Medical and Prescription Drug Plan
(for Puerto Rico Employees)

Summary Plan Description

January 1, 2025

This document is the Summary Plan Description ("SPD") for this benefit. This SPD is required by federal law called the Employee Retirement Income Security Act of 1974 ("ERISA"). This SPD reflects the terms of the benefit in effect as of January 1, 2025. Ecolab has the right to amend or terminate all or part of the Plan at any time.

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ECOLAB HEALTH AND WELFARE BENEFITS PLAN:

MEDICAL, PRESCRIPTION DRUG, DENTAL, VISION AND EAP OPTIONS

ADMINISTRATIVE INFORMATION FOR PUERTO RICO EMPLOYEES SUMMARY PLAN DESCRIPTION

EFFECTIVE JANUARY 1, 2025

Plan Name and Description

The name of the Plan is the Ecolab Health and Welfare Benefits Plan ("Plan"). The Plan provides health and other welfare benefits to Eligible Employees of Ecolab Inc. and subsidiaries of Ecolab Inc. that have adopted the Plan ("Participating Employers" or "Employers") and their Eligible Dependents.

This Administrative Information Summary Plan Description ("Administrative Information SPD") describes the medical, prescription drug, dental, vision and EAP options under the Plan for Puerto Rico Employees.

This Administrative Information SPD and the attached Vendor Benefit Description together make up the ERISA-required Summary Plan Description. The list of options covered under this Administrative Information SPD and the title of the Vendor Benefit Description for each option is below in the *Benefit Options Chart.* The SPD is part of the Plan Document.

Benefit Options Chart

Benefit Type	Insured or Self-Insured	Insurer/ Claims Administrator Name and Contact Information	Vendor Benefit Description
Medical	Self-Insured	Medical Card Systems (MCS) P.O. Box 11247 San Juan, PR 00910-2347 888-758-1616	Medical Plan Option (for Employees Residing in Puerto Rico) Benefit Description
Prescription Drug	Self-Insured	Medical Card Systems (MCS) P.O. Box 11247 San Juan, PR 00910-2347 888-758-1616	Prescription Drug Plan Option (for Employees Residing in Puerto Rico) Benefit Description
Dental	Self-Insured	Delta Dental of Puerto Rico P.O. Box 9020992 San Juan, PR 00902-0992 866-622-6120 www.deltadental.com	Dental Plan Option Certificate of Coverage / Benefit Description

Benefit Type	Insured or Self-Insured	Insurer/ Claims Administrator Name and Contact Information	Vendor Benefit Description
Vision	Insured	EyeMed Fidelity Security Life Insurance Company 3130 Broadway Kansas City, MO 64111-2406 1-833-918-1259 member.eyemedvisioncare.com/ecolab/en	Vision Plan Option Group Vision Insurance Certificate / Benefit Description
EAP	Self-Insured	CIGNA Behavioral Health 11095 Viking Drive Suite 350 Eden Prairie, MN 55344 Member Services at: 1-800-900-3791 www.cignabehavioral.com	Employee Assistance Plan (EAP) Option Benefit Description

Eligible Employees

You are eligible to participate in the Plan if you are an Eligible Employee. If you and your family member are both employed by Ecolab or another Participating Employer ("Employer"), you cannot be enrolled as both an employee and a dependent (you and your family member will both be enrolled as employees, provided you are Eligible Employees). To enroll for coverage under an Insurance Policy, you must also satisfy the eligibility requirements for coverage as set forth in the Policy. Once you meet the eligibility requirements, there is no waiting period to enter the Plan.

Eligible Employee. You are an Eligible Employee if you are:

1. employed by the Employer;
2. in a budgeted position;
3. regularly scheduled to work at least 20 hours per week; and
4. not excluded from the definition of Eligible Employee.

Not Eligible Employee (Excluded). You are not an Eligible Employee (excluded from the definition of Eligible Employee) if you are:

1. classified by the Employer as a temporary employee, a leased employee, or independent contractor;
2. covered by a collective bargaining agreement or contract that does not provide for your participation; or
3. employed by an Ecolab subsidiary that has not adopted the Plan.

Foreign Service for Eligible Employees. If you are a U.S. citizen or resident alien who is transferred to a full-time position with Ecolab or an Ecolab subsidiary in a foreign country (outside of the United States) on a temporary basis for 6 months or more, you will be eligible for coverage under the Ecolab Expatriate option.

Union Employees. If you are covered by a collective bargaining agreement, you are eligible for coverage only if your union agreement provides for your Plan participation.

Reclassification as an Eligible Employee. If you are reclassified as an Eligible Employee by a court, an administrative body or the Employer on a retroactive basis, you will be eligible for coverage only during periods that follow the reclassification. No Plan coverage will be retroactive.

Eligible Dependents

Eligible Dependents are: (1) your Spouse or your Domestic Partner; and (2) your Dependent Child(ren).

You must enroll your Eligible Dependents within the period required by the Plan. Refer to the "Enrollment Periods and Coverage Effective Dates" section below. You must be enrolled in an option to enroll your Eligible Dependents in that option.

Proof of Dependent Status. You must provide documents supporting Eligible Dependent status when you first enroll your Spouse or Domestic Partner or your Dependent Child, such as a birth certificate, marriage certificate or domestic partner affidavit.

If you fail to provide the required documentation by the deadline imposed by the Plan Administrator, your dependent will not be enrolled and cannot enroll until the next Open Enrollment Period (unless you experience a qualifying election change event before then).

You may periodically be required to provide proof of Eligible Dependent status after initial enrollment as well.

Spouse. Spouse means your spouse through marriage recognized as valid under U.S. federal law.

Domestic Partner. To be a Domestic Partner, your partner must be:

1. of the same gender as you and the two of you must be in a civil union, in a registered domestic partnership or a similar arrangement that is legally recognized under the laws of a state in the United States or under the laws of a jurisdiction outside of the United States; or

2. of the same or opposite gender as you and the two of you must:

    a. be at least 18 years old and legally competent to enter into a contract;

    b. not be married to or the domestic partner of anyone else;

    c. be jointly responsible for each other's well-being and financial obligations;

    d. not be related to you by blood to a degree that would prohibit your marriage in your state of residence;

    e. have an ongoing and committed spouse-like relationship and intend to do so indefinitely;

    f. have lived together in the same principal residence for at least 6 months and intend to do so indefinitely; and

g. be jointly responsible for the direction and financial management of your household and take joint financial responsibility for each other's financial obligations.

You must submit your certificate of marriage, civil union or registered domestic partnership or a domestic partner affidavit signed by you and your Domestic Partner. Domestic Partner benefits are only available for an option if provided in the Vendor Benefit Description. Federal tax rules generally require your contribution for coverage for a Domestic Partner and his or her children to be paid on an after-tax basis and the value of employer-paid coverage for the Domestic Partner and his or her children to be imputed to you as income.

Dependent Child. Dependent Child means a child who:

1. has one of the following relationships to you or to your Spouse or Domestic Partner:
    a. biological child;
    b. legally adopted child;
    c. child placed for legal adoption;
    d. foster child; or
    e. legal ward (child for whom you or your Spouse or Domestic Partner are legal guardian); and
2. is either:
    a. under the Limiting Age; or
    b. is eligible for Extended Disabled Dependent Coverage.

Limiting Age. For medical, prescription drug and EAP options, the Limiting Age is age 26, regardless of marital, support, or student status. For dental and vision options, the Limiting Age is age 25, regardless of marital, support or student status.

Extended Disabled Dependent Coverage. To be eligible for Extended Disabled Dependent Coverage, a child must: (1) provide proof of eligibility for Extended Disabled Dependent Coverage when requested; and (2) not be self-supporting due to physical, mental or intellectual disability.

Enrollment Periods and Coverage Effective Dates

You must enroll in the manner directed by Human Resources.

Initial Enrollment. If you are a new Eligible Employee (a new hire or newly eligible for coverage), you must make your benefit elections within 30 days after your hire date or date of initial eligibility, and must be an Eligible Employee on the date of your enrollment. Your coverage will be retroactive to your hire date.

Annual Open Enrollment. All Eligible Employees can make new elections or changes for the next Plan Year during the Open Enrollment Period that occurs in the fall. Open enrollment elections are effective on January 1 following the Open Enrollment Period.

Mid-Year Special Enrollment. Mid-year special enrollment is provided for medical and prescription drug options pursuant to HIPAA for birth or adoption of a child, marriage, loss of other health plan coverage,

losing a child's health insurance coverage through the state or becoming eligible for a premium subsidy from the state to obtain coverage for a child under this Plan. Additional details are provided in the medical Vendor Benefit Description.

Mid-Year Election Changes. Mid-year election changes can only be made if you have experienced a qualifying Mid-Year Election Change Event (see the list below) and make new elections within 30 days after the event. You must make the election in the manner directed by the Plan Administrator. You are required to provide documents supporting your qualifying Mid-Year Election Change Event when you submit your election change form (e.g., birth certificate, marriage certificate, divorce decree).

The Plan Administrator will determine whether you have experienced a qualifying Mid-Year Election Change Event and whether the change you are requesting is consistent with that event in accordance with IRS regulations.

An election change will generally be on the effective on the date of the Mid-Year Election Change Event. Adjusted premium contributions will begin the first pay period after the effective date of your election change. Premium payments will be made for any period of retroactive coverage. Refunds or retroactive adjustments will be made to your premium contributions.

Mid-Year Election Change Events

The following are qualifying Mid-Year Election Change Events for purposes of the Plan:

1. Change in Status Events. The following are change in status events. An election change will be consistent with a change in status only if the change in status: affects eligibility for coverage under an employer plan, or some other plan such as for medical coverage, or coverage under this Plan; and the election change is on account of, and corresponds with, the change in status.

    a. Gain or loss of a Spouse or Domestic Partner;

    b. A change in the number of your Dependent Children, such as through birth or adoption;

    c. A change in your employment or the employment of your Spouse, Domestic Partner or Dependent Child, including:

        i. starting or losing a job;

        ii. a reduction or increase in the hours of employment (including going on and returning from unpaid leave),

        iii. gain or loss of eligibility for benefits under another employer's plan.

    d. Your child satisfying or ceasing to satisfy eligibility requirements for coverage, such as reaching the limiting age.

2. Change in Cost or Coverage Events. The change in cost or coverage events, and the election changes that are permitted as a result, are:

    a. An insignificant cost change in your contribution for Plan coverage will result in an automatic adjustment to your pre-tax contribution.

    b. A significant increase in the cost of a coverage option will permit you to switch to a similar coverage option or, if one is not available, to cancel coverage.

c. A significant decrease in the cost of a coverage option will permit you to elect that coverage option, even if you are not currently a participant.

d. The loss of a coverage option will permit you to change to a similar coverage option if any or, if one is not available, to cancel coverage.

e. The reduction of coverage within a coverage option will permit you to switch to a similar coverage option.

f. The addition or significant improvement of a coverage option will permit you to switch to the new or improved coverage option.

3. Election Lock Events. An election change made under another employer's plan, such as the plan of your Spouse's employer, will permit a corresponding change under this Plan if the other plan permits its participants to make an election change in accordance with the IRS cafeteria plan regulations or the other employer's plan and this Plan have different plan years.

4. QMCSO Events. You may change your election for Plan coverage in a manner that is consistent with a judgment, decree or order (including a Qualified Medical Child Support Order) resulting from a divorce, legal separation, annulment or change in legal custody ("Order") that requires health coverage to be provided for your child by you or another individual, such as your ex-Spouse. You may only elect to cancel coverage for your child under this Plan if the Order requires another individual to provide health coverage for your child and that coverage is actually provided.

The Plan is not obligated to comply with any order requiring you to add your ex-spouse to coverage. The Plan does not cover ex-spouses other than under COBRA continuation coverage. You must notify the Plan of a divorce for your ex-spouse to be eligible for COBRA. See the *COBRA Continuation Coverage* section of this SPD for details. You may be in violation of a court order if you drop your Spouse from coverage prior to divorce or fail to notify the Plan of the divorce and elect COBRA Continuation Coverage for your ex-spouse. You should consult with your divorce attorney.

5. Gain or Loss of Other Health Coverage Events. You may change your election for Plan coverage in a manner that is consistent with the gain or loss by you or your Spouse, Domestic Partner or Dependent Child of entitlement to Medicare or Medicaid. If you or your Spouse, Domestic Partner or Dependent Child loses group health plan coverage under a state children's health insurance program under Title XXI of the Social Security Act (“SCHIPS”), a tribal plan, a state health benefits risk pool, or a foreign governmental plan, you may enroll the individual(s) losing the coverage in corresponding Plan coverage.

6. Mid-Year Special Enrollment Events. If you exercise HIPAA special enrollment rights for medical Plan coverage because you gained an Eligible Dependent through marriage, birth, adoption or placement for adoption or lost other health coverage, pre-tax contributions for premiums for the coverage will be changed automatically.

7. FMLA Events. You may change your elections for Plan coverage when going on or returning from FMLA leave in a manner that is consistent with FMLA requirements and Plan rules.

8. Other Approved Leaves of Absence. Refer to the section entitled “Impact of Leaves of Absence on Benefits.”

Coverage and Benefits Information in Benefits Description

The terms and conditions of coverage and benefits for an option are in the Benefit Description, including:

1. additional eligibility requirements for coverage (if any);
2. commencement and termination of coverage;
3. type and amount of benefits provided;
4. deductibles, co-insurance, co-payments, and benefit maximums;
5. restrictions, limitations and conditions of coverage and benefits;
6. procedure for filing a benefit claim, including the period within which claims must be filed, and the appeal procedure for a denied benefit claim; and
7. the Plan's reimbursement and subrogation rights (for a self-insured option, the *Subrogation and Reimbursement* section of this SPD below will apply to the extent that it is not inconsistent with the subrogation and reimbursement language in the Benefit Description).

Benefit Payments

Benefits do not vest under this Plan. Benefit payments are limited to the amount due under the Plan and late benefit payments will not include interest or penalties.

If a benefit overpayment is made, you are required to promptly repay it. If you do not, the overpayment may be offset from future benefit payments.

Impact of Leaves of Absence on Benefits

Your participation in the Plan during leave of absence depends on whether it is paid or unpaid and the type of leave (e.g., FMLA).

Type of Leave	Going on Approved Leave	Returning from Approved Leave (before or at expiration of Approved Leave)
Paid Leave	Your participation in Plan benefit options (and premium contributions) will continue while you continue to receive pay (sick time, vacation time or short-term disability), unless you experience a qualifying Mid-Year Election Change Event. Refer to the Mid-Year Election Change Events section of this SPD.	Your Plan benefit options and pre-tax premium contribution elections remain in place. You will not be able to make a benefit election change on your return from leave unless you experience a qualifying Mid-Year Election Change Event. Refer to the Mid-Year Election Change Events section of this SPD.
Unpaid Leave, FMLA	You may elect to continue your Plan benefits and pay premiums during your leave on an after-tax basis. If you do not elect to continue coverage, your coverage under the pre-tax benefit options will end as specified in the various SPDs for those benefits, and expenses that you incur during your period of non-participation will not be eligible for reimbursement. If you continue coverage during your leave, but do not return to work at the end of your leave, you may be eligible to continue coverage through COBRA. Refer to the COBRA Continuation Coverage section of this SPD for details.	Your Plan benefit options and pre-tax contribution elections that were in place during your leave will continue, but you can change your election when you return if you have a qualifying Mid-Year Election Change Event. If your Employer covered any premium payments during your leave, you will be required to reimburse the Employer for those amounts when you return. Refer to the *Mid-Year Election Change Events* section of this SPD. If you return within 30 days and in the same plan year, your pre-leave benefits and contributions will automatically resume; if you return after a leave of more than 30 days or in a new plan year, you will be eligible to make new elections but must do so within 30 days of your return.
Unpaid Leave Long-Term Disability (including Worker's Comp)	Your Plan benefit options continue at the active employee rate while you are on approved long term disability leave. If you lose coverage, you may be eligible to elect to continue your Plan benefit options through COBRA. Refer to the *COBRA Continuation Coverage* section of this SPD.	Your Plan benefit options and pre-tax contribution elections that were in place during your leave will continue, but you can change your election when you return if you have a qualifying Mid-Year Election Change Event. If your Employer covered any premium payments during your leave, you will be required to reimburse the Employer for those amounts when you return. Refer to the *Mid-Year Election Change Events* section of this SPD.

Type of Leave	Going on Approved Leave	Returning from Approved Leave (before or at expiration of Approved Leave)
Unpaid Leave, Military	Your Plan benefit options continue through the end of the month following the month in which your military leave begins. You may elect to continue your Plan benefit options after that point to the extent required by USERRA.	If you did not continue your coverage during the entire period of your leave, coverage (and pre-tax premiums for the coverage) will be offered upon your re-employment in accordance with Plan rules and to the extent required by USERRA. If your Employer covered any premium payments during your leave, you will be required to reimburse the Employer for those amounts when you return.
Unpaid Leave, Special	Your Plan benefit options continue at the active employee rate while you are on approved special leave (for up to 2 months) and you continue to pay your premiums. After that point, you may elect to continue your Plan benefit options through COBRA. Refer to the COBRA Continuation Coverage section of this SPD.	Your Plan benefit options and pre-tax contribution elections that were in place during your leave will continue, but you can change your election when you return if you have a qualifying Mid-Year Election Change Event. If your Employer covered any premium payments during your leave, you will be required to reimburse the Employer for those amounts when you return. Refer to the *Mid-Year Election Change Events* section of this SPD. If you return within 30 days and in the same plan year, your pre-leave benefits and contributions will automatically resume; if you return after a leave of more than 30 days or in a new plan year, you will be eligible to make new elections but must do so within 30 days of your return.

Benefit Claims and Appeals

Benefit claims must be filed with the Insurer or Claims Administrator in the period and in the manner provided in the Benefit Description.

The Insurer or Claims Administrator is the named fiduciary for benefit claims and appeals and has complete discretionary power and authority to make benefit determinations. A benefit is not payable unless the Insurer or Claims Administrator says that it is.

You are required to complete the claims and appeal procedure outlined in the Benefit Description before you can bring a claim in a court. After you have completed the claims and appeal procedure, you have a limited time to bring a claim in court. See the "Limitation of Legal Action" section below for more information.

Participation Claims and Appeals

If you believe that you have been improperly denied eligibility to participate in the Plan, enroll dependents, make election changes or correct premium contributions, you may file a Participation Claim with the Plan Administrator. Direct your Participation Claim to the attention of the Human Resources Benefits Department.

Definitions.

1. “Participation Claim” is a claim that relates to anything other than a claim for the payment of benefits that is made by a Claimant in accordance with the Plan’s procedures for filing a Participation Claim. Participation Claim includes claims of eligibility to participate in the Plan, enroll dependents, make coverage changes, and to correct Employee contributions. A Participation Claim does not include an eligibility claim arising out of a request for a Plan benefit (such a claim is subject to the benefit claim and appeal procedures in the Vendor Benefit Description).

2. “Claimant” means an individual who, individually or through a Representative, has made a Participation Claim.

3. A “Representative” is an individual who can act on behalf of the Claimant. A parent or guardian will generally be considered the Representative of a child. In all other situations, the Claimant must notify the Plan in writing of a Representative.

Claim Submission.

1. A Participation Claim must be submitted to the Plan Administrator in writing and include the reason why the Claimant believes that the Participation Claim is valid. Completion and submission of enrollment, coverage change or other forms required by the Plan Administrator satisfies these requirements.

2. A Participation Claim must be made in the manner required by the Plan Administrator and within the period applicable to the type of Claim at issue:

    a. An Employee’s request to enroll himself or herself or a Spouse, Dependent, Domestic Partner or Domestic Partner's Child in Plan coverage must be made within the enrollment or coverage change period required by the Plan (e.g., during open enrollment, within 30 days after an Employee’s hire or becoming eligible for coverage, within the 30 days after the acquisition of a new Dependent or the date of loss of coverage for special enrollment or within 30 days after an event that permits a coverage change).

    b. A request to correct the amount of an Employee coverage contribution must be made within 60 days of the date of the improper contribution. A contribution is made on the date that it is deducted from the Employee’s pay.

Initial Review.

1. The Plan Administrator will provide its initial review determination to the Claimant within 90 days of receiving the Participation Claim. This period can be extended by up to 90 days in special circumstances, provided notice is given to the Claimant.

2. If a Participation Claim is denied in whole or part, the Plan will provide a written notice to the Claimant that includes:

    a. the reason(s) for the denial;

    b. a description of any additional material or information necessary for the Claimant to perfect the Participation Claim and an explanation as to why the information or material is necessary; and

    c. an explanation of the Plan’s appeal review procedure for the Participation Claim, including the applicable time limits.

Appeal Review.

1. The Claimant must appeal an initial Participation Claim denial within 30 days of his or her receipt of the denial. The appeal must be in writing and include the reason why the Claimant believes that the Participation Claim is valid.

2. The Claimant may submit written comments, documents, records, and other information to the Plan Administrator and the information will be considered on review regardless of whether it was submitted or considered in the initial review.

3. The Plan will provide to the Claimant reasonable access to documents, records, and other information which are, in the judgment of the Plan Administrator, relevant to the Participation Claim.

4. The Plan Administrator will provide its appeal review determination to the Claimant within 60 days of receiving the appeal of the denial of the Participation Claim. This period can be extended by up to 60 days in special circumstances, provided notice is given to the Claimant.

5. If the Participation Claim is denied on appeal review, the Plan will provide written notice to the Claimant that includes the reason(s) for the continued denial.

Qualified Medical Child Support Orders

The Plan Administrator will determine whether an order requiring the Plan to provide group health coverage to a child is a Qualified Medical Child Support Order. You can obtain a copy of the QMCSO procedures on request and free of charge from the Plan Administrator. If you are not enrolled, you will be required to enroll in order to enroll your child pursuant to a QMCSO. You must pay the premium required for your coverage and your child's coverage.

The Plan is not obligated to comply with any order requiring you to add your ex-spouse to coverage. The Plan does not cover ex-spouses other than under COBRA continuation coverage. You must notify the Plan of a divorce for your ex-spouse to be eligible for COBRA. See the COBRA Continuation Coverage section of this SPD for details. You may be in violation of a court order if you drop your Spouse from coverage prior to divorce or fail to notify the Plan of the divorce allowing your ex-spouse to elect COBRA Continuation Coverage. You should consult with your divorce attorney.

Post Retirement Benefits Plan

The Ecolab Post Retirement Benefits Plan currently provides medical and dental benefits in addition to a small death benefit. Under the current Post-Retirement Benefits Plan, you may be eligible to participate in the Plan if, when you terminate employment with Ecolab or another Participating Employer ("Employer"), you:

(1) have attained your Social Security full retirement age, or

(2) have attained age 55 and have completed at least 10 years of Eligibility Service. (Eligibility Service means, in general, a year of employment with the Employer in which you complete at least 1,000 hours of service.)

You will be covered for medical and dental benefits only if you timely enroll in the Post-Retirement Benefits Plan upon your termination of employment, or after your COBRA coverage ends. Your cost for the coverage will depend on your hire date with the Employer and your years of Eligibility Service. Ecolab reserves the right to amend or terminate the Post Retirement Benefits Plan at any time.

COBRA Continuation Coverage

If you or your dependent loses coverage due to a COBRA qualifying event (reduction of hours, termination of employment, death, divorce or loss of dependent status), COBRA continuation coverage may be elected to temporarily continue your coverage as provided in this section. You must notify Ecolab Human Resources in writing within 60 days of a death, divorce or loss of Eligible Dependent status. If you do not notify Ecolab within 60 days, COBRA continuation coverage rights will be lost.

Any covered Eligible Employee or Eligible Dependent who loses Plan coverage as a result of a "qualifying event" will be eligible to elect to temporarily continue Plan coverage under a federal law called COBRA as described below.

For employees, the qualifying events are: (1) termination of employment for any reason other than gross misconduct; and (2) a reduction in hours.

For dependents, the qualifying events are: (1) the employee's termination of employment for any reason other than gross misconduct; (2) the employee's loss of eligibility for coverage due to a reduction in work hours; (3) the employee's death; (4) the employee's divorce, legal separation or termination of domestic partnership; or (5) loss of Eligible Dependent status under the Plan.

"You" or "your" refers to an Eligible Employee who is eligible for (and when required, has elected) COBRA continuation coverage. Your "dependent" means your Eligible Dependent who is eligible for (and when required, has elected) COBRA continuation coverage.

"Employer" means Ecolab Inc. or a Participating Employer.

Maximum COBRA Coverage Period

If your qualifying event was termination of employment or reduction of hours, your coverage and the coverage of your dependents can generally be continued for up to 18 months from the date of the employment termination or hours reduction. The coverage period can be extended to up to 29 months if you or your dependent is determined to be disabled for Social Security purposes at any time during the first 60 days of coverage continuation and you satisfy the notice requirement stated in "Disability Determination" below.

The continuation coverage period for your dependent can be extended to up to 36 months if, within the initial 18-month period (or 29-month extended period), coverage under the Plan would otherwise terminate because you die, your dependent ceases to meet the eligibility requirements of the Plan, you and your Spouse become legally separated or divorced, or you and your Domestic Partner end your domestic partnership. This is called a "second qualifying event."

If you enrolled in Medicare benefits before you lost coverage because of a reduction in hours or termination of employment, coverage for your dependents can be extended until up to 18 months after the reduction or termination or up to 36 months after the date of Medicare enrollment, whichever is later.

If the qualifying event was your death, legal separation, divorce, termination of domestic partnership or your dependent's ceasing to meet the eligibility requirements of the Plan, the continuation period would be up to 36 months from the date of the event.

The maximum COBRA coverage periods described above will not be extended even though coverage under the Plan is continued unintentionally, resulting in a delay in termination of coverage, or the Employer reduces or subsidizes, in whole or in part, the premium an individual is required to pay for COBRA coverage. The continuation coverage periods described above are maximum periods that will be reduced as described below.

You Must Provide Notice to the Plan Administrator of Certain Events

There are four instances in which you are required to notify the Plan Administrator or COBRA Administrator of an event. They are below. If you fail to provide the required notice within the period noted below, the right to elect to continue coverage will be lost. The notice must be in writing, must contain the information described below, and must be mailed by first class mail, postage prepaid.

1. *Divorce, Legal Separation, Termination of Domestic Partnership or Loss of Dependent Child Status.* You or your dependent must notify the COBRA Administrator of your divorce, legal separation, termination of domestic partnership or your child's ceasing to qualify as a dependent under the Plan within 60 days of the date of the qualifying event. If the COBRA Administrator is not given the required notice within 60 days, the right to continue coverage will be lost. The notice must contain the following information:

    a. The name, address and Social Security Number of the employee;

    b. The name, address and Social Security Number of each dependent covered by the Plan;

    c. A description of the qualifying event;

d. The date of the qualifying event; and

e. A list of the health plan options under which the affected individuals are covered.

2. *Disability Determination.* If you or any of your dependents were eligible for COBRA coverage as a result of your termination of employment or reduction in hours and elected COBRA coverage, and you or any dependent was determined to be disabled by the Social Security Administration at any time within the first 60 days of COBRA continuation coverage (whether or not the disabled person elected COBRA coverage), you and your dependents who elected COBRA coverage will be eligible for an additional 11 months of COBRA continuation coverage if you notify the COBRA Administrator of such determination within 60 days after the Social Security Administration determination and prior to the expiration of 18 months following the qualifying event. If the COBRA Administrator is not given the required notice within 60 days after the Social Security Administration determination and within the 18 month continuation period, the right to the disability extension will be lost. The notice must contain the following information:

   a. The name, address and Social Security Number of the employee;

   b. The name, address and Social Security Number of each dependent covered by the Plan; and

   c. A copy of the Social Security Administration notice of determination.

3. *End of Disability.* If the Social Security Administration determines that the person has ceased to be disabled, you or your dependent must notify the COBRA Administrator within 30 days. The notice must contain the following information:

   1. The name, address and Social Security Number of the employee;

   2. The name, address and Social Security Number of each dependent covered by the Plan;

   3. A copy of the Social Security Administration notice of determination; and

   4. A list of the group health plan options under which the affected individuals are covered.

4. *Second Qualifying Event.* If during an 18-month or 29-month period of continuation coverage your dependent would otherwise lose coverage because of a second qualifying event which is the employee's divorce, legal separation, or termination of domestic partnership or the child's ceasing to qualify as a dependent under the Plan, you or your dependent must notify the COBRA Administrator within 60 days of the date of the second qualifying event. If the COBRA Administrator is not given the required notice within 60 days, the right to extend continuation coverage to a maximum of 36 months will be lost. The notice must contain the following information:

   a. The name, address and Social Security Number of the employee;

   b. The name, address and Social Security Number of each dependent covered by the Plan;

   c. A description of the second qualifying event;

   d. The date of the second qualifying event; and

   e. A list of the group health plan options under which the affected individuals are covered.

Type of COBRA Coverage Available

An individual electing COBRA continuation coverage may elect to continue the Plan coverage in effect immediately before the qualifying event. If, however, the coverage provided to similarly situated employees is eliminated and the Employer continues to maintain other medical coverage, the individual will have the right to elect that coverage.

While the individual can only elect to continue health care coverage he or she had at the time of the qualifying event, as long as he or she continues the coverage, he or she will have the same coverage options that he or she would have had if the qualifying event had not occurred. For example, he or she may be able to change to a different option offered by the Employer during an open enrollment period or add coverage for newly acquired Eligible Dependents. (Dependents who are added during coverage continuation (after the qualifying event) will not have any independent continuation rights, except for children born to, placed for adoption with or adopted by the employee during the employee's continuation coverage period.)

Who May Elect COBRA Coverage

If you are eligible for COBRA coverage, you can make the election for yourself and for any one or more of your dependents who are eligible for COBRA coverage. If you do not make the election, your Spouse or Domestic Partner can make the election for himself or herself and any covered Dependent Child. Finally, if neither you nor your Spouse or Domestic Partner make the election for a covered Dependent Child, the dependent may make the election for himself or herself. (A child who is born to, or placed for adoption with, the employee while the employee is continuing coverage under COBRA and who becomes covered by the Plan will have independent COBRA election rights as if he or she were covered at the time of the qualifying event.)

Impact of COBRA on other Federal Law Rights

In considering whether to elect continuation coverage, you should take into account that a failure to continue group health plan coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event. You will also have the same special enrollment right at the end of the continuation coverage period if you get continuation coverage for the maximum time available to you.

COBRA Election Period

After a qualifying event or receiving notice of a qualifying event (if notice is required), the COBRA Administrator will send a notice regarding COBRA election rights to individuals eligible for COBRA. The individuals will have 60 days from the date of such notice (or from the date coverage would otherwise terminate because of the qualifying event, if the coverage would stop after the notice is sent) in which to file a written election to continue your coverage. If the individual does not file the required election form within this 60-day period, he or she will lose the right to continue coverage under the Plan. The election form must be submitted to the address specified in the election form.

The Trade Act of 2004 created a tax credit for certain individuals who become eligible for trade adjustment assistance ("eligible individuals"). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including

continuation coverage. An eligible individual who did not elect COBRA coverage will have a second 60-day COBRA election period beginning on the first day of the month in which he or she is determined to be an eligible individual, but only if the election is made within six months after the original termination of employment. Any COBRA coverage elected during the second election period will begin with the first day of the second election period, rather than on the date coverage terminated.

COBRA Premium

You (or your dependent) must pay the full premium (both the employee and employer contribution), plus a 2% administration fee, for any coverage you continue. (The charge will be higher for coverage extended on account of disability.) The premium will be the same premium that would be paid for a person in your situation with respect to whom no qualifying event had occurred (but will include any portion the Employer normally pays for active employees). The first premium payment, covering the period between the date coverage would otherwise stop and the date of the payment, must be made within 45 days after the date you file the election to continue coverage. Subsequent premiums are due monthly on the day of the month coverage would have stopped if COBRA continuation had not been elected, and coverage will end if your or your dependent fails to pay the premium for any month within 30 days after the due date.

Under its current practice, if you die while actively employed by Ecolab or its subsidiary, Ecolab will waive the first 12 months of COBRA premiums for your dependents enrolled in medical coverage at the time of your death. Each dependent can elect to continue coverage at their expense for the remaining 24 months of the continuation period.

No COBRA Coverage Pending Election or Payment

You will not have COBRA coverage until you have elected the coverage and made the required premium payment. Once you make the election and pay the premium, coverage will be reinstated retroactively to the date you lost your coverage.

Termination of Coverage

The continuation coverage will terminate when the first of the following events occurs.

1. The 18-, 29- or 36-month maximum continuation period ends.

2. You fail or your dependent fails to pay the initial premium within 45 days after your election, in which case you will be treated as not having elected to continue your coverage.

3. You fail or your dependent fails to pay any other premium within 30 days after it is due, in which case your coverage will end as of the end of the last period for which you made a timely premium payment.

4. After electing continuation coverage, you become or your dependent enrolls in Medicare benefits or becomes covered by any other group health plan that does not limit or exclude coverage because of a preexisting condition. Coverage already in place at the time of the continuation coverage election will not cause termination of continuation coverage.

5. The Employer ceases to provide group health benefits to any of its employees.

6. For coverage that is continued beyond 18 months because of disability, the disabled person ceases to be disabled, in which case the coverage will terminate as of the first day of the month that begins at least 30 days after date of the Social Security Administration's determination that the person is no longer disabled.

7. The continuation coverage is terminated for cause (e.g., you commit fraud against the Plan).

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator (see contact information below) or the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the Plan and COBRA Administrator Informed of Address Changes

To protect your family's COBRA continuation rights, you should keep the Plan and COBRA Administrator informed of any changes in the addresses of family members.

Keep Copies of Any Notices You Send to the Plan or COBRA Administrator

You should also keep a copy, for your records, of any notices you send to the Plan and COBRA Administrator.

Plan Administrator Contact Information

Ecolab Inc.
Attn: Benefits Department - EUC7
370 Wabasha Street North
St. Paul, MN 55102
If you have questions, call: (800) 533-3539

COBRA Administrator Contact Information:

For legacy Ecolab employees:
ADP Benefit Services
2575 Westside Parkway, Suite 500
Alpharetta, GA 30004-3852
(800) 654-6695

For legacy Nalco employees:
Your Spending Account
P.O. Box 785040
Orlando, FL 32878
(800) 662-5266

USERRA Continuation Coverage

If you leave your job with a Participating Employer to go on a qualifying military leave of absence as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you may elect to continue your coverage as provided in this section.

You will have the right to elect to continue Plan coverage for yourself and your Eligible Dependents during a period of Uniformed Service for up to 24 months, or the date on which you fail to return to work following your period of Uniformed Service, whichever is earlier. USERRA Continuation Coverage will begin on the first day of your leave of absence due to Uniformed Service.

Definitions

1. "Uniformed Service" includes service by an Employee in the Armed Forces, Reserves, federally-activated National Guard and volunteers in the National Disaster Medical System.

2. "Service" means the performance of duty on a voluntary or involuntary basis in the Uniformed Services, including active and inactive duty training or service, examination to determine fitness

for duty, certain funeral honors duties, and certain service by intermittent disaster-response personnel of the National Disaster Medical System.

3. "USERRA Continuation Coverage" means continuation of Plan coverage pursuant to USERRA.

Election of USERRA Continuation Coverage

You will be required to elect USERRA coverage. COBRA election procedures as set forth in COBRA Continuation Coverage Rights section will apply, except that an election for USERRA Continuation Coverage is not required if advance notice of leave is excused under USERRA. If you elect COBRA, you will be considered to have elected USERRA continuation coverage as well.

Cost of USERRA Continuation Coverage

The COBRA rate will apply. You will only be required to pay the active employee rate, however, for a USERRA leave of less than 31 days if you notify the Plan that your Uniformed Service is scheduled to last less than 31 days.

Termination of USERRA Continuation Coverage

USERRA Continuation Coverage will end when the earliest of the following occurs:

1. The 24-month USERRA Continuation Coverage period ends;

2. You fail to report back to work or apply for reemployment within the period required under USERRA after completing Service;

3. The Employer ceases to offer any group health plan to any of its employees; or

4. You fail to pay the required premium contribution within 30 days of the due date.

Coordination of COBRA Coverage and USERRA Coverage

The maximum USERRA Continuation Coverage period is 24 months. The maximum COBRA continuation coverage period may be 18 months, 29 months or 36 months depending on the qualifying event. The USERRA Continuation Coverage period and the COBRA continuation coverage period will run concurrently.

Covered dependents do have independent election rights under COBRA but not under USERRA. You must elect continuation coverage for yourself in order for your Spouse or Domestic Partner or Dependent Child to be eligible for any USERRA Continuation Coverage period that extends beyond the COBRA continuation coverage period.

Reinstatement of Coverage on Return from Service

To the extent required by USERRA, Plan coverage will be reinstated after you return to work even if you do not elect USERRA Continuation Coverage or your USERRA Continuation Coverage terminates for failure to pay a premium. No waiting period will be imposed.

Other Notices

Conditions of Participation

Participation in the Plan by an Eligible Employee is voluntary. Participation in the Plan does not give any Employee the right to continued employment.

As a condition of participation, each Eligible Employee and Eligible Dependent agrees to:

1. be bound by all of the terms and conditions of the Plan and, for an insured option, the Insurance Policy;

2. make the contributions required; and

3. furnish such information and execute such instruments and forms as the Plan Administrator and Insurer or Claims Administrator may request.

Committing Fraud or Intentional Misrepresentation Against the Plan

If you commit fraud or intentional misrepresentation of a material fact against the Plan (which may include enrolling someone in coverage who you know or should know does not qualify as your Eligible Dependent, continuing enrollment of someone in coverage who you know or should know has lost eligibility or filing a false claim) the Plan (or your Participating Employer) may take action, which may include the following:

1. Termination of Plan Coverage. Your coverage may be terminated. Coverage for the person you enrolled may be terminated. If you have committed fraud or made an intentional misrepresentation of a material fact, coverage may be terminated retroactively.

2. Repayment of Plan Benefits. You may be responsible for all benefits paid for a person who was not eligible for coverage or as a result of a false claim.

3. Discipline. You may be subject to discipline, including termination of your employment.

4. Notification of Law Enforcement. Law enforcement may be notified that you have committed intentional misrepresentation or fraud against the Plan.

Limitation of Legal Action

For insured options, the limitation of actions provision contained in the Policy will apply.

For self-insured options (and insured options if the Policy does not contain a limitation of action provision), the following will apply:

No action with respect to eligibility to participate or for any benefit under this Plan may be brought more than six months following the final decision in the final appeal review brought pursuant to the claim and appeal procedure set forth in the Vendor Benefit Description, or for eligibility claims, the participation and claims procedure described in this SPD. In no event can any action with respect to eligibility to participate or with respect to any benefit under this Plan be brought more than three years after the date the event giving rise to the claim occurred.

No Guarantee of Tax Consequences

Although Ecolab intends to provide certain Plan benefits on a tax-free basis, Ecolab does not guarantee that the benefits are tax-free or the tax consequences to you. You are responsible to pay any local, state or federal taxes that you owe as a result of your Plan participation or receipt of Plan benefits.

Availability of the Plan's HIPAA Notice of Privacy Practices

You can obtain a copy of the Plan's HIPAA Notice of Privacy Practices, which describes your privacy rights under the Health Insurance Portability and Accountability Act of 1996, from the Plan Administrator or from the Insurer for an insured option.

The separate HIPAA Plan amendment is part of the Plan document.

Health Care Providers

You are responsible for choosing your own health care provider. You must decide if any provider treating you (including an in-network provider) is right for you. You must decide with your health care provider which care you will receive. Your health care provider, whether in or out of network, is responsible for the care provided to you.

The Plan pays for certain health care expenses. It does not provide health care. Determinations that health care services or supplies are not Covered Expenses (including that they are not medically necessary) are for payment purposes only.

The Insurer or Claims Administrator pays network providers through various types of contractual arrangements, which may include financial incentives to promote the delivery of care in a cost- effective manner (for example, bonuses based on quality, member satisfaction and cost-effectiveness). The financial incentives are not intended to affect your access to health care. If you have questions about whether your network provider's contract includes any financial incentives, you should discuss them with your provider and the Insurer or Claims Administrator.

Wellness Program Incentives

The Insurer, Claims Administrator or Plan may offer incentives to encourage you to participate in wellness programs or disease management programs. The decision whether to participate is yours alone and will not impact your eligibility to participate in the Plan or your employment at Ecolab.

Subrogation and Reimbursement

Insured vs. Self-insured. Subrogation and reimbursement under a fully-insured Option will be as provided in the Policy. This section applies to self-insured medical options to the extent not inconsistent with the Vendor Benefit Description. If it is inconsistent with the Vendor Benefit Description, the Vendor Benefit Description controls.

Subrogation and Reimbursement Rights. Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any benefit, the Plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and benefits the Plan provided to Eligible Employees or Eligible Dependents ("Covered Persons"), from any or all of the following listed below. In addition to any subrogation rights and in consideration of the coverage provided by this Summary Plan Description, the Plan shall also have an independent right to be reimbursed by Covered Persons for the reasonable value of any services and benefits the Plan provides to Covered Persons, from any or all of the following listed below.

1. Third parties, including any person alleged to have caused a Covered Person to suffer injuries or damages.

2. Any person or entity who is or may be obligated to provide benefits or payments to a Covered Person, including benefits or payments for underinsured or uninsured motorist protection, no-fault

or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

3. Any person or entity who is liable for payment to a Covered Person on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties".

Responsibilities of Covered Persons. Covered Persons agree as follows:

1. The Covered Person will cooperate with the Plan in a timely manner in protecting the Plan's legal and equitable rights to subrogation and reimbursement, including, but not limited to:

    a. providing any relevant information requested by the Plan;

    b. signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;

    c. responding to requests for information about any accident or injuries;

    d. appearing at depositions and in court; and

    e. obtaining the consent of the Plan or its agents before releasing any party from liability or payment of medical expenses.

2. Failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits and/or the institution of legal action against a Covered Person.

3. The Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

4. No court costs or attorneys' fees may be deducted from the Plan's recovery without the Plan's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by a Covered Person to pursue his or her damage/personal injury claim.

5. Regardless of whether a Covered Person has been fully compensated or made whole, the Plan may collect from Covered Persons the proceeds of any full or partial recovery that a Covered Person or his or her legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment. The proceeds available for collection shall include, but not be limited to, any and all amounts earmarked as non-economic damage settlement or judgment.

6. Benefits paid by the Plan may also be considered to be benefits advanced.

7. Covered Persons agree that if they receive any payment from any potentially responsible party as a result of an Injury or Sickness, whether by settlement (either before or after any determination of liability), or judgment, the Covered Person will serve as a constructive trustee over the funds and failure to hold such funds in trust will be deemed as a breach of the Covered Person's duties hereunder.

8. Covered Persons or an authorized agent, such as the Covered Person's attorney, must hold any funds received from any potentially responsible party that are due and owed to the Plan, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach

of contract, and may result in the termination of health benefits or the institution of legal action against the Covered Person.

9. The Plan shall be entitled to recover reasonable attorney fees from Covered Persons incurred in collecting from the Covered Person any funds held by the Covered Person that he or she recovered from any Third Party.

10. The Plan may set off from any future benefits otherwise allowed by the Plan the value of benefits paid or advanced under this section to the extent not recovered by the Plan.

11. Covered Persons will neither accept any settlement that does not fully compensate or reimburse the Plan without the Plan's written approval, nor will the Covered Person do anything to prejudice the Plan's rights under this section.

12. Covered Persons will assign to the Plan all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits the Plan provided, plus reasonable costs of collection.

13. The Plan's rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom Covered Persons are seeking recovery, to be paid before any other of the Covered Person's claims are paid.

14. The Plan' rights will not be reduced due to the Covered Person's own negligence.

15. The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in the Covered Person's name, which does not obligate the Plan in any way to pay the Covered Person part of any recovery the Plan might obtain.

16. The Plan shall not be obligated in any way to pursue this right independently or on behalf of the Covered Person.

17. If the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section applies to the parents or guardian of the minor child.

18. If the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Plan beneficiary, this section applies to the personal representative of the deceased Plan beneficiary.

<u>Refund of Overpayments.</u>

1. If the Plan pays benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

   a. All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person; or

   b. All or some of the payment we made exceeded the benefits under the Plan.

2. The refund equals the amount we paid in excess of the amount we should have paid under the Plan.

3. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

4. If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

ERISA Plan Information

Plan Name and Type: Ecolab Health and Welfare Benefits Plan. The Plan provides health and other welfare benefits to Eligible Employees of Ecolab Inc. and other Participating Employers.

Participating Employers: Ecolab Inc. and subsidiaries of Ecolab Inc. that have adopted the Plan. If you have questions about whether your employer is a Participating Employer, contact the Plan Administrator.

Plan Number: The Plan number is 501.

Plan Year: The Plan Year is the 12-month period beginning each January 1 and ending the following December 31.

Plan Sponsor Taxpayer Identification Number: Ecolab's Taxpayer Identification Number is 41-0231510.

Plan Sponsor and Plan Administrator: Ecolab Inc. is the Plan Sponsor and Plan Administrator of the Plan.

Ecolab Inc.
Attn: Benefits Department - EUC7
370 Wabasha Street North
St. Paul, MN 55102
(800) 533-3539

Plan Administrator Discretionary Authority: The Plan Administrator's determinations regarding coverage, claims and all other aspects of the Plan are binding. The Plan Administrator has complete discretionary power and authority with respect to all Plan matters, including eligibility and benefits, factual determinations and Plan interpretation. A benefit is not payable unless the Plan Administrator determines that it is. The Plan Administrator may delegate its authority to Plan service providers, such as the Insurer or Claims Administrator.

Right to Amend or Terminate Plan: Ecolab reserves the right to amend or terminate all or part of this Plan and will do so by written instrument signed by an authorized Ecolab officer. Plan terms cannot be modified by oral statements made by anyone. Misinformation or a mistake does not create a right to eligibility or benefits.

Insurer or Claims Administrator: The name, address and contact information for the Insurer or Claims Administrator for each option is listed in the *Benefits Options Chart* at the front of this SPD.

Premium Contributions and Plan Funding: Premiums for the Plan benefits you elect are paid through your contributions and contributions by your Participating Employer, if any. The Plan Administrator will inform you what Premium amount you will be required to pay for your coverage. To the extent permitted by federal law, your Premium contributions will automatically be paid on a pre-tax basis. Benefits for insured options are paid by the Insurer. Ecolab has no responsibility to pay any benefits under this Plan for insured options. Benefits for self-insured options are paid from Ecolab's general corporate assets.

Legal Process: Legal process may be served on the Plan Administrator at the following address:

Ecolab Inc.
Attn: General Counsel's Office
370 Wabasha Street North
St. Paul, MN 55102

Collective Bargaining Agreements:

A copy of any collective bargaining agreement that provides for participation in this Plan is available for examination.

Provider Lists: Provider lists are furnished automatically, without charge, upon request.

Statement of ERISA Rights

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest Form 5500 and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report, if applicable. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, spouse or dependents if there is a loss of group health plan coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review *COBRA Continuation Coverage and USERRA Continuation Coverage* on the rules governing your COBRA continuation coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit provided under this Plan or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

There are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. The court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator's control. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If the Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Certificate of Benefits
MCS Global

P.O. Box 9023547
San Juan, PR 00902-3547

Group Insurance between MCS Life Insurance Company and ECOLAB MFG., INC.

EMPLOYER:	**ECOLAB MFG., INC.** **DORADO INDUSTRIAL PARK** **LOTS 16, 18 & 19** **DORADO, PR 00646** **(787) 796-1290 EXT. 6801**
GROUP NUMBER:	**79-790462** **HEALTH INSURANCE**
OPTIONAL:	**PHARMACY**
EFFECTIVE DATE:	**01/01/2025**
POLICY YEAR:	**01/01/2025 - 12/31/2025**
TYPE OF COVERAGE:	**H-54 MQ-664 A-984 F**
PROVIDERS DIRECTORY	**PROVIDERS DIRECTORY I**
DRUG FORMULARY	**PREFERRED DRUG LIST (PDL) FORMULARY A**

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 a government insurance information program for the elderly.

WELCOME TO MCS!

Dear Insured:

Welcome to the great family of MCS Life Insurance Company. We appreciate your trust. MCS Life offers a wide variety of health and life insurance group plans which redefine Puerto Rico's health services.

Below you will find a breakdown of the benefits included in this service coverage. To offer you better service, we recommend you to read this document carefully.

If you have any questions or concerns regarding the benefits, you may contact the Customer Service 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 8:00 AM to 4:30 PM; people with hearing impairment (TTY) can call 1-866-627-8182. We also welcome you to visit our web page at www.mcs.com.pr where you can access our directories and forms referred to in this certificate and access our tool My MCS.

Our commitment and mission is to facilitate healthy lives through innovative products and services that meet and foresee the needs of our clients.

Cordially yours,

Roberto Pando Cintrón
President
MCS Life Insurance Company

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PART I: DEFINITIONS

Below are the definitions corresponding to the terms used in this certificate. According to its use in this certificate, 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 certificate. 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.
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 certificate 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 certificate.
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 certificate.
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 certificate, 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 or 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 certificate, 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.
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 certificate.
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 certificate) 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 certificate.
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 certificate) 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 certificate.
Insured Employee	Employee insured under this certificate.
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 certificate, 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 certificate.
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 certificate, 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 certificate.
Plan for Couples	Any eligible person, single or married with a direct dependent (as defined under this certificate).
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 certificate.
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 certificate

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.
Special Laboratory Network and Laboratory PPO Network	Laboratory network contracted to provide laboratory benefits as preferred network under this certificate.
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	In accordance with Law No, 168 of August 1, 2018, it is the practice of medicine at a distance involving the remote diagnosis, treatment and medical education by means of technology resources to optimize health care services. These services must include, but not limited to, complementary and instant services to specialist care: immediate diagnosis by a general practitionary or specialist at a determined area or region; health and medical professionals; digital archiving services for radiological exams, ultrasound scans, medical emergencies and others.
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 certificate, except students in United States. MCS reserves the right to request from the insured proof of insurability showing that the insured meets the residence requirement under this certificate. 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 certificate 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

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.

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 certificate, according to Law No. 15 of February 27, 2007 and Law No. 116 of July17, 2008.

8. An individual loses eligibility for coverage under a group health plan or other health insurance coverage (such as the loss of an employee and their dependents from coverage under the spouse's plan) or when an employer terminates contributions toward health coverage.

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 certificate;
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 certificate 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 certificate 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 certificate. 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 certificate. 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 certificate 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 certificate: 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 certificate.

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") -except for consensual couples- 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 certificate. The insured must comply with the pre-authorization program for those procedures and services established in this certificate. 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 certificate to learn about the corresponding MOOP for your coverage.

The maximum applicable to this certificate 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. 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 individuals 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 Medilinea MD

- MCS Alivia
- Cost-sharing paid by a third party (e.g. Drug Discount Programs)
- Drugs administered at outpatient level, except for chemotherapy, radiotherapy, and drugs used for chemotherapy preparation
- Services by non-participating providers, except in emergencies
- Non-essential Dental services
- Non-essential drugs
- Cost-sharing paid by a third party (e.g. Drug Discount Programs, patient assistance programs provided by manufacturing companies or foundations).
- Amounts paid as shared-costs using any form of direct assistance offered to the insured by a drug manufacturing company to reduce or eliminate immediate out-of-pocket costs for specific branded prescription drugs when an equivalent medically appropriate generic is available, do not have to be accrued to the annual maximum out-of-pocket (MOOP).

Section 1: Health Benefits

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

1. Emergency and urgency 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 certificate through reimbursement, as described below in this certificate. 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 for emergency room for accident or illness.	• 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 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 certificate will be paid according to the fees negotiated by MCS Life with the participating hospitals of the corresponding network in this coverage. Copayment for hospitalization applies.	• 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 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.
	• 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 applies. Maximum of one-hundred twenty (120) days per policy year. Requires pre-authorization from MCS Life Clinical Affairs.
Inpatient Anesthesia	Covered.
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.
Hospitalization due to mental health or controlled substance abuse and/or alcohol (partial and complete)	Covered. Copayment for hospitalization applies. Electroconvulsive therapies require pre-authorization from MCS Life Clinical Affairs.

3. Outpatient Services

Visits to Physicians or Healthcare Professionals	Covered. Corresponding copayment applies to these services according to medical specialty. The services of this certificate include visits to: • General practitioners • Specialists • Subspecialists • Clinical psychologists • Podiatrists • Audiologists • Optometrists • Chiropractors; and • Naturopathic doctors • Nutritionists
Pediatricians	Covered. Specialist copayment applies.
Optometrist	Covered in accordance with Law No. 148 of August 9, 2002. Copayment for specialists 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.
Audiologist	Covered in accordance with Law No. 127 of September 27, 2007, as amended. Copayment for specialist 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.
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 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.
Naturopathic Doctor	Covered in accordance with Law No. 210 of December 14, 2007. Copayment for specialist applies.
Nutritionist	Covered. Also, 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) and for insured with Down Syndrome in accordance with Law No. 97 of May 15, 2018, are covered without limits. Copayment for specialist applies.
Outpatient Facilities	The use of outpatient surgery facilities will be covered; the insured is responsible for copayment 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.
Pre-admission Examinations	Covered. Copayment or coinsurance for exams and labs in the corresponding network applies.
Diagnostic and Surgical Procedures performed in the medical office	Covered. Coinsurance for diagnostic and surgical procedures in the medical office and copayment for medical visit applies. For molecular or genetic testing, refer to item 7, Laboratory and X-rays Services.
Diagnostic and Surgical Procedures Performed in an outpatient facility	Covered. The insured is responsible for the coinsurance for diagnostic and surgical procedures performed at an outpatient facility, plus copayment 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.

Intra-articular injection	Covered. Coinsurance for diagnostic and surgical procedures in the medical office and copayment for medical visits applies. Maximum of twelve (12) injections per policy year.
Outpatient Respiratory Therapy	Covered up to twenty (20) 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.
Circumcision	Covered. • Outpatient facility: Copayment for outpatient facility applies. • Medical office: Coinsurance for diagnostic and surgical procedures in the medical office plus copayment for medical visit applies.
Vasectomy	MCS Life will cover one (1) vasectomy for life, per insured. In medical office: Coinsurance for diagnostic and surgical procedures in the medical office plus copayment for medical visit applies. In outpatient facility: Corresponding copayment applies. Requires pre-authorization from MCS Life Clinical Affairs Department. These services will only be covered through contracted facilities.
Endoscopy in the medical office	Coinsurance for diagnostic and surgical procedures in the medical office plus copayment for medical visit applies as applicable.
Endoscopy in outpatient facility	Coinsurance for endoscopy procedures and copayment for outpatient facility applies. Requires pre-authorization from MCS Life Clinical Affairs Department.
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, coinsurance for chemotherapy and radiotherapy applies, including drugs used prior to chemotherapy.
Dialysis and hemodialysis	Covered. Corresponding copayment 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 certificate (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 for outpatient facilities apply. Requires pre-authorization from MCS Life Clinical Affairs Department.

Orthognathic Surgery	Requires pre-authorization from MCS Life Clinical Affairs Department. • In medical office: Coinsurance for diagnostic and surgical procedures in medical office, plus copayment for medical visit applies. • In outpatient facility: Copayment for outpatient facility applies.
Cervical cryosurgery	Covered. • Medical office: Coinsurance for diagnostic and surgical procedures in medical office, plus copayment for medical visit applies. • Outpatient facility: Copayment for outpatient facility applies. Requires pre-authorization from MCS Life Clinical Affairs Department.
Invasive and non-invasive cardiovascular tests and procedures	Covered. • At medical office: Coinsurance for diagnostic and surgical procedures at a medical office applies, plus copayment for medical visit. • At an outpatient facility: Coinsurance for X-rays applies, plus copayment for outpatient facility.
Septoplasty, Rhinoseptoplasty, and Rhinoplasty post-trauma or for medical necessity	Covered only post-trauma or for medical necessity. Not covered for cosmetic cases. Copayment for outpatient facility applies. Requires pre-authorization from MCS Life Clinical Affairs Department.
Hearing tests	Covered. Coinsurance for laboratory of corresponding network 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 for facility where the service is offered applies.
Cardiac catheterization	Coinsurance for X-rays plus copayment for outpatient facility applies.
Drugs Administered in an Outpatient Level	For medications administered at the medical office or outpatient facility not dispensed by the pharmacy, coinsurance applies for outpatient-administered medications. Covered medications are described in the Preferred Drug List (PDL) A corresponding to this certificate.
Hyperbaric Chamber	Hyperbaric oxygenation treatment for individuals with a diagnosis of autism is covered provided it is recommended by a physician or certified healthcare professional and the treatment is permitted under federal laws and regulations, in accordance with Law No. 63 of July 19, 2019.

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 for general practitioner, specialist, or subspecialist applies.
Coverage for care within hospital facilities for the mother and her newborn. Copayment for hospitalization applies.	Minimum forty-eight (48) hour coverage will be provided for care within hospital 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	• Hospital and outpatient obstetric services. Corresponding copayment for facility or hospital applies. • Obstetric sonographies up to three 3 per pregnancy. Coinsurance for X-rays applies. • Biophysical profile, limited to one (1) per pregnancy, additional ones require pre-authorization from MCS Life Clinical Affairs Department. Coinsurance for X-rays applies. • Fetal Non-Stress Test up to one (1) per pregnancy. Coinsurance for X-rays applies. • Fetal echocardiogram requires pre-authorization from MCS Life Clinical Affairs Department. Coinsurance for X-rays applies. • Amniocentesis (genetic) up to one (1) 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 applies. • Delivery room or for Cesarean section. Copayment for hospitalization applies. • Fetal monitoring for pregnancy (results and interpretation) in hospital. Copayment 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 for medical visit applies.
Newborn care in the hospital (during stay for childbirth) Copayment for hospitalization applies.	The following benefits are covered under this certificate: • 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)	• Routine visits for the baby (*Well Baby Care*). Corresponding copayment 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	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 8, 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.
	• Twenty-three (23) hour stabilization units, after twenty-four (24) hours it is considered a hospitalization.
	• Intensive Outpatient, IOP. Copayment for hospitalization applies. Requires pre-authorization from MCS Life Clinical Affairs.

	• For partial hospitalization, copayment for partial hospitalization applies and requires pre-authorization from MCS Life Clinical Affairs Department. For full hospitalization, corresponding copayment applies. Partial hospitalizations require pre-authorization from MCS Life Clinical Affairs Department.
	• For group therapy visits and collateral visits, corresponding copayment applies.
	• Management of intensive cases with mental health case management intervention.
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: • 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. 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. 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) physical therapies per policy year per insured person. Additional therapies require prior authorization from the MCS Life Clinical Affairs Department. These services will also be covered for treatments for autism conditions, 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 the BIDA law (Well-being, Integration and Development of Persons with Autism) and for insured persons with Down Syndrome in accordance with Law No. 97 of May 15, 2018. Corresponding copayment applies.
Occupational therapies (outpatient)	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) and for insured with Down Syndrome in accordance with Law No. 97 of May 15, 2018. Copayment for physical therapy applies.
Speech and Language Therapy (outpatient)	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) and for insured with Down Syndrome in accordance with Law No. 97 of May 15, 2018. Copayment for physical therapy applies.
Chiropractor Manipulations	Covered up to twenty (20) manipulations per policy year per insured person. Additional therapies require prior authorization from the MCS Life Clinical Affairs Department. Corresponding copayment applies. According to Law No. 220-2012 passed on September 4, 2012, better known as the BIDA (Well-being, Integration, and Development of People with Autism) Act, no limits will be applied to treatments for autism conditions. Also, for insured persons with Down Syndrome in accordance with Law No. 97 of May 15, 2018. Other chiropractor services: Services offered by chiropractors and received by the insured may include radiology and physical therapy services, as long as they are contracted with the participating provider.
Durable Medical Equipment (DME)	Covered. Coinsurance for durable medical equipment applies through providers with a contract and requires pre-authorization from MCS Life Clinical Affairs. Covered equipment are: • Mattress

	• 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 certificate is not covered, including custom made equipment.
Glucometer, lancets and strips	Covered in accordance with Law No. 177 of August 13, 2016, as amended by Law No. 19 of January 12, 2020 for insureds diagnosed by a pediatric endocrinologist or endocrinologist with type 1 Diabetes *Mellitus*. The endocrinology specialist may also prescribe the use of a glucose monitor, along with its accessories, for patients with a clinical condition of predisposition or more risk factors of developing Type 1 Diabetes *Mellitus.* • One (1) glucometer every three (3) years, with replacement for damaged equipment. Coinsurance for Durable Medical Equipment applies. Requires pre-authorization from MCS Life Clinical Affairs. • One (1) glucagon injection and replacement in case of its use or expiration. • Minimum of 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. 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, patients should receive the health care they need, including high quality supplies and treatment. Coinsurance for Durable Medical Equipment applies through contracted providers and requires pre-authorization from MCS Life Clinical Affairs.

Portable Insulin Infusion Pump	Covered, in accordance with Law No. 177 of August 13, 2016, as amended by Law No. 19 of January 12, 2020, (1) portable infusion pump or microinfuser, and its maintenance as therapy for patients diagnosed with type 1 Diabetes Mellitus by a pediatric endocrinologist or endocrinologist. Must meet the same criteria established for a diabetic patient requiring the use of the insulin pump as established by the Centers for Medicare and Medicaid Services. Coinsurance for Durable Medical Equipment applies. Requires pre-authorization from MCS Life Clinical Affairs. The portable insulin infusion pump or microinfuser 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. Coinsurance for Durable Medical Equipment applies through providers with a contract and requires pre-authorization from MCS Life Clinical Affairs.
Technological Equipment Services	Coinsurance for Durable Medical Equipment 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) combined days in the home, per policy year per insured. Corresponding copayment applies. Requires pre-authorization from MCS Life Clinical Affairs. Additional days require medical justification and pre-authorization from MCS Life Clinical Affairs. 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.
X-Rays	Covered with X-ray coinsurance.
PET CT	Coinsurance for special tests applies. Also known as PET Scan. Requires pre-authorization from MCS Life Clinical Affairs Department.
Molecular and/or Genetic Tests	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), by Law No. 97 of May 15, 2018 for the treatment of insureds with Down Syndrome, 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.
Nuclear Medicine	Covered. Coinsurance for X-rays applies.
Polysomnography (Sleep study)	Covered, one (1) study for life per insured. Coinsurance for X-rays applies. Requires pre-authorization from MCS Life Clinical Affairs.
CT Scan	Coinsurance for special tests applies. Requires pre-authorization from MCS Life Clinical Affairs.
Bone densitometry	Covered. Coinsurance for X-rays applies.
Echocardiogram	Covered. Coinsurance for X-rays applies.
Electrocardiogram	Covered. Coinsurance for X-rays applies.
Electroencephalogram	Covered. Coinsurance for X-rays applies.
Angiography	Covered. Coinsurance for X-rays applies.
Holter	Covered. Coinsurance for X-rays applies.
Non-invasive peripheral cerebrovascular tests	Covered. Coinsurance for X-rays applies.
Myelography	Covered. Coinsurance for X-rays applies.
MRA	Covered. Coinsurance for X-rays applies. Requires pre-authorization from MCS Life Clinical Affairs.
MRI	Covered. Coinsurance for specialized tests apply. Requires pre-authorization from MCS Life Clinical Affairs.
Sonography	Covered. Coinsurance for X-rays applies.
SPECT	Covered. Coinsurance for specialized tests applies.
Stress test	Covered. Coinsurance for X-rays applies.
Stress Test with sestamibi, Persantine or Thallium	Covered. Coinsurance for X-rays applies.
Allergy test	Covered. Maximum of fifty (50) per policy year. • In medical office: Coinsurance for laboratory applies. • In laboratory: Coinsurance for laboratory applies.

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

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

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

- one (1) evaluation by a physician, as appropriate for the insured's age and gender

- counseling and treatment to identify and reduce identified risk factors

MCS Life will cover one (1) annual physical exam, provided it is for preventive purposes. An annual comprehensive health evaluation performed by health professionals may include diagnostic tests, among others, according to age, sex, and health condition of the insured. An annual health evaluation for children at the beginning of the school year must include both physical and mental evaluations, oral hygiene, hearing and vision tests, as well as periodic examinations recommended by the American Academy of Pediatrics.

Preventive services for under-age children

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

- History
- Measurements
- Sensory screening
- Development/behavior screening
- Physical exam
- Specific procedures for at-risk patients
- Anticipatory guidelines (such as nutritional counseling)
- Dental referrals
- Annual medical screening at the beginning of the school year.

Preventive service	Indication
Alcohol Abuse	Screening for adults of eighteen (18) years old and older due to alcohol abuse, and counseling on improper alcohol use reduction to any person involved in a risky or hazardous alcohol use.
Anemia / Iron	Perform risk assessment or screening as appropriate, per recommendations in the current edition of the AAP Pediatric Nutrition: Policy of the American Academy of Pediatrics.
Anxiety in Children and Adolescents: Screening: children and adolescents aged 8 to 18 years	Anxiety evaluation in children and adolescents aged 8 to 18 years.
Autism	Screening for children between eighteen (18) and twenty-four (24) months.
Behavioral / Social / Emotional Screening	The American Academy of Pediatrics (AAP) recommends an annual assessment from newborn to 21 years old.
Bilirubin concentration	Screening for newborns.
Blood pressure	Screening for children between the following ages: (0) to (11) months, (1) to (4) years, (5) to (10) years, (11) to (14) years, (15) to (17) years
Blood screening	Screening for newborns.
Cervical Dysplasia	Screening for sexually active girls.
Depression and Suicide Risk in Children and Adolescents	Screening for major depression disorders (MDD) in adolescents ages twelve (12) to eighteen (21).

Development Screening	Screenings for children under the age of three (3), and observation during the entire childhood.
Dyslipidemia	One-time evaluation for children; between the ages of nine (9) and eleven (11) years, between the ages of seventeen (17) and twenty-one (21), and for minors at high risk for lipid disorders between the following ages: 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.
Ocular prophylaxis for gonococcal ophthalmia neonatorum (Gonorrhea)	Topical prophylactic eye medication in all newborns for the prevention of gonococcal ophthalmia neonatorum (Gonorrhea).
Hearing Screening	Hearing loss screening for newborns and children once between the ages of eleven (11) and fourteen (14), once between the ages of fifteen (15) and seventeen (17), and once between the ages of eighteen (18) and twenty-one (21).
Height, Weight, and Body Mass Index Screening	Screening for children between the following ages: zero (0) to eleven (11) months, one (1) to four (4) years, five (5) to (10) years, eleven (11) to fourteen (14) years, fifteen to seventeen (17) years.
Sickle Cell Disease	Screening for newborns.
Hepatitis B Infection	Screening for hepatitis B virus (HBV) infection in newborns through young adults twenty-one (21) years of age who are at increased risk for infection.
Congenital hypothyroidism	Screening for newborns.
Lead screening	For children at risk of lead exposure.
Maternal depression	Screening for mothers of infants at visits of one (1), two (2), four (4) and six (6) months.
Medical history	For all children during development: ages, from zero (0) to twenty-one (21) years old.
Obesity Screening: Minors and Adolescents	Obesity screening for children under six (6) years of age and older and comprehensive counseling, intense behavioral interventions to promote improvement in the child's weight.
Oral Health	Risk assessment for newborn minors up to ten (10) years of age.
Cavity Prevention, Evaluation and Intervention: Under (5) Years of Age	Oral fluoride supplementation to children six (6) months of age and older whose water supply is deficient in fluoride. Application of fluoride varnish to the primary teeth of all infants and minors from the age of eruption of the first teeth.
Phenylketonuria (PKU)	Newborn screening for genetic disorders.
Prevention of Dental Caries in Children Under Five (5) Years of Age: Screening and Interventions	Oral fluoride supplementation starting at six (6) months of age for children whose water supply is deficient in fluoride. If the primary water source is deficient in fluoride, oral fluoride supplementation as recommended by the AAP.
Skin cancer	Counseling for young adults, teens, minors, and parents of minors on how to minimize exposure to ultraviolet (UV) radiation for fair-skinned individuals from six (6) months to twenty-four (24) years of age to reduce their risk of skin cancer.

Sudden cardiac arrest and sudden cardiac death	Risk assessment of sudden heart attack and sudden cardiac death between eleven (11) and twenty-one (21) years of age (to be taken into account the range in which risk assessment may take place) according to AAP policies. (Sudden Death in the Youth: Information for the Primary Care Provider).
Tobacco use: minors and adolescents	Interventions by the doctor, including education or counseling, to prevent the initiation of tobacco use in school-age minors and adolescents.
Tobacco, alcohol, and drug use	Evaluation to identify the use of tobacco, alcohol, and drugs in minors between eleven (11) and twenty-one (21) years of age.
Tuberculin	Tuberculin test for minors at risk of tuberculosis from zero (0) to twenty-one (21) years of age.
Vision screening: children	Eye exam at least once in minors between the ages of three (3) to five (5) years to detect amblyopia or its risk factors.

Preventive services for adults

The physician will determine preventive medicine services for the adult, in accordance with the insured's age and gender, including as a minimum the following services:

Preventive service	Indication
Abdominal Aortic Aneurysm (AAA) Screening	One (1) ultra-sonogram for the screening of AAA in men ages sixty-five (65) to seventy-five (75) who have smoked at some point.
Evaluation for anxiety disorder	Evaluation for anxiety disorder of adults sixty-four (64) years of age or younger, including pregnant and postpartum individuals.
Prediabetes and Type 2 Diabetes Mellitus screening in asymptomatic adults	Screening and examination for abnormal blood glucose, as part of screening for prediabetes and type II diabetes in asymptomatic adults aged thirty-five (35) to seventy (70) years who are overweight or obese. Clinicians should offer or refer patients with prediabetes to effective preventive interventions.
Colorectal Cancer Screening	Evaluation of colorectal cancer in adults, by fecal occult blood tests, sigmoidoscopy or colonoscopy, beginning at the age of forty-five (45) to seventy-five (75) years of age, in accordance with Law No. 218 of August 30, 2012. The risks and benefits of these screening methods vary. A follow-up colonoscopy after a positive result from a noninvasive screening test. This is a screening test, so policyholders won't have to pay anything out of pocket.
Depression and Suicide Risk Assessment for Adults	Depression screening for adult population, including pregnant or postpartum individuals, and adults sixty-five (65) years of age and older.
Preventing Falls in Older Adults	Vitamin D supplements to prevent falls in adults sixty-five (65) years of age and older who live in the community and are at increased risk for falls.
Advice on healthy diets and exercise to prevent cardiovascular disease	Counseling and recommendation for overweight or obese adults with high risk factors to develop cardiovascular conditions to promote a healthy diet and physical activity for the purpose of preventing such conditions.

Hepatitis B virus (HBV) infection	Screening for adults at high risk for HBV.
Hepatitis C virus (HCV) screening test)	Screening for hepatitis C virus (HCV) infection in adolescents and adults between the ages of eighteen (18) years to seventy-nine (79) years.
Evaluation of hypertension in adults aged 18 years and older without known hypertension	Hypertension Screening for insured persons eighteen (18) years of age and older. Measurements should be obtained outside the clinical setting to confirm the diagnosis before starting treatment.
HIV Prevention – (*Preexposure prophylaxis* o PrEP)	Requires MCS Life Clinical Affairs preauthorization. Doctors may offer pre-exposure prophylaxis (PrEP) with antiretroviral therapy for people at high risk of contracting HIV, referred by their doctor to use these medications and reduce the risk of HIV infection. Visit the link below for clinical considerations; https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis#bootstrap-panel--7 . For members at high risk for HIV referred by their doctor to use these medications, zero ($0) copay or zero (0%) percent coinsurance will apply. The insured must have their annual physical exam, as well as HIV tests that show a negative result. Once completed, the insured is provided with a ninety (90) day dispatch, before the end of these ninety (90) days the insured must repeat the HIV tests that continue to show a negative result, to continue the treatment. In the event that the insured interrupts the treatment, he or she will have up to two (2) attempts per policy year.
Cholesterol Screening	Evaluation for men and women for lipid disorders if they are at increased risk of coronary heart disease in accordance with Law No. 218 of August 30, 2012.
Human immunodeficiency virus (HIV) screening: Adolescents and non-pregnant adults	Evaluation of human immunodeficiency virus (HIV) in adolescents and adults between fifteen (15) and sixty-five (65) years of age. Younger teens and older adults who are at higher risk should also be evaluated. Human immunodeficiency virus (HIV) testing as part of routine testing of any medical evaluation performed at least once every five (5) years, based on clinical judgment for adolescents and adults between thirteen (13) and sixty-five (65) years of age at low risk and annually for all persons at high risk. For pregnant women, the applicable requirements are described in the "Preventive Services for Women, including pregnant women" section, further in this certificate.
Lung Cancer Evaluation	Annual screening for lung cancer with low-dose CT scans in adults aged from fifty (50) to eighty (80) years who have a history of smoking twenty (20) packs per year and currently smoke or have quit smoking for the last fifteen (15) years. The screening should be discontinued once a person has not smoked for fifteen (15) years or develops a health problem that severely limits life expectancy or the ability or willingness to undergo a healing lung surgery.
Detection of latent TB infection	LTBI screening in higher-risk populations. See the "Assessment of Risk" section at the following link, https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/latent-

	tuberculosis-infection-screening for additional information about adults at higher risk.
Obesity Assessment and Counseling: Adults	Counseling and screening for all adults. Doctors can offer and refer to intensive behavioral interventions with multiple components for those who have a Body Mass Index (BMI) of thirty kilograms per square meters (30 kg/m2) or higher.
Sexually Transmitted Infections Counseling	High-intensity behavioral counseling to prevent sexually transmitted diseases for all sexually active adolescents and for adults who are at increased risk of contracting related diseases.
Skin Cancer	Counseling to young adults, adolescents, children, and parents of small children on the benefits of reducing their exposure to ultraviolet radiation (UV), for people with fair skin from six (6) months of age to twenty-four (24) years to reduce the skin cancer risk.
Use of Statin to Prevent Cardiovascular Disease in Adults: Preventive Medication	Use of statin for prevention of CVD for adults aged 40 to 75 years who have one (1) or more CVD risk factors (i.e. dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk of a cardiovascular event of 10% or greater.
Syphilis infection in non-pregnant adolescents and Adults	Screening for syphilis infection in asymptomatic persons, nonpregnant adolescents and adults who are at increased risk for infection.
Tobacco Use and Medication: nonpregnant adults	Screening for all adults and interventions for stopping tobacco use. For those who use products to quit tobacco use, this plan covers *U.S. Food and Drug Administration* (FDA)-approved drugs used to stop smoking for an attempt of ninety (90) consecutive days and up to two (2) attempts per year.
Tuberculosis screening: adults	Tuberculin test for adults at risk of latent tuberculosis infection (LTBI).
Unhealthy alcohol consumption: adults	Screening for unhealthy alcohol consumption is recommended in primary care scenarios in adults eighteen (18) years of age or older, including pregnant women, as well as providing brief behavioral counseling interventions to people involved in risky or dangerous alcohol consumption behavior in order to reduce unhealthy alcohol consumption.
Harmful drug use	A question-based evaluation on the unhealthy use of drugs is recommended in adults eighteen (18) years of age or older. Implementation of the evaluation should be performed when services can be offered or derived for an accurate diagnosis, effective treatment, and proper care. (Evaluation refers to questions on the unhealthy use of drugs, not biologic sample testing.)

Preventive services for women, including pregnant women

Preventive Service	Indication
Asymptomatic Bacteriuria Screening Test: Pregnant People	Evaluation for the detection of asymptomatic bacteriuria by urine culture in pregnant persons.
BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing	Screening and counseling to women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing.
Use of Preventive Medications to Reduce Breast Cancer Risk	Clinical orientation for patients with a high risk of developing breast cancer, allowing the patient to decide with her physician if drug therapy is appropriate for reducing the risk of developing the disease. The physician may prescribe drugs to reduce the risk of developing breast cancer, such as tamoxifen, raloxifen, or aromatase inhibitors, for women thirty-five (35) years of age or older, who are at increased risk for this disease and at low risk for adverse drug effects.
Mammogram Screening for Breast Cancer	Screening every one (1) or two (2) years for women over forty (40), with or without clinical breast exam. Screening every two (2) years for women ages fifty (50) to seventy-four (74).
Breastfeeding	Comprehensive lactation support services (including consultation, counseling, physician education and peer support services, and breastfeeding equipment and supplies) during the prenatal, perinatal, and postpartum periods to optimize successful initiation and maintenance of breastfeeding. Breastfeeding equipment and supplies include, but are not limited to, doble electric breast pumps as a primary option to manual breast pumps (including pump parts and maintenance) and breast milk storage supplies. Breastfeeding equipment may also include equipment and supplies as clinically indicated to support mothers with breastfeeding difficulties and those who need additional services. Breastfeeding equipment is covered by a doctor's order after the third trimester of pregnancy and for the duration of breastfeeding. Additional supplies for the breastfeeding machine are covered, and the equipment is available through contracted providers.
Cervical Cancer Screening	Cervical cancer screening every three (3) years with cervical cytology (Pap test) only in women between twenty-one (21) and twenty-nine (29) years old. For women between thirty (30) and sixty-five (65) years old, is recommended screening with cervical cytology every three (3) years, every five (5) years with high-risk human papillomavirus (hrHPV), or every five (5) years cotesting with hrHPV and cytology test.
Chlamydia Infection Screening in all sexually active women, including pregnant persons	Chlamydia infection screening in all sexually active women twenty-four (24) years of age and younger, and in women twenty-five years or older who are at increased risk for infection.

Contraceptive Methods	All FDA-approved, assigned, or authorized contraceptive methods, sterilization procedures, screening, patient education, counseling, and provision of contraceptives (including in the immediate postpartum period) for all women of reproductive capacity as required are covered with no cost-sharing. Contraceptive care also includes care and follow-up. The following methods will be covered through your medical coverage as an outpatient service, including insertion and removal for applicable devices: • Sterilization surgery for men and women • Surgical sterilization of implants for women • Implantable rod • Copper intrauterine device • Intrauterine device with progesterone • Injection • Diaphragm with spermicide • Sponge with spermicide • Cervical cap with spermicide • Spermicide The following methods will be covered by the drug coverage. Please refer to the Drug Formulary applicable to this certificate: • Oral contraceptives (combined pill) • Oral contraceptives (progestin only) • Oral contraceptives extended/continuous use • Patches • Vaginal contraceptive ring • Emergency contraception (ulipristal acetate) • Female condom • Male condom • Spermicide The list of contraceptives includes those currently listed in the FDA's birth control guide and any additional contraceptives approved, granted, or approved by the FDA. Any insertion and removal of contraceptive devices is covered. The CSPR nor applicable federal law established any difference in contraceptive levels. If the formulary includes contraception, no cost-sharing may apply, regardless of the specific tier.
Counseling for Healthy Weight and Weight Gain in Pregnancy: Pregnant People	Effective behavioral interventions are offered to pregnant persons to promote healthy weight gain and prevent gestational overweight in pregnancy.
Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening Women of Reproductive Age	Screening women of childbearing potential for intimate partner violence (IPV), such as domestic violence, and providing or referring women who test positive for intervention services.

Folic Acid Supplements to Prevent Neural Tube Defects: Preventive Medications	Recommendation of the use of daily folic acid supplements containing four tenths to eight tenths (0.4 to 0.8 mg) or four hundred to eight hundred milligrams (400 to 800µg) for women who are planning or can become pregnant. Physician's order is required.
Diabetes in pregnancy	Screening pregnant women for gestational diabetes mellitus (GDM) after 24 weeks of gestation (preferably between 24 and 28 weeks of gestation) to prevent adverse birth outcomes. Screening pregnant women with risk factors for type 2 diabetes or GDM before 24 weeks of gestation—ideally at the first prenatal visit.
Screening for gonorrhea infection	Screening for gonorrhea in all sexually active women twenty-four (24) years of age or younger, and in women twenty-five (25) years of age or older who are at increased risk of infection.
Hepatitis B Virus	Screening for pregnant women, at their first prenatal visit.
Human immunodeficiency virus (HIV) screening: pregnant people	All pregnant people will be tested as follows: • First HIV test during the first trimester of pregnancy or at the first prenatal visit • Second test during the third trimester of gestation, between twenty-eight (28) and thirty-four (34) weeks of pregnancy • During delivery if the pregnant woman has never been tested and her HIV status is unknown As set forth in the Department of Health of Puerto Rico Administrative Order No. 307 of August 14, 2013.
Screening for Human Immunodeficiency Virus Infection (HIV)	All adolescent and adult women, ages 15 and older, receive a screening test for HIV at least once during their lifetime. Earlier or additional screening should be based on risk and rescreening annually or more often may be appropriate beginning at age 13 for adolescent and adult women with an increased risk of HIV infection. Risk assessment and prevention education for HIV infection beginning at age 13 and continuing as determined by risk. A screening test for HIV is recommended for all pregnant women upon initiation of prenatal care with rescreening during pregnancy based on risk factors. Rapid HIV testing is recommended for pregnant women who present in active labor with an undocumented HIV status. Screening during pregnancy enables prevention of vertical transmission.
Prevention of obesity in middle-aged women	Guidance to middle-aged women between forty (40) and sixty (60) years of age with a normal or overweight body mass index (BMI) (18.5-29.9 kg/m2) to maintain weight or limit weight gain to prevent obesity. Counseling may include an individualized discussion about healthy eating and physical activity.
Osteoporosis (postmenopausal women under sixty-five (65) years of age)	Osteoporosis testing with bone measurement testing is recommended to prevent osteoporotic fractures in postmenopausal women under sixty-five (65) years of age who are at increased risk for osteoporosis, as determined by a formal clinical risk assessment tool.

Osteoporosis (women over sixty-five (65) years of age)	Evaluation of osteoporosis with bone measurement tests to prevent osteoporotic fractures in women over sixty-five (65) years of age.
Perinatal Depression Intervention and Counseling	Provide or refer to counseling interventions for pregnant or postpartum women who are at increased risk for perinatal depression.
Prevention of preeclampsia: aspirin for pregnant people at high risk of preeclampsia	Supplemented with a low dose of aspirin (81 mg/d) as a preventive medication after twelve (12) weeks of gestation in people at high risk of preeclampsia.
Hypertensive disorders of pregnancy: asymptomatic pregnant people	Evaluation of hypertensive disorders in pregnant people with blood pressure measurements throughout pregnancy.
Blood group classification – Rh factor (D)	Rh (D) blood type and antibody screening for all pregnant women during the first antenatal visit. Repeat testing for Rh(D) is also recommended for nonsensitized pregnant women who test negative for Rh(D) factor between twenty-four (24) to twenty-eight (28) weeks of pregnancy, unless the biological father is known to be Rh(D)-negative.
Anxiety Evaluation	Screening for anxiety in adolescent and adult women, including pregnant or postpartum women. Optimal assessment intervals are unknown and clinical judgement should be used to determine the frequency of assessment. Given the high prevalence of anxiety disorders, lack of recognition in clinical practice, and multiple problems associated with untreated anxiety, clinicians should consider screening women who have not been screened recently.
Diabetes after pregnancy	Evaluation of type 2 diabetes in women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and who have not been previously diagnosed with type 2 diabetes. Ideally, initial testing should occur within the first year postpartum and can be performed as early as four (4) to six (6) weeks postpartum. Women who were not screened during the first postpartum year or those with a negative baseline should be screened at least every three (3) years for a minimum of ten (10) years after pregnancy. For those with a positive screening test result in the early postpartum period, the test should be repeated at least six (6) months postpartum to confirm the diagnosis of diabetes regardless of the type of initial test (i.e., fasting plasma glucose, hemoglobin *A1C*, oral test, and glucose tolerance test). Repeat testing is also recommended for women screened for hemoglobin *A1C* during the first 6 months postpartum, regardless of whether the test results are positive or negative because the hemoglobin *A1C* test is less accurate during the first 6 months postpartum.
Syphilis Screening: Pregnant Women	Early evaluation of syphilis infection in all pregnant women.
Evaluation of urinary incontinence in women	Screening annually for urinary incontinence. Factors associated with an increased risk of urinary incontinence include increased parity, advanced age, and obesity; however, these factors should not be used to limit detection.

Tobacco use: Pregnant person	Clinical inquiry of pregnant persons about tobacco use, advice on smoking cessation, and provision of behavioral interventions to stop tobacco use in pregnant people.
Well Women Visits also known as *Well Women Visits*	Annual preventive care (depending on the woman's health status, health needs, and other risk factors) for adult women in order to obtain recommended and appropriate preventive services for their age and development, including preconception care and services needed for prenatal care. These visits include the women's preventive services listed in this certificate/certificate. If the physician determines that the patient requires additional visits, they will be covered with zero ($0) copay or zero (0%) coinsurance as appropriate.
HIV Prevention – (*Preexposure prophylaxis* o PrEP)	Requires MCS Life Clinical Affairs preauthorization. Doctors may offer pre-exposure prophylaxis (PrEP) with antiretroviral therapy for women at high risk of contracting HIV, referred by their doctor to use these medications and reduce the risk of HIV infection. Visit the link below for clinical considerations; https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis#bootstrap-panel--7. Zero ($0) copay or zero (0%) percent coinsurance will apply. The insured must have their annual physical exam, as well as HIV tests that show a negative result. Once completed, the insured is provided with a ninety (90) day dispatch, before the end of these ninety (90) days the insured must repeat the HIV tests that continue to show a negative result, to continue the treatment. In the event that the insured interrupts the treatment, he or she will have up to two (2) attempts per policy year.

Immunizations

Immunizations, counseling, and vaccines administration recommended by the U.S. Preventive Services Task Force (USPSTF) and by the vaccination itinerary of the Puerto Rico Department of Health, are covered for children, adolescents under twenty-one (21) years of age and adults as specified in the Puerto Rico Department of Health vaccination itineraries and the Center for Disease Control (CDC). Including booster shots. Immunizations are covered at zero ($0) copayment or zero (0%) coinsurance. The insured person will pay the amount that corresponds to the visit to the physician or ambulatory 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 for children in accordance with the Puerto Rico department of health schedule	
Hepatitis B (Hep B)	As indicated in the Puerto Rico Department of Health Schedule for this certificate's current year. The insured can request the current itinerary by phone at the MCS Life Customer Service Call Center at (787) 281-2800.
Diphtheria, Tetanus and Pertussis (Whooping Cough) (DTaP)	
Tetanus and Diphtheria Toxoids (Tdap)	
Rotavirus (RV)	
Inactivated Polio Virus (IPV)	

Haemophilus Influenza, Type B (Hib)	
Pneumococcal (PCV) and (PPV)	
Measles, Mumps and Rubella (MMR)	
Varicella (Var)	
Hepatitis A (Hep A)	
Meningococcal (MCV)**	
Influenza	
Human papillomavirus (HPV)* - vaccine to prevent cervical cancer	
Center for disease control (CDC) vaccination schedule for children, adolescents and adults	
Tetanus, Diphtheria and Pertussis (Td/Tdap)	As indicated in the Puerto Rico Department of Health Schedule for this certificate's current year. The insured can request the current itinerary by phone at the MCS Life Customer Service Call Center at (787) 281-2800.
Human papillomavirus (HPV)* – vaccine to prevent cervical cancer	
Chickenpox	
Zoster	
Measles, mumps, and rubella (MMR)	
Influenza	
Pneumococcal	
Hepatitis A	
Hepatitis B	
Meningococcal**	
COVID 19***	
Dengue****	
Monkeypox*****	
Respiratory syncytial virus (RSV) (known as the Synagis® vaccine) ******	

* Immunization against the HPV virus will be covered for males and females nine (9) years of age and older and adolescents with a history of sexual abuse or rape, who have not started or completed the series of three (3) doses, according to Law No. 255 of September 15, 2012.

** Immunization for meningitis (MCV4) or the meningococcal vaccine will be covered as required by the OCS's ruling letter (Ruling Letter CN-2011-131-AV).

*** COVID-19 immunization will be covered for infants and children 6 months to 12 years of age and adolescents 13 to 18 years of age, adolescents over nineteen (19) years of age, and adults, according to the order established by the Puerto Rico Department of Health and the recommendations of the Advisory Committee on Immunization Practices (ACIP), of the Centers for Disease Control and Prevention (CDC). and pursuant to Section 2.050(C) of the CSSPR.

**** Dengue vaccine will be covered for children ages 9 to 16, who live in dengue-endemic areas and have laboratory confirmation of prior infection. After six months of confirmation of dengue infection, a series of 3 doses will be administered with six-month waiting intervals between each dose as recommended by the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC).

***** Monkeypox vaccination is recommended for anyone at risk of infection.

****** Vaccination is recommended for people during pregnancy and adults over 60 years of age, according to CDC recommendations.

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 certificate.
Rhogam Vaccine	Please refer to Section 6, Major Medical Expense Benefits.

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).
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.
Acquired Immunodeficiency Syndrome (AIDS/HIV)	Covered as any other condition, in accordance with Law No. 349 of September 2, 2000, as amended.
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 certificate. 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.
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. Also covered are pelvic exams and all types of Pap smears that may be required by physician specification to detect, diagnose and treat early stage abnormalities that may lead to cervical cancer.
Effective Screening for Breast Cancer	In accordance with Law No. 10 of January 3, 2020, mammograms, and other breast cancer diagnostic and screening tests will be covered, as per acceptable practices. Included also are the criteria for evaluation exams for breast cancer for women who meet the following requirements: • Baseline mammogram for women between thirty-five (35) and thirty-nine (39) years of age; • Annual mammogram for women forty (40) years of age or older • Annual mammogram, follow-up treatment or complementary diagnostic tests for women forty (40) years or older with breast classification of heterogeneously dense or extremely dense, as determined by a mammogram performed by a radiologist, based on the breast density scale of the Breast Imaging Reporting and Data System or BI-RADS, declared by the American College of Radiology; • Annual mammogram, follow-up treatment or complementary diagnostic tests for women at high risk of developing breast cancer

	due to family history, to her own history as cancer patient, to the presence of high risk markers in her genetic profile or any other factor determined by her physician.
Braille System	Pursuant to the CSSPR, as amended by Law No. 162 of December 30, 2020, MCS Life will provide the blind insured with an Evidence of Coverage under this certificate, in Braille, when requested through the subscription form.
Cancer treatment, drugs and diagnostic tests	Covered pursuant to Special Law to Ensure Access to Treatment and Diagnosis of Cancer Patients in Puerto Rico, also known as the Gabriela Nicole Correa Act, Law No. 79 of August 1, 2020 (Law 79-2020). • Every patient will have the right to receive treatment, drugs, and diagnostic tests recommended by their physician, according to the guidelines of the National Comprehensive Cancer Network (NCCN) and/or approved by the *U.S. Food and Drugs Administration* (FDA), as well as those necessary to treat and minimize adverse effects, subject to the provisions of the Law. Also included are guidelines from the Local Coverage Determination-LCD from First Coast Service Options Inc., the Medicare Approved Compendia List, the National Coverage Determination Alphabetical Index, the Milliman Care Guidelines and the ASES Internal Guidelines. • Every insured shall have the right to receive an approval or denial of medications, treatments and diagnostic tests listed in the National Comprehensive Cancer Network (NCCN) guidelines or those approved by the U.S. Food & Drug Administration (FDA), within twenty-four (24) to seventy-two (72) hours of receipt of the request, or within twenty-four (24) hours if it is an urgent or expedited case. If the medical plan, whether it is an individual or group plan, does not issue its determination within said term, it shall be understood that the medications, treatments and/or diagnostic tests were approved by the plan. • Each insured with a cancer diagnosis shall have the right to a specialized oncology physician as a primary care provider; provided the health professional consents to such designation. • The rights under Act 79-2020 are stated in addition to benefits stated under the Cancer Patients and Survivors Act (Act No. 275 of September 27, 2012. • All insureds shall have the right to receive the treatment recommended by their physician, with no limitations to receive the most effective and state-of-the-art treatment available in the market, in accordance with the coverage of this certificate/this certificate. MCS Life shall not discriminate in the final interpretation, nor contain rules of interpretation or review contrary to the provisions of Law 79-2020, in relation to the delivery, processing, payment or reimbursement of the cost of health care services, treatments, medications or diagnostic tests included as mandatory and uniform, according to the law.

Cybertherapy	Pursuant to Law No. 48 of April 29, 2020, the Law to Regulate Cybertherapy in Puerto Rico, MCS Life will cover as if it were an in-person service, services provided by any licensed health professional authorized to practice physical therapy, occupational therapy, speech-language therapy, psychology, counseling, social work, rehabilitation counseling and educational therapy in Puerto Rico. The health professional must have in force and compliance they Certification issue by the Puerto Rico Department of Health, and said certification must be in effect.

Law No. 134 of August 12, 2020	Pursuant to Law No. 134 of August 12, 2020, the insured person:
	
	• Will have access to the MCS Life web portal, where:
	  ○ The provider listing is available, and updated within twenty (20) days of inclusion or exclusion of a provider to the network, or of receiving notification of a change in a physician's affiliation with a facility.
	  ○ Examples of expected costs for frequently billed out-of-network services will be available for reference.
	• For information on the status of your policy networks and costs, you may contact MCS Life Customer Service Department at 787-281-2800 (Metro Area) or 1-888-758-1616 (Toll Free) seven (7) days a week from 7:30 am to 11:30 pm.
	
	You will receive a notice from MCS Life when the status of a provider changes from an in-network provider to an out-of-network provider, after receiving authorization to provide services. You will receive this notice at least thirty (30) days prior to the authorized service being performed. Otherwise, the insured person's financial responsibility will be limited to the amount they would have incurred under an in-network provider.

Air Ambulance Services in Puerto Rico	Covered according to the medical necessity established at the time of the service, through contracted providers. Corresponding coinsurance applies.

10. Services in the United States

Emergency Services in the United States	Copayment, coinsurance and/or deductible applies for emergency services in the United States. Emergency services in the United States will be covered as any other emergency through **United HealthCare**. The insured must show his or her plan card for the facility to verify eligibility with MCS Life. In case the provider is not part of the **United HealthCare**, the insured is required to notify MCS Life in or before forty-eight (48) hours after having received the emergency services to negotiate payment of such services with the facility.

Treatments and Services not Available in Puerto Rico (in the United States)	Treatments and services not available in Puerto Rico will be coordinated through **United HealthCare** and require pre-authorization from MCS Life. Copayment, coinsurance and/or deductible for the coordinated service in the United States applies. Out-of-network services are covered through reimbursement according to MCS rates in Puerto Rico minus deductibles, copayments and coinsurances.
Ground ambulance services in the United States	Ground ambulance service will be covered by reimbursement to the insured person. The maximum amount to be reimbursed will be seventy-five dollars ($75) per trip. For ground ambulance services for an emergency, the total cost of the service will be paid directly to the provider. The service will only be covered if the insured meets the following requirements: • The insured was transported by an ambulance service as described in Part I of Definitions under "Ambulance"; • The insured suffered an illness or injury for which other types of transportation are not recommended; • The insured was transported; o from the residence or place of emergency to the hospital or skilled nursing facility (SNF) or o between hospital and hospital or skilled nursing facility when the institution who transfers or authorizes the discharge is not appropriate for covered services or o from the hospital to the residence for patients whose health condition does not allow the use of other means of transportation; • The request for reimbursement for the service includes the medical certificate of the transport, the place of patient pick-up and the destination; • It is not a case covered by the Automobile Accident Compensation Administration (ACAA), the State Insurance Fund Corporation (CFSE) or any other third party liability or the equivalent of these agencies in the United States.
Services for Students in the United States	The following outpatient services will be covered through the contracted network for students in the United States: • Generalist visits. Corresponding coinsurance applies. • Specialist visits. Corresponding coinsurance applies. • Subspecialist visits. Corresponding coinsurance applies. • Laboratory and X-ray services. Corresponding coinsurance applies. • Specialty diagnostic procedures. Corresponding coinsurance applies. • Ambulatory surgical services and facility. Corresponding coinsurance applies.

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

A. Services eligible for reimbursement in this certificate:

Social worker	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	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*).
Non-participating Providers in Puerto Rico	MCS Life will reimburse the insured the amount which would have been paid if the treatment, service or supply would have been offered by an MCS Life participating provider, minus any applicable copayment or coinsurance, except in cases of emergency. Services by non-participating dentists will not be reimbursed.
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 certificate. 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

Organ and bone marrow transplant services will be covered at the negotiated rates with the Puerto Rico and U.S. provider network up to two million dollars ($2,000,000) per lifetime of the insured.

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.

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.

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.

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 certificate 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 certificate.

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 certificate. 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: Major Medical Expense Benefits

The following major medical expense benefits require pre-authorization from the MCS Life Clinical Affairs Department.

Major Medical Benefit Cost Sharing

A. Deductible. The applicable deductible for covered Major Medical Expenses will be 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, each insured person is responsible for paying twenty percent (20%) coinsurance for covered medical services.
b. After paying the deductible applicable to Major Medical Expenses, each insured family is responsible for paying twenty percent (20%) coinsurance for covered medical services.
c. In the event that an insured person or family has incurred any expense for benefits covered by reimbursement, as described later in this benefit, they will be responsible for the difference between the expense incurred and the rates established by MCS Life. MCS Life will only reimburse the percentage applicable to the service, based on the rates established by MCS Life for said benefits.

Hospice	Covered only for terminally ill patients with a life expectancy of six (6) months or less. Twenty percent (20%) coinsurance applies. Requires pre-authorization from MCS Life Clinical Affairs.
Allergy Vaccine	Covered. The insured will pay the amount of twenty percent (20%) coinsurance that corresponds to the vaccine and the doctor's visit for an outpatient service. Requires pre-authorization from MCS Life Clinical Affairs.
Durable Medical Equipment (DME)	Covered. Applies twenty percent (20%) coinsurance. Coverage applies to durable medical equipment not covered in the Durable Medical Equipment benefit described in section 6, Rehabilitation, Habilitation and Durable Medical Equipment Services of this certificate, includes orthotic devices, devices, internal or external prosthesis, respiratory equipment, including respiratory therapy machine. CPAP and BPAP will be covered once every five (5) years. Prosthetic devices (internal and external) to replace parts or a physical organ, or to maintain its function, will be limited to one (1) prosthesis per limb per life of each insured. Coinsurance applies for durable medical equipment. Requires pre-authorization from MCS Life Clinical Affairs.
Hyperbaric chamber	Twenty percent (20%) coinsurance applies. Requires pre-authorization from MCS Life Clinical Affairs.
Gynecomastia	Covered. Twenty percent (20%) coinsurance applies. Requires pre-authorization from MCS Life Clinical Affairs.
Surgical assistance in hospital	Covered. Twenty percent (20%) coinsurance applies. Requires pre-authorization from MCS Life Clinical Affairs.

Respiratory Therapies	Covered. Twenty percent (20%) coinsurance applies. Unlimited respiratory therapies, after exhausting the maximum respiratory therapies established in the Ambulatory Respiratory Therapy benefit of this certificate. Requires pre-authorization from MCS Life Clinical Affairs.

Applicable Major Medical Expense benefit limits

Services covered under this certificate are subject to the limits set forth in the Basic Coverage of the policy, unless this certificate states otherwise. Likewise, included services will only be covered when incurred as a result of an illness or injury, medically necessary and performed or ordered by a doctor, as established in this certificate. Other exclusions are detailed in the Major Medical Expense Exclusions section.

Major Medical Expense Benefits covered by reimbursement. For services covered by reimbursement, MCS Life will reimburse eighty percent 80% of charges, based on MCS Life's contracted rates, less applicable coinsurance. In the case of non-contracted services, reimbursement will be paid based on the usual and customary charges of where the service is provided and eighty percent 80% of the charges will be reimbursed, less the applicable coinsurance.

Procedure for submitting a refund. Refer to Part III, Section 2 of this certificate which describes the process and requirements for submitting a refund which will be applicable to the benefits described in this section.

Epidural anesthesia during childbirth	You will be reimbursed at eighty percent (80%) based on the rates contracted by MCS Life in Puerto Rico, less the applicable coinsurance, up to a maximum of two hundred eighty-eight dollars $288.
Air ambulance in the United States	Covered. One (1) trip per policy year per insured person. It will be reimbursed at eighty percent 80% based on the rates contracted by MCS Life in Puerto Rico, less the applicable coinsurance.
Rhogam Vaccine	Covered. It will be reimbursed at eighty percent (80%) based on the rates contracted by MCS Life. Copayment applies per visit to the doctor according to specialty.

Section 7: Programs Included as Part of Your Benefits

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

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. 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. To access the services of MCS Medilínea MD, please enter the following link: http//mcs.com.pr/es/Paginas/bienestar/programas-bienestar/MCS-Medilínea-MD.aspx 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 for children under thirty-six (36) months will be required to complete a separate medical history release form prior to making an appointment or having a consultation with a physician from the contracted telemedicine provider. Children under thirty-six (36) months who present with fever should be referred to their pediatrician or emergency room. In acute cases and when the doctor understands that the use of medications is warranted according to the patient's clinical condition, the prescription will be coordinated directly to the insured's preferred pharmacy. If the doctor determines that the condition for which the patient is seeking consultation cannot be treated through this platform, the insured will be referred to an emergency room or their primary doctor. The patient is responsible for verifying their benefit description documents and/or medication formulary to determine if MCS Life will cover certain prescriptions.
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

Section 1: Coverage exclusions

The following services are not covered under this certificate:

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 certificate.
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 certificate, telephone, television, custodial care, rest home, convalescent home (except for skilled nursing facilities that are covered under this certificate) 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 certificate 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. Notwithstanding the provisions of points 9 and 10, 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 certificate), surgical interventions that are not after a bariatric surgery, in accordance with Law No. 212 of August 9, 2008.
13. Also excluded are hospital, medical-surgical services and complications associated with cosmetic or beautifying operations, treatments or care to correct defects in physical appearance, unless it is a reconstructive intervention to restore tissues damaged by disease or accidental bodily injury or surgery to correct congenital, oral anomaly of a newborn, regardless of whether or not there is medical justification for the procedure, except as provided in Act No. 212 of August 9, 2008; Act for the Treatment of Morbid Obesity and Metabolic Syndrome with Bariatric Surgery and the Women's Health and Cancer Rights Act of August 9, 2008.
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 certificate.
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 certificate.
29. Fetal monitoring in medical offices (belts).
30. Oral surgeries additional to those described in this certificate, 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 certificate.
36. Durable Medical Equipment not described in this certificate, including custom made medical equipment, including also the Optune service and equipment.
37. Services not pre-authorized and that require pre-authorization from MCS Life Clinical Affairs, as described in the benefits of this certificate.
38. Services in the United States, except for emergencies or those services that are not available in Puerto Rico. Services not available in Puerto Rico require pre-authorization from MCS Life Clinical Affairs Department.
39. Expenses for contraceptive methods for men other than vasectomy, as established in this certificate.
40. Complementary medicine services not offered by providers contracted by the MCS Alivia program.
41. Expenses following the first thirty (30) days for newborns of dependent daughters of the main insured after delivery.
42. 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.
43. Water ambulance.
44. Expenses for technology, procedures or new diagnostic tests in the market during the effective calendar year of this certificate. 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.
45. 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.
46. Growth hormones.
47. Total maxillary or mandibular reconstructions, including removal of exostosis (mandibular or maxillary).
48. 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.
49. Elective hospitalization for students in the United States or any other service in the United States not described in this certificate.
50. Coverage to residents in the United States.
51. 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.
52. 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.
53. Coverage excluded for optional or collateral dependents.

54. Surgical assistance in the hospital. Please refer to Major Medical Expenses section.
55. Nerve conduction velocity test services.
56. Neurologic tests and procedure services, except for insured persons with autism conditions in accordance with Law No. 220 of 2012 approved on September 4, 2012, better known as the BIDA law (Welfare, Integration and Development of Persons with Autism), and for insured persons with Down Syndrome in accordance with Law No. 97 of May 15, 2018.
57. Scalenotomy services.
58. Outpatient audiology tests that are not preventive services required by the USPSTF or the Office of the Commissioner of Puerto Rico.
59. Hyperbaric chamber, except for autism patients, pursuant to Act No. 63 of July 19, 2019
60. 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.
61. Glucometer, lancets and strips and insulin pump for persons not diagnosed with type I Diabetes Mellitus.
62. Electromyogram services.
63. Rhogam vaccine administration services. Please refer to Major Medical Expenses section.
64. Consultations to specialists or subspecialists through Telemedicine services, except for pediatricians, family medicine and internists.
65. No prescriptions for refills of existent drugs will be issued through the Telemedicine service.
66. No prescriptions will be issued for a supply longer than thirty (30) days through the Telemedicine service.
67. No prescriptions for maintenance drugs and/or refills will be issued through the Telemedicine service.
68. Telemedicine consultations for out-of-network or contracted platform through the Telemedicine service.
69. Internal and external prosthetic services. Please refer to Major Medical Expenses section.
70. Services or administration of allergy vaccines. Please refer to Major Medical Expenses section.
71. Services or complications of Gynecomastia. Please refer to Major Medical Expenses section.
72. CPAP, which is forced air equipment that is supplied to the airways by means of continuous positive pressure. Please refer to Major Medical Expenses section.
73. Expenses for sports medicine services, natural medicine that is not described in this certificate, music therapy, psychoanalysis and cardiac rehabilitation.
74. Gene Therapy: Any new technology, treatment, drug or device that alters the body's genes, genetic correction or expression of and drugs categorized as Cell and Gene Therapy.
75. Medicinal Cannabis.

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.

Section 5: Major Medical Expense Exclusions

MCS Life will not cover or reimburse Major Medical Expense services if:

1. They are excluded under the Exclusions and Limitations of this certificate, unless the Major Medical Expenses coverage includes such benefit.
2. Result from illness or bodily injury arising from, or in the course of, employment of the insured person.
3. Expenses caused by war or international armed conflict.

4. Services while confined in an institution that is a school or other training institution, place of rest, nursing home or private sanatorium.
5. Services of a social worker including psychological or psychiatric social worker.
6. Maritime ambulance.
7. Surgical assistance in an outpatient facility.

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.

Procedures for an ordinary pre-authorization pursuant to Article 24.090 of the CSSPR

A. MCS Life shall maintain written procedures for making the preauthorization, also known as standard utilization review and benefit determinations on requests for benefits submitted by the insured persons and for notifying its determinations within the specified time frames required under the CSSPR, Article 24.090.

B. Prospective Review

1. a. The Determination:
    i. Prospective review determinations, and insured's notification will be made within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than fifteen (15) days after the date the request was received.
    ii. In case MCS Life delivers an adverse determination, the insured will be notified in accordance with item F of this section.

b. MCS Life may extend or waive the determination and notice time period one time for up to fifteen (15) days, provided the following requirements:
    i. That an extension is necessary due to matters beyond MCS Life's control.
    ii. The insured will be notified prior to the expiration of the initial fifteen (15)-day time period, of the circumstances requiring the time extension and the date by which the determination is expected to be made.

c. If the extension is necessary due to the failure of the insured to submit the necessary information for MCS Life to reach a determination, the notice of extension shall meet the following requirements:
    i. Specifically describe the additional information necessary to complete the request.
    ii. The insured will be given at least forty-five (45) days from the date of receipt of the notice of extension, to provide the specified additional information.

2) The Notice:
    a. In case the initial request fails to meet the requirements to file a preauthorization, MCS Life shall notify the insured of such failure and provide information on the proper procedures to be followed for filing a request properly.
    b. The notice shall be provided, as soon as possible, but in no event later than five (5) days following the date of receipt of the request and the notice may be provided orally or, if so requested by the insured, in writing.

C. **Concurrent Review**

1) For concurrent review requests, involving a request by the insured to extend the course of treatment (at a healthcare professional's office or any other place where outpatient healthcare services are provided), beyond the approved initial period of time or the number of treatments previously approved by MCS Life, if the request is made at least twenty-four (24) hours prior to the expiration of the original period of time or number of treatments, MCS Life shall make a determination with respect to the request and notify the insured within the following twenty-four (24) hours after receiving the request, pursuant to Art. 24.100 of the CSSPR. Likewise, the following rules shall apply:
    a. Any reduction or termination by MCS Life of the treatment before the end of the period or number of treatments previously approved, other than by health plan amendment or termination of the health plan, shall constitute an adverse determination.
    b. In case MCS Life delivers an adverse determination, the insured will be notified in accordance with item F of this section.

D. **Retrospective Review**

1. Determination
    a. In case of a retrospective review determination, MCS Life shall make the determination within a reasonable period of time, but in no event later than thirty (30) days after the date of receiving the request.
    b. In case MCS Life delivers an adverse determination, the insured will be notified in accordance with item F of this section.

2. Extension
    a. MCS Life may extend the determination and notifying time period one time for up to fifteen (15) days, provided the following requirements:
        i. That an extension is necessary due to matters beyond MCS Life's control.
        ii. The insured will be notified prior to the expiration of the initial thirty (30)-day time period, of the circumstances requiring the time extension and the date by which the determination is expected to be made.
    b. The extension is necessary due to the failure of the insured to submit the necessary to reach a determination on the request, the notice of extension shall:
        i. Specifically describe the additional information necessary to complete the request.
        ii. The insured will be given at least forty-five (45) days as of the date of receipt of the notice of extension, to provide the specified additional information.

E. Time period for making a determination of a request

1. The time period required by MCS Life to make a determination under items B and D of this section, shall begin on the date the request is filed in accordance with the procedures established pursuant to Article 24.070 of CSSPR without regard to whether all of the information necessary to make the determination accompanies the filing.

2. Time Periods Interruptions
    a. If the time period is extended due to the insured's failure to submit the information necessary for MCS Life to make the determination, the time period shall be tolled from the date on which MCS Life sends the notification of the extension to the insured or until the earlier of:
        i. The date on which the insured responds to the request for additional information; or
        ii. The date on which the specified information should have been submitted.
    b. If the insured fails to submit the additional information before the end of the extension period, MCS Life may deny the certification of the requested benefit.

F. **Adverse Determinations**

1. Whenever MCS Life notifies an adverse determination such notification shall set forth:

    a. Information sufficient to identify the benefit request or claim involved, including, the date of service; the provider; the claim amount; the diagnosis code and its meaning; and the treatment code and its meaning.
    b. The specific reasons for the adverse determination, including the denial code and its meaning, as well as a description of the standard, if any, that was used in denying such benefit request or claim.
    c. Reference to the specific MCS Life provisions on which the determination is based.
    d. A description of any additional material or information necessary for the insured to complete the request, including an explanation of why the material or information is necessary.
    e. A description of MCS Life's internal grievance procedures including any time periods applicable to those procedures;
    f. If the adverse determination was relied upon a rule, guideline, internal protocol or other similar criterion, a copy shall be provided free of charge to the covered person.
    g. if the adverse determination is based on a medical necessity for the service or treatment or the experimental or investigational nature thereof or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination and for applying the terms of the health plan to the covered person medical circumstances shall be included with the notification.
    h. A statement of the right of the covered person, as appropriate, to contact the Office of the Commissioner or the Office of the Patient's Advocate at any time for assistance or, to file a civil suit in a court of competent jurisdiction upon completion of MCS Life grievance procedure process. The statement shall include contact information for the Office of the Commissioner or the Office of the Patient's Advocate.

Procedure for an accelerated preauthorization pursuant to CSSPR, Article 24.100.

Your provider may request an accelerated or urgent preauthorization, also known as accelerated utilization review. MCS Life will consider such request as an urgent care one, as long as it is required because it endangers the life, health or full recovery of the insured, or, because it would expose the insured to pain that cannot be handled properly without the requested service or treatment.

A. MCS Life shall maintain written procedures for making the accelerated utilization review and benefit determinations on requests for urgent care and for notifying its determinations within the specified time frames required under CSSPR, Article 24.100.

1) If the covered person fails to meet its filing procedures with regard to an urgent care request, MCS Life shall notify the covered person or enrollee of such failure and provide the proper procedures to be followed for filing a request.

2) The Notice of the Failure:
   a. Shall be provided to the covered person, as soon as possible, but in no event later than twenty-four (24) hours after receipt of the request.
   b. May be provided orally or, if requested by the covered person or enrollee, in writing.

B. The Determination:

1) For urgent care requests filed with all the necessary information, MCS Life shall notify the covered person of its determination, whether adverse or not, as soon as possible, taking into account the medical condition of the covered person, but in no event later than twenty-fours (24) hours after the date of the receipt of the request, unless the covered person has failed to provide sufficient information for MCS Life to make a determination.

   a. In case MCS Life delivers an adverse determination, the insured will be notified in accordance with item E of this section.

2) Deficient Information Notice:
   a. If the application is complete but the clinical information provided is not sufficient to make a determination, MCS Life will notify such deficiency in the document (orally or in writing) and shall indicate the specified information needed, as soon as possible, but in no event later than twenty-four (24) hours after the date of receipt of the request.
   b. The insured shall have up to fourteen (14) days as of the date the notice of deficient information was received, to provide the additional clinical information.
   c. MCS Life will notify the insured its determination in or before the following forty-eight (48) hours after the earlier of the following:
      i. Date of receipt of the requested specified additional information
      ii. The due date provided to submit the requested specified information.
   d. If the additionally requested specified information is not received within the given fourteen (14)-day period, the request will be denied due to lack of necessary clinical information to make a determination.
   e. In case MCS Life issues an adverse determination, the insured will be notified in accordance with item E of this section.

C. In the case of requests for concurrent urgent care review, in which the insured requests an extension of treatment, (in the office of a health professional, or another place where outpatient health care services are provided), beyond the period originally approved or the amount of previously approved treatments, if the request is made at least twenty-four (24) hours before the expiration of the original term or if the number of previously approved treatments is met, MCS will make its determination regarding the request and notify the insured, taking into consideration the covered person's health condition, within twenty-four (24) hours, from the moment the request was received.

D. The time period required by MCS Life to make a determination under items B and C of this section, shall begin on the date the request is filed in accordance with the procedures established pursuant to Article 24.070 of CSSPR without regard to whether all of the information necessary to make the determination accompanies the filing.

E. Adverse Determinations

1. Whenever MCS Life notifies an adverse determination, such notification shall set forth:
   a. Information sufficient to identify the benefit request or claim involved, including, the date of service; the provider; the claim amount; the diagnosis code and its meaning; and the treatment code and its meaning.
   b. The specific reasons for the adverse determination, including the denial code and its meaning, as well as a description of the standard, if any, that was used in denying such benefit request or claim.
   c. Reference to the specific MCS Life provisions on which the determination is based.
   d. A description of any additional material or information necessary for the insured to complete the request, including an explanation of why the material or information is necessary.
   e. A description of MCS Life's internal grievance procedures including any time periods applicable to those procedures;
   f. A description of MCS Life's internal procedures of accelerated grievance review, including any time periods applicable to those procedures;
   g. If the adverse determination was relied upon a rule, guideline, internal protocol or other similar criterion, a copy shall be provided free of charge to the covered person.
   h. if the adverse determination is based on a medical necessity for the service or treatment or the experimental or investigational nature thereof or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination and for applying the terms of the health plan to the covered person medical circumstances shall be included with the notification.
   i. A statement of the right of the covered person, as appropriate, to contact the Office of the Commissioner or the Office of the Patient's Advocate at any time for assistance or, to file a civil suit in a court of competent jurisdiction upon completion of MCS Life grievance procedure process. The statement shall include contact information for the Office of the Commissioner or the Office of the Patient's Advocate.

Notice of determination by MCS Life

When the service for which the preauthorization is requested complies with all established criteria, the provider will be authorized and given an authorization number. In addition, an approval letter will be sent both to the provider or facility, that requested the preauthorization, as well as to the insured. The preauthorization will be effective during thirty (30) calendar days. When the service is denied, a letter giving the reasons for the denial will be sent, including the references on which the denial was based. In addition, we will inform the insured of the right to appeal the denial and the corresponding process.

Preauthorizations are not required for emergency cases.

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 certificate issued by MCS Life does not provide that the final interpretation of the terms in this certificate 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 certificate for the reasons indicated in this certificate, 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 certificate.

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 certificate 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 certificate 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 certificate. 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 certificate 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 certificate, 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 certificate, to whom will the benefits be paid, and the rights of the insured as set forth in this certificate, 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 certificate 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 certificate, before sixty (60) days have elapsed after having submitted written proof of a loss, according to the requirements of this certificate. 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 certificate 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 certificate, including its endorsements and attachments, if any, constitute the complete text of the insurance agreement. No change in this certificate 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 certificate 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: GRIEVANCE SYSTEM

The insured has the right to submit a grievance not related with an adverse determination and a review of an appeal 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 grievance 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 grievance 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 grievance and appeals procedure which warrants the insureds the right to submittal, of efficiently investigating the grievance and the prompt and timely decision of grievance 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 grievance.

In addition, the following persons or entities may submit a claim or grievance 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;
- 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 grievance 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 grievance 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.

Grievance 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 grievance 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 grievance unrelated to adverse determinations

MCS Life will notify the insured of the access to a grievance process. A grievance 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 grievance 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 grievance 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:

Grievance and Appeals Unit
MCS Plaza PO Box 195429
San Juan, Puerto Rico 00919-5429

- MCS Life will notify the insured of having the right to submit comments in writing, documentation, records and other material related to the grievance.
- 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 Patient Advocate: The insured can visit the office of the Health Ombudsman throughout the Island or headquarters located at Ponce de Leon Ave. Mercantil, Plaza Building, Floor 9, Hato Rey, P.R. 00917, by calling 787-977-0909 or toll fee 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 World Plaza Building, #268 Ave. Luis Muñoz Rivera, 9th floor, San Juan Puerto Rico 00918, or visiting the OCS website at: www.ocs.gobierno.pr.

Ordinary revisions of grievances not related to an adverse determination

Pursuant to Article 22.080 of Chapter 22 of the CSSPR:

A. MCS Life establishes written procedures for standard reviews of grievance that do not involve an adverse determination.

B. 1. The procedures shall permit a covered person, or his/her authorized representative, to file a grievance that does not involve an adverse determination with MCS Life under the provisions of this Section.

2. a. The covered person or, if applicable, or his/her authorized representative, shall be entitled to submit written documents for the persons designated by MCS to consider when conducting the standard review.

   b. MCS Life shall notify the covered person or, if applicable, his/her authorized representative, of such his/her rights pursuant to subparagraph (2) (a) within three (3) business days after receiving the grievance.

C. 1. Upon receipt of the grievance, MCS Life shall designate one or more persons to conduct the ordinary review.

2. To conduct the ordinary review of the grievance, MCS Life shall not designate the same person that handled the matter that is the subject of such grievance.
3. MCS Life shall provide the covered person, if applicable, his/her authorized representative, with the name, address, and telephone number of the persons designated to conduct the ordinary review of the grievance.

D. MCS Life shall provide written notification of the decision to the covered person, if applicable, his/her authorized representative, within thirty (30) calendar days after the receipt of the grievance.

E. The written decision issued pursuant to item D shall contain:

1. The titles and qualifying credentials of the persons participating in the standard review process (the reviewers);
2. A statement of the reviewers' understanding of the grievance;
3. The reviewers' determination in clear terms and the contract basis or medical rationale for the insured to respond to MCS Life's position;
4. A reference to the evidence or documentation used as the basis for the determination.
5. If applicable, a written statement including:

   a. A description of the process to obtain an additional voluntary review if the covered person wishes to request a voluntary review pursuant to the voluntary review process;
   b. The written procedures governing the voluntary review, including any required timeframe for the review; and
6. A statement of a covered person's right to contact the Office of the Commissioner of Insurance or the Office of the Patient's Advocate for assistance at any time, including the telephone number and address of the Office of the Commissioner of Insurance and the Office of the Patient's Advocate.

Confidentiality

All documents and information related to grievance are considered Protected Health Information, and will be treated in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations and other applicable Commonwealth of Puerto Rico laws. It is established that the HIPAA is applicable in our jurisdiction and is above the Insurance Code with respect to the provisions required by the law, if these are not described in said Code or if they are not as rigorous as the federal requirements.

Submittal of Grievance Related to an Adverse Determination

Revision of the first level of an adverse determination:

The insured can submit a grievance 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 grievance 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 grievance 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:

Grievance and Appeals Unit
MCS Plaza PO Box 195429
San Juan, Puerto Rico 00919-5429

- 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 Patient Advocate: The insured can visit the office of the Health Ombudsman throughout the Island or headquarters located at Ponce de Leon Ave., Mercantil Plaza Building, Floor 9, Hato Rey, PR 00917, by calling 787-977-0909 or toll fee 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 World Plaza Building, #268 Ave. Luis Muñoz Rivera, 9th floor, San Juan Puerto Rico 00918, or visiting the OCS website at: www.ocs.gobierno.pr.

Accelerated Reviews of Appeal Involving an Adverse Determination.

Pursuant to Article 22.100 of chapter 22 of the CSSPR:

A. MCS Life shall establish written procedures for the accelerated review of urgent care requests involving an adverse determination.

B. The procedures shall allow the covered person, or his/her authorized representative, to request an accelerated review under this section to MCS Life either orally or in writing.

C. MCS Life shall appoint an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. Such clinical peers shall not have been involved in making the initial adverse determination.

D. In an accelerated review, all the necessary information, including MCS Life's decision, shall be transmitted between MCS Life and the covered person or, if applicable, his/her authorized representative, by telephone, fax, or the most expeditious method available.

E. An accelerated review decision shall be made and the covered person or, if applicable, his/her authorized representative, shall be notified of the decision in accordance with item G as expeditiously as the covered person's medical condition requires, but in no event in more than forty-eight (48) hours after the receipt of the request for the accelerated review.

F. For purposes of calculating the time periods within which a decision is required to be made and notified under item E, the time period shall begin on the date the request for an accelerated review is filed with MCS Life without regard to whether all the information necessary to make the determination accompanies such filing.

G. (1) A notification of a decision shall indicate the following, in a manner that is comprehensible to the covered person or, if applicable, his/her authorized representative:

a. The titles and qualifying credentials of the persons participating in the accelerated review process (the reviewers);

b. A statement of the reviewers' understanding of the covered person's request for an accelerated review;

c. The reviewers' determination in clear terms, and the contract basis or medical rationale for the insured to respond to the health insurance organization or MCS Life's position;

d. A reference to the evidence or documentation used as the basis for the determination; and

e. If the decision results in a final adverse determination, the notice shall provide:

i. The specific reasons for the adverse determination;

ii. Reference to the specific MCS Life's provisions on which the determination is based.

iii. If MCS Life relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, a copy of such specific rule, guideline, protocol or other similar criterion relied upon to make the adverse determination shall be provided, upon request and free of charge, to the covered person;

iv. If the final adverse determination is based on a medical necessity, experimental or investigational treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for making the determination;

v. If applicable, instructions for requesting:

1. A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination in accordance with clause (e)(iii); or

2. A written statement of the scientific or clinical rationale for the adverse determination in accordance with clause (e) (iv);

vi. A description of the procedures for obtaining an independent external review pursuant to the chapter on "Health Insurance Organization or Insurer External Review" of the Code;

vii. A statement indicating the covered person's right to bring a civil action in a court of competent jurisdiction;

viii. The following statement, stressing the voluntary nature of the procedures: "You and your health plan may have other voluntary alternative dispute resolution options, such as mediation or arbitration. To find out what may be available, contact the Commissioner of Insurance"; and

ix. A statement of a covered person's right to contact the Office of the Commissioner of Insurance or the Office of the Patient's Advocate for assistance at any time with the telephone number and address of the Office of the Commissioner of Insurance and the Office of the Patient's Advocate.

2. a. MCS Life shall provide the notice required under this section orally, in writing, or electronically.

   b. If notice of the adverse determination is provided orally, MCS Life shall provide written or electronic notice within three (3) business days following the oral notification.

3. None of these provisions shall be construed to limit the power of MCS Life to render an adverse determination ineffective without following the procedure set forth herein.

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 appeal 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 appeal.

If the insured submits an appeal 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 appeal 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

1. Notice of the Right to External Review (cf. Art. 28.050 of the CSSPR):

In compliance with Sec. 28.050 of the CSSPR, in notices of adverse determinations, MCS Life will inform the insured of his or her right to request an independent external review and a description of the procedures for requesting such external review. MCS Life will include in notices of adverse determination, the following language, or a substantially equivalent language:

"We have denied your healthcare service request, course of treatment or its payment. You may have a right to a review of this determination by healthcare professionals who are unrelated to us if, with respect to the requested healthcare service or treatment, our determination entails an evaluation of the health need, its appropriateness, the place where the health service is offered or the level or efficacy of the service. To such effects, you, your personal representative, or physician may file a request for an independent external review by:

- *Visiting MCS Life Service Centers: The insured may visit the nearest MCS Life Service Center to submit a letter of request and/or completing an independent external review form.*
- *Call Centers: The insured can call 1-888-758-1616 or the phone number shown on the back of the health plan card to submit a verbal request or receive instructions on how to submit a request in writing. TTY/TDD users can call 1-866-627-8182.*
- *Regular mail: Sending a letter of request and contract number to the following address:*

Grievances & Appeals Unit

MCS Plaza PO Box 195429

San Juan, Puerto Rico 00919-5429"

The notice may vary as per the Puerto Rico Insurance Commissioner's regulations, who may establish the format and content of this notice.

2. Request for an independent external review (cf. Art. 28.060 of the CSSPR):

If the insured disagrees with the adverse determination (which may include the denial of experimental or investigational services) or with MCS Life decision of an 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 from an external, independent organization, as set forth in Art. 28.050 and Art. 28.060 of the CSSPR, which complies with the requirements established by the OCS and as set forth in Section 1001 of PPACA.

3. Requirement of exhausting MCS Life process of internal claims (cf. Art. 28.070 of the CSSPR):

No request for an external review will proceed until the insured has exhausted the process of internal claims review previously described. It will be considered that the insured has exhausted MCS Life process of internal review, as set forth in Article 28.070 of the CSSPR, when the insured or its personal representative:

- submits an internal claim and
- has not received written determination from MCS Life within thirty (30) days from the date in which the claim was submitted, unless an extension has been requested or agreed on.

If MCS Life fails to comply with the required processes for handling appeals (e.g. notice of determination within established time limits), the appeal will be deemed denied on the premise that the insured exhausted the internal appeals processes and the insured will have the right to seek external review and file a judicial claim under section 502(a) of ERISA and other state forums.

4. Request of an ordinary external review (cf. Art. 28.080 of the CSSPR):

Not later than one-hundred twenty (120) days following receipt of a notice of an adverse determination or of a final adverse determination, the insured, its personal representative or physician, may submit a request for an external review to MCS Life or directly to one of the independent review organizations, through the means referred to in the written determination issued by MCS Life.

MCS Life within five (5) days following receipt of a request for an external review will complete a preliminary review of the request before submitting it to the independent review organization, as provided for in Art. 28.080 of the CSSPR, to determine the following:

- if the requester was insured under the health plan at the time in which the healthcare service was requested or rendered;
- If reasonably understood that the healthcare service object of the adverse determination or final adverse determination is a service covered by the health plan, except when MCS Life has determined that the

service is not covered due to non-compliance with requirements of medical necessity, appropriateness, place where the service is provided, level of care or efficacy of service;

- If the insured has exhausted the process of internal claim, as set forth in Article 28.070 of the CSSPR, and described in Part VII of this certificate;
- If the insured has provided all the required information and forms.

Not later than the next business day of completing the preliminary review, MCS Life will notify the insured in writing if:

a. the request for external review is complete and

b. the request is eligible for external review.

If in the preliminary review MCS Life noticed that:

- the application submitted is incomplete then the insured or its personal representative will received written notice of the requirements necessary to complete the application including those required documents;
- the application is not eligible for external review, then MCS Life will provide written notice of the reasons for ineligibility to this process and the insured's right to appeal this determination by filing an appeal with OCS.

If, otherwise, the insured has provided all of the information required for the external review process and the application is eligible, MCS Life will proceed to refer the application to one of the three (3) contracted independent review organizations listed below:

- *Advance Medical Review,*
- *Amalgamated Medical Care Management*
- *BHM Healthcare Solutions.*

Independent review organizations are certified by an accrediting organization that ensures that the personnel conducting the reviews are qualified and independent of the plan. In making its determination, the designated independent review organization will not be bound by any decisions or findings resulting from the utilization review process or MCS Life's internal grievance process. Independent review organizations must submit their determination within forty-five (45) days of receipt of the request for external review, as provided in Sec. 28.080 of the CSSPR.

If the independent review organization's determination reverses the adverse determination or final adverse determination under review, MCS Life will immediately approve coverage or payment for the service or benefit under review.

The designation of an independent review organization to conduct a review shall be made by randomly selecting one from among the independent review organizations contracted and qualified to conduct the particular external review at issue, taking into consideration the nature of the health care services subject to the adverse determination being reviewed, as well as any other relevant circumstances, including potential conflicts of interest.

5. Request for accelerated external review (cf. Art. 28.090 of the CSSPR):

In compliance with Article 28.090 of the CSSPR, the insured or its personal representative may file a request for accelerated external review upon receiving any of the following if received:

- an adverse determination, provided:

- insured's health condition regarding the necessary time to conduct an accelerated internal review, that would endanger the life, health or full recuperation;
- the insured has filed an accelerated internal review of a claim for which an adverse determination was made; o

- a final adverse determination, provided:
  - the insured suffers a health condition in which the time needed for an ordinary external review, as provided Article 28.080 of the CSSPR, would endanger the life, health or full recuperation;
  - the final adverse determination is regarding the admission to a healthcare facility, availability of service, or the continued stay at a facility where the insured received emergency services and the insured has not been yet discharged from where the emergency services were received.

Upon receiving a request for an accelerated external review, MCS Life must determine whether the application satisfies the review requirements by conducting a preliminary review (as described in Section 4 "Request for Ordinary External Review") and notify the insured of its determination as to whether the application is eligible for external review. If MCS Life determines, upon preliminary review, that the application is ineligible for external review it shall advise the insured that such determination of ineligibility may be appealed to the OCS.

MCS Life will proceed to refer the application to one of the three (3) contracted independent review organizations listed below:

- *Advance Medical Review,*
- *Amalgamated Medical Care Management*
- *BHM Healthcare Solutions.*

In making its determination, the designated independent review organization will not be bound by any decisions or findings resulting from the utilization review process or MCS Life's internal grievance process. Independent review organizations shall submit their determination as expeditiously as the insured's health condition or circumstances require, within seventy-two (72) hours of receipt of the request for expedited external review, as provided in Article 28.090 of the CSSPR.

If the independent review organization's determination reverses the adverse determination or final adverse determination under review, MCS Life will immediately approve coverage or payment for the service or benefit that was the subject of the expedited external review.

6. External review of an adverse determinations based on experimental or investigational treatment (cf. Art. 28.100 of the CSSPR):

The insured, personal representative or physician, within one-hundred twenty (120) days following receipt notice of adverse determination because its experimental or investigational nature, the insured, must submit a request to MCS Life, or directly to one of the independent review organizations, through the means mentioned in the written resolution issued by MCS Life.

The insured may request verbally an accelerated external review of an adverse determination or final adverse determination denying a recommended or requested healthcare service or treatment due to its experimental or investigational nature, provided the physician certifies in writing that the denied healthcare service or treatment would be significantly less effective if not initiated promptly.

Upon receiving copy of the request, MCS Life must determine immediately whether the application satisfies the review requirements by conducting a preliminary review and notify the insured of its determination as to whether the application is eligible for external review. If MCS Life determines, upon preliminary review, that the

application is ineligible for external review it shall advise the insured that such determination of ineligibility may be appealed to the OCS.

The preliminary review of the application will determine whether the application meets the following requirements:

- The person is or had been insured by the health plan when the denied healthcare service or treatment was recommended or requested or,
- The recommended or requested healthcare service or treatment object of the adverse determination or final adverse determination:
    - is a benefit covered under the insured's health plan, but MCS Life has determined that the service or treatment is experimental or investigational in nature;
    - it is not expressly mentioned as a benefit excluded in accordance with the insured's health plan;
- The insured's physician has certified in writing that one of the following situations applies:
    - usual and customary healthcare services or treatments have not been effective in improving the insured's condition;
    - usual and customary healthcare services or treatments are not medically adequate for the insured;
    - the health plan does not cover a healthcare service or treatment that is more beneficial than the recommended or requested healthcare service or treatment;
- The physician caring for the insured:
    - has recommended a healthcare service or treatment, certifying in writing that, in his or her opinion, will probably be of greater benefit to the insured than other usual or customary healthcare services or treatments available; or
    - has certified in writing that scientifically validated studies have been conducted, according to acceptable protocols, to show that the health care service or treatment requested by the insured has a greater probability of showing benefit than any other usual or customary healthcare service or treatment available;
- The insured has exhausted MCS Life process of internal claim, except if such remedy is not required to be exhausted in accordance with Article 28.070 of the CSSPR; and
- The insured has provided all the required information and forms to process the external review.

Not later than the next business day of completing the preliminary review, MCS Life will notify the insured in writing if:

a. the request for external review is complete and
b. the request is eligible for external review.

If in the preliminary review MCS Life noticed that:

- the application submitted is incomplete then the insured or its personal representative will receive written notice of the requirements necessary to complete the application including those required documents;
- the application is not eligible for external review, then MCS Life will provide written notice of the reasons for ineligibility to this process and the insured's right to appeal this determination by filing an appeal with OCS.

If, otherwise, the insured has provided all of the information required for the external review process and the application is eligible, MCS Life will proceed to refer the application to one of the three (3) contracted independent review organizations listed below:

- *Advance Medical Review,*
- *Amalgamated Medical Care Management*
- *BHM Healthcare Solutions.*

Independent review organizations are certified by an accrediting organization that ensures that the personnel conducting the reviews are qualified and independent of the plan. In making its determination, the designated independent review organization will not be bound by any decisions or findings resulting from the utilization review process or MCS Life's internal grievance process. Independent review organizations must submit their determination within forty-five (45) days of receipt of the request for external review, as provided in Sec. 28.080 of the CSSPR.

If the independent review organization's determination reverses the adverse determination or final adverse determination under review, MCS Life will immediately approve coverage or payment for the service or benefit under review.

The designation of an independent review organization to conduct a review shall be made by randomly selecting one from among the independent review organizations contracted and qualified to conduct the particular external review at issue, taking into consideration the nature of the health care services subject to the adverse determination being reviewed, as well as any other relevant circumstances, including potential conflicts of interest.

7. Obligatory external review determination (cf. Art. 28.110 of the CSSPR):

As set forth in Art. 28.110 of the CSSPR, a determination of an external review implies a mandate for MCS Life as well as the insured, except in cases in which one or other parts find an additional proper remedy that conforms to the laws applicable to Puerto Rico or federal laws. The insured cannot submit other requests of external review regarding an adverse determination or final adverse determination for which a determination has been made after an external review, as set forth in Chapter 28 of the CSSPR.

8. Miscellaneous Provisions:

The OCS has delegated, Federal Hearings & Appeal Services, Inc. (FHAS). as the independent reviewer, pursuant to Letter CC-2023-2017-D of September 15, 2023.

The premise that the insured exhausted the internal grievances process does not apply to the violations and will not affect the insured, while the plan can demonstrate that the violation was for a good cause, or that it was out of the plan’s control and 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 violations on the part of MCS Life. The insured may request a written explanation of said violation and receive a reply from MCS Life in ten (10) days, including an explanation as to why it is understood the violation does not exhaust the internal grievances 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 certificate. The tax ID number assigned to the employer by the Internal Revenue Service is the number shown in the first page of this certificate.

Plan Name and Number

Refer to the first page of this certificate. 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 certificate.

Claims Administrator for this certificate

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 certificate is simply to modify official documents of the plan. If case of inconsistency between this certificate 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 certificate 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 certificate, 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 certificate.

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 certificate, 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 certificate 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 -except for consensual couples-, 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 certificate.

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 certificate 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 certificate. 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 certificate, 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 certificate, 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 certificate.

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 certificate 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 certificate.

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 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 certificate. 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.

Laboratories

This product has two options for accessing laboratory services in which the insured can pay a lower copayment or coinsurance when using the special network laboratories.

- Special Laboratory Network: Corresponding copayment or coinsurance applies. The insured should refer to the Providers Directory 1 to learn about the special laboratory network.
- PPO Laboratory Network: Corresponding copayment or coinsurance applies. The insured should refer to the Providers Directory 1 to learn about the PPO Laboratory Network.

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 http://us1.welcometouhc.com/ or call the Assistance Center to locate a Provider at 1-877-563-9016.

PART XII: COPAYMENT, COINSURANCE AND DEDUCTIBLES TABLE

Deductible and Maximum Out-of-Pocket (MOOP)	
Annual Initial Deductible for Medical Benefits	
Individual	N/A
Family	N/A
Maximum Out-of-Pocket (MOOP) Expenses for Medical Benefits and Prescription Drugs	
Individual	$6,350
Family	$12,700
Essential Health Benefits	
Emergency and Urgency Services	
Accident	$0
Illness	$75
Urgency Center	$35
Hospitalization	
Hospitalization (including mental health, regular or partial)	$75
Skilled Nursing Facility	$0
Outpatient Services	
General Practitioner	$10
Specialists (including psychiatrists, psychologists, podiatrists, chiropractors (first visit), audiologists, optometrists)	$15
Subspecialists	$20
Outpatient Facility	$75
Diagnostic and Surgical Procedures in the Medical Office	25%
Diagnostic and Surgical Procedures in Outpatient Facility	25%
Endoscopic Procedures	25%
Chemotherapy and Radiotherapy	5%
Drugs administered in outpatient level	5%
Dialysis and hemodialysis	$0
Rehabilitation, Habilitation and Durable Medical Equipment Services	
Physical therapy	$7
Outpatient Respiratory Therapy	$5
Home Health Care	$0
Durable Medical Equipment (DME)	20%
Chiropractor Manipulations	$7
Mental Health	
Group therapy	$15
Collateral visits	$15
Laboratory and X-ray Services	
Laboratory - Special Network / PPO Network	35% / 50%
X-rays	35%
Special Tests (CT Scan, PET CT, MRI, SPECT)	35%

Molecular and/or Genetic Tests	35% / 50%
Preventive, Wellness and Chronic Disease Management Services	
Preventive Services (including for women and autism)	0%
Preventive Immunizations (vaccines)	$0
Immunization (vaccines) for Respiratory Syncytial Virus	30%
Other Services Covered	
Air ambulance in Puerto Rico	20%
Services in United States	
Emergency Services in the United States	20%
Pre-authorized services and treatments unavailable in Puerto Rico (in the United States)	20%
Ground ambulance in the United States	20%
Students in United States	20%
Bariatric Surgery Benefit for the Treatment of Morbid Obesity	
Bariatric surgery procedure	40%
Life Insurance	$0
Bone, Skin, Cornea, Organs and Bone Marrow Transplants	$0
Programs included as part of the benefits	
MCS Alivia	$15
MCS Medilinea MD	$10
Major Medical Expenses	
Deductible Per Person	$100
Deductible Per Family	$300
Maximum disbursement amount	
By Individual	N/A
By Family	N/A
Benefits	
Hospice	20%
Allergy Shots	20%
Durable medical equipment	20%
Hyperbaric chamber	20%
Gynecomastia	20%
Surgical assistance in hospital	20%
Respiratory Therapies additional to the basic coverage	20%
Benefits covered by reimbursement	
Epidural anesthesia during childbirth	20%
Air ambulance in the United States	20%
Rhogam Vaccine	20%

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."



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PRESCRIPTION DRUGS BENEFIT ENDORSEMENT 8/2017
MCs Life Insurance Company Rev. 9/2022

This endorsement is part of the group policy to which it is attached and is issued in consideration of the payment of the corresponding premiums and is subject to the terms and conditions of the policy, which are not in conflict with the terms and conditions of the endorsement.

I. Definitions:

Coinsurance	Amount of money expressed in percent, which the insured of this endorsement must pay to the provider at the time of receiving certain services. This amount of money varies according to the cost of the services and the rates contracted by MCS Life.
Copayment	Fixed amount of money that the insured of this endorsement must pay to the provider at the time of receiving certain services.
Deductible	Amount paid by the insured, before beginning to receive services covered by this endorsement.
Pharmacy	Health service establishment, authorized and registered in accordance with the provisions of federal or state law, to engage in the provision of pharmaceutical services, which includes: the dispensing of prescription drugs, non-prescription drugs, devices and other products related to the health, the provision of pharmaceutical care and other services within the functions of the pharmacist established 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	Medications to treat health conditions of sudden onset and short duration.
Generic 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.

Preferred Bioequivalent Generic 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 Generic 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 Name Drugs	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 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.
Pharmacies Special Network	Pharmacy network contracted to provide this rider's pharmacy benefits.
Refills	Drugs 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 generic drugs, preferred bioequivalent generic drugs, non-preferred bioequivalent generic drugs, preferred brand drugs, non-preferred brand drugs, specialty drugs, preferred specialty drugs and non-preferred specialty drugs.

In compliance with Law No. 203 of 2012, which amends 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 the inclusion of new prescription drugs on the Preferred Drug List (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 drug 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: C: 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 difference in cost between the brand-name drug and the generic drug, plus the copayment or coinsurance for the corresponding generic 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 generic drug.
Over-the-Counter Drugs (OTC)	Corresponding copayment 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 or access www.mcs.com.pr. **Steps to request medications by mail:** 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 three (3) refills with ninety (90) day supply, for a total amount of three hundred and sixty-five (365) 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:

Specialty drugs covered under the Specialty Drug Program, under the terms and conditions of this policy, are identified on the Drug Formulary as Preferred Specialty Drugs and Non-Preferred Specialty Drugs, and are covered only if the service is obtained through the specialty pharmacy contracted under the MCS Life Specialty Drug Program.

To achieve better service to the insured, most specialty medications must be pre-authorized by the MCS Life Pharmacy Department. The Health Plan will not cover those specialized medications that require pre-authorization and have not been pre-authorized.

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 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 contraceptive drugs. Please refer to the formulary or preferred drug list 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;
- 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 professional 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 forty-eight (48) 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 twenty-four (24) hours.

In compliance with Article 4.070(B) of the CSSPR. as amended by Act No. 142 of October 9, 2020, and while such law is in effect and is not amended or repealed, MCS Life will provide temporary immediate coverage for forty-eight (48) hours and twenty-four (24) hours in controlled drug cases, for an initial prescription of the prescribed drug during the medical exception request process until it provides written notice of the final determination. To do so, the doctor or health professional who issued the prescription must state in writing that the prescribed medication requested is medically necessary for the treatment of the insured's disease or condition. This initial prescription will be covered by MCS Life even if such prescription drug is excluded from the applicable drug formulary of this policy or is subject to a prescription drug management procedure.

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.
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.

VII. Copayment and Coinsurance Table

Preferred Drug List (PDL) A - 1	Special Network
Annual Deductible for Prescription Drugs (Pharmacy)	
Individual	N/A
Family	N/A
Maximum-out-of-Pocket (MOOP) for Medical Benefits and Prescription Drugs	
Individual	$6,350
Family	$12,700
Point of Service:	
Bioequivalent Preferred	$7
Bioequivalent Non-Preferred	$7
Brand-name Preferred	15% min. $20
Brand-name Non-Preferred	15% min. $20
Retail 90-day Supply (maintenance drugs only):	
Bioequivalent Preferred	$14
Bioequivalent Non-preferred	$14
Preferred Brand-name Drug	15% min. $40
Non-Preferred Brand-name Drug	15% min. $40
Prescription Drug by Mail (90-day supply)	
Bioequivalent Preferred	$14
Bioequivalent Non-Preferred	$14
Preferred Brand-name Drug	15% min. $40
Non-Preferred Brand-name Drug	15% min. $40
Specialty Drugs Program:	
Bioequivalent Preferred	30% max. $200
Bioequivalent Non-Preferred	30% max. $200
Brand-name Preferred	30% max. $200
Brand-name Non-Preferred	30% max. $200
Oral Chemotherapy	5%
OTC	
Over-the-Counter (OTC)	$1

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