization and to the insured. The pre-authorization will be effective for thirty (30) calendar days. If the service is denied, a letter stating the reason for the denial, including references on which the denial was based will be sent. It will also inform of the right to appeal the denial and the corresponding process.

The letter with the final determination of the pre-authorization request will be sent to the insured, the provider requesting the pre-authorization, and/or the facility requesting service.

Emergency cases do not require pre-authorization.

PART VI: GENERAL PROVISIONS

Coordination of benefits

Section 1: Coordination of benefits

The provision about Coordination of Benefits (COB) is the method MCS Life employs to determine payment for claims when an insured has more than one insurance plan.

When the insured is covered under more than one health plan, either group or individual or if Medicare eligible, insurance companies are allowed to apply rules set forth by the National Association of Insurance Commissioners (NAIC) as well as Medicare rules, as set forth by the Centers for Medicare and Medicaid Services (CMS), to determine the order of payment for a claim. The purpose is to assure that the sum of combined payments for healthcare expenses is not more than the expenses of covered health care.

The insured should inform about all plans under which he or she or dependents have coverage. This information allows MCS Life determine if it is the "primary" or "secondary" payer of the benefits.

NOTICE TO COVERED PERSONS

If the insured or his or her dependents are covered under more than one health benefits plan, he or she should place a claim to each plan and inform the providers about the existence of all coverages.

1. Definitions for the terms of the coordination of benefits process

Plan	For the purposes of the COB, a plan is a type of coverage that allows the coordination of benefits. 1. Primary Plan – will pay services as per established benefits without taking into consideration the existence of another plan. 2. Secondary Plan – will pay any covered service that has not been paid by the primary plan, taking into consideration that the services are paid according to the provisions and limitations of each policy.
This plan	For the purposes of the COB, "this plan" means that part of the benefits agreement that covers health care to which the COB provisions are applicable and that may be reduced according to the benefits covered by the other plan. Any other part of the services agreement and/or benefits covered is apart from this plan, as it happens under a dental coverage, which will only coordinate benefits with a plan that covers similar benefits.
Allowable Expense	"**Allowable expense**" is any part of the healthcare expense, including coinsurances, copayments and any applicable deductibles, that is covered, in full or in part, by any of the plans under which the insured is covered for whom the COB claim is submitted. When a plan provides benefits in the form of services, the least reasonable value of each service is considered as an allowable expense and a paid benefit. Expenses not covered under any of the plans with which the insured has coverage, is not an allowable expense. In addition, any expense that a provider, because of law or agreement, is not allowed to bill to a covered person, is not an allowable expense. Below are examples of non-allowable expenses: 1. The difference between a semi-private hospital room and a private room is not an allowable expense, unless one of the plans provides coverage for expenses of a private hospital room or the patient stay in the private room is medically necessary (according to the generally accepted terms within the medical practice).

	2. If an insured is covered under two (2) or more plans that calculate benefit payments based on usual and customary charges, or on a method of reimbursement consisting on a list of relative value or other similar reimbursement method, any amount billed by the provider that exceeds the higher amount of reimbursement for a specific benefit is not allowable expense. 3. If an insured is covered under two (2) or more plans that provide benefits or services based on negotiated rates, any amount exceeding the highest negotiated rate is not an allowable expense. 4. If an insured is covered under a plan that calculates benefits or services based on usual and customary rates and under another plan that provides benefits or services based on negotiated rates, the payment agreement of the primary plan will be the allowable expense for all plans. However, if the provider has contracted with the secondary plan for offering benefits or services for a specific negotiated amount or an amount different to the payment agreement with the primary plan, and if allowed by the provider agreement, such charges or negotiated payment will the allowable expense used by the secondary plan to determine benefits. 5. The amount in any reduced benefit resulting from a non-compliance of the insured with the provisions of the primary plan is not an allowable expense. Some examples of this type of plan provision are second opinions for surgeries, admission pre-authorizations, and when preferred providers are not used.
Closed Panel Plan	A "**closed panel plan**" is a plan that provides healthcare benefits to individuals covered primarily in the form of services through a panel of providers that has contracted with or are employed by a plan and that excludes coverage from the services provided by other providers, except in cases or emergency or referrals by a member of the panel.
Custodial Parent	"**Custodial parent**" is the parent to whom a judicial decision has granted custody or, in absence of a judicial decision, is the parent with whom the child lives more than half of the calendar year, excluding temporary visits.

2. Determination of Purchase Order as per NAIC Rules:

1. **Dependent or Non-dependent Rule:** The plan that cover a person as main insured is the primary plan and the one that covers as dependent is the secondary plan.
2. **Dependents of Non-separated Parents (Birthday Rule)**. The plan of the parent whose birthday comes first (month and year) will be the primary plan, the other plan is the secondary. If both parents celebrate their birthdays on the same day, the primary plan is the plan of the parent who is the oldest.
    a. If the plan is secondary and does not count with the birthday rule, the rule based on the gender of the parents (gender rule) will prevail; the father's plan will be primary and that of the mother secondary. This rule will prevail over the birthday rule.
3. **Dependents of Separated or Divorced Parents:** Unless there is a court order that determines otherwise, in which case the court determination will prevail over this coordination rule, the primary plan is that of the parent who holds custody. The secondary plan will be that of the parent with no custody over the child. When there is another insurance covering the dependent, the order of benefits will be as follows:
    i. First, the plan of the parent who holds custody of the dependent;

ii. Then, the plan of the spouse of the parent who holds custody of the dependent;
iii. Finally, the plan of the parent who does not hold custody of the dependent.

4. **Active, Retired or Laid Off Employees:**
   i. If the children of retired or laid off insureds are also dependents of an active employee, the plan that covers the active employee will be the primary plan and the plan of the retired or laid off person will be the secondary plan.
   ii. When determining the coordination for a retired employee who is a dependent in a plan of an active employee, the plan that will cover the retired employee will be his or her primary plan. In this case, the rule dependent/non-dependent will prevail.
   iii. If an insured is not subject to the situations described above, the plan that has covered the insured for the longest time will be the primary plan and the plan that has covered the insured for the shortest time will the secondary plan (rule of seniority).
   iv. The plan with no COB clause will be the primary plan with respect to the one with a clause.
5. **Coordination with other Federal Health Programs:** There are five government health programs that are coordinated with private health plans: *Medicaid, The Indian Health Service (IHS), Tricare & Champs, Veterans Administration (VA), and The Federal Employees Health Benefit Act (FEHBA).*

   i. In accordance with laws and regulations applicable to *Medicaid*, the *Indian Health Services* (IHS), military programs *Tricare,* and the program for dependents of members of the armed forces (CHAMPUS), these plans will be secondary to a private plan.
   ii. When services are provided at a Veterans Administration (VA) facility, where veterans may get medical services for any condition, VA is secondary to a private plan, unless the condition being treated is related to trauma or diseases post military service (service connected), in which case, VA will be primary.

6. **Coordination in Health Reform**: The Government of Puerto Rico's Health Plan will always be the secondary payer before any other plan, without exception. The employer plan will always be the primary payer.
7. **Coordination with Medicare:**
   i. *Medicare* due to age – If an insured has Medicare due to age (older than sixty-five (65) years), the employer plan of the insured and/or his or her spouse will be primary if the employer group to which he or she belongs to has a payroll of twenty (20) employees or more.
   ii. *Medicare* due to disability – If an insured has Medicare for disability (younger than sixty-five (65) years old), the employer plan of the insured, his or her spouse and/or any family member will be primary if the employer group to which he or she belongs has a payroll of one-hundred (100) employees or more.
   iii. Medicare due to renal disease – If the insured has Medicare due to a renal condition, Medicare establishes a period of coordination of thirty (30) months in which it considers the employer plan as primary. When Medicare grants renal status or ESRD (End-Stage Renal Disease), it does not take into account the age of the insured, the number of employees of the employer nor if the person is in the group of active or retired employees. Even when Medicare establishes a thirty (30) month period of coordination, MCS Life will apply a period of coverage for dialysis, according to the policy or product to which the insured is subscribed.
   iv. Medicare is primary when the insured:
      - has Medicare (except for renal disease) along with an employer plan for retirees;

- has Health Reform;
- has other direct payment health coverage; is a beneficiary under COBRA (non-renal patient).

If the rules above do not determine the order of the benefits, allowable expenses will be shared equally between the plans according to the definition of the plan. In addition, this plan will not pay more than it would have had to pay if it had been the primary plan.

When this plan is primary, it determines the payment of its benefits first, before those of other plans and without taking into consideration the benefits of the other plan. When this plan is secondary, it determines its benefits after those of the other plan and may reduce the benefits it pays in such a way that all the plan's benefits do not exceed 100% of the total allowable expenses.

3. Rules for Determining the Order of Payment of Benefits.
When an insured has health insurance coverage under two (2) or more plans, the rules to determine the order of payment of the benefits will be as follows:

A. The primary plan pays or provides benefits according to the terms of coverage, without taking into consideration the benefits covered under any other plan.
B. A plan without COB provisions consistent with this Section, will always be the primary plan except when the certificate of coverage or policy specifies which will be the primary plan. This provision does not apply to coverage obtained in virtue of a membership to a group that is not designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be in excess of any other part of the plan provided with the owner of the agreement.
C. A plan can take into consideration the benefits paid or provided by another plan when calculating the payment of benefits solely when it is secondary to that other plan.

4. Effect of the Benefits of this Plan
A. When this plan is secondary, it can reduce its benefits in such a way that the total benefits paid or provided by all the plans during one plan year do not exceed the total allowable expenses. When determining the amount that should be paid for a claim, the secondary plan will calculate the benefits that it would have paid in absence of the other health care coverage and will apply the calculated amount to any allowable expense under its plan that has not been paid by the primary plan. Then, the secondary plan may reduce its payment in that amount in such a way that when combined with the amount paid by the primary plan, the total benefits paid or provided by all the plans for the claim does not exceed the total allowable expense for that claim. In addition, the secondary plan should credit to its plan deductible any amount that it would have accredited to its deductible in absence of other health care coverage.
B. If a covered person is affiliated to two (2) or more closed panel plans and if, for any reason, like when a provider outside the panel offers a service, the benefits are not payable by one of the closed panel plans, the COB will not be applicable between that plan and other closed panel plans.

5. Right to Receive, Use, and Disclose Necessary Information.
Certain information is needed about health care coverage and services in order to apply these COB rules and to determine the payable benefits under this plan and other plans. MCS Life may obtain the necessary information and share it with other organizations or people in order to apply these rules and to determine the payable benefits under this plan and other plans that cover the claimant of the benefits. MCS Life does not need to inform or obtain consent from any person to obtain and share the necessary information. Any person who submits a claim of benefits under this plan should offer any information needed by MCS Life to apply these rules and determine payable benefits.

6. Facilitating Payment
A payment by another plan may include an amount that should have been paid by MCS Life. If this were the case, MCS Life can refund such amount to the entity that made the payment. Such amount will be treated as a benefit paid by MCS Life, and as such, MCS Life will not have to pay that amount again. The term "payment made" means the cash reasonable value of the benefits provided in the form of services.

7. Right to Recover
If the amount of the payments made by MCS Life is greater than the amount that should have been paid under COB, the excess amount may be recovered from one or more people to whom the payment was made or for whom the payments were made for; or from any other person who may be responsible for the benefits or services provided in the form of services. The "amount of payments made" includes the cash reasonable value of any benefit provided in the form of services.

Other provisions:

1. PROHIBITION OF THE USE OF DISCRETIONARY CLAUSES: In accordance with Article 12.040 of the Insurance Health Code of Puerto Rico, this policy issued by MCS Life does not provide that the final interpretation of the terms in this policy are subject to the discretion of MCS Life, nor will contain interpretation or revision norms in infringement of the laws of Puerto Rico. Adverse determinations issued by MCS Life, as well as disputes or controversies that arise between MCS Life and an insured will be subject to internal as well as external review procedures as established in the code.

2. ACTIONS BY THIRD PARTIES**:** If due to a third party negligence or fault, the insured or any dependent suffers a disease of injury covered under the policy, MCS Life will have the right to subrogate to the rights of the insured to claim and receive from the third party compensation equivalent to the expenses incurred in treating the insured, caused by such fault or negligence. The insured is obliged to acknowledge MCS Life's right of subrogation, and is responsible for notifying MCS Life of any action initiated against that third party, stipulating that, in case of any contrary action, the insured will be responsible for paying such expenses to MCS Life. The insured acknowledges the right of MCS Life to bring about on his or her behalf the necessary actions to recover the costs incurred as a result of the third party's fault or negligence.

    a. MCS Life is not obliged to respond to the insured for any act or omission, of fact or law, that due to fault or negligence of the provider may result in a cause for claim by the insured, and that as such the provider could be responsible.

3. CANCELLATION OR TERMINATION: MCS Life can cancel this policy for the reasons indicated in this policy, for not complying with the eligibility requirements, and for the reasons described in Art. 2.050 of the Puerto Rico Health Insurance Code and Art. 7(a) of Law No. 161 of November 1, 2010, that states that:

    a. "Every health care plan that includes in its policy agreement a provision to the effects that the health care plan cannot be revoked or amended once the beneficiary is covered under the plan or included on the coverage, unless the premium is not paid and for not meeting the grace periods granted by the Insurance Code of Puerto Rico; is involved in an act constituting fraud; or intentionally makes false representation prohibited by the plan, about an important and material issue for accepting the risk, or for the risk assumed by the insurer".

b. MCS Life reserves the right to notify the insured of the termination or cancellation of the policy for non-payment of lapsed premiums, subject to the grace period, non-compliance with the minimum level of participation in the plan or non-compliance with the eligibility requirements of *bona fide* residents. In case of cancellation, written notice will be provided thirty (30) days before cancellation of coverage, as described in this policy.

c. The main insured may terminate coverage by sending written notice to MCS Life, and such termination will become effective upon receipt of the notice or at any later date specified on it, stating that the main insured will be responsible for payment of premiums up to termination of the policy. Immediately after termination of the policy, the main insured should return to MCS Life his or her plan card and that of all dependents. Termination will have no effect on the claims for services rendered before the date of termination. In case the card is not returned to MCS Life, as provided, MCS Life will have the right to recover the costs incurred for payment of claims for services offered to the insured whose card was not returned and that the insured has continued using.

d. In case of cancellation by the insured, MCS Life will promptly return the part not used of any satisfied premium. If MCS Life cancels, the insured will be responsible for paying the amount of premium accrued. Cancellation will be without perjury of any claim originated before the effective date of cancellation.

4. RESCISSION: MCS Life reserves the right to rescind coverage (invalidate retroactively to the original effective date) of any covered person in case of fraud or false representation made of a material act. MCS Life may rescind coverage under this policy as per reasons set forth in the *Patient Protection and Affordable Care Act* (PPACA) and Art. 2.050 of the Puerto Rico Health Insurance Code which states that:

   a. "Health insurance organizations or insurers cannot rescind or cancel a health plan, either for individuals or groups, after the insured person is covered under a health plan, except in cases involving fraud or intentional tergiversation of substantial data of the insured or of a person requesting medical insurance on behalf of another. The health insurance organization or insurer that decides to rescind or cancel coverage of health insurance should provide notice, with at least thirty (30) days in advance, to each insured of the plan or, the main insured, in the case of individual health insurance plans, who may be affected by the proposed rescission or cancellation of the coverage".

   b. In case of rescission of coverage, MCS Life will provide the insured written notice, with at least thirty (30) days in advance, to each insured of the plan who may be affected by the proposed rescission of coverage.

5. RECOVERY OF CLAIMS: In case coverage of an individual is rescinded as a result of fraud or false representation of a material act, according to the Section "Cancellation or Termination" or "Rescission", and claims have been paid by MCS Life, the individual will be responsible for paying such claims.

   a. MCS Life reserves the right to rescind coverage (invalidate retroactively to the original effective date) of any covered person in case of fraud or false representation of a material act.

b. In case of cancellation, MCS Life will provide the insured written notice thirty (30) days in advance of coverage cancellation. For more details, refer to clause on "Cancellation or Termination".

6. PERSONAL RIGHTS: The rights and benefits of this policy are non-transferable. No insured person may cede, transfer or dispose of any right or benefit that may be claimed in virtue of a policy in favor of a third party. MCS Life reserves the right to recover all expenses incurred in case that the insured person, expressly or implicitly, allows that noninsured people use the insured card issued on his or her name by MCS Life; and provided that the recovery of such expenses will not impede that MCS Life can cancel the insurance agreement upon discovery of such illegal use of the card, nor impede the criminal filing of the insured person or of the person making illegal use of the card.

   a. In accordance with Law No. 309 of August 25, 2002, as amended, the patient who terminates a doctor-patient relationship has the right to a copy of his or her medical record in a period not to exceed five (5) work days, by paying reasonable costs that will not exceed seventy-five cents ($0.75) per page, up to a maximum of twenty-five dollars ($25) per medical record.

7. EXEMPTION OF RESPONSIBILITY FOR THE INSURED: The insured person is not responsible for the payment of covered services that MCS Life denies to the contracted provider for offering such services due to non-compliance with the terms of the agreement between MCS Life and the provider.

8. IDENTIFICATION: MCS Life will issue a card to each insured person. The insured is required to show this card to any MCS Life participating provider to which services are requested to be covered under this policy. In addition, the insured should show a second photo identification as required. To receive benefits, MCS Life issues an identification card to the insured. The identification card states that the person is insured and has the right to use the card at network participating providers. The owner of the card is MCS Life. MCS Life reserves the right to terminate the insurance of any insured person whose identification card has been improperly used and that, as a result, has submitted false and/or fraudulent claims. If the insured person's insurance terminates or if the insurance of the dependent included herein terminates, the insured person should return the card to MCS Life. In case that this policy or this benefit is cancelled, all insured persons should return their identification cards to MCS Life.

9. PAYMENT OF PREMIUM**:** The main insured, or the person identified as the payer of the premium on the application, will be responsible for the payment of the corresponding premium of this policy, establishing that such responsibility will cover all lapsed premiums up to the date of termination of the policy, in accordance with the clause on "Cancellation or Termination". In case that the payment of premiums is made by check or automatic debit and bank account funds are insufficient, MCS Life will reprocess the corresponding charges of the lapsed premiums. This will occur at two (2) consecutive times. If the balance of the premiums is not recovered, the policy will be cancelled by sent notice as per clause two (2) on "Cancellation or Termination".

10. GRACE PERIOD: A grace period of thirty-one (31) days is granted for payment of each monthly premium payable after the first premium; grace period during which the policy will continue to be in effect, subject to the right of the main insured to cancellation according to the clause on policy cancellation.

11. POSSESSION: The person who applies for insurance benefits for a minor and signs an application for enrollment, will be the payer of the policy. In addition, this person will be responsible for the payment of the applicable premiums. If the payer of the policy does not meet his or her obligations, including

payment of the premiums during the effectiveness of the insurance, the insurance could continue to be in effect, provided the corresponding premiums are paid, and a new payer is designated and approved to assume all responsibilities.

12. ISSUANCE OF CERTIFICATES: MCS Life will issue to the policy holder, to be delivered to each insured, an individual certificate stating coverage to which the insurance has right under this policy, to whom will the benefits be paid, and the rights of the insured as set forth in this policy, especially, the right to conversion assisting in case of coverage cancellation.

13. OBLIGATIONS OF THE INSURED: The insured will comply with his or her obligations, as set forth in Art. 16 of Law No. 194 of August 25, 2000, as amended, stating the following:

    a. It is required and expected that every insured familiarizes with the "Bill of Rights and Responsibilities of the Patient" or of a reasonable and adequate summary, as prepared and authorized by the Department of Health. As proof of compliance with this requirement, it is required that every insured, before signing any agreement, signs a written statement or waiver declaring that he or she has received, read and is familiarized with the "Bill of Rights and Responsibilities of the Patient" or a summary approved by the Department of Health.

14. NOTICE OF CLAIM AND MODEL OF CLAIM: Written notice of claim to MCS Life should be provided within a twenty (20) day term after the occurrence or initiation of a loss of coverage of the policy, or after such term, as soon as reasonably possible. MCS Life will provide the claimants the corresponding forms to show evidence of the service. In case that the insured receives covered services from a non-participant professional services provider outside Puerto Rico, or services that, although offered by participants are paid by reimbursement, MCS Life will provide the forms directly to the insured after receiving the corresponding notice of claim.

    a. If such models are not delivered within the next fifteen (15) days, it will be understood that the claimant has met the requirements of this policy regarding the evidence of claimed services, if he or she submits, within the time period set forth in the policy for presenting such evidence, written proof covering the procedure and nature and level of claim.

15. FALSE REPRESENTATION OF SMOKING OR NON-SMOKING STATUS: The insured should indicate his or her smoking or non-smoking status at the time of plan enrollment. If the insured indicates at the time of initial enrollment a non-smoking status and during the course of the policy year MDS Life becomes aware that his or her smoking status has been falsely represented, MCS Life may apply retroactively to the effective date of coverage all related payable sums to the monthly rate or premium with arrangement to the policy, according to the corresponding smoking status of the plan. The retroactive amount of the monthly premium with arrangement will become effective immediately and the insurer will be notified of the action in a written letter. The payment of the total amount of the corresponding rate for the retroactive smoker plan should be made on or before thirty (30) days from issuing the letter. If payment is not received during said period, MCS Life could cancel the insurer's coverage until the established payments in this clause have been met.

16. CHANGE OF STATUS OF SMOKER OR NON-SMOKER: If the insured, at the time of enrollment indicates a non-smoker status and later changes to a smoker status, this change should be notified in a written medical certificate to MCS Life. If, contrary to this, the insured indicates a smoker status and later changes to a non-smoker status, this change should be notified to MCS Life in a written medical certificate stating that at least six (6) months have elapsed without smoking. After the insured has

submitted the required evidence, a change will be made to the rate, which will become effective on the first day of the following month of the change. The insured is responsible for visiting a Service Center and showing the required evidence to complete the process.

17. CIVIL ACTIONS: No civil action will take place or action to recover, with arrangement to this policy, before sixty (60) days have elapsed after having submitted written proof of a loss, according to the requirements of this policy. No action will take place after three years have elapsed from the date required to submit written proof of a loss.

18. PAYMENT FOR CLAIMS: Benefits provided under this policy will be payable to participating professionals or service providers if the insured has received services that, even if rendered by participants, are paid through reimbursement, provided all required reports are submitted to MCS Life.

19. SUBROGATION CLAUSE: MCS Life will exert the right to subrogation and, as a result, recover the amounts paid in such cases. This may include cases that may be covered under an accident insurance policy of the insured for a self-owned business. If a ruling is issued by a competent court or a transactional agreement is met, in which the insured receives monetary compensation, the insured should immediately notify MCS Life to exert its right to recover medical expenses incurred by the health plan when the one responsible for payment were another insurer or entity. If the insured does not notify MCS Life and receives monetary compensation, the insured will be responsible for returning any amount paid in claims by the health insurance plan, in this case, MCS Life. The insured has the obligation of notifying MCS Life immediately after becoming aware that the services covered are services whose primary responsibility of payment rely on another insurance or third party. In addition, he or she should notify of any other action taken, either judicial or non-judicial, or of another type, for the services that should be covered by another insurance or third party.

20. RIGHT OF THE PATIENT TO CONTINUITY OF HEALTH CARE SERVICES: Subject to the corresponding payment of premiums established by MCS, the insured will have the right to continuity of health insurance benefits for ninety (90) days after coverage termination in the following cases: (a) If the patient is hospitalized at the time of coverage termination, the ninety (90) day period will be counted from the date of discharge; (b) If an insured is on her second trimester of pregnancy at the time of coverage termination and has been receiving pregnancy care before the date of coverage termination, the period of coverage regarding pregnancy-related services will be extended until hospital discharge of the mother due to delivery or discharge of the neonate, whichever comes last; and (c) in case of insureds with a diagnosis of terminal illness contracted before the date of coverage termination and for which the insured has been receiving treatment before that date, the period of coverage will be extended during the remaining life time of the patient.

21. SOLE AGREEMENT – CHANGES: This policy, including its endorsements and attachments, if any, constitute the complete text of the insurance agreement. No change in this policy will be valid until approved by MCS Life's countersigning manager and the Office of the Insurance Commissioner of Puerto Rico, unless the approval is endorsed in the document or attached to it. No person has the authority to make changes to this policy or waive any of its provisions.

22. RENEWAL OF COVERAGE: MCS Life will renew the health plan to all eligible employees and dependents of large groups (in case the large group plan offers coverage for dependents), except in the following cases:

    A. Due to non-payment of premiums, taking into consideration the grace period required by the Insurance Code;

B. When the covered person or insured's acts constitute fraud. In such case, the insurer may decide not to renew the health plan to that covered individual or insured for one (1) year from the date of coverage termination;

C. When the covered person or insured has made intentional false representation of an important and material act under the terms of the health plan, in which case, the insurer may decide not to renew the health plan to that covered individual or insured for one (1) year from the date of coverage termination;

D. For non-compliance with minimal participation requirements as set forth in Chapter 8 of the Puerto Rico Health Insurance Code (CSSPR, by its Spanish acronym)

E. For non-compliance with the requirement of employer contribution;

F. When MCS Life determines to discontinue the offering of all formal health plans with employers of large groups in Puerto Rico, in which case, MCS Life will notify the Health Insurance Commissioner of Puerto Rico, employers, and covered persons or insureds in writing of its determination of not renewing with at least one-hundred eighty (180) days before the date of renewal of the health plan.

G. When MCS Life determines to discontinue the offering of a specific product for all employers of large groups in Puerto Rico, in which case MCS Life will notify the employer and all its participants and beneficiaries under such coverage through the main insured of the discontinuation of the product in writing with at least ninety (90) natural days before the date of discontinuation.

H. Before the determination of the Insurance Commissioner of Puerto Rico that continuity of the health plan does not respond to the best interests of the owners of the policies, or could affect the ability of MCS Life to comply with its contractual obligations.

I. When an employer's employee no longer lives, works, or resides within the geographical area established by the insurer (in the case of health plans available in the large group market through a preferred network plan).

MCS Life will comply at all times with the applicable federal regulations, as coded in 45 C.F.R. Sec. 146.152 (*Guaranteed Renewability of Coverage for Employers in the Group Market*).

PART VII: COMPLAINT SYSTEM

The insured has the right to submit a complaint not related with an adverse determination and a review of a complaint related with an adverse determination in accordance with Law No. 194 of August 25, 2000, Bill of Rights and Responsibilities of the Patient, Law No. 161 of November 1, 2010 to amend Art. 2 and 7 of Law No. 194 of 2000 and in accordance with the *Patient Protection and Affordable Care Act 75 Fed. Reg. 43330-43364 (July 23, 2010).*

In case in which the insured has a complaint or doubt on the benefits of the coverage, he or she may submit a claim by visiting or calling our Customer Service Department or visiting one of our Service Centers located throughout the Island, where the complaint will be carefully taken care of and all the necessary measures will be taken to solve the issue in the most efficient and rapid way possible.

There is also a complaint and appeals procedure which warrants the insureds the right to submittal, of efficiently investigating the complaint and the prompt and timely decision of complaints and appeals; as our purpose is that our insureds are satisfied with the service being offered and to achieve that the rights and responsibilities of those involved are respected. In addition, this procedure warrants the confidentiality between the parts.

The insured or his or her personal representative (family, friend, counsel), by written consent may submit a claim or complaint.

In addition, the following persons or entities may submit a claim or complaint on behalf of the insured:

- The health service provider through written consent;
- Persons authorized by court or according to state laws to act on behalf of the insured;
- A representative assigned by the state on behalf of a deceased insured.
- Staff of a government agency, like the Office of the Insurance Commissioner, the Office of the Health Ombudsman, House of Representatives, the Senate, Office of the Citizen Ombudsman, and the Office of the Governor.

MCS Life will confirm that the person submitting the complaint is the personal representative assigned by the insured by calling the insured or by means of any provided written documentation. If MCS Life cannot confirm representation, a letter will be sent to the insured notifying that his or her case will not be processed until the information has been received.

Procedure

Availability of assistance for submitting complaints and its process:

Taking into consideration the special needs of insureds with hearing or visual deficiencies, and/or reading limitations, MCS Life provides services, at no cost, to insureds by a:

- TTY/TDD Line: 1-866-627-8182
- Sign language and/or foreign language interpreters or written translation services
- Audio tapes
- Braille

MCS Life makes sure all services, either clinical as well as non-clinical, are available to all members and that are culturally competent, including for those with limited speech or reading skills in English and Spanish, and for those from diverse cultural and ethnic scenarios.

MCS Life does not discriminate due to race, color, nationality, age, disability or sex. MCS Life warrants a right, just and quality resolution of complaints regarding any prohibited behavior or action under Section 1557 of the Affordable Care Act.

Complaint submittal

MCS Life will try to solve any situation or question submitted by insureds in any call or during visits of an unsatisfied insured or his or her authorized representative to one of the Service Centers. In the case of claims received through a phone call, MCS Life has a call back system available to let the insured know the status of his or her petition. If the insured is not satisfied with the alternatives offered by the MCS Service Representative, the insured receives orientation on the formal procedure to evaluate the claim through the complaint process. The insured always has the right to submit a claim unrelated to an adverse determination without the need to exhaust the complaint process.

Situations that may be taken care of through the call back system, considering they are intended for cases of brief interventions or actions, will be the following:

- Eligibility issues: questions regarding the insured's eligibility in the plan. It includes validation of electronic files interchanged with business partners, such as Pharmacy Benefit Managers (PBMs), among others.
- Status of requests, like: pre-authorizations, special conditions registry, drug approvals, and others.
- General orientation about the plan.
- Assistance with appointment coordination and searching participating providers.

Submittal of complaints unrelated to adverse determinations

MCS Life will notify the insured of the access to a complaint process. A complaint may be submitted in writing or verbally by:

- Visit to Service Centers: The insured may visit the nearest MCS Life Service Centers to present his or her case by means of a letter and/or completing the complaint form provided by MCS Life.
- Call Center: The claimant can call 1-888-758-1616 or the number shown on the back of the health plan card to submit a formal verbal complaint or get instructions on how to submit a case in writing. TTY/TDD users can call 1-866-627-8182 .
- Regular mail: Sending a letter presenting the allegations and contract number to the following address:

Complaint and Appeals Unit
MCS Plaza PO Box 191720
San Juan, Puerto Rico 00919-1720

- MCS Life will notify the insured of having the right to submit comments in writing, documentation, records and other material related to the complaint.
- In addition, MCS Life will notify the insured of having the right to receive assistance in submitting a complaint by authorized personnel or a government officer, like:

    - Office of the Health Ombudsman: The insured can visit the office of the Health Ombudsman throughout the Island or headquarters located at 1215 Ponce de León Ave., Stop 18, San Juan, Puerto Rico , by calling 787 977-1100 or toll free at 1-800-981-0031 or visiting the website at www.ops.pr.gov in accordance with that provided in the Bill of Rights of the Patient and Law No. 161 of November 1, 2010.

    - Office of the Insurance Commissioner: The insured can contact the Office of the Insurance Commissioner at 787-304-8686 of fax at 787-273-6082 ; or visiting the office located at Gam Tower Building, Tabonuco St., Suite 400, San Patricio, Guaynabo, Puerto Rico , or visiting the OCS website at: www.ocs.gobierno.pr.

Investigation, Resolution, and Notification of a Complaint Not Related to an Adverse Determination

The insured has the right to submit to MCS Life a complaint not related with an adverse determination. MCS Life will evaluate and resolve the complaint as soon as required by the medical condition of the insured, but not to exceed thirty (30) calendar days from the receipt of the complaint.

An MCS Life complaints specialist will initiate the investigation with the involved parties, analyze all documentation in the record, contact the parties to listen to both sides, and collect all the necessary evidence to make a determination.

MCS Life will provide the insured in three (3) work days a receipt of the complaint, the address and phone number of the people designated to review the complaint. The insured has the right to submit comments in writing, documentation, records, and other material related to the complaint. The designated persons will not be those who handled the issue object of the complaint.

The Complaints and Appeals Specialist will issue a written resolution in or before thirty (30) calendar days from the receipt of the complaint. The resolution will include:

- the titles and credentials of the persons participating in the review process of the complaint (the reviewers);
- a statement of the interpretation made by the reviewers of the complaint;
- the determination of the reviewers, in clear terms, and the contractual base or medical justification for the insured to respond to the opinion of MCS Life;
- reference to the evidence or documentation on which the determination was made;
- a notice of the right that assists the insured to contact the Office of the Commissioner or the Office of the Health Ombudsman to request assistance at all times, the phone number and address of the Office of the Commissioner or the Office of the Health Ombudsman.

Confidentiality

All documentation and information pertaining to cases of complaints are considered protected health information and will be treated in accordance with HIPAA regulations and other applicable laws of the Commonwealth of Puerto Rico.

Submittal of Complaints Related to an Adverse Determination

Revision of the first level of an adverse determination:

The insured can submit a complaint on or before one-hundred eighty (180) days from the date of receipt of the resolution of the adverse determination of benefits issued by MCS Life.

A complaint pertaining to an adverse determination may be submitted in writing (or verbally if it entails a request for accelerated care) by:

- Visiting an MCS Life Service Center: The insured can visit the nearest MCS Life Service Center to submit a case by means of a letter and/or completing a complaint form.
- Call Centers: The insured can call at 1-888-758-1616 or the phone number on the back of the health plan to submit a review resource verbally or for instructions on how to submit a case in writing. TTY/TDD users can call 1-866-627-8182 .
- Regular mail: Sending a letter with pertinent allegations and contract number to the following address:

Complaints and Appeals Unit
MCS Plaza PO Box 191720
San Juan, Puerto Rico 00919-1720

- MCS Life will notify the insured of the right to submit written documentation for the consideration of the people designated by MCS Life to conduct the review.
- In addition, MCS Life will notify the insured of the right to receive assistance on submitting an appeal by authorized personnel or a government officer, such as:

- Office of the Health Ombudsman: The insured can visit the office of the Health Ombudsman throughout the Island or headquarters located at 1215 Ponce de León Ave., Stop 18, San Juan, Puerto Rico , by calling 787 977-1100 or toll free at 1-800-981-0031 or visiting the website at www.ops.pr.gov in accordance with that provided in the Bill of Rights of the Patient and Law No. 161 of November 1, 2010.

- Office of the Insurance Commissioner: The insured can contact the Office of the Insurance Commissioner at 787-304-8686 of fax at 787-273-6082 ; visiting the office located at Gam Tower Building, Tabonuco St., Suite 400, San Patricio, Guaynabo, Puerto Rico , or visiting the OCS website at: www.ocs.gobierno.pr .

Investigation, Resolution, and Notification of a Complaint Related to an Adverse Determination

MCS Life will evaluate and resolve an appeal as soon as required by the medical condition of the insured taking into consideration medical requirements and according to the type of claim:

- Accelerated reviews of complaints pertaining to an adverse determination - MCS Life will work on the accelerated review and should respond to allegations within a term not greater than forty-eight (48) hours from the receipt of the request for accelerated review. The term will begin on the date of submittal of the accelerated review at MCS Life, regardless if the submittal includes all the required information to make a determination.
- In an accelerated review, all the necessary information, including the determination of the health insurance organization or insurer, will be transmitted between the health insurance organizations or insurer and the covered person or insured or, if applicable, his or her personal representative, by phone, fax or the most expedited way available.
- First level review of an adverse determination with prospective review - MCS Life will work on the review and should respond to allegations in a term not greater than fifteen (15) calendar days from having received the request. MCS Life will provide the insured within three (3) work days of having received the complaint the name, address, and phone number of the persons designated to conduct the review of the complaint. The insured has the right to submit written comments, documentation, records, and other materials related to the complaint. The insured may request free access to all documentation and records, and to get copies of these as well as pertinent information of the complaint.
- First level review of an adverse determination related to a retrospective review- MCS Life will work on the review in a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) calendar days from having received the complaint. MCS Life will provide the insured within three (3) work days of the receipt of the complaint the name, address, and phone number of the person designated to conduct the review of the complaint. The insured has the right to submit written comments, documentation, records and other materials related to the complaint. The insured may request free access to all documentation and records, and to get copies of these as well as pertinent information on the complaint.

While conducting a review, the reviewers will take into account all comments, documentation, and records, as well as any information related to the request of the revision regardless of the information that has been submitted or considered when making the initial adverse determination.

MCS Life will designate one or several clinical peers of the same or similar specialty to the health professionals that would normally manage the case for which the adverse determination was made, and that have not been previously involved in making decisions or level of review. When the initial denial has been based on lack of medical necessity, the complaint will be evaluated by a health professional with the appropriate clinical expertise

to treat the condition or illness of the insured. If more than one clinical peers is designated for the review, MCS Life will make sure that they have the adequate expertise.

Once the documentation received along with the review has been evaluated, it will be determined if additional information is required. MCS Life will provide the insured or his or her personal representative the reasonable opportunity to submit evidence and allegations, of fact or of law, in person or in writing. In the case of accolated complaints, this opportunity will be limited due to the availability of time for the resolution of this type of complaint, in or before twenty-four (24) hours.

If MCS Life believes that the complaint does not contain all the necessary information to make a determination, it will clearly indicate the insured of the reasons why the complaint cannot be processed, and will let the insured know what additional documentation or information should be submitted.

The insured will be able to examine, before and during the investigation and resolution process, the complaint record (medical records, new evidence to consider, identification of medical experts and vocational staff consulted, as well as any other document related to the complaint), and to request copy of this documentation free of charge, subject to the exceptions and limitations imposed under the applicable laws pertaining to confidential or privileged information.

MCS Life complaint specialist will issue a written resolution on or before the terms established according to the complaint category.

MCS will provide the information related to accelerated reviews verbally, in writing, or electronically. If notice of the adverse determination is provided verbally, MCS will also provide written or electronic notice not later than three (3) days from the verbal notice.

The notice will include:

- titles and credentials of those participating in the first level review process (the reviewers);
- a statement of the interpretation made by the reviewers regarding the complaint;
- the determination of the reviewers in clear terms and the contractual base or medical justification in order for the insured to be able to respond to MCS Life decision;
- evidence or documentation on which the determination was based.

In case MS Life issues an adverse determination after having conducted the complaint review, as defined in this policy and per applicable laws and regulations, the notice for such determination will state, in a comprehensible manner for the insured:

- the specific reasons for the adverse determination;
- reference to the specific provisions of coverage in which the determination was based;
- a statement mentioning the right of the covered person to receive, without charge and upon request, reasonable access to all documentation, including copies, records and other pertinent information. To determine if a document, record or other information is pertinent to the claim, the definition in accordance with ERISA (2560.503) will be used. Pertinent means that: (a) They were used in the determination of benefits; (b) records or other information was submitted, considered or generated regarding the adverse determination, although the determination of benefit did not depend on such documentation, records or other information; (c) It is shown that when making the determination, the health insurance organization followed, consistently, the same procedures and administrative assurances that are followed with other people covered or insureds in similar circumstances; or (d) they constitute health insurance policy statements or guidelines of the health plan related to the healthcare service or treatment denied and the diagnosis of the person covered, regardless if taken into consideration or not at the time of making the initial adverse determination.

- the right to request, at no cost, copy of the rule, guide, internal protocol or other similar criteria on which the adverse determination was based, if applicable, and the instructions for its request;
- the right to request, at no cost, an explanation of the scientific or clinical rationale when making the adverse determination based on the medical necessity or experimental or investigational nature of the treatment, if applicable, and the instructions for its request.
- a description of the procedures to submit an independent external review.
- a notice of the right of the covered person to contact the Office of the Commissioner or the Office of the Health Ombudsman to request help at all times, with phone numbers and addresses of the Office of the Commissioner and the Office of the Health Ombudsman.
- a statement of the right of the employee to file a civil action under ERISA Section 502(a) after an adverse determination of benefits under review.
- the right to seek other voluntary options of dispute resolution between the insured and the plan, like mediation. One of the ways to identify available options is by contacting the U.S. Department of Labor or the Office of the Insurance Commissioner of Puerto Rico.

In case MCS Life does not comply with its obligations under this process, the insured person may initiate the external review process for the claim or exert any of the available remedies under ERISA §502(a) or under the laws of Puerto Rico.

Continuity of services

In case of concurrent review determinations, if MCS Life has previously certified the treatment in course for a determined length of time or for a determined amount of treatments, MCS Life will notify the insured of the adverse determination in advance to the reduction or termination, in such a way that the insured may submit an internal complaint before the reduction or termination of the benefit.

The health care service or treatment object of the adverse determination will continue until MCS Life notifies the insured of the determination related to the internal complaint.

If the insured submits a complaint because the plan, during the course of the approved treatment, decided to reduce, suspend or terminate such treatment, MCS Life will continue the benefits during the appeal.

If MCS Life's decision to deny the complaint is maintained, the insured will be responsible for paying the costs of the services or benefits received while the appeals process was pending. In this case, MCS Life reserves the right to recover such costs from the insured.

External Reviews

If the covered person is not satisfied with an MCS Life adverse determination, including denials of service for being experimental or investigational in nature or of the decision on the internal review, or if MCS Life does not provide a determination within the time limits set forth for internal reviews, the insured may request a review before an external independent organization that meets the requirements of the Insurance Commissioner of Puerto Rico and with that provided in PPACA Section 1001. Independent review organizations are certified by an accrediting organization that assures that the staff that makes the reviews has the necessary qualifications and is independent from the plan.

The insured, his or her personal representative or physician should submit such request to MCS Life, or directly before one of the independent review organizations through the means mentioned on the written resolution issued by MCS Life within one-hundred twenty (120) days of having received notice of the adverse determination.

MCS Life will have a five (5) day term after having received an external review request to complete a preliminary review of the request before submitting it to the independent review organization to determine the following:

- if the requestor was a covered person at the time of receiving the services;
- if it is understood that the service object of the adverse determination is a covered service according to the health plan;
- if the insured exhausted the internal complaint process;
- if the covered person or insured has provided all the required information and forms.

If the insured has provided all the required information for the external review process, MCS Life will proceed to refer the request to one of the following three independent review organizations contracted: *Advance Medical Review, Alicare BHM Healthcare Solutions* . The designation of the independent review organization to conduct the review will be done by randomly selecting one among the independent review organizations contracted and qualified for the particular external review, taking into consideration the nature of the healthcare services object of the adverse determination that is being reviewed, as well as any other pertinent circumstances, including potential conflicts of interests.

If, on the other hand, MCS Life determines that the request for external review does not meet the information requirements required, MCS Life will proceed to notify the insured or his or her personal representative of the inappropriateness of such request under of the following modalities:

- the submitted request is incomplete or does not meet the established requirements of law for the external review process. The insured will receive written notice of the necessary requirements to complete the request, including the required documentation; or
- if the insured is not eligible for an external review, MCS Life will notify in writing of the reasons for the ineligibility to this process and the right of the insured to appeal the determination by means of a resource submitted before the Office of the Insurance Commissioner of Puerto Rico.

The independent review organization should submit its determination within forty-five (45) days after having received the review request and seventy-two (72) hours for the accelerated external reviews.

The insured or his or her representative may submit an accelerated review if an adverse determination is received and:

- the insured suffers a health condition to which the required time for the accelerated internal review of the appeal could endanger the life, health or full recovery;
- the insured has submitted an accelerated internal review for which an adverse determination has been made;
- the insured suffers a health condition to which the time set for an ordinary external review could endanger the life, health or full recovery;
- the final adverse determination has to do with an admission to a healthcare facility, the availability of a service or continued stay at a facility where the insured received emergency services and he or she has not been discharge from the facility where the emergency services were offered.

MCS Life will obey the decision of the independent review organization immediately.

The insured will pay a face amount of twenty-five dollars ($25.00) for each review. The cost cannot exceed seventy-five dollars ($75.00) per policy year for the same insured. The amount paid by the covered person or insured will be reimbursed if the determination is in his or her favor.

No external review request will proceed until the insured has exhausted the internal complaint appeal process described in the previous Section. The insured will have exhausted MCS Life internal complaint process when the insured or his or her personal representative:

- has submitted an internal complaint resource and

- the insured or his or her personal representative has not received from MCS Life written notice of the determination within thirty (30) calendar days from the time of receipt of the complaint resource without the parties having agreed on the length of time for issuing the determination.

If MCS Life does not comply with the process required for managing a complaint (i.e., notice of the determination within the established time limits), the complaint will be considered denied under the premise that the insured exhausted the internal complaint processes and the insured will have the right to request an external review and submit a judicial claim under ERISA Section 502(a) and other state forums.

The premise that the insured exhausted the internal complaint processes will not apply to violations that do not affect the insure; whenever the plan can demonstrate that the violation was for a good cause or that it was out of the control of the health plan and that the violation occurred during a good faith exchange of information between the insured and MCS Life. This exception does not apply if the violation is part of a pattern of violation from MCS Life. The insured may request written explanation of such violation and will receive a response from MCS Life in ten (10) days, including an explanation of why it is not understood that the violation does not exhaust the internal complaint process.

PART VIII: HIPAA PROVISIONS

This regulation sets forth the federal requirements related to changes, access, and renewal of group health insurances and to companies providing health insurances.

Creditable Coverage under CSSPR

MCS Life will provide a creditable coverage certification form to people as set forth on the Puerto Rico Health Insurance Code:

(1) when the person is no longer covered under another health plan or has coverage due to a continuation provision, in accordance with COBRA; or

(2) in the case of a covered person or insured under a continuation provision in accordance with COBRA, when the person is no longer covered under such provision.

The creditable coverage will contain the following:

(1) the period of creditable coverage according to the other health plan and
(2) the waiting period, if any, and, if applicable, the enrollment period stipulated for the person regarding the other health plan coverage.

Creditable Coverage under HIPAA

In accordance with the *Health Insurance Portability and Accountability Act* (HIPAA) of 1996.

The employee, spouse and/or dependents will have the right to receive a separate and independent certification of creditable coverage from the plan at: (a) termination of plan coverage; (2) termination of COBRA coverage or when it is exhausted (if COBRA is selected); and (c) again, upon the insured request when the request takes place within twenty-four (24) months following the termination of any of the above-mentioned coverages.

The employee should keep a copy of the certification of creditable coverage, as it is possible that proof of previous coverage might be required to enroll in a new health plan. If the person is purchasing individual coverage, it is possible that proof of previous certification of coverage may also be required by the insurer.

Anti-discrimination

The law prohibits establishing eligibility rules and continuity of eligibility based on health status-related factors.

Special Enrollment Period under CHIP

Under the Children's Health Insurance Program (CHIP) Act of 2009, as amended, which became effective on April 1, 2009, the insured may change the plan selected for him/herself or for any eligible dependent within the following sixty (60) days of enrollment due to: 1) termination of Medicaid or CHIP coverage due to loss of eligibility or 2) has become eligible for a state premium program of assistance under Medicaid or CHIP coverage. In either case, coverage becomes effective the first day of the month following enrollment.

PART IX: ERISA PROVISIONS

Employer or Sponsor

The company that sponsors the plan, as described in the first page of this policy. The tax ID number assigned to the employer by the Internal Revenue Service is the number shown in the first page of this policy.

Plan Name and Number

Refer to the first page of this policy. This plan includes the provisions related to the health insurance plan, prescription drug plan and Employees Assistance Program (EAP), for the employer's eligible employees and participating subsidiaries and divisions.

Plan Administrator

The plan administrator is the employer sponsoring the plan. Refer to the first page of this policy.

Policy Claims Administrator

The claims administrator determines the eligibility of benefits under the plan, according to the plan's official document(s). The claims administrator is:

MCS Life Insurance Company
P.O. Box 9023547
San Juan, PR 00902-3547

The plan administrator and the claims administrator have exclusive discretionary power to:

- Analyze and interpret the provisions of the health plan;
- Make determinations based on facts;
- Solve all the questions related to eligibility of benefits;
- Determine the amount of said benefits;

- Solve issues arising from the administration, interpretation and/or implementation of the health plan;
- Correct any errors;
- Reconcile discrepancies; and
- Supply any omissions concerning the health plan.

Its decisions on these issues are final and mandatory. The employer, as the plan administrator, has reserved the right to delegate any or all portion of its discretionary power described in the previous sentence on the claims administrator, and the decisions made by such representative regarding said issues are final and mandatory. Any interpretation or determination made according to the discretionary power of the plan administrator or its representative will be upheld in a judicial review unless it is proven that the interpretation or determination was a discretionary abuse.

If the employee has questions about the plan, the plan administrator should be contacted. For questions regarding claims submittal status, contact the claims administrator.

Plan Documents

The only intention of this policy is simply to modify official documents of the plan. If case of inconsistency between this policy and the official document(s) of the plan, as they may be amended from time to time, the provisions of the document(s) of this policy will prevail.

Future of the Plan

The employer expects to continue the plan indefinitely. However, the employer reserves the right to amend, modify or terminate the plan, or part of the plan, including this policy, at any time and for any reason. The employer takes these actions through the resolutions of its board of directors or an administrative committee or other parties authorized by the board of directors.

If the plan is terminated, the former employee will not receive any other benefit under the plan, except payment for benefits due to loss, or covered expenses incurred before the plan was terminated.

Plan Year

Refer to the first page of this policy.

Contact Information

If the employee has questions about his or her benefits, in general, the plan administrator should be contacted. For questions related to benefits covered under this policy, the insured should contact the employee's services providers by phone.

Family and Medical Leave/Military Leave

This Section refers to continuation of benefits for two specific types of leaves: family or medical leave and military leave. For additional information on these types of leaves, contact the employer's human resources department or the plan administrator.

DECLINED CLAIMS REVIEW

Claims and Appeals Process

If the employee, the employee's beneficiary or the employee's personal representative feel that an error has been committed in any of the employee's benefits programs, the employee, his or her beneficiary or personal representative have the right to request a reconsideration under the plan, according to the procedures established by the plan administrator.

Claims Review Procedures

For information on how to submit the initial claim of the employee, see the claim submittal procedures described in the plan document or the insurance agreement or related documents that describe the employee's benefits program.

For each one of the plan options, the plan offers a specific amount of time, as required by law, to evaluate and respond to claims for covered benefits under the Employment Retirement Income Security Act of 1974 (ERISA). The time frame the plan has to evaluate and respond to a claim begins on the date the claim is initially submitted. The process for submitting a claim for the various benefits offered under the plan can vary. If the employee has questions about how to appeal a claim, he or she should contact the plan administrator or review the health insurance agreements documentation or this policy for the benefit in question.

Adverse Benefit Determination

If the plan is not in total agreement with the employee's claim, the employee may receive an "Adverse Benefit Determination", that is, – a denial, or benefit reduction or termination, or the denial of the offering or payment (in full or partially) of a benefit. This may also include denial of the participation in the plan. An adverse benefit determination also means a denied claim on the basis that the treatment is experimental or investigational in nature or not medically necessary. The notice will include:

- the specific reasons for the adverse determination;
- the specific provisions in the plan on which the determination is based;
- a description of any necessary additional information to reconsider the claim and the reason why said information is necessary;
- a description of the plan's review procedures and the time frame applicable to such procedures;
- a statement of the right of the employee to file a civil action under ERISA Section 502(a) after an adverse determination of benefits under review;
- any rule, guideline, protocol, or similar internal criteria used as base for the adverse determination. The rule, guideline, protocol or specific criteria, or a statement indicating that a copy of such information will be provided to at no cost to the insured, if requested;
- for adverse determinations based on medical necessity, experimental treatment or other exclusions or similar limitations, an explanation of the scientific or clinical judgment used in the decision, or a statement indicating that an explanation will be provided at no cost, if requested; and
- for adverse determinations pertaining to urgent care, a description of the expedite review process for such claims (this notice may be verbally within the period of time for expedite processes, provided written notice is provided no later than three (3) days following verbal notice).

How to Appeal a Claim

If the employee receives notice of an adverse benefit determination and disagrees with the decision, he or she has the right to request a complete and fair review of the claim and of the adverse benefit determination. The employee (or designated representative) can appeal and request a review of the claim, in accordance with the

time frames under ERISA. The request can be in writing, except for claims for urgent care, which the employee may submit verbally or in writing, and should be submitted to the claims administrator.

Employee's Rights under ERISA

As a plan participant, the employee has certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974. ERISA sets forth that all participants have the right to:

Receive Information About the Plan and the Employee's Benefits

- The employee can review in the plan's administrator's office and at other specific locations, such as the workplace, all documentation that regulates the plan, including insurance agreements, collective bargaining agreements, and a copy of the most recent annual report (Form 5500 Series), if any, filed by the plans with the U.S. Department of Labor and available at the Public Disclosure Room for the Employee Benefits Security Administration. No charges apply for this review.
- Obtain, through a written request to the plan administrator, copies of the documents that rule the plan's operation, including insurance contracts and agreements of group negotiations and copies of the most recent annual report (Form 5500 Series) and an updated summary plan description.
- Receive a summary of the plan's annual financial reports, if ERISA requires one. The law requires the plan administrator to provide each participant a copy of any Summary Annual Report (SAR).

Group Health Insurance Plan Continuation Coverage

Health insurance continuation coverage for the employee, spouse or dependents, if coverage is lost under a health plan due to a qualifying event. It is possible that the employee or his or her dependents need to pay for said coverage. Review this summary and other documents that regulate plans on the rules that govern the rights of the employees on continued coverage under COBRA.

The group health insurance plan or the health insurance company should provide the employee a Certification of Creditable Coverage, free of charge, when the employee loses coverage under a health insurance plan, when the employee obtains the right to choose continued coverage under COBRA, when the employee's coverage under COBRA is reduced, when the employee requests it before losing coverage, or when the employee requests it up to twenty-four (24) months after losing coverage.

Plan Termination Amendment

The plan administrator can amend the plan in order to add or eliminate any plan benefit, implement employee financial participation, or charge the amount of financial participation or percent participation required from the employee, or change the plan's terms at any time, without previous notice to the employee**.**

The plan administrator also reserves the right to terminate the plan at any time without the consent of the covered person and without previous notice to any covered person. This right of termination includes the right to terminate coverage of retired insureds and their covered dependents, provided the plan administrator notifies of the termination to the retired insured, in writing, at least ninety (90) days before termination.

Prudent Actions by Plan Fiduciaries

In addition to establishing the rights of plan participants, ERISA imposes duties on the people responsible for operating the employee's benefits plan. People operating the employees plan, called plan "Fiduciaries", are

expected to do so, in a prudent fashion and in the best interest of the employees, of other participants and beneficiaries.

Asserting Employee's right

If an employee's benefits claim is denied or ignored, partially or in full, the employee has the right to know the reasons why, obtain copies of the documents related to the decision, free of charge, and appeal any denial within the established deadlines. Under ERISA, there are certain steps that the employee can take to assert the previously mentioned rights. Likewise, if it so happens that the fiduciaries make bad use of the plan assets, or if discrimination occurs against the employee for asserting his or her right, the employer can seek assistance from the U.S. Department of Labor or file a civil action with the federal court. For additional information on how to assert your rights under the plan, please contact the plan administrator.

Assistance with Employee's Questions

For employee's questions regarding the plan, the employee should contact the plan administrator. If the employee has any question about this statement, or the employee's rights under ERISA, or for assistance obtaining documents from the plan administrator, please contact the nearest office of the Employee Benefits Security Administration (previously known as the Pension and Welfare Benefits Administration) or the U.S. Department of Labor, shown in the employee's telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 *Constitution Avenue N.W.*
Washington, DC 20210

PART X: COBRA

CONTINUATION OF COVERAGE

Section 1: COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

The Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended, requires the employer to provide the employee and/or spouse, previous spouses of the employee and covered direct dependent children that qualify as beneficiaries under COBRA the opportunity to continue coverage. This is done under the medical benefits program, temporarily, and following the group health insurance plan premium fees, plus an administrative charge, in accordance with COBRA. It is granted when qualifying events established by COBRA occur, in which otherwise the employee's coverage would had ended. COBRA only applies to groups of twenty (20) employees or more.

As a qualified beneficiary, the employee or eligible dependents can opt for continuing medical, prescription drugs, dental, and vision coverage, healthcare flexible spending account, and the employee assistance program (EAP) coverage in force on the date that the employee's coverage would otherwise would end.

The employee can also, under certain circumstances, be eligible to continue participating in the healthcare flexible spending account.

Qualified beneficiaries include the employee, the employee's spouse and the dependent children covered under the medical benefits program, right before the coverage ends. A covered beneficiary also includes the biological or adopted child of the employee, while the employee is enrolled in COBRA continuation coverage, provided the employee notifies the claims administrator within thirty (30) days following the request to include that dependent in the coverage.

The employee does not need evidence of insurability to select continuation coverage. However, COBRA continuation coverage is provided subject to employee's eligibility for coverage. The employer reserves the right to terminate employee's coverage retroactively, if it is determined that the employee is not eligible under the terms of the medical benefits program.

The employee will have sixty 60) days from the date of the qualifying event to choose COBRA continuation coverage. If the employee does not choose COBRA coverage within that time frame, he or she will not be eligible for COBRA coverage.

The employee will have to pay the premium in full plus two (2%) percent for administrative costs for continuation coverage. There is a grace period of thirty (30) days to make the payment of the regularly scheduled premium. A grace period of forty-five (45) days applies for the first payment of the premium.

COBRA continuation coverage for the medical benefits program is administrated by the COBRA administrator, which is the employer, as described in the first page of this policy.

Section 2: Work Leave

A leave that has qualified under the Family and Medical Leave Act (FMLA) does not make an employee eligible for coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). However, regardless of whether the employee loses coverage due to lack of payment of the premium while on a FMLA leave, the employee is still eligible for COBRA up to the last day of the FMLA leave, if he or she decides not to return to active work. The employee's continuation coverage can start as soon as one of the followings events occurs:

- when the employee informs the employer that he or she is definitely not returning to work when the leave period ends; or
- at the end of the leave period, assuming the employee will not return to work.

For FMLA leave purposes, the employee will be eligible for COBRA, as described above, only if:

- The employee or employee dependent is covered under the medical benefits program the day before the leave begins (or the employee or employee dependent starts coverage during an FMLA leave); and
- The employee does not return to work at the end of the FMLA leave.

Section 3: Who is covered?

If the employee has medical, prescription drug, dental, and vision coverage, or EAP benefits sponsored by the employer and loses coverage under the group health insurance plan due to reduction of working hours or termination of employment (for reasons other than misconduct on part of the employee), he or she has the right to choose continuation coverage. If the employee decides not to return to work after a leave that qualifies under FMLA, the event that will cause continuation coverage is the earliest date between the date the employee informs that he or she is not returning to work after the leave period ends, or the last day of the FMLA leave.

If the individual is the spouse of an employee and he/she is covered under a medical benefits program sponsored by the employer the day prior to the qualifying event, the person is a qualified beneficiary and has the right to choose continuation coverage if he/she loses coverage under a group health insurance sponsored by the employer for any of the following reasons:

- Death of spouse;
- Loss of spouse employment (for reasons other than misconduct);
- Reduction in spouse working hours;
- Divorce or legal separation of the spouse; or
- Spouse becomes Medicare eligible.

If the individual is a dependent child of an employee covered under a medical benefits program sponsored by the employer the day before the qualifying event, the individual is a qualified beneficiary and has the right to choose continuation coverage if he/she loses group health insurance plan coverage under the program due to any of the following reasons:

- Death of employee;
- Loss of employee's employment (for reasons other than misconduct) or reduction of working hours;
- Divorce or legal separation of the employee;
- Employee becomes Medicare eligible; or
- Dependent is no longer a "dependent child" under the program sponsored by the employer.

If the covered employee chooses continuation coverage and later has a child (either a biological, adopted or child placed for adoption) during the continuation coverage period, the new child is also eligible to become a qualified beneficiary. According to the terms of the group health insurance sponsored by the employer and federal law requirements, these qualified beneficiaries can be added to COBRA coverage by notifying the COBRA administrator about the birth, adoption or placement for adoption of the new child. This notification must be submitted in the specially designed COBRA form for these purposes and include any information or additional documentation that should accompany the form.

If the covered employee does not notify the employer on time (as per the terms of the group health insurance sponsored by the employer), the option to choose COBRA coverage for the child will not be offered.

Section 4: Separate Selections

Each qualified beneficiary has the right to independently choose COBRA coverage. For example, if the person can choose between various types of coverage, each qualified beneficiary that is eligible for continuation coverage has the right to separately choose between the different types of coverage. Therefore, a spouse or a dependent child has the right to choose continuation coverage, even if the covered employee does not make this selection. Likewise, a spouse or dependent child can choose a different coverage from the one chosen by the employee.

Section 5: Employees' Duties

According to the law, the employee or family member has the responsibility to notify the employer identified on the first page of this policy about a divorce, legal separation or loss of dependent child status, if under medical, prescription drug, dental and/or life insurance, as per coverage selection of the employer, as described on the first page of this policy. This notification must be submitted in the designed form used for this purpose and include any information or documentation that should accompany this notification.

This notification should be provided within sixty (60) days following the divorce, legal separation or loss of dependent child status (or if later, on the date in which coverage would otherwise would have been lost due to the event). If the employee or the family member does not provide this notification to the employer, identified on the first page of this policy, within this sixty (60) day period, the option to choose continuation coverage will not be offered to any family member that loses coverage.

When the employer is notified of the occurrence of these events, the employer, in turn, will notify the employee about his/her right to choose continuation coverage. If the employee or the family member does not notify the employer identified on the first page of this policy, and a claim is mistakenly paid for expenses incurred after the date the coverage would have normally terminated due to divorce, legal separation or loss of dependent child status, then the employee and the family member will be required to reimburse the group health insurance plan sponsored by the employer any claim paid in error.

Section 6: Employer's Duties

Qualified beneficiaries will be notified of their right to automatically choose continuation coverage (without action required from the employee or the member of the family), upon the occurrence of any of the following events resulting in loss of coverage:

- Death of employee;
- Loss of employee's employment (for reasons other than misconduct);
- Reduction in employee's working hours; or
- Employee becomes Medicare eligible.

Section 7: Choosing COBRA

According to the law, the employee may choose continuation coverage within sixty (60) days following the date in which coverage would have been lost due to any of the events described above or, if later, sixty (60) days after the employer notifies the person about his/her right to choose continuation coverage. An employee or the family member who does not choose continuation coverage during the time frame described above, will lose the right to choose continuation coverage. For choosing COBRA coverage, the employee should contact the employer listed on the first page of this policy.

If the employee chooses continuation coverage, the employer will be required to offer the same coverage as the coverage provided under the medical benefits plan to employees or family members under a similar situation. This means that if the employee or the family member's coverage in similar situations is modified, the employee's coverage will be modified. "Similar situation" refers to the employee or the current dependent who has not had a qualifying event.

Section 8: Duration of COBRA

Initial COBRA Coverage

COBRA requires that the employee is given the opportunity to keep continuation coverage for a limited period of time of eighteen (18) to thirty-six (36) months, depending on the type of beneficiary and the type of qualifying event that led to the rights under COBRA. However, the continuation coverage period is subject to early cancellation if any of the events mentioned below occurs, as established under COBRA. The employer should

offer continuation coverage to qualified beneficiaries (covered employees, spouses and legally dependent children) during an eighteen (18) month period, when the following qualifying events occur:

- Termination of the covered employee's employment (for reasons other than a serious misconduct); or
- Reduction of employee's working hours.

The employer should offer continuation coverage during a thirty-six (36) month period to the spouse and the legally dependent children of a covered employee when one of the following qualifying events occur:

- Death of the covered employee;
- Divorce or legal separation of the covered employee and spouse;
- Covered employee becomes Medicare eligible; or
- A legally dependent child is no longer classified as such under the plan's provisions (for example, when the minor reaches the age of majority*);*
- Substantial loss of coverage from a health insurance plan for retired persons within one (1) year before or after the start of a bankruptcy procedure by the employer.

If the employee loses coverage - medical, prescription drugs, dental, vision, employee assistance program (EAP) or a healthcare flexible spending account (FSA) - due to loss of employment or reduction of working hours, and he/she becomes a Medicare beneficiary less than eighteen (18) months before the qualifying event, coverage under COBRA for employee's spouse and dependents may become effective up to thirty-six (36) months from the date the employee began coverage under Medicare. For example, if a covered employee becomes Medicare eligible eight (8) months before the employment termination date (termination of employment is a COBRA qualifying event), COBRA coverage for the spouse and children will be effective for twenty-eight (28) months – (thirty-six (36) months minus eight (8) months).

Eighteen (18) Month Continuation Coverage Period Extension

Second qualifying event

If an employee is receiving the maximum eighteen (18) months period of continuation coverage, he/she could have the right to an eighteen (18) month period extension if he/she experiences a second qualifying event, such as death of the covered employee, divorce or legal separation of the covered employee and spouse, covered employee becomes Medicare eligible (under certain circumstances), or loss of dependent child status under the plan. The second qualifying event could extend the continuation coverage period of eighteen (18) months to a maximum of thirty-six (36) months, but coverage can never exceed the thirty-six (36) months period from the date of the original event that made the qualified beneficiary eligible to choose coverage. The second event can be a second qualifying event only if it would have caused the qualified beneficiary to lose coverage under the plan in absence of the first qualifying event.

Section 9: Employee's Duties Once a Second Qualifying Event Occurs

If the covered employee or a family member experiences a second qualifying event that would give him/her the right to additional months of coverage, he/she must notify the employer. The notification should be submitted in the form designed for such purposes and should include all the required information and documentation.

This notification should be provided within sixty (60) days following the second qualifying event (or, if later than that, on the date in which coverage would normally have been lost due to the second qualifying event).

In addition, the covered employee or family member must provide any support documentation required by the employer, if any; for example, death certificate, divorce sentence, separation agreement, birth certificate of the dependent, driving license, marriage certificate or a letter from the Social Security Administration indicating that the person is Medicare eligible.

When the employer is notified about the occurrence of any these events, the automatically covered family member has the right to continuation coverage extension. If the covered employee or family member does not provide the employer the appropriate notification and support documentation required during the sixty (60) day notification period, the covered family member will not have continuation coverage rights.

Section 10: Special Disability Rules

In addition, if a qualified beneficiary is under the maximum continuation coverage period of eighteen (18) months and becomes disabled, he/she could be eligible for the maximum extension period. The eighteen (18) month coverage can be extended to twenty-nine (29) months, if the Social Security Administration determines that the employee or the covered family member was disabled (for Social Security disability purposes) at the time of the qualifying event or at any time during the first sixty (60) days of continuation coverage. This eleven (11) month extension is available to all family members that are qualified beneficiaries due to loss of employment or reduction of working hours, even if not disabled.

In order to benefit from this extension, the qualified beneficiary should notify the COBRA administrator, within sixty (60) days following the Social Security determination of disability and before the original continuation coverage period of eighteen (18) months ends. Notification should be provided in the form designed for these purposes and should include any information or additional documentation required.

If during the continuation coverage period, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the person must notify the employer mentioned on the first page of this policy of such determination, within thirty (30) days following the date of the determination, at which time the eleven (11) month extension will end. This notification should be provided in the same way and include the information required for a disability notification, as described above.

If a qualified beneficiary becomes disabled and another qualifying event occurs during the twenty-nine (29) month continuation coverage period, then the continuation coverage period is thirty-six (36) months after loss of employment or reduction of working hours.

Section 11: Medicare - Second Limited Selection Period

The Trade Reform Act of 2002 created a special COBRA right applicable to employees that have lost their jobs or who have experienced a reduction of their working hours and that qualify for a trade readjustment allowance or alternative trade adjustment assistance. These individuals can benefit from a tax credit or obtain advanced payment of sixty-five (65%) percent of the premiums for a qualified health insurance coverage, including COBRA continuation coverage. These individuals also have right to a second opportunity to choose COBRA coverage for themselves or for certain family members (if they have not already chosen COBRA coverage). This selection should occur within a sixty (60) day period starting the first day of the month in which the person becomes eligible for assistance under the Trade Reform Act of 2002. Nevertheless, this selection cannot occur after six (6) months from the date in which the person's group health insurance coverage ends.

If the employee has question regarding the Trade Reform Act provisions or if the employee qualifies or could qualify for assistance under the Trade Reform Act of 2002, he/she should contact the Human Resource

Department for more information, or call the toll-free number of the Health Care Tax Credit Customer Contact Center at 1-866-628-4282. More information may also be obtained on the Trade Reform Act of 2002 by visiting: www.doleta.gov/tradeact/2002act_summary.cfm

Section 12: Early COBRA Termination

The law provides cancellation of the employee's continuation coverage before the eighteen (18), twenty-nine (29) or thirty-six (36) months period expires for any of the following six reasons:

- The employer no longer provides group health insurance coverage to its employees;
- The premium of the continuation coverage is not paid on time (within the applicable grace period);
- The qualified beneficiary is covered –after the date of selection of COBRA – under another group health insurance (either as an employee or not) that does not include any applicable exclusion or limitation of a pre-existing condition;
- The qualified beneficiary is Medicare eligible after the COBRA selection date;
- The qualified beneficiary incurs in any conduct that would justify the termination of coverage of any plan participant on equal basis (for example, fraud); or
- Coverage has been extended for up to twenty-nine (29) months due to disability, and a final determination has been made by the disability carrier that the person is no longer disabled.

HIPAA restricts the extent to which group health insurance plans can impose limitations for pre-existing conditions. If the employee is covered under another group health insurance plan and that plan includes limitations for pre-existing conditions that affect the employee, the employee's COBRA coverage cannot be terminated. However, if the rules for pre-existing conditions of the other plan do not apply to the employee due to HIPAA restrictions regarding pre-existing condition clauses, the medical benefits program can terminate the employee's COBRA coverage.

Section 13: COBRA and FMLA

A leave that qualifies under the Family and Medical Leave Act (FMLA) does not make the employee eligible for COBRA coverage. However, regardless if the employee loses coverage for lack of payment of the premium while under FMLA leave, the employee is still eligible for COBRA on the last day of the FMLA leave, if the employee decides not to return to active work. The employee's continuation coverage will begin if one of the following occurs:

- When the employee informs the employer that he/she is definitely not returning to work at the end of the leave; or
- At the end of the leave, assuming that the employee does not return to work.

For FMLA leave purposes, the employee will be eligible for COBRA, as described above, only if:

- The employee or the employee dependent is covered under the medical benefits program the day before the leave period begins (or the employee or the employee dependent is covered under FMLA during the leave; and
- The employee does not return to work at the end of the FMLA leave.

Coverage Costs

According to the law, the employee may be required to pay up to one-hundred two (102%) percent of the continuation coverage premium. If employee's coverage is extended from eighteen (18) to twenty-nine (29)

months due to disability, the employee may be required to pay up to one hundred fifty (150%) percent of the premium starting on the nineteenth (19th) month of continuation coverage. The coverage cost for group health insurance changes periodically. If the employee chooses continuation coverage, the employer will notify the employee about any price changes.

The initial payment for continuation coverage expires forty-five (45) days following the date in which the employee made the selection. From there on, the employee must pay monthly for coverage for which there is a grace period of thirty (30) days. If the employee has any questions regarding COBRA coverage or its enforcement, he or he should contact the human resources department.

Contacting the Employer

If the employee has any question regarding COBRA coverage, or its enforcement, he or she should contact the employer's human resources department listed on the first page of this policy.

The employee can also contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). The addresses and telephone numbers of EBSA's regional and district offices are available in its webpage at, https://www.dol.gov/agencies/ebsa.

Keep Employee's Plan Informed about Any Change of Address

In order to protect the rights of the employee or family members, the employee should keep the company informed of any change of address of the employee or family members. The employee should also keep a copy, for his or her records, of any notification he or she sends to the employer, which should be mailed to the above address.

PART XI: MODEL OF ACCESS TO SERVICES

Medical

Your MCS Life health plan is designed to provide free selection of physicians, facilities, and specialists through the VIP Network and the Preferred Provider Network (PPO).

Under this model the insured does not need referral from a primary physician to access services from a specialist or subspecialist within any of the networks applicable to this policy. The insured has direct access and free selection of primary physicians as well as of specialists and subspecialists.

Under this model, the insured does not need referral from a primary physician to access services from a specialist or subspecialist within the PPO network. The insured has direct access and free selection of a primary physician as well as of specialists and subspecialists. To ensure receiving health insure benefits, the insured should visit a service provider within the MCS Life PPO network.

Hospitals

Hospitals contracted for this model are classified as hospitals for the Preferred Provider (PPO) Network. For information on copayments or coinsurances for each level, please refer to Part XII of this policy.

Laboratories

The contracted network for this policy is the PPO Laboratory Network:

- PPO Laboratory Network: Corresponding copayment or coinsurance applies.

Contracted Network in the United States

United HealthCare: Providers network contracted to offer services in the United States. For details on the providers in this network, please visit www.uhc.com or call the Assistance Center to locate a Provider at 1-800-226-5116 .

PART XII: COPAYMENT, COINSURANCE AND DEDUCTIBLES TABLE

Deductible and Maximum Out of Pocket (MOOP)	
Maximum Out of Pocket (MOOP) for Medical Benefits and Prescription Drugs	
Individual	$6,350
Family	$12,700
Essential Health Benefits	
Emergency and Urgent Services	
Accident	$0
Illness	$50
Hospitalization	
Hospitalization	$150
Skilled Nursing Facility	$0
Surgery Assistance	$0
Outpatient Services	
General Practitioner	$10
Specialist includes psychiatrist, psychologists, chiropractors (first visit)	$15
Subspecialist includes optometrist	$15
Outpatient Facility	$75
Diagnostics and Surgery Procedures, at a Medical Office	25%
Endoscopic Procedures	25%
Chemotherapy and Radiotherapy	0%
Dialysis and hemodialysis	0%
Hyperbaric Chamber	20%
Rehabilitation Services, Habilitation and Durable Medical Equipment	
Physical Therapy	$7
Outpatient Respiratory Therapy	$7
Home Health Care	$0
Durable Medical Equipment (DME)	25%
Chiropractic Manipulations	$15
Mental Health	
Group Therapy	$15
Collateral Visits	$15
Laboratory and X-ray Services	
Laboratory	30%
X-rays	30%
Specialized Tests (CT Scan, PET CT, MRI, SPECT)	30%
Preventive, Wellness and Chronic Disease Management Services	
Preventive Services (including women and those with autism)	0%
Preventive Immunizations (vaccines)	$0
Immunization (vaccine) for Respiratory Syncytial Virus	30%

Other Covered Services	
Air Ambulance in Puerto Rico	20%
Bariatric Surgery Benefit for the Treatment of Morbid Obesity	
Bariatric Surgery Procedure	40%
Transplant of bone, skin, cornea, organs and bone marrow	0%
Programs Included as Part of the Benefits	
MCS Alivia	$15
MCS Medilínea MD	$25
MCS Care Clubs	0%

Major Medical:	
Deductible per Person	$100.00
Deductible per Family	$300.00
Charges in excess of: Deductible per individual (Refer to Part III - Covered Benefits / Maximum Out-of-Pocket Expenses –MOOP)	(Refer to Part III - Covered Benefits / Maximum Out-of-Pocket Expenses - MOOP)
Charges in excess of: Family Deductible (Refer to Part III - Covered Benefits / Maximum Out-of-Pocket Expenses –MOOP	(Refer to Part III - Covered Benefits / Maximum Out-of-Pocket Expenses - MOOP)
Pharmacy[1]	
Point of Service (POS)	
Bioequivalent Preferred	$5.00
Bioequivalent Non Preferred	$5.00
Brand Preferred	$20.00
Brand Non Preferred	$35.00
Local Pharmacy Supplied 90 Days	
Bioequivalent Preferred	$10.00
Bioequivalent Non Preferred	$10.00
Brand Preferred	$40.00
Brand Non Preferred	$70.00
Mail Order – Maintenance Drugs Only	
Bioequivalent Preferred	$10.00
Bioequivalent Non Preferred	$10.00
Brand Preferred	$40.00
Brand Non Preferred	$70.00
Specialty Drugs Program	30% Max. $200
Bioequivalent Preferred	30% Max. $200
Bioequivalent Non Preferred	30% Max. $200
Brand Preferred	30% Max. $200
Brand Non Preferred	0%
Oral Chemotherapy	$1.00
Over the Counter Drugs (OTC)	
[1] For more details about your pharmacy benefits please refer to the pharmacy endorsement attached to this document.	

Dental [1] One thousand dollars ($1,000) maximum benefit per policy year. Applies only for insured persons over the age of nineteen(19)	**Generalist**	**Specialist**
	0%	0%
Diagnostic and preventive services	20%	20%
-Space maintainers	20%	20%
Restorative services	50%	50%
-Crown restorations	20%	50%
Endodontics and / or Periodontics Services	20%	50%
Oral surgery services	20%	20%
Prosthodontics (dentures)	50%	50%
[1] For more details about your dental benefits please refer to the dental endorsement attached to this document.		

ANTI-FRAUD NOTIFICATION

In accordance with the provisions of Law No. 18 of January 8, 2004, we advise you that Article 27.320 of the Insurance Code of Puerto Rico sets forth the following:

"Any person who knowingly and with the intention of defrauding submits false information in an insurance application, or submits, helps, or causes the submittal of a fraudulent claim for payment of a loss or other benefit, or submits more than one claim for the same damage or loss, will incur in a felony and, if convicted, will be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) dollars and not more than ten thousand ($10,000) dollars, or a fixed term of imprisonment of three (3) years, or both penalties. If aggravating circumstances are present, the fixed penalty established may be increased up to five (5) years; if extenuating circumstances are present, it may be reduced up to two (2) years."

P.O. Box 9023547
San Juan, PR 00902-3547
(787) 758-2500

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MCS LIFE INSURANCE COMPANY
MCS Plaza
255 Ponce de León Ave.
San Juan, PR 00917-1919

ENDORSEMENT TO THE GROUP POLICY REGARDING YOUR PHARMACY BENEFIT

This endorsement is part of the policy to which it is attached, and it is issued considering the payment in advance for the corresponding premiums and is subject to the policy's terms and conditions that do not conflict with the endorsement's terms and conditions.

I. Definitions:

Coinsurance	Amount of money expressed in percent that the insured must pay to the provider upon receiving certain services. This amount of money varies according to the services costs and contracted fares by MCS Life.
Copayment	Fixed amount of money the insured under this rider must pay to provider at the time certain services are received.
Deductible	Amount paid by the insured before receiving services covered by this rider.
Pharmacy	Health service establishment authorized and registered in accordance with the provisions of federal or state law, and engaged in the provision of pharmaceutical services, including: the dispensing of prescription drugs; over-the-counter (OTC) drugs, devices and other health-related products, as well as the provision of pharmaceutical care and other services within the pharmaceutical functions provided by law.
Non-participating Pharmacy	A pharmacy that cannot offer the services described in this rider because is not part of MCS Life Provider network.
Participating Pharmacy	A pharmacy that is part of the MCS Life provider network contracted to provide services to MCS Life's insureds.
Acute Drugs	Drugs that treat sudden onset and short-term health conditions.
Preferred Bioequivalent Drugs	Drugs listed by the Food and Drug Administration (FDA) as therapeutically equivalent to a brand name drug because they contain the same active ingredients and are identical in potency, dosage form, and route of administration or have comparable bioavailability. Medications categorized as

	"preferred" have usually been in the market for a longer time and are less expensive than other available generics.
Non-preferred Bioequivalent Drug	Drugs listed by the Food and Drug Administration (FDA) as therapeutically equivalent to a brand name drug because they contain the same active ingredients and are identical in potency, dosage form, and route of administration or have comparable bioavailability. Medications categorized as "preferred" have usually been in the market for a longer time and are less expensive than other available generics.
Drug, Medicine or Medication	All drug in adequate dosage form suitable to be used by humans.
Specialty Drug	Drugs that must be stored and distributed in an unconventional manner and require close monitoring and supervision during therapy. These include injectable drugs, oral drugs, infusion or inhaled drugs, biotech drugs and biologicals products. Drugs that have a high potential for adverse effects and high-cost drugs (greater than five hundred dollars ($ 500) are also considered to be specialty drugs.
Preferred Specialty Drugs	Drugs that must be stored and distributed in an unconventional manner and require close monitoring and supervision during therapy. These include injectable drugs, oral drugs, infusion or inhaled drugs, biotech drugs and biologicals products. Drugs that have a high potential for adverse effects and high-cost drugs (greater than five hundred dollars ($ 500) are also considered to be specialty drugs. Medications categorized as "preferred" have usually been in the market for a longer time and cost less compared to other available specialty drugs.
Non-Preferred Specialty Drug	Drugs that must be stored and distributed in an unconventional manner and require close monitoring and supervision during therapy. These include injectable drugs, oral drugs, infusion or inhaled drugs, biotech drugs and biologicals products. Drugs that have a high potential for adverse effects and high-cost drugs (greater than five hundred dollars ($ 500) are also considered to be specialty drugs.
Maintenance Drugs	Maintenance drugs are those whose most common use is to treat a chronic illness. Drug therapy is not considered curative. Maintenance drugs are administered continually -for more than ninety (90) days- instead of intermittently.
Brand Name Drugs	Drugs offered to general public under a commercial Brand-name or Trademark.
Preferred Brand Name Drugs	Drugs that do not have an available generic equivalent. They have been on the market a long time, and therefore their safety and effectiveness have been evaluated.
Non-preferred Brand	These are generally high-cost drugs that have recently arrived on the market. In many cases, there is an available alternative to the preferred brand-name

Name Drugs	drug.
Over the Counter (OTC) Drugs	These are drugs that do not have a federal legend, are in accordance with Puerto Rico and United States laws, and can be sold without a prescription.
Prescription Drugs	Drugs that Puerto Rico and United States laws require to be dispensed by a pharmacist with a prescription at a duly authorized pharmacy.
Prescription	An order issued by a person who is licensed, certified or legally authorized to write prescriptions for drugs, and presented to a pharmacist for dispensing a prescription drug.
PPO Pharmacies Network	Pharmacy network contracted to provide this rider's pharmacy benefits.
Refills	Drug dispense that is repeated through written instructions from the physician.

II. Prescription Drugs

MCS Life provides this benefit for the payment of drugs prescribed by a physician, approved by the Food and Drug Administration (FDA), purchased by the insured, and acquired by an insured person, prepared and dispensed by an authorized pharmacist. This coverage includes preferred bioequivalent drugs, non-preferred bioequivalent drugs, preferred brand drugs, non-preferred brand drugs, specialty drugs, preferred specialty drugs and non-preferred specialty drugs.

In compliance with Public Law No. 203 of 2012, amending the Puerto Rico Health Insurance Code, MCS Life will provide for the covered drugs dispense, regardless of the illness, ailment, injury, condition or disease for which they are prescribed, as long that (1) the drug is approved by the FDA for at least one of the indications and (2) the drug is recognized for the treatment of the illness, ailment, injury condition or disease in one of the following standard reference compendiums:

- *The American Hospital Formulary Service - Drug Information;*
- *Drug Facts and Comparisons®*
- *The American Dental Association*
- *Dental Therapeutics or*
- *The United States Pharmacopoeia - Drug Information*
- In medical literature evaluated by peers, which means a scientific study that has been published in an academic journal or other publication in which the original manuscripts are disclosed after having been evaluated by independent and impartial experts, and after the International Committee of Medical Journal Editors has determined this complies with Uniform Requirements for Manuscripts sent to biomedical journals. The medical literature evaluated by peers does not include publications or publication supplements that receive a large part of their sponsorship from companies that

manufacture pharmaceutical products, or from a health insurance organization or insurer.

In addition, the medically necessary services are associated with the administration of drugs through medical service coverage.

During the term of the policy, changes in the prescription drug formulary or preferred drug list (PDL) can only occur if it is due to safety reasons, the prescription drug manufacturer cannot supply it, it has been withdrawn from the market, or the change implies the inclusion of new prescription drugs in in the PDL. For these purposes, and no later than the effective date of the change, MCS Life will notify, or will make efforts for a third party report changes to the following:

- All covered or insured persons and
- Participating pharmacies, only if the change implies new prescription drugs inclusion on the PDL. In this case, the insurer must notify thirty (30) day prior to the effective date of the inclusion.

Preferred Drug List (PDL)	This preferred drugs list covers all the available drugs in the market, approved by FDA, except those excluded from the benefit. To learn about the coverage exclusions the Insured may refer to Part V in this Rider. The list will mention all preventive drugs and those for coverage preferred categories. The PDL applicable to this coverage will be available on the website www.mcs.com.pr or the insured can request the list by telephone to the MCS Life Customer Service Call Center at (787) 281-2800.
Drug Dispensing Rules	The applicable drug dispensing rule is the following; This rider's prescription benefit requires as mandatory that the insured receives the generic drugs (first option). • If the drug does not have a generic version, a brand-name drug will be dispensed to the insured who will pay the copayment or coinsurance of the corresponding brand-name drug. • If the physician prescribes a brand-name drug with a description of "do not replace" when a generic version is available, the insured must assume the cost difference between the brand-name drug and the generic drug, plus the copayment or coinsurance for the corresponding brand drug. • If the insured requests a brand-name drug prescription when a generic version is available, the insured must assume the cost difference between the brand-name drug and the generic drug, plus the copayment or coinsurance for the corresponding brand-name drug.
Over-the-Counter Drugs (OTC)	Corresponding copayments or coinsurance applies. OTC drugs do not contain a federal legend, and the physician must provide a prescription indicating OTC and including over-the-counter drugs the insured needs for his or her healthcare.

Mail Prescription Drug Program	A voluntary program that allows the insured to receive maintenance drugs through the regular mail system, authorizing a supply of up to ninety (90) days. Drugs dispensed through this program are specifically those used for the treatment of long-term chronic conditions such as diabetes, high blood pressure, thyroid disorders, and cardiac arrhythmias, among others. The drugs available under this program will be maintenance drugs and preventive drugs. For information about ordering drugs through the mail order program, please contact the MCS Life Customer Service Call Center. 1. Ask the physician to write two (2) original prescriptions for the maintenance drugs you need: • One, so the participating pharmacy will dispense the drug while you wait for the supply to arrive by mail. • The other prescription is to be sent to the Mail Prescription Drug Program for a ninety (90) day supply. • It is important that the physician authorizes and clearly indicates the maintenance drugs refills. 2. Complete the mail order form available at www.mcs.com.pr under "Forms" or request it at one of the MCS Life Customer Service Centers. 3. Include the form, the original prescriptions and the corresponding copayment for each prescription in the envelope to be sent by mail. • Payments can be made by check, money order or credit card. • The ninety (90) day supply will take between fourteen (14) and eighteen (18) days to arrive. • You will receive a new order form with each dispense. 4. You may get prescription refills by mail, as long the physician has authorized it. 5. To order, choose any of the followings: • Call 1-800-344-8075. • Complete the form and send it by mail. • Online: www.mcs.com.pr under "Forms." 6. Order three (3) weeks before the drug runs out. Suggested dates for requesting the refills will appear on the drug label.

Covered Supplies and Medications:

The drugs benefit has the following dispensing limits:

Acute Medication	Initial dispense of fifteen (15) days and zero (0) refills.
Maintenance Drugs, dispensed in a retail pharmacy	Initial dispense of thirty (30) days and five (5) refills with a thirty (30) day supply for each refill for a total amount of one hundred and eighty (180) day supply per prescription. For maintenance drugs, in accordance with the Puerto Rico Health Insurance Code, Art. 4.120, when the insured's history warrants, provided the patient health is not put at risk, and at the discretion of the health care provider, the health provider prescribes maintenance drugs that include refills for up to a term of no more than one hundred eighty (180) days, subject to the limitations of the medical plan's

	coverage.
Maintenance Drugs, by mail (voluntary)	Initial dispense of ninety (90) days and one (1) refill with ninety (90) day supply, for a total amount of one hundred and eighty (180) day supply per prescription.
Specialty Drugs Preferred and Non-preferred	Every specialty drug requires preauthorization of the MCS Life's Pharmacy Department. The Insured will receive a specialty drug supply in the contracted specialty pharmacies within MCS Life pharmacies network applicable to the coverage. Please refer to the Provider Directory for information on contracted pharmacies to provide these services. **Specialty Drugs Program:** The Specialty Drug Program is coordinated through the Specialty Pharmacy Network. This program is focused on managing specialty drugs to treat chronic diseases that require special precautions when administered. For your convenience, the MCS Life's Specialty Drugs Program have a toll free hotline at 1.888.456.4283 available from Monday through Friday, from 8:00 a.m. to 6:00 p.m. (ET). Below we provide relevant information regarding the Specialty Drugs Program: • The Insured will receive a (30) thirty-day supply of the specialty drug per prescription. • MCS Life's Specialty Drug Program will verify the benefits to which the Insured is entitled when a specialty drug has been prescribed, in accordance with the terms of the health plan, to determine whether the drug is covered, the extent of the coverage, eligibility and the applicable copayments. • The Specialty Drug Program will provide the Insured with specific education regarding Insured's health condition, counseling about specialty drug administration and assistance for managing therapy as for appropriate clinical doses, the safety and efficacy of the therapy. • A week before the next supply, the Specialty Drug Program will contact the identified Insured and will coordinate the date and delivery place. **Supply:** The specialty drugs covered under this program, are identified in the Drug Formulary as *Specialty Drugs* and *Non-Preferred Specialty Drugs*, and are covered only if the service is obtained from a contracted Specialty Pharmacy under MCS Life's Specialty Drug Program in accordance with the terms and conditions of this policy. To offer a better service to the Insured, the specialty drug needs to be preauthorized by the MCS Life's Pharmacy Department. The

	health plan will not cover those specialty drugs that have not been preauthorized. For more information, special situations or emergencies the Insured may contact a program representative, toll free at the phone number 1-888-456-4283. The specialty drugs are not considered emergency dispense, but in case it may occur, this will be addressed within the first twenty-four (24) to seventy-two (72) hours. **Dispense:** The program provides that the Insured may receive a delivery: • For acute specialty drug prescriptions: fifteen (15) days and zero (0) refills. • For maintenance specialty drug prescriptions: thirty (30) days and five (5) refills. If the Insured gets the prescription or its refills with a non-participating pharmacy, he/she shall pay the total cost to the pharmacy. Thereafter, the Insured may submit a reimbursement claim to MCS Life, filing the original prescription receipt. MCS Life will reimburse the Insured the amount for prescription charge, less any deductible or coinsurance, or the amount that would have covered if the prescription has been acquired in a participant pharmacy, whichever is lesser.

Covered Drugs that do not contain a Federal Legend	
Insulin	Insulin and syringes for insulin administration
Over-the-Counter Drugs (OTC)	See the formulary or preferred drug list (PDL) for details on the drugs covered.

Drugs Covered by Local and/or Federal Law

Drugs for preventive services are covered, as required by federal PPACA laws, Public Law No. 111-148 (PPACA), and the Health Care and Education Reconciliation Act of 2010, Public Law No. *111-152* (HCERA), as established by the U.S. Preventive Services Task Force (USPSTF) and by the Puerto Rico Health Insurance Code (PRHIC).

The insured will not pay a copayment or coinsurance for drugs required by federal law, including folic acid supplements for pregnant insureds, tamoxifen or raloxifene for women with a high risk of breast cancer and at high risk for adverse drug affects, aspirin to prevent cardiovascular disease, and iron supplements to prevent anemia in children between the ages of six (6) and twelve (12) months and aspirin supplement for pregnant women as preeclampsia prevention and Vitamin D to prevent falls, statin use to prevent cardiovascular diseases and medication to quit smoking.

MCS Life will cover all contraceptive methods approved by the FDA, in accordance with the Affordable Care Act (ACA). The insured will not pay a copayment or coinsurance for the contraceptives drugs. Please refer to the preferred drug list (PDL) to find out what these medications are.

This plan covers those medications to quit smoking approved by the Food and Drug Administration (FDA), as established by the United States Preventive Service Task Force *(*USPSTF*)*.

This plan covers the buprenorphine for the treatment of opium dependence, as provided in Public Law No. 140 of September 22, 2010.

This plan covers anti-cancer drugs in their various forms of administrations: intravenous, oral, and injectable or via intrathecal, according to the specialist's or oncologist's order, and in accordance with Public Law No. 107 of 2012, as amended.

III. Requirements & Procedures for Prescription Drug Exceptions

MCS Life establishes and maintains a procedure to request drug exceptions that allow the insured or a representative to request them in writing, if the physician who issued the prescription has determined the requested prescription drug is medically necessary for the treatment of an illness or medical condition the insured suffers from, and approves:

- A prescription drug that is not covered according to the formulary or preferred drug list (PDL);
- Continued coverage for a prescription drug that MCS Life had discontinued from the form for reasons other than the manufacturer could not supply the drug or it was withdrawn from the market, or
- A prescription drug that will not be covered until the step therapy requirement is met or will not be covered by the prescribed dose amount.
- An exception to a management procedure that implies that the prescription drug is not covered until it meets the step therapy requirements or is not covered for the prescribed dosage.
- There is no prescription drug in the formulary that is clinically acceptable to treat the disease or medical condition of the insured person.
- If the alternate prescription drug appears on the form or a first-line is required to conform to the step therapy and:
    a. It has been ineffective in the treatment of the disease, based on clinical, medical and scientific evidence. Given the physical and mental characteristics known about the insured and the known characteristics of the prescription drug regimen, it is very likely that it will be ineffective or will affect the effectiveness of the prescription or the patient's compliance with the drug or;

    b. Has caused, or there is clinical, medical and scientific evidence that it is likely to cause an adverse reaction or other damage to the insured person or

    c. The insured person was already at a more advanced level in the step therapy than the other medical plan, so it would be unreasonable to require starting again at a lower level of the step therapy.

d. The available dosage, according to the limitation of the prescribed drug, has been ineffective in the treatment of the insured's illness or medical condition or, based on clinical, medical and scientific evidence and, given the insured patient's relevant known physical and mental characteristics and the known characteristics of the prescribed drug regime, it is very likely to be ineffective, or will affect the effectiveness of the prescription drug or the patient's compliance.

MCS Life requires all exceptions to contain a medical justification that includes:

1. Name of the Insured
2. Group or Contract Number
3. Insured's History
4. Primary diagnosis related to the prescription drug subject to the medical exception request, and
5. A clinical rationale as to why:
   - the prescription drug named on the form is not acceptable for that particular patient;
   - the prescription drug is no longer acceptable for that particular patient, whether the request for medical exception relates to step therapy; or
   - the available dose for prescription drug is not acceptable for that particular patient, if the medical exception request relates to a dose limitation for that patient and
6. Reason for the prescription drug covered by the medical exception request is needed for the patient, or if the reason for the exception is required to dose limitation for that particular patient.

Upon receipt of a request for a medical exception, MCS Life will ensure that the request is reviewed by the appropriate health professionals (depending on the health condition that prompted the medical exception) who, when making their determination regarding the request, will consider the specific facts and circumstances applicable to the insured for which the request was presented, using documented clinical review criteria that:

- is based on solid clinical, medical and scientific evidence and
- if available, relevant guidelines that could include accepted practice guidelines, evidence-based practice guidelines, practice guidelines developed by the MCS Life pharmacy and therapeutic committee, or other practice guidelines developed by the federal government or national or professionals societies, boards or associations in the pharmacy field.

Health professionals designated by MCS Life to review the exception requests will ensure that the determinations correspond to the benefits and exclusions provided in the insured's medical plan. To review the exception requests, the designated health professionals must have drug management experience. The referred determinations must be properly reported and list the qualifications of the health professionals who made the determination.

The exception request procedure will require MCS Life to make the determination with respect to the presented request and notify the insured or personal representative of that determination. The evaluation will be in accordance with the urgency of the insured's medical condition, and will never take more than seventy-two (72) hours from the date the request or certification was received, in the case of MCS Life requesting it, whichever date was later. For controlled drugs, this term will not exceed thirty-six (36) hours.

If MCS Life does not make a determination with respect to the drug exception request, or provide notification within the period mentioned above:

- The insured is entitled to a 30-day supply of the prescription drug that is the object of the request; and depending on whether the supply is requested or prescribed, or if step therapy, for the coverage terms.

- MCS Life will make a determination with respect to the drug exception request before the insured finishes consuming the supplied drug.

- If MCS Life does not make a determination regarding the drug exception request, nor provides notification of the determination before the covered person or ensured finishes consuming the supplied drug, coverage must remain on the same terms and continue while the insured continues to be prescribed the drug, and it is deemed safe for the person's illness or medical condition, unless the limits of the applicable benefits have been exhausted.

- If a drug exception request in accordance with this process is approved, MCS Life will cover the prescription drug that is the object of this request and will not require the insured to request approval for a refill, nor for a new prescription, to continue using the same prescription drug once the initial prescription refills are consumed. All of the above is subject to the drug coverage in this policy, provided that:

    1. the person who issued the prescription to the insured continues to prescribe this drug to treat the same illness or medical condition and;
    2. the prescribed medication continues to be considered safe for the treatment of the insured's illness or medical condition.

MCS Life will not establish a special form level, copayment or other cost-sharing requirement applicable only to prescription drugs approved by exception requests.

For any denial made by MCS Life regarding a drug exception request:

- The insured will be notified (and the personal representative, if applicable) in writing or by electronic means, if the insured has agreed to receive the information in that manner;
- The person who issued the prescription will be notified by electronic means by request or in writing;
- An appeal can be made by filing a complaint, according to the Complaints & Appeals process described in your policy or benefits certificate.

The denial will be expressed to the insured or personal representative, if applicable, in an understandable way:

1. The specific reasons for the denial;
2. References to the evidence or documentation used, including the clinical review criteria and practice guidelines, as well as the clinical, medical and scientific evidence considered in determining the request denial;
3. Instructions on how to request a written declaration of the clinical, medical or scientific justification for the denial and

4. A description of the process and procedures for presenting a complaint to appeal the denial, according to the Complaints & Appeals process described in your policy or benefits certificate.

IV. Reimbursement Request Process

To request a reimbursement for the services described in this section, the Insured must fill out and submit a reimbursement form within one hundred and eighty (180) days after receiving the service, which is subject to the terms described in the policy or benefits certificate to which it is attached. The fare will be reimbursed according to terms of reimbursement described in the Services Covered by Reimbursement section in your policy or benefits certificate. The insured may access through www.mcs.com.pr, request a copy on the MCS Life Customer Service, or calling the Customer Service Department at 787-281-2800 (metro area) or 1-888-758-1616 (toll free), Monday through Friday from 8:00 a.m. to 8:00 p.m. and Saturdays from 8:00 a.m. to 4:30 p.m.

The insured must submit the reimbursement form with the original and official receipt of drugs requested for reimbursement. If this information is not provided in the original receipt, the Insured must provide it in the reimbursement form signed by the prescription's dispensing pharmacist. The receipt must contain the following information and comply with the requirements described below:

1. prescription number
2. the pharmacy's National Provider Identifier (NPI)
3. the date of dispensing
4. the drug name and dosage
5. the National Drug Code (NDC)
6. the prescribing physician DEA number
7. the amount, supply days and total paid.

A. Services Eligible for Prescription Drug Reimbursement (Pharmacy Benefit):

For prescription drug reimbursements (pharmacy benefit), refunds will be considered only under the following circumstances:

- The insured did not have the plan card. (Examples: the new card had not yet arrived, the insured did not have the card at the time of purchase, or lost the card).
- The supply was for a vacation (only if purchased in U.S. territory and not requested in time for the trip, nor was a pharmacy in our network visited).
- The claim was rejected by the pharmacy (Examples: the pharmacy had technical problems, incorrectly processed an NDC, the insured's information the pharmacy had on file was not the same as what was on file with the plan).
- Consideration of the claim for Coordination of Benefits (COB, secondary coverage). The pharmacy did not process the COB electronically and/or the insured did not reveal that he or she had more than one health insurance plan.
- A purchase was made outside the network (the insured purchased drugs at a non-contracted pharmacy).

V. Prescription Drug Exclusions

MCS Life will not be responsible for the cost of the following benefits:

1. Drugs or medications expressly excluded by the policy or benefits certificate attached.
2. Drugs or medications that do not require a doctor's prescription that are not covered under the terms of the coverage or that are not part of the formulary or preferred drug list (PDL) except insulin.
3. Immunization agents (vaccines, toxoids, toxins) that are not expressly covered in the policy; biological serum, blood or plasma, cosmetics, dietary supplements and beauty items.
4. Artifacts or therapeutic items, including hypodermic needles (except for the administration of insulin), syringes and accessories.
5. Any charges when administering prescription drugs or injectable drugs.
6. Prescription drugs that can be obtained free of charge under local, state or federal programs.
7. Experimental drugs or treatments labeled "Warning: Limited by federal law for research use" except in case of a patient suffering from a life-threatening illness, and there is no approved effective treatment in existence, when the insured is eligible to participate in an authorized treatment study in accordance with the provisions of the study's protocol, and when such treatment, as long as the insured's participation in the study provides a potential benefit, and the doctor referring this study understands that the insured's participation is appropriate or the insured provides MCS Life evidence that his or her participation is appropriate, MCS Life will pay for the insured's routine medical expenses. The insured's routine medical expenses will not be expenses related to the study, nor exams to be used as part of the study, nor expenses that reasonably must be paid by the entity that carried out the study.
8. Drug refills exceeding the number specified by the physician, exceeding the maximum of 180-day supply per prescription or dispensed after the prescription's last effective date, as established by the Act of Pharmacy of Puerto Rico.
9. Any amount of dispensed drugs or medications exceeding a fifteen (15) day supply for acute drugs or a thirty (30) day supply for maintenance drugs.
10. Drugs used to treat impotence.
11. Vitamins and supplements, except those required as preventive services.
12. Anabolic drugs.
13. Weight reduction drugs.
14. Growth hormones.
15. Injectable immunoglobulin.
16. Lancets and strips in pharmacy.
17. Infertility or fertility drugs.
18. Certain drugs that the FDA has determined to be unadvisable to treat a condition for which it was previously prescribed.
19. The following medicines or services are not covered:
    a) drugs used in research sponsored by the manufacturers or a government entity, as well as;
    b) drugs or services provided during research, if the sponsor of such research provides drugs or services without charging the participants.
20. MCS Life will require the Pharmacy and Therapeutics Committee to perform the evaluation of new prescription drugs approved by the Food and Drug Administration within a term not

greater than ninety (90) days, counted from the date of approval issued by the FDA. MCS Life will issue its determination within a period of no more than ninety (90) days, counted from the time the new prescription drug enters the market, the pharmacy and therapeutic committee shall issue its determination as to whether or not it will include the new drug on the formulary or preferred drug list (PDL).

21. Refills ordered by a dentist or podiatrist.
22. Contraceptives not approved by the FDA. In addition, FDA-approved contraceptives will not be covered without the physician's prescription.
23. Charges for drugs or medications administered in medical office under the pharmacy coverage.
24. Accumulation of expenses paid by an assistance program or by a third party for the maximum out-of-pocket (MOOP) amount.

VI. General Provisions

The MCS Life's insurance card must be presented to any participating pharmacy when requesting benefits in order to be covered by this rider. When receiving drugs, the insured must sign for the received services and provide a photo ID.

A pharmacy has no obligation to dispense a prescription if it, for any reason in accord to a sound professional judgment, must not be provided.

MCS Life will not cover any excess amount to "Maximum Benefits per Insured per Policy Year", as established in the Copayment and Coinsurance Table.

MCS LIFE INSURANCE COMPANY
San Juan, Puerto Rico

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San Juan, PR 00917-1919

ENDORSEMENT TO THE GROUP POLICY REGARDING YOUR DENTAL BENEFIT

This endorsement is part of the policy to which it is attached, and it is issued considering the payment in advance for the corresponding premiums and is subject to the policy's terms and conditions that do not conflict with the endorsement's terms and conditions.

DENTAL

Eligible charges incurred in or outside of Puerto Rico will be paid according to the **established rates**. Dental services are covered up to a maximum of one thousand dollars ($1,000) per policy year.

Categories of service:

Diagnosis

a) One (1) initial comprehensive oral exam by a general dentist or specialist every thirty-six (36) months.
b) One (1) periodic oral exam every six (6) months.
c) One (1) emergency exam every six (6) months.
d) A complete set of x-rays of your mouth or panoramic r-rays every thirty-six (36) months.
e) Four (4) individual periapical x-rays over a period of twelve (12) months.
f) A set of Bitewing x-rays every twelve (12) months.
g) Vitality test

Preventive

a) Oral cleaning in adults and children every six (6) months.
b) Application of fluoride to children under nineteen (19) years of age every six (6) months. Covered at 100%.
c) Fissure Sealants fissure limited to one (1) treatment for the life of the permanent posterior teeth up to first molars and up to age fourteen (14).
d) Space maintainers (applicable coinsurance).

Restorative

a) **Amalgam restorations.** Amalgam restorations will be covered every thirty-six (36) months. If a replacement is requested by the same dentist before the set time, it is necessary to submit a written report and x-rays that justify treatment not less than six (6) months from the initial restoration. During this period of three (3) years there will be one (1) duly justified replacement.

b) **Resin restorations.** Resin restorations on anterior teeth and the buccal of the posteriors through the first permanent molars will be covered every thirty-six (36) months. If a replacement is required by the same dentist before the set time, it is necessary to submit a written report and x-rays that would justify the treatment and not less than six (6) months must have elapsed since the initial restoration. During this period of three (3) years there will be only one (1) duly justified replacement.

c) **Restorations with crowns in metal or porcelain in those parts that cannot be restored with amalgam or resin, or those treated with Endodontics.** A crown replacement is considered after five (5) year of their first insertion.

d) Restoration with stainless steel crowns for those deciduous molars which cannot be restored with amalgam or resin and are limited to one (1) per tooth per life.

e) Construction of post and core

f) Sedative treatment

Endodontics

Endodontics services covered through general practitioners dentists:

a) Direct pulp covering (excluding final restoration)
b) Indirect pulp covering (excluding final restoration)
c) Therapeutic Pulpotomy - excludes final restoration.
d) Removal of pulp tissue in primary or permanent teeth.
e) Complete canal treatment in anterior teeth excluding final restoration
f) Complete canal treatment in premolars excluding final restoration.
g) Complete canal treatment excluding final restoration.
h) Endodontic retreatment of previous root canal in anterior tooth. Repeat the complete canal treatment.
i) Endodontic Retreatment of previous root canal in premolars.
j) Endodontic Retreatment of previous root canal in molar.

Endodontics services covered through Endodontists:

a) Direct pulp covering (excludes final restoration)
b) Indirect pulp covering (excludes final restoration)

c) Therapeutic Pulpotomy - excludes final restoration.
d) Removal of the pulp tissue in primary or permanent teeth.
e) Complete canal treatment in anterior teeth excluding final restoration
f) Complete canal treatment in premolars excluding final restoration.
g) Complete canal treatment in molar excluding final restoration.
h) Endodontic Retreatment of previous root canal in anterior tooth. Repeat the full canal treatment.
i) Endodontic Retreatment of previous root canal in premolars.
j) Endodontic Retreatment of previous root canal in molar.
k) Apexification / Recalcification - initial visit.
l) Apexification / Recalcification - interim replacement of medication and intermediate visit
m) Apexification / Recalcification - final visit.
n) Apicoectomy / Periradicular surgery - anterior teeth.
o) Apicoectomy/Periradicular surgery - first premolars root canal.
p) Apicoectomy/Periradicular surgery - first molars root canal.
q) Apicoectomy/Periradicular surgery - each additional root.
r) Retrograde Sealant - per root
s) Root amputation-per root
t) Hemisection (includes the removal of the root), does not include the Endodontic treatment of the remnant root.

Note: Coinsurance for services provided by Endodontists may vary from the co-insurance for generalist dentist.

Periodontics

Periodontal services Covered through general practitioners dentists:

a) Gingivectomy or gingivoplasty - per quadrant
b) Gingivectomy or gingivoplasty - one or three teeth per quadrant
c) Periodontal curettage and root planing - per quadrant.
d) Periodontal curettage and root - planing one to three teeth per quadrant
e) Deep cleaning throughout the entire mouth for a comprehensive assessment and diagnosis (Full mouth debridement)

Periodontal services Covered through Periodontists:

a) Non-surgical periodontal disease services.
b) Periodontal curettage and root planing - per quadrant
c) Periodontal curettage and root planing - one or three teeth per quadrant
d) Deep cleaning throughout the entire mouth for a comprehensive assessment and to make a diagnosis (Full mouth debridement).
e) Periodontal maintenance.
    I. Periodontal disease surgical services
f) Gingivectomy or gingivoplasty - per quadrant
g) Gingivectomy or gingivoplasty - one or three teeth per quadrant
h) Procedure of gingival flap including root planning - per quadrant

i) Gingival flap procedure including root planning - one to three teeth per quadrant.
j) Elongated Crown.
k) Bone surgery (including flap) - per quadrant.
l) Bone surgery (including flap) - one to three teeth per quadrant.
m) Bone graft - first area in a quadrant.
n) Bone graft - additional area in a quadrant.
o) Soft tissue graft of tissue soft (including the donor area).

Note: Coinsurance for services provided by the Periodontists may vary from the co-insurance for generalist dentist.

Prosthodontics

a) Insertion of complete dentures, partial dentures or fixed prostheses for the replacement of one or more teeth. These are performed according to the rules and limitations of each policy. The replacement of one of these prostheses is effective five (5) years after their initial insertion.
b) Complete or partial dentures repair.
c) All dentures adjustments, repairs and relines are included in the rates for up to six (6) months from its inclusion. After six (6) months of insertion the patient is entitled to one (1) adjustment per prosthesis in a five (5) years term. Repairs are limited to three (3) per year and the adjustment, "reline" and tissue conditioners are limited to one (1) every five years.

Oral surgery

These services may be performed by general dentists or maxillofacial surgeons.

a) Simple extractions.
b) Surgical and retained root extractions.
c) Third molar extractions.

The amount of benefits payable for any charge are subject to all the provisions of this policy. Dental services cannot exceed the annual limit on the coverage.

Extension of medical benefits

Extensions of benefits are provided as follows:

In case of termination of insurance for Dental Benefit, any eligible procedure started before the expiration date shall be completed within 31 days after the expiration date so that the charges will be paid.

a) Eligible charges incurred in or outside of Puerto Rico will be paid in accordance to MCS Plan rates.

Predetermination of benefits

The predetermination of benefit is the mechanism by which the provider submits to MCS the treatment plan prior to the provision of services. Treatment must be submitted in the ADA form, 2006 version. In assessing the treatment plan, MCS determines your financial responsibility for services recommended by the provider and the financial responsibility of the insured to the company. MCS will subsequently notify the insured person and the dentist on the benefits payable under this policy.

Preauthorized services must be billed on the date in which are received, not before. Invoiced services prior to the referral or subsequent to the expiration date, while mediate an extension, will not be paid or charged to the insured.

EXCLUSIONS

The following services are considered to be general exclusions and should be applied to all cases, unless MCS stated otherwise written and due to the particular design of some group coverage specifically:

1) Services that are provided with aesthetic purposes.
2) Services that are provided to correct vertical dimension or occlusion.
3) Implants and prostheses related to implants.
4) Crowns for teeth with periodontal problems- splinted.
5) Total maxillary or mandibular reconstruction.
6) Fixed bridges at the same time to a partial in the same arch to replace teeth in posterior areas, it is considered only the partial.
7) Services related to temporomandibular joint dysfunction (TMJ).
8) Services related to accidents or diseases covered by or related to the law of the Workers Compensation Fund Insurance of the State, ACAA, Veteran, etc.
9) Instructions related to oral hygiene and diets.
10) Replacement of removable bridges by fixed bridges for allergy reasons.
11) Replacement of lost prosthesis.
12) Services started prior the patient have dental coverage.
13) Prosthesis services to replace missing natural pieces prior to the patient dental coverage, unless otherwise specified by coverage.
14) Charges to correct congenital anomalies.
15) Any other service not included specifically on the insured coverage.
16) Closing of diastemas for aesthetic reasons is not a benefit.

Note: for more details on your benefits coverage please refer to the parent policy and its corresponding endorsements.

DP-02092016

MCS LIFE INSURANCE COMPANY

San Juan, Puerto Rico

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Rider
Maximum Out of Pocket (MOOP)

This rider is part of the policy to which it adheres and is subject to the terms and conditions of the policy, which are not in conflict with the terms and conditions of the endorsement.

Part III - Covered Benefits - the following information is added before the first paragraph:

Maximum of pocket expenses (MOOP) - Covered - medical – hospital

In compliance with the Internal Revenue Code (Internal Revenue Service, IRS for its acronym in English) of medical benefits, surgical, and hospital benefits and Major Medical covered expenses are subject to a maximum out of pocket expenses (MOOP by its acronym in English). The MOOP is determined annually by the IRS. After the insured reaches the established maximum, MCS Life will cover these benefits at 100%. Such benefits are medical, surgical, hospital and major medical expenses benefits.

Refer to Part identified as Exclusions and Limitations of Coverage for full details of the limits for certain benefits.

Deductible and Maximum Out of Pocket (MOOP):	
Maximum Out of Pocket (MOOP) for Medical Benefits: Medical, Surgical, Hospital and Major Medical	
Individual	$6,350
Familiar	$12,700

SECTION 7: MAJOR MEDICAL EXPENSES

The second paragraph of this section is modified including amending subsections 1 - 3 in compliance with Internal Revenue Code (IRS for its acronym in English) to remove the MOOP from this coverage. The subsequent information remains the same. It will read as follows:

The benefits under this coverage will be subject to following annual deductibles:

1. Cash Deductible:
   a. per person: $100 per policy year
   b. per family: $300 per policy year

2. Every insured person will be responsible, after the cash deductible accumulated, of 20% of covered medical expenses.

3. Each insured family will be responsible, after the cash deductible accumulated, of 20% of covered medical expenses.

   Note: For more details about your benefits please refer to the policy matrix and its corresponding riders.