Humana Insurance of Puerto Rico, Inc.

(Hereinafter "the Company")

PPO Program Humana Complete
RX 3

19728PR0010

Schedule of Benefits Coverage

Schedule of Benefits

This schedule of benefits should be attached and made part of PPO Program Policy: Attachment I

Services and Benefits Procedures

1. Benefits and services are subject to the terms and conditions included in the group policy and to the exclusions and limitations described in this attachment.
2. Insured must receive services from participating facilities, contracted providers or under the order, direction and approval of the contracted provider upon presentation of the identification card issued by the Company. The Insured is responsible for paying applicable copayment, coinsurance or deductible.

Deductible

Deductible	Individual	Family
Network Provider	$0	$0
Non-Network Provider	$0	$0

Annual Maximum Out-of Pocket

Maximum out-of pocket limit	Individual	Family
Maximum out-of pocket limit ("MOOP") Network Provider	6,350	$12,700
Maximum out-of pocket limit ("MOOP") Non-Network Provider	$19,050	$38,100

This includes copayments and coinsurance expenses of the Medical and Pharmacy coverage, in addition to accumulated expenses of the pharmacy benefits coverage deductibles.

Once the individual or family maximum out of pocket limit is met for the policy year for network providers, the percentage of benefits provided by network providers for covered expense will be paid at a rate of 100% for the rest of the policy year, subject to all terms, limits and exclusions of this Schedule of Benefits Coverage. Any expenses (medical and pharmacy) you might incur for covered expenses provided by a network provider will apply to the maximum out of pocket limit for network providers. Any expenses (medical and pharmacy) you might incur (as contracted fee for similar services by a provider in Puerto Rico) for covered expenses provided by out of network provider will apply to the maximum out of pocket limit for out of network providers.

The accumulation period will begin on the effective date of the policy and will end when the policy terminates. From there on, it will be from the renovation date until the policy year end.

The Maximum Out-of Pocket is based on the maximum amount allowed by the Office of the Commissioner of Insurance of Puerto Rico.

Essential Health Benefits

Ambulatory Services

The following services are covered, less any applicable co-insurance or copayment per visit:

1. Unlimited office visits to physicians, less applicable copayment or coinsurance:

   Generalists: $10.00

   Specialists: $15.00

   Sub-specialists: $15.00

2. Chiropractic Services, one (1) initial visit, one (1) follow-up visit, less $15.00 visit copayment or and up to twenty (20) manipulations per insured, per policy year. Physical therapies unlimited, less $10.00 copayment.
3. Six (6) Nutritionist consultations per insured per policy year, less $15.00 visit copayment or per visit.
4. Laboratories, X-rays and its reproduction, unlimited, less 25% of coinsurance. Genetic tests require pre-authorization, less 25% of coinsurance.
5. Electrocardiograms, unlimited, less 25% of coinsurance.
6. Sonograms, unlimited, less 25% of coinsurance.
7. Computerized tomography, unlimited, less 25% of coinsurance. Pre-authorization required.
8. Positron Emission Tomography (PET), unlimited, less 25% of coinsurance. Pre-authorization required.
9. Electroencephalogram, unlimited, less 25% of coinsurance.
10. Electromyogram, unlimited, less 25% of coinsurance.
11. Magnetic Resonance, including MRI and MRA, unlimited, less 25% of coinsurance. Preauthorization required.
12. One (1) sleep study or polysomnography covered per insured, per policy year, less 25% of coinsurance. Pre-authorization required.
13. Nuclear medicine tests, unlimited, less 25% of coinsurance.
14. Respiratory therapy, unlimited, less $10.00 copayment.
15. Physical therapy, including rehabilitation and habilitation, unlimited for all conditions including autisms, as prescribed and under the supervision of an orthopedist or a physical medicine specialist, less $10.00 copayment.

16. Speech therapy, combined at the physician office or at home, when ordered by a physician and rendered by a licensed speech therapist; up to a maximum of forty (40) therapies, per insured per policy year, less $15.00 copayment. Unlimited speech and language therapies for autism according to Law No. 220 of September 4, 2012.
17. Occupational therapy for the purpose of training and aiding in the restoration of normal physical function and or prevent further deterioration of the same; resulting illness, from trauma, stroke or a surgical procedure while insured under the policy, unlimited for all conditions including autisms, less $15.00 copayment.
18. Ambulatory surgery at ambulatory surgery facilities, including Mental Health, less $50.00 of copayment.
19. Endoscopies, diagnostic and therapeutic, unlimited, less $15.00 office copayment or less $50.00 facility copayment.
20. Lithotripsy, unlimited, less $50.00 ambulatory facility copayment per rendered service. Pre-authorization required.
21. Vasectomy at physician's office, less $15.00 office visit copayment.
22. Acute and chronic services related to End Stage Renal Disease, such as dialysis, hemodialysis and complications directly related to the disease are covered up to a maximum of ninety (90) days starting on the date on which the disease is diagnosed, In case of admission apply $100.00 copayment.
23. Allergy tests, including allergenic and biological extracts, drugs, patches and provocative tests, up to a maximum of fifty (50) tests per insured per policy year, less 25% coinsurance.
24. Intra-articular injections, unlimited, less $15.00 office copayment or less $50.00 facility copayment.
25. Audiologist visits according to Law No. 127 of September 27, 2007; Audiometry and tympanometry tests when ordered by a physician, one (1) of each test per insured, per policy year, less 25% of coinsurance.
26. Orthognathic surgery (mandibular or maxillary osteotomy - Le Fort). Expenses for implants related to orthognathic surgery are excluded, less $50.00 facility or $100.00 hospital copayment. Pre-authorization required.
27. Treatment and services for morbid obesity as medically necessary. One (1) bariatric surgery using one of the following techniques, gastric bypass, adjustable gastric band or sleeve gastrectomy per lifetime, according to Law 212 dated on August 9, 2008, less $100.00 copayment. Surgeries for removing excess skin (commonly known as folds) shall not be covered, unless the physician certifies that it is necessary to remove the excess skin because it affects the functions of any part of the body. Bariatric surgery requires pre-authorization.
28. In the event that an insured voluntarily enrolls in a research clinical trial, Humana will cover diagnostic tests which are usually associated with his condition as long as they are covered by his/her health insurance policy. These services are subject to the maximum limits specified under the policy, less $15.00 copayment or 25% coinsurance. Tests which are not covered by his/her policy, and which are strictly linked to the goal of the research, will not be reimbursed by Humana. The process and results of the investigation are the responsibility of the researcher and the insured.
29. Diagnostic tests and treatments associated with hemophilia, unlimited, less $15.00 copayment or 25% coinsurance.
30. Unlimited naturopathic physician visits according to Law 210 dated on December 14, 2007, less $15.00 copayment.
31. Eye refraction test by an ophthalmologist or optometrist, one (1) per insured per policy year within the Humana Insurance network, less $15.00 copayment.
32. Ophthalmic Diagnostic Tests, less $15.00 copayment.
33. Mammography, when they are not presented as a preventive test required by ACA, but as a follow up to a diagnosis or treatment of a condition, less $50.00 facility copayment.
34. Podiatry visits; Treatment of diseases and disorders of the foot and ankle, including injections and surgical procedures, less $15.00 visit copayment or $50.00 facility copayment.
35. Cervical Cryosurgery, less $15.00 copayment.

36. Nerve Conducting Velocity Test, unlimited, per policy year, less 25% coinsurance.

37. Humana will cover the Nutritional Supplement free of phenylalanine, based on low phenylalanine protein hydrolysates for patients diagnosed with the genetic disorder Phenylketonuria (PKU), without age limits, and for other recommended diagnostic, prevention and treatment of people with innate metabolic errors, in accordance to Act 139 of August 8, 2016. Covered at 100%.

38. Anesthesia services and hospitalization services, unlimited, in accordance with Act No. 352 of 1999; Pre-authorization is required. These services will be available when the member has dental coverage with Humana and when at least one of the following scenarios occurs:

    a. When a pediatric dentist, oral or maxillofacial surgeon member of the medical faculty of a hospital, licensed by the Government of Puerto Rico, determines that the member's condition is significantly complex in accordance with criteria established by the American Academy of Pediatric Dentistry.
    b. When the patient due to age or disability is unable to resist or tolerate pain, or cooperate with the treatment indicated in dental procedures;
    c. When the infant, child, adolescent or person with a physical or mental disability has a medical condition in which it is essential to carry out dental treatment under general anesthesia in an outpatient surgical center or hospital and which otherwise could represent a significant risk to the patient's health;
    d. When local anesthesia is ineffective or contraindicated due to an acute infection, anatomical variation or allergic condition;
    e. When the patient is an infant, child, adolescent, person with a physical or mental disability, and is in a state of fear or anxiety that prevents the dental treatment under traditional procedures of dental treatment and their condition Of such magnitude, that postponing or delaying treatment would result in pain, infection, loss of teeth or dental morbidity;
    f. When a patient has received extensive and severe dental trauma where the use of local anesthesia would compromise the quality of services or be ineffective in managing pain and apprehension.

To evaluate the services, a medical order must be sent to Humana with the diagnosis of the insured, as well as the reasons that justify the use of general anesthesia and hospital. Humana will approve or deny the request, in accordance with the criteria previously established, within two (2) days as of the date on which the member submits all required documentation.

The documents are:

- Medical order with diagnostics.
- Justification in the medical order.

Preventive Services

1. Annual preventive services are **covered at 100%** (without copayment or coinsurance) when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF), the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), The Health Resources and Services Administration, and the Puerto Rico Department of Health.

   For more information and updates on preventive services, visit: //www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

   a) Routine physical examination, including height, weight, and body mass index (BMI), for children and adults.

   b) High Blood pressure screening. The USPSTF recommends screening for high blood pressure in adults age (18) years and older. It is recommended obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.

   c) Cholesterol screening, for children and adults.

d) Screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults 40 years of age and older. The risks and benefits of these methods vary.

e) Screening for obesity, and counseling, for children and adults. The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of (30) kg/m2 or higher to intensive, multicomponent behavioral interventions.

f) Screening for Tobacco Use for all adult. The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA) approved pharmacotherapy for cessation to adults who use tobacco.

   The dispatch of FDA approved medication for smoke cessation is covered for (90) consecutive days in one intent and until (2) intents per year. Smoking cessation drugs are covered under the Pharmacy Coverage Section with prescription.

g) Tobacco use interventions: children and adolescents; recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

h) Screening for gestational diabetes mellitus (GDM) in asymptomatic pregnant women after (24) weeks of gestation and those at high risk of developing gestational diabetes.

i) Screening for abnormal blood glucose and Diabetes Mellitus Type 2 in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer, or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.

   In addition, it is recommended screening for diabetes type 2 in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than (135/80) mm Hg.

j) Screening for alcohol abuse, and behavioral counseling. It is recommended that clinicians screen adults aged (18) years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

k) Screening for tobacco, alcohol or drug use for children 11 to 21 years of age.

l) Immunizations for infants, children, and adults in accord with accepted medical practice and as recommended by the Advisory Committee for Immunization Practices (ACIP) of the Centers for Disease Control (CDC) and the American Academy of Pediatrics, as long as the individual is covered by this health insurance, including follow up (catch up).

   - Immunizations for Adults (21 years or older), including catch-ups – Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza (Flu Shot), Meningococcal, Measles/Mumps/Rubella, Pneumococcal, Tetanus/Diphtheria/Pertussis, Varicella

   - Immunizations for Children (less than 21 years old), including catch-ups – Haemophilus Influenzae Type b, Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza (Flu Shot), Meningococcal, Measles/Mumps/Rubella, Pneumococcal, Rotavirus, Tetanus/Diphtheria/Pertussis, Varicella, , inactivated poliovirus

m) Cervical cancer screening The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).

n) Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate. Office visits and consultations regarding checkups for healthy women (well-woman visits). Health and Human Services recognizes that several visits may be necessary to get all recommended preventive services, depending on the health status of women, their health needs and other risk factors.

o) Breast cancer mammography screenings every one (1) to two (2) years for insured over 40 years, biannual for insured between fifty (50) and seventy-four (74) years. This includes guidance and advice regarding chemoprevention, and the chemoprevention of breast cancer in women when indicated. Counseling for women at higher risk. The USPSTF recommends that clinicians engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk.

For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk- reducing medications, such as tamoxifen or raloxifene.

p) Pap Smear

q) Prostatic Specific Antigen test (PSA) for men

r) Behavioral counseling regarding sexually transmitted diseases (STD's), for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs).

s) Screening for intimate partner violence (IPV), such as domestic violence, for women of childbearing age. Physicians shall also provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.

t) Screening for autism for children up to 36 months.

u) Osteoporosis screening: postmenopausal women younger than 65 years at increased risk of osteoporosis The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool. Osteoporosis screening: women 65 years and older. The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporosis fractures in women 65 years and older.

v) Screening for hearing loss all newborns infants.

w) Screening for elevated blood lead levels in children aged (1) to (6) years who are both at average and increased risk, and in asymptomatic pregnant women.

x) One (1) lifetime screening test for abdominal aortic aneurism (AAA) in men 65-75 years old who have ever been smokers.

y) Counseling regarding the use of aspirin in prevention of disease, for both men and women 45-79 years of age who are cardiovascular and colorectal cancer risks. The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged (50) to (59) years who have a (10)% or greater (10) year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least (10) years, and are willing to take low-dose aspirin daily for at least (10) years. For aspirin, prescription is required.

z) Counseling regarding folic acid supplements for women who may become pregnant. The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing (0.4) to (0.8) mg of folic acid. For folic acid, prescription is required.

aa) Hypothyroidism: Screening for congenital hypothyroidism in newborns.

bb) Screening for cervical dysplasia for sexually active females.

cc) Screening for sickle cell disease in newborns.

dd) Vision screening for all children at least once in all children between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.

ee) Screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up.

ff) Medical history: For all children throughout development.

gg) Behavioral Assessment for children of all ages. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

hh) Screening for this genetic disorder Phenylketonuria (PKU) in newborns.

ii) Obesity in children and adolescents: The USPSTF recommends that clinicians screen for obesity in children and adolescents (6) years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.

jj) Screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

kk) Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care. Also, is recommended repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at (24)-(28) weeks gestation, unless the biological father is known to be Rh (D)-negative.

ll) BRCA: Screening and risk assessment for women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.

mm) Screening for asymptomatic bacteriuria with urine culture for pregnant women at (12) to (16) weeks of gestation or at the first prenatal visit, if later.

nn) Screening for syphilis for all pregnant women and for any adolescent or adult who is at increased risk for infection.

oo) Screening for chlamydia and gonorrhea in sexually active women age (24) years or younger and in older women who are at increased risk for infection.

pp) Preventive medication for the eyes of all newborn for the prevention of gonorrhea.

qq) Skin cancer behavioral counseling The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.

rr) Preeclampsia prevention: aspirin, recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk. For aspirin, prescription is required.

ss) Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors: recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.

tt) Dental caries prevention: The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.

It is recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. The fluoride varnish is covered under the Dental Services Section.

uu) Oral health: Risk assessment for young children. Ages: (0) to (11) months, (1) to (4) years, (5) to (10) years.

vv) Lung cancer screening: recommends annual screening for lung cancer with low-dose computed tomography in adult ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

ww) Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. The USPSTF recommends exercise or physical therapy and vitamin D supplementation to prevent falls.

xx) Hepatitis B screening in persons at high risk for infection. Hepatitis B screening is also cover for pregnant women at their first prenatal visit.

yy) Hepatitis C virus infection screening: adults The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.

zz) Tuberculosis : Testing for children at higher risk of tuberculosis. Ages: (0) to (11) months, (1) to (4) years, (5) to (10) years, (11) to (14) years, (15) to (21) years.

aaa) Prevention of cardiovascular diseases: It is recommended that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.

bbb) Preeclampsia Screening in pregnant women with blood pressure measurements throughout pregnancy.

ccc) Tobacco Smoking cessation: The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.

ddd) Developmental Screening and Surveillance: Screening for children under age (3), and surveillance throughout childhood.

eee) Dyslipidemia: Screening for children at higher risk of lipid disorders. Ages: (1) to (4) years, (5) to (10) years, (11) to (14) years, (15) to (16) years.

fff) Hepatitis B virus infection: screening nonpregnant adolescents and adults The USPSTF recommends screening for hepatitis B virus (HBV) infection in persons at high risk for infection.

Tuberculosis latent infection screening: adults The USPSTF recommends screening for latent tuberculosis infection in populations at increased Risk.

2. Preventive services **covered at 100%** (without copay) when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF) and the Health Resources and Services Administration.

For more information and updates on preventive services, visit:
//www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

- Women's contraceptives and contraception counseling. All women's contraceptive methods approved by the Federal Drug Administration (FDA) by prescription are covered, including counseling, placement and removal of uterine devices, administration of medication and sterilization
- Any device insertion and removal of contraceptive methods is covered.

3. Preventive services **covered at 100%** (without copay) during and immediately following pregnancy when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF) and the Health Resources and Services Administration. For this service, insured has to call the *Humana Beginnings* program at 1-866-488-5992, for screening process. Humana recommends to participate in the Humana Beginnings Program starting the first trimester of gestation.

For more information and updates on preventive services, visit:
//www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

- Comprehensive breastfeeding support with guidance and counseling, during pregnancy and after birth, and the necessary breastfeeding equipment and supplies, including the breast pump with prescription.

4. Screening for Human Immunodeficiency Virus (HIV) covered at 100% (without co-payment or coinsurance), according to the recommendation of the Centers for Disease Control and Prevention (CDC) and in compliance to the Act No. 45 of May 16, 2016, as part of the routine testing of a medical evaluation at least once every five (5) years, based on the clinical criteria for adolescents and adults between the ages of thirteen (13) and Sixty-five (65) years of age at low risk. For people of high risk between the ages of thirteen (13) and sixty-five (65) is covered annually.

Clinicians should screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown. For pregnant women, two tests are covered: 1) A first HIV test during the first trimester of pregnancy at the first prenatal visit, and 2) A second test during the third trimester of pregnancy (between the (28) and (34) weeks of pregnancy.

Hospital Services

Hospital admissions must be authorized by Humana and the services to be offered must be provided under the determinations of an attending physician. A member or his (her) responsible caretaker is responsible for the predetermined co-payment for any admission that so specifies.

Inpatient Care:	$100.00 per admission
Outpatient Surgery-Facility:	$50.00 per rendered service

1. Hospital services included in the contracted per diem:
   - Semi-private room or similar facility, unlimited. In cases in which an insured use the services of a private room, it is his/her responsibility to pay the difference between the cost of medical services billed and the contracted fees.
   - Specialized units for critical care services including: intensive care unit (ICU), intermediate care unit, coronary care unit (CCU), neonatal intensive care unit (NICU), and pediatric intensive care unit (PICU).
   - Operating, recovery, and maternity rooms.
   - Drugs prescribed by physician during hospital stay that are included in the per diem.
   - Oxygen and its administration.
   - Laboratory and radiology.
   - Disposable supplies.
   - Special and regular diets.
   - Regular hospital nursing service

2. Hyperalimentation services, unlimited
3. Universal Neonatal Hearing Screening according to Law No. 311 dated on December 19, 2003, which includes: hearing evaluations for the follow-up treatment needed by the patient.
4. Surgical procedures for benefits included under the basic coverage.
5. Anesthetic agents and their administration including sedation. Anesthesia services and hospitalization services, unlimited, in accordance with Act No. 352 of 1999; Pre-authorization is required. These services will be available when the member has dental coverage with Humana and when at least one of the following scenarios occurs:

a. When a pediatric dentist, oral or maxillofacial surgeon member of the medical faculty of a hospital, licensed by the Government of Puerto Rico, determines that the member's condition is significantly complex in accordance with criteria established by the American Academy of Pediatric Dentistry.
b. When the patient due to age or disability is unable to resist or tolerate pain, or cooperate with the treatment indicated in dental procedures;
c. When the infant, child, adolescent or person with a physical or mental disability has a medical condition in which it is essential to carry out dental treatment under general anesthesia in an outpatient surgical center or hospital and which otherwise could represent a significant risk to the patient's health;
d. When local anesthesia is ineffective or contraindicated due to an acute infection, anatomical variation or allergic condition;

e. When the patient is an infant, child, adolescent, person with a physical or mental disability, and is in a state of fear or anxiety that prevents the dental treatment under traditional procedures of dental treatment and their condition Of such magnitude, that postponing or delaying treatment would result in pain, infection, loss of teeth or dental morbidity;
f. When a patient has received extensive and severe dental trauma where the use of local anesthesia would compromise the quality of services or be ineffective in managing pain and apprehension.

To evaluate the services, a medical order must be sent to Humana with the diagnosis of the insured, as well as the reasons that justify the use of general anesthesia and hospital. Humana will approve or deny the request, in accordance with the criteria previously established, within two (2) days as of the date on which the member submits all required documentation.

The documents are:

- Medical order with diagnostics.
- Justification in the medical order.

6. Sonogram, Computerized Tomography and Magnetic Resonance (MRI and MRA), unlimited
7. Electrocardiogram, unlimited
8. Nuclear medicine studies and digital angiography, unlimited.
9. Blood transfusions including autologous process, all components and compatibility tests.
10. Respiratory Therapy.
11. Physical Therapy, maximum of forty (40) therapy sessions per insured, per hospital stay.
12. Acute and chronic services related to End Stage Renal Disease, such as dialysis, hemodialysis and complications directly related to the disease are covered up to a maximum of ninety (90) days starting on the date on which the disease is diagnosed.
13. Treatment and services for morbid obesity as medically necessary. One (1) bariatric surgery using one of the following techniques, gastric bypass, and adjustable gastric band or sleeve gastrectomy per lifetime, according to Law No. 212 dated on August 9, 2008.
14. Surgical procedures in ambulatory surgery in a hospital, less applicable copayment or coinsurance.
15. Surgeon Assistant when medically necessary: pre-authorization required, less 25% coinsurance.

Transplant or Graft

Cornea transplant or bone, skin graft services received by the insured will be covered, less $100.00 copayment; pre-authorization is required. The covered transplant or graft includes pre-transplant, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation.

In-Home Services

In-Home Health Services, authorized by a main doctor and Humana.

Home health care must be provided by an agency that is dedicated, licensed and managed according to the regulations established by a group of medical professionals that keeps medical records of the patients and operates according to the laws of the Commonwealth of Puerto Rico. These services are covered if they begin within fourteen (14) days after release from a hospital or expert nursing facility due to a hospitalization of at least three (3) days, and are provided because of the same condition or in relation to the condition for which the patient was hospitalized.

If the patient is in the hospital, Home health services must be requested by the attending physician in the hospital. If the patient is out of the hospital, Home health services must be requested by the main doctor with medical justification. The doctor must present a care plan and estimated time of the duration of services, according to the individual needs of the patient. The program will provide education for the patient and family members responsible for his/her health care. This benefit will be covered for forty (40) days initially, and an additional twenty (20) days, subject to medical necessity certification.

In-home health services include:

1. Care by a nurse or under the supervision of a graduate nurse.
2. Respiratory therapy care, less $10.00 copayment
3. Collection of samples for lab tests, less 25% coinsurance
4. Care and maintenance of catheters.
5. Administration of intravenous antibiotics, subject to Humana's case management program.
6. Ulcer care through Humana's case management program.
7. Physical therapies, up to forty (40), less $10.00 copayment. For condition of autism, unlimited as mention in law No. 220 of September 4, 2012.
8. Occupational therapy for the purpose of training and aiding in the restoration of normal physical function and or prevent further deterioration of the same; resulting illness, from trauma, stroke or a surgical procedure while insured under the policy, unlimited for all conditions including autisms, less $15.00 copayment.
9. Speech therapy, when ordered by a physician and rendered by a licensed speech therapist; combined at the physician office or at home, up to a maximum of forty (40) therapy sessions per insured per policy year less $15.00 visit copayment. Speech therapies are unlimited for Autism and language as mention in Law No. 220 of September 4, 2012.
10. Hyperalimentation services, unlimited, less 25% coinsurance.

Skilled Nursing Facility

Skilled nursing facility covered up to a maximum of one hundred and twenty (120) days per insured per policy year, covered at 100%. These services will be covered if they begin within the fourteen (14) days following the release from the hospital due to a hospitalization of at least three (3) days, and if they are rendered because of the same condition or in relation to the condition leading to the hospitalization.

If the patient is in the hospital, Home health services must be requested by the attending physician in the hospital. If the patient is out of the hospital, Home health services must be requested by the main doctor with medical justification. Pre-authorization is required.

Durable Medical Equipment, Supplies, Prosthesis, Orthosis and Implants

1. The purchase or rental of medically necessary Durable Medical Equipment, less 25% coinsurance. The cost or rental of durable medical equipment will be covered. If the cost of renting the equipment is more than an insured would pay to buy it, Humana will covered up to the amount of the purchased equipment. We do not pay for equipment or devices not specifically designed and intended for the treatment of an injury or sickness. Required pre-authorization. Including glucometer and insulin pump mention in Law No. 177 of August 13, 2016. Covered for children and adults.

   Pre-authorization is required. If the endocrinologist recommends a specific glucometer due to the treatment utilizes, or order a particular insulin pump due to the necessity of the member, the provider must submit to Humana a justification. Humana will then cover the equipment specifically ordered by the endocrinologist, whether it is a specific glucometer or insulin pump is required.

2. Initial placement of a medically necessary prosthesis and its supportive device, except for those excluded. We will also cover the replacement of such prosthesis if it is determined by the insured's physician to be necessary because of growth or change. Less 25% coinsurance. Required pre-authorization.

3. Orthotics (No cover pre-fabricated, over-the-counter - OTC) and supplemented (No cover over-the-counter - OTC), less 25% coinsurance. Requires pre-authorization.

4. Implants, less 25% coinsurance. Requires pre-authorization.

Ambulance Services

Also an emergency may arise from a call managed thru the 911 System which refer to a dedicated telephone system that is available 24/7 for receiving emergency calls that deal with public security. System 9-1-1 was created by virtue of Law No. 144 dated on December 22nd, 1994 as amended, known as the "Law for rapid response to emergency calls with Public Security" or "Law for calls 9-1-1.

1. Land transportation by an ambulance, between facilities, authorized by the Public Service Commission and the Health Department as mention in Law No. 183 of August 6, 2008, to a hospital or between health facilities, e.g. between a hospital and a radiology institute or between a skilled nursing facility and a hospital, and when ordered by a physician, including psychiatric emergencies. Services requested for psychiatric and medical emergencies through the 911 will be paid in full directly to the provider.
2. Land transportation by an ambulance authorized by the Public Service Commission and the Health Department as mention in Law No. 183 of August 6, 2008, including psychiatric emergencies, less $35.00 copayment per trip.
   a. from the insured residence or place of emergency to the Skilled Nursing Facilities or Hospice, when is medically necessaries.
   b. From the hospital to the residence, if the condition of the patient discharged requires.
3. Land ambulance services for psychiatric and medical emergencies through 911 will be paid in full by Humana directly to the provider. The service will only cover if the insured meets the following requirements:

a. The patient suffered an illness or injury for which other types of transportation are not recommended;

b. Psychiatric emergencies as mention in Law No. 183 of August 6, 2008;

c. The health condition of the patient does not allow the use of other types of transportation;

d. It is not a case covered by the Automobile Accident Compensation Administration (ACAA), the State Workmen's Compensation Fund (CFSE) or any other insurance with primary responsibility

4. The general hospital and the psychiatric hospital must both comply with all EMTALA regulations regarding the draft and preparation of a "Protocol for the Process of Transferring Patients" which is here requested and required."

5. Maritime and air transportation services by an ambulance within Puerto Rico, subject to medical need for it, less $35.00 copayment. Pre-authorization is required unless it is a life or death emergency.

Cancer Services and Treatments

1. Ambulatory services for the treatment of radiotherapy and/or chemotherapy, including intravenously, via injection or intrathecally, according to the instructions of the medical doctor or oncologist. Oral chemotherapy is cover under the Pharmacy Coverage Section covered 100%. This is, according to Law No. 107 dated on June 5, 2012.

2. Medically necessary oral and parenteral medication for pain management of patients suffering terminal cancer.

3. All the benefits, including radiotherapy and/or chemotherapy in the hospital services, less $100.00 hospital copayment.

4. Stoma care and maintenance: colostomy, gastrostomy and cystostomy.

5. For the insured who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, the coverage includes:

   a) all stages of reconstruction of the breast on which the mastectomy has been performed

   b) surgery and reconstruction of the other breast to produce a symmetrical appearance

   c) prosthesis and physical complications of mastectomy, including lymphedemas

According to Law No. 275 dated on September 27, 2012, patients with a diagnosis of cancer have the following rights:

- To know and understand their treatment and rehabilitation plans, and the pain management protocol specifically appropriate for their case. The patient with cancer has the right to priority treatment for his/her pain; and is entitled to aggressive pain management techniques based on scientific evidence and approved by the Food and Drug Administration (FDA).

- To receive a copy of their file in an expeditious manner when they wish a second medical opinion or a consultation with another provider.

- The right to information, counseling and guidance regarding the possible short and long term effects on fertility of the cancer itself, and of the diagnostic tests and treatments to be received.

- Continuity in medical care and other health services, such as diagnostic tests for early detection, and access to oncologists, radiation therapists and surgical specialists involved in the initial diagnosis, and in his/her management once regarded a cancer survivor; continuity is necessary for close monitoring against recurrence and adverse effects of treatment, and to maintain physical and emotional health as a surviving patient with cancer.

- To be included in their employer's group healthcare insurance plan with no increase in their premium compared to all other members of the Group, and without exclusion of coverage because of a previous diagnosis of cancer.
- No private insurer can reduce benefits or terminate the policy of a patient with cancer, or that of a child who has survived cancer, as long as the health emergency lasts.
- Elderly patients who have a diagnosis of cancer or who are cancer survivors will be offered clear and up-to-date information about the prevention, detection and treatment of cancer taking into account conditions which might affect communication and their sensory, mobility or cognitive impairments. Elderly patients with a diagnosis of cancer will receive the support appropriate for their age, including but not limited to community support services and psychosocial and palliative services.
- Included as covered services will be pelvic examinations, and all type of vaginal cytology preparations which may be specifically required by medical order to detect, diagnose and treat early anomalies which might lead to cancer of the cervix.
- To provide extended coverage for the payment of studies and tests to monitor cancer of the breast, such as office visits to specialists, clinical breast examinations, mammography and digital mammography, magnetic resonance mammography and sono-mammography, and such treatments as, but not limited to, mastectomies, reconstructive surgery after mastectomy for the reconstruction of the removed breast, the reconstruction of the other breast to achieve a symmetrical appearance, breast prosthesis, treatment of complications at all stages of the mastectomy, including lymphedema (an inflammation which sometimes occurs after treatment for breast cancer), and any other reconstructive surgery after mastectomy which may be necessary for the physical and emotional recovery of the patient.

Maternity Services

The female employee, the wife or cohabitant, and the dependent daughter of any employee covered by the insurance plan for families or couples, will have maternity benefit coverage. The minimum hospital stay for both patient and newborn has been established by Law No. 248 of the Commonwealth of Puerto Rico dated on August 15, 1999, at 48 hours for a normal delivery, without complications, and 96 hours for a Cesarean-section delivery. Hospital discharges prior to length of stays stipulated by the law must have the consent of the patient. The maternity benefit covers a follow-up visit during the 48-hour period following discharge, at which time the newborn infant can also be checked. Services will include, but not be limited to support and physical care for the benefits of the minor, education to both parents on caring for the minor, support and training on breast feeding, orientation on support at home and the performance of any treatments and medicine test both for the infant and the mother.

Covered maternity benefits include the following services:

1. Hospitalization, less $100.00 copayment.
    a. Delivery, including Cesarean Section.
    b. Delivery and recovery rooms.
    c. Nursery and incubator.
    d. Neonatal intensive care unit (NICU)
    e. Fetal monitoring during delivery.
    f. Postpartum sterilization before discharge
2. Ambulatory (unlimited services)
    a. Pre-natal and post-natal care, less $15.00 copayment per visit
    b. Genetic amniocentesis, less 25% coinsurance
    c. Spontaneous abortion

d. Ambulatory fetal monitoring, less 25% coinsurance

e. Biophysical profile, unlimited.

3. Vaccines

   a. RhoGam Vaccine, less 25% of coinsurance
   b. Vaccine for the treatment of the Respiratory Syncytial Virus according to Law No. 165 dated on August 30, 2006 and protocol approved by Puerto Rico's Department of Health.

4. Ambulatory sterilization, covered at 100%.

Pediatric Services

1. Unlimited visits, less $15.00 copayment per visit.
2. Well Child Care, less $15.00 copayment per visit.
3. Universal Neonatal Hearing Screening, according to Law No. 311 dated on December 19, 2003, which includes: hearing evaluations for the follow-up treatment needed by the patient.
4. Annual exam according to Law No. 296 dated on September 1st, 2000, which includes: physical and mental evaluation, oral health, hearing and vision screening, and screenings recommended by the American Academy of Pediatrics.
5. Circumcision and dilatation for newborns before discharge from the hospital, at ambulatory facility, or physician office, less $50.00 copayment or $15.00 copayment.
6. Immunizations according to established medical practices and as recommended by the Advisory Committee on Immunization Practices (CDC) and the American Academy of Pediatrics, while included as insured under the policy, Human Papilloma Virus vaccine according to Law No. 255 dated on September 15, 2012. For children who have been sexually abused, the HPV vaccine (HPV) is covered beginning at age nine (9).
7. Coverage for technical equipment of ventilators for children which are vital for the maintenance of life, including children who depend on medical equipment such as respirators or supplemental oxygen, an 8-hour daily shift of a skilled nurse with experience in respiratory therapy or respiratory therapists with nursing experience, the necessary supplies to work with the technical equipment, physical and occupational therapy, laboratories, radiology, and prescribed medications which must be dispensed by a participating pharmacy of our network which is freely selected by our insured, all as authorized by the laws of Puerto Rico as outlined in Law No. 62 dated May 4, 2015, less copayment. For those who have started treatment as minors and become age 21, all the aforementioned services will continue to be covered. This benefit applies also to children who have had a tracheotomy to enable breathing and require home care because of the risk of airway obstruction; this requires a prescription by a physician.
8. Care and treatment of congenital defects and anomalies diagnosed by a doctor, without exclusion due to a preexisting condition. This covers newborns, recently adopted newborns or newborns recently placed for adoption. These services are subject to any applicable copayment or coinsurance.
9. Vaccine for the treatment of the Respiratory Syncytial Virus according to Law No. 165 dated August 30, 2006 and protocol approved by Puerto Rico's Department of Health. Pre-authorization required.

Urgent / Emergency Room Services

Services provided in Urgent / Emergency Rooms will be provided without prior-authorization or waiting period; will be provided regardless if the provider is a participating provider, according to the Law number 194 of August 25, 2000. For services provided in Urgent / Emergency Rooms of non-participant providers, the insured will pay to the

provider the same amount as if a participating provider, as long as there is an important and justifiable medical reason for not transferring the patient to a contracted facility.

If Urgent / Emergency services are provided to a patient by a non-participant provider, the patient is not responsible for payment of services that exceed the applicable amount if it had received the services of a participant provider. Humana will compensate the provider that offers the service and it will be obligated to accept such compensation with an amount of not less than the contracted by Humana to offer the same services. In addition, under these circumstances, such Urgent / Emergency services will be provided regardless of the conditions by the health insurance.

If the patient receives health services posterior to the urgent / emergency services, or after being stabilized, and these would normally be covered services except for the fact that they are rendered by a non-participating provider, Humana will reimburse the patient for that part of the costs incurred that would be normally paid by the plan, as long as there is an important and justifiable reason for not transferring the patient to a contracted facility.

Emergencies handled by the 911 system – this refers to the public safety system of urgent / emergency calls through the number 9-1-1.

After the insured individual receives complete urgent / emergency care and stabilization, the facility will transfer the patient to a Humana or Choice Care facility as soon as it is medically possible. Such transfer must not in any way affect the treatment being given or harm the insured patient's health. Humana will assist in the coordination of this transfer, as stipulated in Law No. 194 dated on August 25, 2000.

1. Urgent / Emergency room services due to accidents are covered in full.
2. Urgent room services resulting from illness are covered, less $35.00 copayment
3. Emergency room services resulting from illness are covered, less $35.00 copayment
4. Urgent / Emergency room services' copayment or coinsurance will be waived if patient is admitted; in that case the hospital admission copayment or coinsurance will apply.

For examples of emergency conditions, refer to the definition "Condition of emergency".

Protocol to be followed in the process of transferring patients with psychiatric conditions from one health facility to another.

Regarding an in-patient who presents emotional disturbances in a general hospital or in an urgent / emergency room:

1. Screening and evaluation of the patient will be performed as stipulated in Law No. 35 of 1994 and EMTALA, including all the necessary tests to establish a diagnosis.
2. Organic disease must be ruled-out before reaching a psychiatric diagnosis.
3. During initial evaluation, the general hospital must consider and rule-out the possibility that the etiology of the symptoms of anxiety and agitation presented by the patient at the moment of the emergency are of organic origin.
4. The personnel of the general hospital must consult a mental-health professional to establish continuity of care and obtain permission for transfer from the family or a person properly authorized.

5. The patient is to be stabilized in regard to his/her physical condition or illness. The time spent at the general hospital will depend on the evaluations of organic conditions necessary to establish the state of health of the individual. In cases of poisoning, the general hospital will be responsible for contacting the Poison Control Center in order to determine how long it will take to eliminate the potentially toxic substance taken by the patient. That time-frame will become the minimal period of time for the patient to remain in the urgent / emergency room before transfer to a psychiatric facility.

6. Once the patient's physical condition is stabilized he/she can be transferred to a psychiatric hospital. Simultaneously, the emergency room must send a clear and concise summary to the psychiatric facility of all tests and treatment done, follow-up recommended and information on the physician who attended the patient in the emergency room.

7. The attending physician at the general hospital is responsible for communicating by telephone with the psychiatric facility in order to discuss the case in detail and explain the symptoms and signs presented by the patient to be transferred. At the same time the patient's transfer can be coordinated.

8. The psychiatric hospital must commit to accept the patient to be transferred for further care.

If the patient involved has the economic capacity to pay for the transportation by ambulance or other means necessary for transfer, or has insurance which covers this service, the transportation necessary for transfer will be paid by the patient or his insurance. In such cases the hospital will be paid directly, if it has actually paid for these services; the health insurance plan is responsible for this payment to the hospital. Cases in which the patient is covered for mental health services by the government health insurance. If necessary, and in the absence of other alternatives, transportation will be provided by the ambulances which service the public safety system of emergency calls through 9-1-1. Transportation will be covered from wherever the patient who needs the service is located to whatever hospital facility that can provide the care necessary. Ambulance transportation must comply with the requirements of Law No. 35 of 1994 and EMTALA.

The general hospital and the psychiatric hospital must both comply with all EMTALA regulations regarding the draft and preparation of a "Protocol for the Process of Transferring Patients" which is here requested and required.

NOTE: Urgencies / Emergencies which are secondary to accidents are covered 100%. The urgent / emergency room copayment or coinsurance does not apply if the patient insured is admitted to the hospital; in that case the co-payment of admission to hospital applies.

Psychiatric urgencies / emergencies will be covered with the applicable copayment or coinsurance.

Cardiovascular Procedures

1. Diagnostic Tests and treatment, including the invasive and non-invasive cardiovascular procedures, less 25% of coinsurance.
2. Physician services, less $15.00 office copayment
3. Surgical procedures, less $50.00 facility copayment
4. Repair or replacement of heart valves, pacemaker and any other applicable device, with $0.00 copayment. Defibrillator pacemaker required pre-authorization.

Neurological Procedures

1. Diagnostic tests and treatment, less 25% of coinsurance.
2. Physician services, less $15.00 office copayment
3. Surgical procedures, including neuroendovascular, less $50.00 facility copayment
4. Repair or replacement of valves, and any other medically necessary device, with $0.00 copayment.

Mental Health Services

1. Unlimited visits to professionals, psychology doctors and other providers who because of their education, training or experience, and the proper competency, are able to offer psychological health services, less $15.00 copayment
2. Unlimited office visits to psychiatrist and/or psychologist of children and teens/adults less $15.00 copayment
3. Group therapies, less $15.00 copayment
4. Collateral visits, less $15.00 copayment
5. Unlimited hospital services, less $100.00 admission copayment. Two (2) days of partial hospitalization are equivalent to one (1) day of regular hospitalization.

This service includes emergency psychiatric transportation by an ambulance authorized by the Service Public Commission (*Comisión de Servicio Público*) and the Health Department (*Departamento de Salud*), as stated in Article 4.20 (b) of Law No. 183 of 6 August 2008. Services requested for psychiatric emergencies through the 911 will be paid in full directly to the provider.

Alcoholism & Substance Abuse Services

1. Unlimited visits to professionals, psychology doctors and other providers who because of their education, training or experience, and the proper competency, are able to offer health services in substance abuse, less $15.00 copayment
2. Unlimited office visits to psychiatrist and/or psychologist of children and teens/adults, less $15.00 copayment
3. Unlimited therapies, treatment and follow-up at one or more service levels, which may combine multiple types of therapy, less $15.00 copayment
4. Unlimited residential treatment for alcoholism and substance abuse including detox, less $100.00 copayment.
5. Unlimited hospital services, less $100.00 admission copayment. Two (2) days of partial hospitalization are equivalent to one (1) day of regular hospitalization. Pre-authorization required.

Autism

Autism is recognized as physico-mental health condition. In compliance with Law of Puerto Rico No. 220 dated on September 4, 2012 with the Puerto Rico Department of Health and utilizing as reference the guidelines of the American Association of Pediatrics coverage for these conditions will include diagnostic and therapeutic services in persons diagnosed with disorders within the continuum of Autism.

Covered benefits include visits to physicians and other health providers and the ordered tests and procedures determined to be medically necessary. The specialized services most commonly utilized are related to neurology, psychotherapy, immunology, genetics, gastroenterology, nutrition, speech and language therapy, occupational and physical therapy. Coverage/benefits are not limited only to the previously mentioned services. These services are subject to any applicable copayment or coinsurance, except for the screening for autism for children up to 36 months.

Dental Services

The dental care benefits described below are available using Humana's provider network in Puerto Rico.

Preventive and Diagnostic Services

The following services will be **covered at 100%** In-network:

1. Initial oral examination, one (1) every three (3) years
2. Periodic examination, one (1) every six (6) months
3. Specific oral evaluation, one (1) every six (6) months
4. Complete series of radiographs (FMX), one (1) every three (3) years
5. Panoramic radiographs, up to one (1) every three (3) years
6. Periapical radiographs, one (1) and five (5) additional per policy year
7. Bitewing radiographs, one (1) set every twelve (12) months
8. Prophylaxis adult and child, one (1) every six (6) months
9. Application of fluoride to children up to nineteen (19) years, one (1) every six (6) months
10. Sealants application, limited to children up to fourteen (14) years, one (1) treatment per tooth per lifetime in permanent molars and premolars not previously restored.
11. Application of fluoride varnish for infants and children up to age 5 years, one (1) every six (6) months.
12. Space maintainers, to replace deciduous teeth that are lost permanently, one (1) per area per lifetime.
13. Pulp vitality test, one (1) per visit
14. Re-cementation of space maintainer
15. General anesthesia, administered by an anesthesiologist, and hospital services according to Law No. 352 of December 22, 1999.

Non-Contracted Dentists

If the insured uses the services of a non-participant dentist or facility, Humana will reimburse the insured the fee of the contracted dentist or facility (with the receipt of the payment made to the dentist that provided the service).

Pediatric Vision Care Services

The vision care benefits described below are available until the 21st birthday.

Lenses: One (1) set of lenses per insured, per policy year, with $0.00 copayment. Service is available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers.

- ✓ Lenses for eyeglasses: the lenses included the following selection:
  - CR-39 Plastic for single vision lenses, bi-focal lenses, or tri-focal lenses
  - Polycarbonate for single vision lenses

Frames: The insured can select any frame available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers throughout Puerto Rico with $0.00 copayment. The benefit includes frame from the collection. Coverage includes one (1) frame per policy year.

Contact lenses: Instead of eyeglass benefit (frame and lenses), the member may choose standard disposable contact lenses. The disposable contact lens benefit consists of two (2) boxes per policy year, with $0.00 copayment. Services are available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers.

One (1) pair of low vision eyeglasses or magnifiers as medically necessary for insured with significant loss of vision (low vision), but not total blindness using an exclusive network of Humana Insurance, less $15.00 copayment.

Pharmacy Coverage

What is the formulary?

A Formulary is a prescription drug list developed and approved by Humana and which is regularly evaluated to include or exclude prescription drugs, which is used to determine benefits covered under the pharmacy coverage. The formulary includes generic/bioequivalent, preferred brand, non-preferred brand, and specialty drugs.

The formulary is available in our webpage, Humana.com. There, you can also find information about your prescription medications that may have Utilization Management requirements and the authorization forms with the information required to evaluate them, if applicable. Humana will provide the insured a copy of the formulary, along with information about which prescription drugs are subject to Utilization Management requirements.

Humana will require that the Pharmacy and Therapeutics Committee has an established process, in writing, to consider and update changes in formulary or those that may require Utilization Management, on a timely manner and based on:

- New scientific medical evidence or any other prescription drug related information for covered, non-covered or those that may require Utilization Management, to determine if a change is needed in the formulary or the utilization management criteria;

- if applicable, any clinical information that Humana receives, related to an exception request that would allow the Pharmacy and Therapeutics Committee to determine if the drugs covered in the formulary or those that may require Utilization Management, meet the member's needs, and

- safety and effectiveness information for covered drugs or those that may require Utilization Management, information about prescription drugs that may be clinically similar or bioequivalent, but that are not covered in the formulary nor require Utilization Management, information that may arise from quality assurance activities in the insurance company or information from prescription drug claims received after the latest Pharmacy and Therapeutic meeting.

- Humana will require that the Pharmacy and Therapeutics Committee performs the evaluation of new prescription drugs approved by the Food and Drug Administration (FDA) in no more than a ninety (90) days period, from the FDA approval date. The Pharmacy and Therapeutics Committee should make a determination to include or not include a new prescription drug in the formulary, in a term no more than ninety (90) days from the date the drug is available on the market.

Humana guarantees that the Pharmacy and Therapeutics Committee establishes disclosure policies and requirements in which the identification of possible conflicts of interest between members of the committee and the developers or manufacturers of prescription drugs is contemplated. No member of the Pharmacy and Therapeutics Committee may have any relationship or interest, financial or otherwise, with the developers or manufacturers of the prescription drugs.

Humana guarantees that the Pharmacy and Therapeutics Committee will establish and comply with a written procedure to evaluate medical and scientific evidence related to the safety and efficacy of prescription medications, including information to compare similar prescription medications and bioequivalent, on deciding which prescription medications are to be included in the formulary and on developing other pharmacy benefit management processes. Humana also guarantees that the Pharmacy and Therapeutics Committee will establish protocols for the analysis, and possible inclusion in formulary, of medications for "off-label use" for those health conditions in which, through medical or scientific evidence, the efficacy of the medication has been established.

Pharmacy and Therapeutics Committees must document all their protocols and processes and present registers and documents to Humana upon request.

Humana may contract with other persons to perform the functions of the Pharmacy and Therapeutics Committee. Humana will be accountable to the Commissioner of Insurance for non-compliance and violations incurred by its' Pharmacy and Therapeutics Committee.

Humana will only be able to make changes in the formulary or the Utilization Management while the policy is active; if the change is because of safety, the drug is no longer available in the market, if a new prescription drug will be added in the formulary. If this happened, Humana will notify this no later than when the change is made, to:

- All covered members and
- participating pharmacies, only if the change is because a new prescription drug will be added to the formulary. In this case, Humana will notify thirty (30) days before the change is made.

Humana will meet the following requirements:

Humana will maintain and facilitate the information below to the members, prescribers and pharmacies, by electronic means and if requested by the member or the Pharmacy, written:

- The formulary (prescription drug list) organized by therapeutic categories and the list known as "Maximum Allowable Cost";
- Information about prescription drugs and those that may require Utilization Management, if applicable, which was developed and maintained according to the "Código de Seguros de Salud de Puerto Rico".

- Information about the documentation that may need to be presented by the insured or the personal representative to request a medical exception and the way in which to present this documentation. For details, see Section Application and Process Exception in this Certificate.

How do I use the formulary?

Drugs are listed in the formulary alphabetically.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage based on FDA indications and dosing, like gender, age, and dose limitations. Requirements and limits may include:

- **Prior Authorization (PA):** Humana requires you or your doctor to get prior authorization for certain drugs. This means that your doctor must contact Humana to get approval before you fill or refill a prescription for any drug that needs prior authorization. Your plan benefits won't cover this drug without prior authorization. You'll pay the entire cost of the drug if you decide to buy it.
- **Quantity limits (QL):** For certain drugs Humana limits the amount of the drug that we'll cover. Humana might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. Specialty drugs are limited to a 30-day supply regardless of drug-tier placement.
- **Specialty drugs (SP):** High-cost drugs, including high technology and self-administered injectable medications, requiring special monitoring.
- **This coverage focuses on the use of bioequivalent drugs as a first alternative; however, the insured has the option to choose between a brand drug or a bioequivalent**. If an insured chooses to purchase a brand drug, and an equivalent generic/bioequivalente is available, the insured must pay the difference in cost between the brand and the generic/bioequivalent, plus any applicable brand copay or coinsurance dispensed. If the insured chooses the bioequivalent drug, he or she will only pay the copayment or coinsurance for the bioequivalent drug dispensed. If there is no bioequivalent alternative on the market, the insured will pay the applicable copayment or coinsurance for the brand-name drug dispensed. However, if the physician orders a brand-name drug and writes a prescription as dispensed as written, the insured is responsible only for the copayment or coinsurance of the brand name drug.

What if my drug is not on the formulary?

If your drug isn't included in this printed list of covered drugs, you should visit **Humana.com** to see if your drug is covered. You can also contact Customer Care and ask if your drug is covered.

If Humana doesn't cover your drug, you have two options:

- You can ask Customer Care for a list of similar drugs that are covered by Humana. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Humana.
- You can ask Humana to make an exception and cover your drug. See below for information about how to request an exception.

You are responsible, when applicable, for all or some of the payments for the following:

- The copayment or coinsurance*; and

* If the charge from the pharmacy dispensing the medication is lower than the copayment or coinsurance, you will be responsible for the lesser amount. The amount we pay the pharmacy for the medication might not reflect the final cost to us. Your copayments or coinsurances are made according to the prescription or refill of the prescription and will not be adjusted if Humana gets a discount for volume or a sale on prescription medications.

Pharmacy Annual Deductible

Deductible	Individual	Family
Network Provider	$0	$0
Non-Network Provider	$0	$0

Pharmacy Annual Deductible is the amount that an Individual / Family must pay for calendar year before Humana provides payment for pharmacy covered benefits. The deductible will not apply to Tier 1 Drugs. Once the Individual member in an Individual policy meets the applicable Individual annual deductible, Humana shall provide payment for covered benefits.

For Individual coverage or Family coverage, there is a deductible pharmacy services in-network and a deductible for pharmacy services out-of-network. Pharmacy expenses of benefits you might incur for covered expenses provided by a network provider will apply to the network providers' deductible. Pharmacy expenses you might incur (as provider fee for in-network) for covered expenses provided by out of network will apply to the out of network providers' deductible.

The accumulation period will begin on the effective date of the policy and will end when the policy terminates. From there on, it will be from the renovation date until the policy year end.

Coverage Description

Covered Prescription Drugs List

The following drugs will be covered when prescribed by an authorized doctor:

1. Drugs, medicines or medications that under Federal or state law, may be dispensed only by prescription from a health care practitioner; this includes brand, generic, acute and maintenance medications;
2. Drugs, medicines or medications that are included on the drug list, including the drugs covered by the "Patient protection and Affordable Care Act", like contraceptives, breast cancer risk-reducing medications, among others.
3. Insulin and diabetes supplies;
4. Hypodermic needles or syringes when prescribed by a health care practitioner for use with insulin or self-administered injectable drugs (Hypodermic needles and syringes used in conjunction with covered drugs may be available at no cost to you);
5. Specialty drugs and Self-Administered Injectable Drugs approved by Humana;
6. Spacers and/or peak flow meters for the treatment of asthma;

7. Drugs, medicines or medications on the Women's Healthcare Drug List with a prescription from a health care practitioner;
8. Buprenorphine.

Humana provides for the dispensed of covered drug, regardless of the condition, illness, injury, condition or disease for which they are prescribed, if:

• The drug has FDA approval for at least one indication and

• the drug is recognized for treatment of the disease, illness, injury, condition or disease in question in one of the standard reference compendia or through peer-reviewed medical literature generally accepted.

This drug coverage also includes medically necessary services that are associated with drug administration.

If *you* request a *brand-name medication* when a *generic medication* is available, *your payment* is greater. *You* are responsible for the applicable *generic medication copayment* or coinsurance and 100% of the difference between the amount *we* would have paid the dispensing *pharmacy* for the *brand-name medication* and the amount *we* would have paid the dispensing *pharmacy* for the *generic medication*. If the prescribing *physician* determines that the *brand-name medication* is *medically necessary*, *you* are only responsible for the applicable *copayment or coinsurance* of a *brand-name medication*.

Drugs, Medicines or Medications on the Women's Healthcare Drug List from a N*etwork Pharmacy* are covered in Full (without cost-sharing)

Prescription Drugs Covered without cost sharing from a Network Pharmacy. For more details please refer to drugs list/ formulary.

1. Generic aspirin, for both men and women from 45 to 79 with cardiovascular risk and as prevention of pre-eclampsia: after 12 weeks of gestation in women who are at high risk of pre-eclampsia, both with a medical prescription.
2. Generic folic acid for women planning a pregnancy, with medical prescription.
3. Cancer treatment included within the pharmacy benefit and processed (including oral and auto-administered injectable) in a Network Pharmacy is covered in full, with medical prescription. Intravenously and intrathecally are covered under the Cancer Services and Treatment Section.
4. Breast cancer risk-reducing medications, with medical prescription such as tamoxifen or raloxifene for women who are at increased risk for breast cancer and at low risk of adverse effects to the drug.
5. Smoking cessation drugs, including over-the-counter (OTC), with medical prescription. Covers smoking cessation drugs for 90 consecutive days in an attempt and two (2) cessation attempts per year.
6. Statins in low- to moderate-dose statin for the prevention of cardiovascular disease events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater.

Immunizations for infants, children, and adults are covered through the Medical Coverage in accord with accepted medical practice and as recommended by the Advisory Committee for Immunization Practices (ACIP) of the Centers for Disease Control (CDC), the American Academy of Pediatrics, and are also covered under the vaccination schedule of the Puerto Rico Department of Health.

Benefit Program

The healthcare provider will be able to prescribe maintenance medications to the member with enough refills not to exceed 180 days, according to the plan limitations, when the medical history of the member permits it and no risk are identified.

Contracted/participant pharmacy

Contracted or participant pharmacies are pharmacies that are legally authorized by the relevant authorities, which has signed a contract with Humana to provide pharmacy benefits to its insured.

You are responsible of the following:

Retail Pharmacy / Specialty Pharmacy

Tier 1 Drugs means a category of generic prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 1 drugs.

Tier 2 Drugs means a category of preferred brand prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 2 drugs.

Tier 3 Drugs means a category of non-preferred brand prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 3 drugs.

Tier 3 Drugs: Specialty Drugs means a category of specialty prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 3 drugs.

Tier 1 drugs	80% coinsurance per prescription or refill per 30-day supply
Tier 2 drugs	80% coinsurance per prescription or refill per 30-day supply
Tier 3 drugs	80% coinsurance per prescription or refill per 30-day supply
Tier 3 drugs: Specialty drugs	80% coinsurance per prescription or refill per 30-day supply

Specialty Drugs through Medical Coverage

Benefits:

A. When medically necessary, specialty drugs administered in a professional setting, including office or infusion center, are covered less the applicable copayment or coinsurance of the specialty drugs in the pharmacy coverage.
B. All utilization requirements of the pharmacy coverage, including but not limited to pre-authorization or quantity limits, shall apply.

90 days program

The retail pharmacies participate in our program which allows you to receive a 90-day supply of a prescription or refill. Your cost is 3 times the applicable copayment or coinsurance as outlined above. Self-administered injectable drugs and specialty drugs are limited to a 30-day supply from a retail pharmacy or specialty pharmacy.

Mail Order Pharmacy
This is a service that delivers medications by mail. It applies to prescriptions or refilled prescriptions covered in the policy.

For up to a 90-day supply of a prescription or refill	2 times the applicable copayment or coinsurance, as outlined above under Retail Pharmacy / Specialty Pharmacy

Mail Order Process:

Your health and well-being is very important to us. Please note that Humana Pharmacy can offer the value and services that you expect from your pharmacy. The routine process to be followed in procuring your maintenance medications by mail is easy and saves time.

The first time you use mail order to receive your medication, ask your doctor for two prescriptions. The first prescription should be written for a one-month supply that can be immediately filled at a participating retail pharmacy. The second prescription should be written for a 90-day supply of the medication with refills and the doctor will send it to Pharmacy Solution. You can use the service for all your maintenance medications.

1. Humana Pharmacy receives the request to fill your prescription. Your physician provider can actually send your prescription by fax (1-800-379-7617), through the telephone (1-800-833-1315-TTY: 711), by filling out a form designed for this purpose (Registration form for prescriptions by mail), onsite at HumanaParmacy.com, or by mail (Humana Pharmacy, PO Box 745099, Cincinnati, OH, 45274- 5099).
2. Humana Pharmacy verifies your pharmacy benefit coverage, enters your order and creates an exclusive shipping number.
3. The Humana pharmacist then reviews the order for a prescribed medication to verify that it is correct and complete. If it is incomplete or incorrect, it is returned with the reason for the rejection.
4. The Humana pharmacist approves the prescription.
5. After approved, the prescription then goes through the billing process.
6. An automated system fills your prescription and a pharmacist verifies that each medication is correct.
7. The prescription is filled in a period of seven (7) to ten (10) days of the time when Humana Pharmacy first received the request for your medications.

Out-Of-Network Pharmacy

When an *out-of-network pharmacy* is used, *you* must pay for the *prescription* or refill at the time it is dispensed. *You* must file a claim for reimbursement with *us*. In addition to any applicable *copayments coinsurances*, *prescription drug deductibles*, *you* are responsible for 30% of the *default rate* (the contracted fee that Humana agreed to pay a pharmacy within the network of providers for a drug) *and* the difference between the *default rate* and the *out-of-network pharmacy's* charge. Example: A pharmacy non-participant has a drug charge of $ 70.00 and the default rate is $50.00, the insured will be responsible for $ 15.00 (30% of the default rate-$ 50.00) plus $ 20.00 which is the price difference between the default rate ($50.00) and the charge of the drug in non-participating pharmacy ($70.00), plus the copayment that has that drug at a contracted pharmacy or coinsurance of the default rate. Any amount *you* pay over the *default rate* and any applicable *copayments*, coinsurances, *pharmacy annual deductible* and percentage amounts *you* pay to an *out-of-network pharmacy* do not apply toward *your maximum out-of-pocket* or any maximum *out-of-pocket*, if any. The charge received from an *out-of-network pharmacy* for a *prescription* or refill may be higher than the *default rate.*

Prior authorization

A prescription drug that is safe and effective for one person may not be safe and effective for another. This is why certain drugs must go through an evaluation and authorization process at Humana before they can be dispensed to members. This process is based on the evaluation of clinical standards for its safe use. The United States Food and Drug Administration (FDA) has recommended these drugs as safe and effective, but due to a high level of concern about their appropriate use, therapeutic indication, and cost, Humana's National Pharmacy and Therapeutics Committee has decided that a prior-authorization must be obtained for dispensing and use. To request coverage for a drug with prior authorization, the physician can contact the Humana Clinical Pharmacy Review (HCPR) at 1-866-488-5991 or by fax 1-855-681-8650

Prior authorization process:

The Humana Clinical Pharmacy Review (HCPR) will receive calls from providers requesting authorizations related to clinical review.

- Requests that require clinical review will be evaluated by the Humana Clinical Pharmacy Review (HCPR) staff. Decisions will be made according to approved clinical protocols established by the Humana's Pharmacy and Therapeutics Committee, as applicable.

- If the request is approved, the authorization is added on Humana's claim processing system. Then, the decision is notified to the person or entity who requested the authorization, whether the member, the physician, or personal representative.

- Requests that do not meet clinical criteria are denied and the decision is notified to the person or entity who has requested the authorization, whether the member, the physician, or the personal representative.

- If additional information is required to complete the evaluation of the request, a prior authorization form will be sent to physician's office by fax. If there is no fax available at physician's office it will be sent to pharmacy.

Humana Clinical Pharmacy Review (HCPR) will evaluate the request for authorization in a period not exceeding 72 hours after being received. In those cases where the physician requesting the case to be worked as expedited because the member's health could be affected, request will be evaluated in a period not exceeding 24 working hours.

Exception request and process

How do I request an exception to the formulary?

You, your physician, or your Personal Representative can contact Humana to ask for an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it's not on our formulary.
- You can ask us not to apply coverage restrictions or limits on your drug. For example, if your drug has a quantity limit, you can ask us not to apply the limit and to cover more.
- Continuum of coverage for a specific prescription drug that Humana will remove from the formulary for reasons other than health or because the drug is no longer available or because the manufacturer removed it from the market; or
- An exception to Utilization Management criteria that indicates the drug may not be covered in the prescribed quantity.

Your doctor should contact us to ask us for an initial coverage decision for a formulary or utilization restriction exception. We must make our decision within 72 hours of getting your prescribing doctor's supporting

statement. For controlled medicines, the term should not exceed thirty-six (36) hours after getting your prescribing doctor's supporting statement.

The member or your appointed representative will only be able to make a request in writing, if the physician or other prescriber has determined that the requested medication is medically necessary for the treatment of the disease of the member because:

a. There is no covered prescription drug in the plan's formulary that is a clinically accepted alternative to treat the member's disease:
b. The prescription drug alternative(s) listed on the formulary:
    i. Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
    ii. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
c. The number of doses available under a dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

The following information would be required as part of the supporting statement in an Exception request:

- Name , group number or policy ID, member ID;
- Patient's history
- Primary diagnosis, related to the requested prescription medication
- Reason why:
    - The covered prescription drug would not be an acceptable alternative for this member; or
    - The prescription drug alternative(s) listed on the formulary or required to be used in accordance with requirements would not be acceptable for this member; or
    - The number of doses available under a dose restriction for the requested prescription drug would not be acceptable;
- Reason why the Exception request is needed, for either the requested prescription drug or the limit of available doses.

Exception requests will be evaluated by appropriate healthcare professionals, according to the member's condition; who will consider specific facts and circumstances within each case and use clinical criteria that is:

- Based on scientific, clinical evidence based medicine; and
- If available, clinical practice guidelines, which may include, evidence based practice guidelines, clinical criteria developed by Humana's Pharmacy Committee or any other practice guidelines that may have been developed by the federal government, national associations or medical/pharmacy professional associations.

Experienced healthcare professionals will evaluate Exception requests according to the member's coverage - pharmacy benefit and exclusions.

If a medical exception is granted, Humana will provide coverage for the requested medication and will not require that the member requests an approval for a refill, nor for a new prescription, in order to continue using the same prescription drug after the refills of the first prescription run out. This is subject to the coverage terms and provided that:

a. The prescribing physician continues prescribing the medication for the same disease or medical condition;
b. The prescription drug continues being safe for the treatment of the member's disease or medical condition.

Humana will not establish a new or special formulary tier, copay for any other cost-sharing requirement that would only apply for the prescription drugs approved through the Exception process.

All denials for an exception request by Humana:

a. Will be notified to the member or the appointed representative, in writing, or by electronic means, if the member has agreed to receive the information that way;
b. Will notify, by electronic means, to the physician or other prescriber, as requested, in writing; and
c. It may be appealed through an appeal request, according to the Section Procedures to Address Complaints, Grievances and Appeals of the Policy.

The denial will describe in a comprehensible way for the member or the personal representative, if applicable:

a) The specific reason for the denial;

b) references to the evidence and documentation, which include the clinical criteria for evaluation and practice guidelines, clinical, medical and scientific evidence that was used and considered to make a denial determination for the request;

c) instructions on how to request a written statement for the clinical, medical and scientific justification of the denial; and

d) a description of the process and procedures to request an appeal for the decision, according to the Section Procedures to Address Complaints, Grievances and Appeals of the Policy, including the timeframes for these procedures.

If Humana does not make a decision with respect to the request for exception, or does not notify it in the above mentioned timeframe:

- The insured shall be entitled to be provided with the prescription drug that is the object of the request for up to thirty (30) days; and
- Humana shall make a decision with respect to the request for exception prior to that time when the insured finish the medication provided.
- If the insured finishes the medication provided, Humana shall maintain coverage under the same terms and in a continuous manner, so long as the same medication is prescribed to the insured and it is deemed safe for the treatment of the illness or medical condition, unless applicable limits to benefits have been exhausted.

If the member is not satisfied with Humana decision, he/she has the right to appeal it; following the Procedure to address Complaints, Grievances and Appeals that is part of the Policy and this Schedule of Benefits.

Other Benefits

Ambulatory Services

1. SPECT test, less 25% of coinsurance. Pre-authorization required.

2. Cardiovascular rehabilitation services at a dedicated center. Includes services by licensed physicians and registered nurses. Rehabilitation program must include education and supervised exercises that lead to risk factor recognition and management and improved exercise capacity. This benefit does not include maintenance exercise programs. Program must not exceed twelve (12) sessions in duration, less $100.00 copayment. Pre-authorization required.

3. Orthopedic devices: casts, splints, braces and crutches, with $0.00 copayment.
4. Laparoscopy, covered at ambulatory facility or at hospital, less $50.00 ambulatory facility copayment, $100.00 hospital copayment per rendered service.
5. Adult circumcision, less $15.00 office visit or $50.00 facility copayment.
6. Breast biopsies, unlimited, less $50.00 facility or $100.00 hospital copayment.
7. Allergy vaccines, up to a maximum of twenty (20) per insured, policy year, less 25% coinsurance.
8. Epidural blocks for pain management administered by medically qualified and recognized specialist, one (1) per anatomical region per insured per policy year, less $15.00 copayment.
9. Maxillofacial surgery, diagnostic and therapeutic services for accidental injuries, jaw fractures, neoplasms, injuries to natural teeth, including their replacement within a period of six months following an accident, provided the insured was covered by the policy when the accident occurred, less $100.00 copayment. Pre-authorization required.
10. Assistant Surgeon, when medically necessary: pre-notification required. Less applicable 25% coinsurance.
11. Reconstructive surgery for injuries due to an accident while the insured is covered under the policy and is not covered under any other program (ACAA, FSE, etc.), less $100.00 copayment.
12. Diagnostic tests and treatment associated with Hepatitis C, unlimited, less 25% coinsurance.
13. Diabetes paraphernalia for children and adults: lancets, syringes for insulin administration and glucometer strips up to a maximum of one hundred and fifty (150) of each one per month, less 25% coinsurance.
14. Hyperbaric Oxygenation treatment for people diagnosed with autism spectrum disorder, provided that it is recommended by a certified medical professional or health professional and the treatment is allowed by federal laws and regulations, as provided by Law 63 of July 19, 2019. Less $50.00 facility or $100.00 admission copayment.

Employee Assistance Program (EAP)

The program is offered by [Inspira, Lucy Lopez Roig, APS OptiMind] and includes the following:

1. Counseling, support, guidance and brief psychological therapy for life situations, including labor problems, emotional problems, relationships, and alcohol or drug abuse, covered at 100%, [Up to sixteen (16) sessions per policy year for each insured. Sessions are divided between the employee and dependents; eight (8) sessions for the employee and eight (8) sessions for dependents - Up to eight (8) visits per situation per insured – Unlimited]. Sessions may include the following:
    - crisis intervention
    - initial evaluation
    - marital or family counseling
    - referral to appropriate mental health resources when indicated for specialized treatment or assistance, including long-term therapy or psychiatric treatment.
2. Special crisis intervention services in case of catastrophic or traumatic events at the work-site.
3. Financial advice
4. Legal advice
5. Implementation orientation to administration and personnel
6. Workshops and orientations for employees
7. [Up to 10 occupational evaluations per employee]

Hospice

Hospice Care Program means a coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill insured and his or her insured family members, by providing palliative and supportive medical, nursing and other services through at-home or inpatient care. The hospice must be licensed according to the laws of the Commonwealth of Puerto Rico. It must provide a program of treatment for a person who have been medically diagnosed as having no reasonable prospect of cure for their illness and, as estimated by a physician, are expected to live less than six (6) months as a result of that illness.

Humana will pay benefits for charges for a hospice care program, which is submitted in writing and approved by us. The insured must submit in writing his or her intent to enroll in a hospice care program approved by us. Hospice benefits are subject to the applicable copayment. All the hospice services are subject to $100.00 admission copayment. All services must be received within a twelve (12) month period. Pre-authorization required.

Organ and Tissue Transplant

We will pay benefits of a Covered Organ Transplant as defined below, incurred by an insured for an organ transplant approved in advance by Humana, subject to those terms, conditions and limitations described below and contained in the group policy. These services are subject to any applicable copayment or coinsurance. Please contact the company's Transplant Management Department when in-need of these services.

Covered Organ Transplant means only the services, care, and treatment received for or in connection with the pre-approved transplant of the organs identified hereafter, which are determined by Humana to be medically necessary services and which are not experimental or investigational.

The covered organ transplant includes pre-transplant, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation of the following organs or procedures only:

a) Heart;
b) Lung(s);
c) Heart-lung;
d) Liver;
e) Kidney;
f) Bone Marrow;
g) Intestine;
h) Simultaneous pancreas/kidney;
i) Pancreas following kidney;
j) Any organ not listed above required by state or federal law.

The term bone marrow identified in the foregoing covered organ transplant definition refers to the transplant of human blood precursor cells which are administered to a patient following high dose, ablative or myelosuppresive chemotherapy. a) Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. b) If chemotherapy is an integral part of the treatment involving a covered organ transplant of bone marrow, the term bone marrow includes the harvesting, the transplantation and the chemotherapy components. c) Storage of cord blood and stem cells will not be covered unless as an integral part of a covered organ transplant of bone marrow approved by Humana.

For a covered organ transplant procedure to be considered totally approved, a written authorization by Humana is required.

a. The insured or his/her physician must notify Humana in advance regarding the need for an evaluation to determine if the organ transplant will be covered. Within five working days of the receipt of this request, Human will contact the insured and his/her physician to clarify transplant benefits available under the insurance, if any.

b. If the product includes benefits of organ transplants, and once the insured has chosen the facility for transplant, Humana proceeds to approve a pre-transplant evaluation.

c. The transplant facility proceeds with the evaluation of the candidate for transplant and must submit to Humana for review seven (7) specific points or articles evaluated.

d. Humana then reviews the clinical results of the facility's evaluation, confirms eligibility, and proceeds to approval on the same day.

e. For solid organ transplants, no medical review is necessary by Humana; bone marrow transplants do require a medical review for final determination.

f. If the transplant is denied, the insured and the physician will receive oral and written explanations of their rights to appeal through the Complaints, Grievances and Appeals system of Humana.

Covered Services:

For approved covered Organ Transplants and all related complications, we will cover only the following expenses:

1. Hospital benefits shown in the schedule of benefits under the Hospital Services section of the group policy will be paid at: (a) 100% of reasonable charges if received at a participating hospital designated by us as an approved transplant facility; and (b) 70% of reasonable charges if received at non-participating hospital.

   Physician benefits shown in this Schedule of Benefits under the Ambulatory Services section of this group policy will be paid at (a) 100% of reasonable charges if received from a participating physician designated by us as an approved transplant provider; and (b) 70% of reasonable charges if received form a non-participating physician.

2. Organ acquisition and donor costs. (a) Except for Bone Marrow transplants, donor costs are not payable under the group policy if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. (b) Coverage for Bone Marrow transplant procedures will include costs associated with donor-patient to the same extent and limitations associated with the insured, except the reasonable costs of searching for the donor may be limited to the immediate family members and the National Bone Marrow Donor Program.

3. Direct non-medical costs* for the insured receiving the covered organ transplant will be paid for: (a) transportation to and from the hospital where the covered organ transplant is performed; and (b) temporary lodging at a prearranged location up to $75.00 per day when requested by the hospital and approved by Humana.

   Transportation costs for the insured to and from the hospital where the covered organ transplant is performed will be paid at: (a) 100% of the reasonable charges if the covered organ transplant is received at a participating hospital designated by Humana as an approved transplant facility; or, (b) 70% of reasonable charges if the covered organ transplant is received at a non-participating hospital.

   Coverage of *non-medical cost will be available only if the insured will travel to the United States for transplant.

4. Direct non-medical costs* for one member of the insured's immediate family (two members if the patient is under age 18 years) will be paid for: (a) transportation to and from the approved facility where the covered organ transplant is performed; and (b) temporary lodging at a prearranged location during the insured's confinement in a hospital, not to exceed $75.00 per day.

   Transportation costs for the insured's immediate family member(s) to and from the hospital where the covered organ transplant is received.

   Coverage of non-medical* will be available only if an immediate family member(s) accompanies the patient to the United States for a transplant.

*All direct non-medical expenses for the insured receiving the covered organ transplant and his/her family member(s) are limited to a combined maximum coverage of $10,000.

Exclusions:

No benefit is payable for or in connection with a covered organ transplant if:

1. We are not contacted for authorization prior to referral for evaluation of the covered organ transplant, unless such authorization is waived by Humana.
2. We do not approve coverage for the covered organ transplant, based on our established criteria.
3. Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received.
4. The expense related to the transplantation of any non-human organ or tissue, unless otherwise stated in the group policy.
5. The expense related to the donation or acquisition of an organ for a recipient who is not covered by Humana.
6. A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow up care, immunosuppressive drugs, and complications of such transplant.
7. The insured for whom a covered organ transplant is requested has not met pre-transplant criteria as established by Humana.

Once the covered organ transplant is approved, we will advise the insured's physician. Benefits are payable only if the pre-transplant services, the covered organ transplant and post-discharge services are approved by Humana.

Services Out of Puerto Rico

Services rendered on the United States of America:

If insured needs a procedure, treatment, test or office visit in the United States as a second opinion, follow up treatment or because the treatment is not available in Puerto Rico, can submit evidence of the incurred expenses, we will reimburse according the established rates for each treatment in Puerto Rico. Apply the copayment or coinsurance of the benefit described in the policy. Pre-authorization required.

These do not include benefits not available in Puerto Rico, available in the United States of America. For these benefits, refer to Section Service Not Available in Puerto Rico, Available in the United States.

Emergency Services Outside Puerto Rico

I. Emergency Services (Including emergency hospitalizations) received in the United States of America:

A. Services received in contracted Humana or ChoiceCare facilities:

1. Whenever possible emergency services should be received in a facility contracted with the Humana or ChoiceCare Networks.
2. Humana P.R. must receive notice of all emergency services within 72 hours of the insured receiving the services.
3. Payments for emergency services and related admissions provided by a contracted provider will be paid according to the Urgent / Emergency Room Services Section under this Schedule of Benefits, less $35.00 copayment.

B. Services received outside of contracted Humana or ChoiceCare facilities:

1. For services provided in emergency rooms of non-participating providers, payment will be the same as if a participating provider, less $35.00 copayment.
2. The physician must receive notice of all emergency services within 72 hours of the insured receiving the services.

   The attending physician may transfer the insured to a contracted facility as soon as medically feasible. Such transfer should in no way compromise or be detrimental to the insured's medical condition or treatment. Humana will assist in the coordination of such transfer.

II. Emergency Services received outside the United States of America or Puerto Rico:

A. The insured will be reimbursed 100% of the contracted fee for similar services by a provider in Puerto Rico or, billed charges, whichever is less, less $35.00 copayment.

1. If the insured requires hospitalization and cannot be transported to a contracted facility in Puerto Rico or the United States, Humana will attempt to negotiate the best possible fee with the non-participating facility for the benefit of the insured.

2. If the insured can be transported without risk to a participating facility in the United States or Puerto Rico, then the admission copayment or coinsurance only will apply from this point forward.

All claims for services rendered outside of Puerto Rico or the United States must be submitted to Humana with all supporting medical and financial records within a period of one (1) year from the date of service or date of discharge (whichever is later) to ensure reimbursement where applicable.

Ambulatory Services for Dependent Studying in College in the United States of America

Dependent studying in college in the United States of America, as included in the definition of direct dependent, (b) through (g), can receive coverage for covered services provided by contracted providers in the United States. To receive coverage the following conditions must be met:

- The dependent studying college degree, in accordance to the definition of dependent indent (b) through (g), must be eligible for coverage, under the Plan and the ambulatory services received in the United States must be covered services under the Humana PPO Policy.

- The insured university student must be a full-time student at an accredited university in the United States. For purposes of this requirement, it will be presumed that the student is full-time if he/she studies twelve (12) credits; six (6) credits in the case of students studying graduate studies. Any exception to this assumption of credit requirements must be certified by the university institution.
- The dependent college student must coordinate and obtain prior authorization from Humana P.R. for the services unless the services meet criteria for urgent or emergency treatment as set forth in the Policy.
- Services provided by a provider in the Humana or ChoiceCare provider network shall be paid according to the benefits under the Policy. Any copays, coinsurance and/or deductibles set forth in the policy applicable to the benefits shall apply.

If the service is rendered by a provider not participating in the Humana or ChoiceCare network, the service will the service will be reimbursed based on contracted fees for similar services in Puerto Rico, less applicable copayments, coinsurances and deductibles. The insured is responsible for the difference between the Humana contracted rate in Puerto Rico and the facility billed charges.

Important:

1. ChoiceCare is a network of providers, including physicians and hospitals, contracted by Humana in the United States. The insured does not need to contact ChoiceCare to access a covered service. The logo on the card will be the identifier to the provider. Since the services require pre-authorization and coordination, Humana will help the insured identify the appropriate provider or facility. A full ChoiceCare directory is available on the web at www.humana.com.
2. For coordination or pre-authorization the member should call Humana's Customer Service Department at 1-800-314-3121.

Services Not Available in Puerto Rico, Available in the United States of America

This benefit is for services not available in Puerto Rico, available in the United States of America, including equipment, treatment and facilities, among others.

A. Humana will cover such services only if the following five conditions are met.

   1. The Insured must be eligible for coverage under the Plan and the services requested must be Included this Schedule of Benefits.

   2. The provider referring must demonstrate that the equipment, treatment or facilities required to provide medically necessary covered services to the insured are unavailable in Puerto Rico**.** A service will not be deemed unavailable in Puerto Rico if the request for services to be provided outside of Puerto Rico involves a modification to the equipment, technique, or surgical approach available in Puerto Rico or is based on the reputation or recognition of any given provider.

   3. The service must be coordinated and pre-authorized with Humana in Puerto Rico at least five (5) working days prior to the date the service will be rendered.

   4. The service must be provided by Humana or ChoiceCare network providers/facilities.

   5. All services under this Section are subject to the applicable copayments and coinsurances for services as described in this Schedule of Benefits.

B. These services or treatments require pre-authorization with Humana, except in emergencies**.** If the service or treatment is not authorized by and coordinated with Humana in Puerto Rico, the insured will be responsible for the entire payment for such service or treatment. Humana will reimburse the patient based on the applicable Humana fee in Puerto Rico, less applicable

copayments or coinsurances as described in this Schedule of benefits only if conditions A1, A2 are met. To receive reimbursement, the insured must provide Humana with all supporting medical and financial information within one (1) year of service or discharge.

Important Notes:

1. ChoiceCare is a network of providers, including physicians and hospitals, contracted by Humana in the United States. The insured does not need to contact ChoiceCare to access a covered service. The logo on the card will be the identifier to the provider. Since the services require pre-authorization and coordination, Humana will help the insured identify the appropriate provider or facility. A full ChoiceCare directory is available on the web at www.humana.com.

2. For coordination or pre-authorization the member should call Humana's Customer Service Department at 1-800-314-3121.

Telemedicine Service
(Virtual Medical Consultation)

Benefit:
Telemedicine service through virtual medical consultation to the insured allows you to receive access to health or minor emergency consultations with a certified primary care physician for the practice of Telemedicine in accordance with Act No. 168 of 2018. Less $20.00 copayment per virtual medical consultation. Through the following website: **www.mdlive.com/humanapr.**
As part of the services of this virtual platform, the insured can also share medical results of their studies.

In cases where the doctor understands that he or she needs medication use according to the insured's clinical picture, the prescription will be coordinated directly to the insured's preferred pharmacy through one of our contracted provider pharmacies.

This Telemedicine service does not replace your doctor, if you have an emergency, it is important that you call the emergency system at 911 or visit the nearest emergency room.

If the doctor determines that the condition by which the insured accesses the virtual consultation cannot be attended through this service, the insured will be immediately referred to an emergency room or personal doctor.

The insured is responsible for verifying their certificate of benefits, description of benefits and / or the medication form to verify if the service is covered.

Medical Exclusions

1. Procedures and/or health services in an experimental or research stage which are not supported by clinical evidence documented in the medical literature of the United States of America, except in connection with a life-threatening condition of the insured for which no effective treatment is available. Humana will pay only for the routine medical expenses associated with the order of such procedure or service which are not reimbursed by the entity conducting the service.
2. Expenses related to illness or injury resulting from war or uprisings.
3. Correspond Services be received, according to the State Workmen's' Compensation Fund Law (*Ley del Fondo de Seguro del Estado*), liability of the insured, private compensation plans at work, car accidents (Automobile Accident Compensation Administration (*Administración de Compensación por Accidentes de Automóviles*,

ACAA, for its Spanish acronym).and other services available under state or federal laws. They will also be excluded such services when they are denied by government agencies concerning non-compliance or violation of the requirements or provisions of the above laws, although such failure or violation does not constitute a crime.

4. Expenses caused by military service, war, civil insurrection, international armed conflict, except in those cases where the services received are related to an injury sustained while the insured was active in the military (service connected), in which case Humana will collected such charges from the U.S. Department of Veterans Affairs.
5. Accidents occurring while the insured is participating in races such as: automobile, motorcycle, four-track, boats or other tests of speed, in areas set aside for such activities or any other place.
6. Services provided and/or covered pursuant to state or federal legislation for which the Insured is not legally required to pay.
7. Services received free of charge, rendered by the spouse, parents, siblings, or children of the Insured.
8. Hospitalizations for procedures which can be performed on an ambulatory basis.
9. Hospitalization for diagnostic purposes only; custodial, rest or convalescence services.
10. Services rendered at a time when the policy is not in effect.
11. Electronic prosthesis, including myoelectric arm and cochlear implant, and the removal or insertion of any device, and any other described as non-covered, except the breast prosthesis covered in case of mastectomy.
12. Services considered unreasonable or medically unnecessary for diagnosis or treatment of an illness or injury.
13. Expenses for custodial services, private nurses, personal commodity services such as telephone, television, etc. and all medical services or expenses in convalescence facilities, except for home healthcare services which have been authorized by Humana.
14. Music therapy
15. Cosmetic/esthetic maxillofacial and dental procedures.
16. Esthetic mammoplasty except as applicable in Woman's Rights Cancer Act, and the esthetic mammoplasty in accordance with the Law No. 275 dated on September 27, 2012.
17. Cosmetic/esthetic surgery, except septoplasty when medically justified and with prior authorization.
18. Repair or replacement of instruments or prosthetic devices due to normal wear and tear and impairment.
19. Corrective footwear.
20. Services, treatments, and therapies of alternative medicine by physicians or other certified trained professionals, except naturopathic physician visits.
21. Sports medicine.
22. Eyeglasses and contact lenses for adults, hearing aids.
23. Congenital or genetic deformities and metabolic deformities, except in newborns, recently adopted newborns or newborns recently placed for adoption.
24. All services and/or treatments related to infertility or impotence, except test to detect infertility.
25. Expenses for Physical Examinations to adults required by the employer or health certificates for any type of license and all diagnostic tests or services for these purposes. Except for the annual exam according to Law No. 296 dated on September 1st, 2000, which includes: physical and mental evaluation, oral health, hearing and vision screening, and screenings recommended by the American Academy of Pediatrics.
26. Elective abortions.
27. Acne surgery and acne treatment, including drugs.
28. Growth hormones and all related treatment.

29. Embryo transplantation.
30. Human chorionic gonadotropin (HCG) injections.
31. Vaccinations required for travel.
32. Tuboplasty, vasovasostomy, and any procedure or service for the purpose of fertility.
33. Sickness or injury caused by the insured engaging in an illegal occupation; or committing or attempting to commit a criminal act, except those injuries resulting from an act of domestic violence or medical condition.
34. Enrollment in a health, athletic, or similar club; or a weight loss or similar program.
35. Purchase or rental of supplies of common household use such as: exercise cycles; air purifiers; central or unit air conditioners; water purifiers; allergenic pillows or mattresses; or waterbeds. Except for technical equipment of ventilators for children which are vital for the maintenance of life, including children and those who have started treatment as minors and become age 21, who depend on medical equipment such as respirators or supplemental oxygen, as authorized by the laws of Puerto Rico as outlined in Law Number 62 dated May 4, 2015.
36. Purchase or rental of: motorized transportation equipment; escalators or elevators; saunas or attachment pools; professional medical equipment such as blood pressure kits; or supplies or attachments for any of these items.
37. Expert witness required by a Court that is not included under the benefits or requirements of the mental health law.
38. Services and supplies for treatment of temporomandibular joint disorder or dysfunction (TMJ) and craniomandibular jaw disorders (CMJ) which are recognized as dental procedures. This includes, but is not limited to, the extraction of teeth and the application of orthodontic devices and splints.
39. New diagnostic and therapeutic services/procedures that are done with approved FDA equipment/devices that become available posterior to the effective date of the policy. Unless, the insured suffers from a life-threatening condition for which there is no effective treatment. Humana would then pay for routine medical expenses of the patient which are not covered by the entity carrying out the study.
40. Epidural anesthesia during delivery.
41. Air and maritime ambulance services outside of Puerto Rico, except for dependent studying in the United States
42. Any and all services or treatments not specifically described as covered benefits, except for the services and benefits included in a law that are required to be included in the coverage.

Dental Coverage Exclusions

1. Services or treatments presented for beauty or cosmetic reasons.
2. Services received free of charge; services rendered by spouses, parents, brothers/sisters or children of the insured.
3. Experimental or investigative procedures and/or services, or the drugs related to them.
4. Services rendered before the effective date of the policy.
5. Expenses related to injuries caused by war or disturbances.

6. Illnesses or accidents covered by the State Insurance Fund law -*Ley del Fondo del Seguro del Estado* (FSE) and/or the Automobile Accidents Compensation Administration -*Administración de Compensaciones por Accidentes de Automóviles* (ACAA).
7. Any benefit or service not specified in the dental coverage.
8. Services not used during the policy year do not accumulate for the following year.

Vision Coverage Limitations and Exclusions

1. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
2. Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan
3. Services provided as a result of any worker's compensation law (*Ley del Fondo del Seguro del Estado* -FSE) and/or the Automobile Accidents Compensation Administration (*Administración de Compensaciones por Accidentes de Automóviles* - ACAA).
4. Lenses or vision devices that are not prescribed.
5. Unspecified contact lenses on the vision coverage.
6. Any other frame that is out of the collection.
7. Any treatment or service that is not specified on the vision coverage.

Pharmacy Coverage Limitations and Exclusions

1. Legend drugs which are not deemed medically necessary by us;
2. Any drug prescribed for a sickness or bodily injury not covered under the policy;
3. Any drug, medicine or medication labeled "Caution-limited by federal law to investigational use" or any experimental or investigational drug, medicine or medication, even though a charge is made to you; not covered:
    a. Medications used in research trials which have the sponsorship of manufacturers or government entities.
    b. Medications or services offered during research trials when the sponsor of such tests offers these services and medications at no cost to the participants
4. Allergen extracts(covered under the Medical Coverage);
5. Therapeutic devices or appliances including, but not limited to:
    A. Hypodermic needles and syringes (except needles and syringes for use with insulin, and self-administered injectable drugs whose coverage is approved by us);
    B. Support garments;
    C. Test reagents;
    D. Mechanical pumps for delivery of medications; and

E. Other non-medical substances;

6. Dietary supplements; (except for formulas or low protein modified foods necessary for the treatment of phenylketonuria or certain other heritable diseases of amino and organic acids);
7. Nutritional products;
8. Minerals;
9. Herbs and vitamins, except Vitamin D, prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride, OTC Ferrous Sulfate which are covered for Women's Preventive Healthcare;
10. Anorectic or any drug used for the purpose of weight control;
11. Any drug used for cosmetic purposes, including but not limited to:
    A. Tretinoin;
    B. Dermatologicals or hair growth stimulants; or
    C. Pigmenting or de-pigmenting agents, e.g. Solaquin;
12. Any drug or medicine that is:
    a. Lawfully obtainable without a prescription (over the counter drugs), except insulin
13. Progesterone crystals or powder in any compounded dosage form;
14. Abortifacients (drugs used to induce abortions);
15. Infertility services including medications;
16. Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra;
17. Any drug, medicine or medication that is consumed or injected at the place where the prescription is given, or dispensed by the health care practitioner;
18. Prescriptions that are to be taken by or administered to you, in whole or in part, while you are a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
    A. Hospital;
    B. Skilled nursing facility; or
    C. Hospice facility;
    D. Physician office (unless coverage is approved by us)
19. Injectable drugs such as:
    A. Biological sera (covered under the Medical Coverage)
    B. Blood (covered under the Medical Coverage)
    C. Blood plasma (covered under the Medical Coverage)
20. Prescription refills:
    A. In excess of the number specified by the health care practitioner; or
    B. Dispensed more than one year from the date of the original order;
21. Any portion of a prescription or refill that exceeds a 90-day supply, received from a mail order pharmacy or a retail pharmacy that participates in our program which allows you to receive a 90-day supply of a prescription or refill;

22. Any portion of a prescription or refill that exceeds a 30-day supply, received from a retail pharmacy that does not participate in our program which allows you to receive a 90-day supply of a prescription or refill;

23. Any portion of a specialty drug or self-administered injectable drug received from a retail pharmacy or a specialty pharmacy that exceeds a 30-day supply, unless otherwise determined by us;
24. Any portion of a prescription or refill that:
    A. Exceeds our drug specific dispensing limit, e.g. IMITREX; or
    B. Is dispensed to an insured whose age is outside the drug specific age limits;
    C. Exceeds the duration-specific dispensing limit;
25. Any drug for which a charge is customarily not made;
26. Any drug, medicine or medication received by you:
    A. Before becoming covered under this rider; or
    B. After the date your coverage under this rider has ended;
27. Any costs related to the mailing, sending or delivery of prescription drugs;
28. Any intentional misuse (improper use)of this benefit, including prescriptions purchased for consumption by someone other than you;
29. Any prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
30. Drug delivery implants;
31. More than one prescription or refill for the same drug or therapeutic equivalent medication prescribed by one or more health care practitioners and dispensed by one or more pharmacies until you have used, or should have used, at least 75% of the previous prescription or refill, unless the drug or therapeutic equivalent medication is purchased through a mail order pharmacy, or a retail pharmacy that participates in our program which allows you to receive a 90-day supply of a prescription or refill, in which case you have used, or should have used 66% of the previous prescription. (Based on the dosage schedule prescribed by the health care practitioner);
32. Any copayment or coinsurance you paid for a prescription that has been filled, regardless of whether the prescription is revoked or changed due to adverse reaction or change in dosage or prescription;
33. Bulk Chemicals and Pain Patch not approved by the Food and Drug Administration (FDA)

34. When the FDA has determined that a medication is contraindicated for the condition for which it is prescribed.

These limitations and exclusions apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, service, treatment, supply, or prescription. This does not prevent your health care practitioner or pharmacist from providing or performing the procedure, service, treatment, supply, or prescription; however, the procedure, service, treatment, supply or prescription will not be a covered expense.

Humana Insurance of Puerto Rico, Inc.

(Hereinafter "the Company")

PPO Program Humana Complete
RX 3

19728PR0010

Schedule of Benefits Coverage

Schedule of Benefits

This schedule of benefits should be attached and made part of PPO Program Policy: Attachment I

Services and Benefits Procedures

1. Benefits and services are subject to the terms and conditions included in the group policy and to the exclusions and limitations described in this attachment.
2. Insured must receive services from participating facilities, contracted providers or under the order, direction and approval of the contracted provider upon presentation of the identification card issued by the Company. The Insured is responsible for paying applicable copayment, coinsurance or deductible.

Deductible

Deductible	Individual	Family
Network Provider	$0	$0
Non-Network Provider	$0	$0

Annual Maximum Out-of Pocket

Maximum out-of pocket limit	Individual	Family
Maximum out-of pocket limit ("MOOP") Network Provider	$6,350	$12,700
Maximum out-of pocket limit ("MOOP") Non-Network Provider	$19,050	$38,100

This includes copayments and coinsurance expenses of the Medical and Pharmacy coverage, in addition to accumulated expenses of the pharmacy benefits coverage deductibles.

Once the individual or family maximum out of pocket limit is met for the policy year for network providers, the percentage of benefits provided by network providers for covered expense will be paid at a rate of 100% for the rest of the policy year, subject to all terms, limits and exclusions of this Schedule of Benefits Coverage. Any expenses (medical and pharmacy) you might incur for covered expenses provided by a network provider will apply to the maximum out of pocket limit for network providers. Any expenses (medical and pharmacy) you might incur (as contracted fee for similar services by a provider in Puerto Rico) for covered expenses provided by out of network provider will apply to the maximum out of pocket limit for out of network providers.

The accumulation period will begin on the effective date of the policy and will end when the policy terminates. From there on, it will be from the renovation date until the policy year end.

The Maximum Out-of Pocket is based on the maximum amount allowed by the Office of the Commissioner of Insurance of Puerto Rico.

Essential Health Benefits

Ambulatory Services

The following services are covered, less any applicable co-insurance or copayment per visit:

1. Unlimited office visits to physicians, less applicable copayment or coinsurance:

   Generalists: $10.00

   Specialists: $15.00

   Sub-specialists: $15.00

2. Chiropractic Services, one (1) initial visit, one (1) follow-up visit, less $15.00 visit copayment or and up to twenty (20) manipulations per insured, per policy year. Physical therapies unlimited, less $10.00 copayment.
3. Six (6) Nutritionist consultations per insured per policy year, less $15.00 visit copayment or per visit.
4. Laboratories, X-rays and its reproduction, unlimited, less 30% of coinsurance. Genetic tests require pre-authorization, less 30% of coinsurance.
5. Electrocardiograms, unlimited, less 30% of coinsurance.
6. Sonograms, unlimited, less 30% of coinsurance.
7. Computerized tomography, unlimited, less 30% of coinsurance. Pre-authorization required.
8. Positron Emission Tomography (PET), unlimited, less 30% of coinsurance. Pre-authorization required.
9. Electroencephalogram, unlimited, less 30% of coinsurance.
10. Electromyogram, unlimited, less 30% of coinsurance.
11. Magnetic Resonance, including MRI and MRA, unlimited, less 30% of coinsurance. Preauthorization required.
12. One (1) sleep study or polysomnography covered per insured, per policy year, less 30% of coinsurance. Pre-authorization required.
13. Nuclear medicine tests, unlimited, less 30% of coinsurance.
14. Respiratory therapy, unlimited, less $10.00 copayment.
15. Physical therapy, including rehabilitation and habilitation, unlimited for all conditions including autisms, as prescribed and under the supervision of an orthopedist or a physical medicine specialist, less $10.00 copayment.

16. Speech therapy, combined at the physician office or at home, when ordered by a physician and rendered by a licensed speech therapist; up to a maximum of forty (40) therapies, per insured per policy year, less $15.00 copayment. Unlimited speech and language therapies for autism according to Law No. 220 of September 4, 2012.
17. Occupational therapy for the purpose of training and aiding in the restoration of normal physical function and or prevent further deterioration of the same; resulting illness, from trauma, stroke or a surgical procedure while insured under the policy, unlimited for all conditions including autisms, less $15.00 copayment.
18. Ambulatory surgery at ambulatory surgery facilities, including Mental Health, less $75.00 of copayment.
19. Endoscopies, diagnostic and therapeutic, unlimited, less $15.00 office copayment or less $75.00 facility copayment.
20. Lithotripsy, unlimited, less $75.00 ambulatory facility copayment per rendered service. Pre-authorization required.
21. Vasectomy at physician's office, less $15.00 office visit copayment.
22. Acute and chronic services related to End Stage Renal Disease, such as dialysis, hemodialysis and complications directly related to the disease are covered up to a maximum of ninety (90) days starting on the date on which the disease is diagnosed, In case of admission apply $150.00 copayment.
23. Allergy tests, including allergenic and biological extracts, drugs, patches and provocative tests, up to a maximum of fifty (50) tests per insured per policy year, less 30% coinsurance.
24. Intra-articular injections, unlimited, less $15.00 office copayment or less $75.00 facility copayment.
25. Audiologist visits according to Law No. 127 of September 27, 2007; Audiometry and tympanometry tests when ordered by a physician, one (1) of each test per insured, per policy year, less 30% of coinsurance.
26. Orthognathic surgery (mandibular or maxillary osteotomy - Le Fort). Expenses for implants related to orthognathic surgery are excluded, less $75.00 facility or $150.00 hospital copayment. Pre-authorization required.
27. Treatment and services for morbid obesity as medically necessary. One (1) bariatric surgery using one of the following techniques, gastric bypass, adjustable gastric band or sleeve gastrectomy per lifetime, according to Law 212 dated on August 9, 2008, less $150.00 copayment. Surgeries for removing excess skin (commonly known as folds) shall not be covered, unless the physician certifies that it is necessary to remove the excess skin because it affects the functions of any part of the body. Bariatric surgery requires pre-authorization.
28. In the event that an insured voluntarily enrolls in a research clinical trial, Humana will cover diagnostic tests which are usually associated with his condition as long as they are covered by his/her health insurance policy. These services are subject to the maximum limits specified under the policy, less $15.00 copayment or 30% coinsurance. Tests which are not covered by his/her policy, and which are strictly linked to the goal of the research, will not be reimbursed by Humana. The process and results of the investigation are the responsibility of the researcher and the insured.
29. Diagnostic tests and treatments associated with hemophilia, unlimited, less $15.00 copayment or 30% coinsurance.
30. Unlimited naturopathic physician visits according to Law 210 dated on December 14, 2007, less $15.00 copayment.
31. Eye refraction test by an ophthalmologist or optometrist, one (1) per insured per policy year within the Humana Insurance network, less $15.00 copayment.
32. Ophthalmic Diagnostic Tests, less $15.00 copayment.
33. Mammography, when they are not presented as a preventive test required by ACA, but as a follow up to a diagnosis or treatment of a condition, less $75.00 facility copayment.
34. Podiatry visits; Treatment of diseases and disorders of the foot and ankle, including injections and surgical procedures, less $15.00 visit copayment or $75.00 facility copayment.
35. Cervical Cryosurgery, less $15.00 copayment.

36. Nerve Conducting Velocity Test, unlimited, per policy year, less 30% coinsurance.

37. Humana will cover the Nutritional Supplement free of phenylalanine, based on low phenylalanine protein hydrolysates for patients diagnosed with the genetic disorder Phenylketonuria (PKU), without age limits, and for other recommended diagnostic, prevention and treatment of people with innate metabolic errors, in accordance to Act 139 of August 8, 2016. Covered at 100%.

38. Anesthesia services and hospitalization services, unlimited, in accordance with Act No. 352 of 1999; Pre-authorization is required. These services will be available when the member has dental coverage with Humana and when at least one of the following scenarios occurs:

    a. When a pediatric dentist, oral or maxillofacial surgeon member of the medical faculty of a hospital, licensed by the Government of Puerto Rico, determines that the member's condition is significantly complex in accordance with criteria established by the American Academy of Pediatric Dentistry.
    b. When the patient due to age or disability is unable to resist or tolerate pain, or cooperate with the treatment indicated in dental procedures;
    c. When the infant, child, adolescent or person with a physical or mental disability has a medical condition in which it is essential to carry out dental treatment under general anesthesia in an outpatient surgical center or hospital and which otherwise could represent a significant risk to the patient's health;
    d. When local anesthesia is ineffective or contraindicated due to an acute infection, anatomical variation or allergic condition;
    e. When the patient is an infant, child, adolescent, person with a physical or mental disability, and is in a state of fear or anxiety that prevents the dental treatment under traditional procedures of dental treatment and their condition Of such magnitude, that postponing or delaying treatment would result in pain, infection, loss of teeth or dental morbidity;
    f. When a patient has received extensive and severe dental trauma where the use of local anesthesia would compromise the quality of services or be ineffective in managing pain and apprehension.

To evaluate the services, a medical order must be sent to Humana with the diagnosis of the insured, as well as the reasons that justify the use of general anesthesia and hospital. Humana will approve or deny the request, in accordance with the criteria previously established, within two (2) days as of the date on which the member submits all required documentation.

The documents are:

- Medical order with diagnostics.
- Justification in the medical order.

Preventive Services

1. Annual preventive services are **covered at 100%** (without copayment or coinsurance) when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF), the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), The Health Resources and Services Administration, and the Puerto Rico Department of Health.

   For more information and updates on preventive services, visit: //www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

   a) Routine physical examination, including height, weight, and body mass index (BMI), for children and adults.

   b) High Blood pressure screening. The USPSTF recommends screening for high blood pressure in adults age (18) years and older. It is recommended obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.

   c) Cholesterol screening, for children and adults.

d) Screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults 40 years of age and older. The risks and benefits of these methods vary.

e) Screening for obesity, and counseling, for children and adults. The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of (30) kg/m2 or higher to intensive, multicomponent behavioral interventions.

f) Screening for Tobacco Use for all adult. The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA) approved pharmacotherapy for cessation to adults who use tobacco.

   The dispatch of FDA approved medication for smoke cessation is covered for (90) consecutive days in one intent and until (2) intents per year. Smoking cessation drugs are covered under the Pharmacy Coverage Section with prescription.

g) Tobacco use interventions: children and adolescents; recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

h) Screening for gestational diabetes mellitus (GDM) in asymptomatic pregnant women after (24) weeks of gestation and those at high risk of developing gestational diabetes.

i) Screening for abnormal blood glucose and Diabetes Mellitus Type 2 in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer, or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.

   In addition, it is recommended screening for diabetes type 2 in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than (135/80) mm Hg.

j) Screening for alcohol abuse, and behavioral counseling. It is recommended that clinicians screen adults aged (18) years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

k) Screening for tobacco, alcohol or drug use for children 11 to 21 years of age.

l) Immunizations for infants, children, and adults in accord with accepted medical practice and as recommended by the Advisory Committee for Immunization Practices (ACIP) of the Centers for Disease Control (CDC) and the American Academy of Pediatrics, as long as the individual is covered by this health insurance, including follow up (catch up).

   - Immunizations for Adults (21 years or older), including catch-ups – Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza (Flu Shot), Meningococcal, Measles/Mumps/Rubella, Pneumococcal, Tetanus/Diphtheria/Pertussis, Varicella

   - Immunizations for Children (less than 21 years old), including catch-ups – Haemophilus Influenzae Type b, Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza (Flu Shot), Meningococcal, Measles/Mumps/Rubella, Pneumococcal, Rotavirus, Tetanus/Diphtheria/Pertussis, Varicella, , inactivated poliovirus

m) Cervical cancer screening The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).

n) Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate. Office visits and consultations regarding checkups for healthy women (well-woman visits). Health and Human Services recognizes that several visits may be necessary to get all recommended preventive services, depending on the health status of women, their health needs and other risk factors.

o) Breast cancer mammography screenings every one (1) to two (2) years for insured over 40 years, biannual for insured between fifty (50) and seventy-four (74) years. This includes guidance and advice regarding chemoprevention, and the chemoprevention of breast cancer in women when indicated. Counseling for women at higher risk. The USPSTF recommends that clinicians engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk.

   For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk- reducing medications, such as tamoxifen or raloxifene.

p) Pap Smear

q) Prostatic Specific Antigen test (PSA) for men

r) Behavioral counseling regarding sexually transmitted diseases (STD's), for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs).

s) Screening for intimate partner violence (IPV), such as domestic violence, for women of childbearing age. Physicians shall also provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.

t) Screening for autism for children up to 36 months.

u) Osteoporosis screening: postmenopausal women younger than 65 years at increased risk of osteoporosis The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool. Osteoporosis screening: women 65 years and older. The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporosis fractures in women 65 years and older.

v) Screening for hearing loss all newborns infants.

w) Screening for elevated blood lead levels in children aged (1) to (6) years who are both at average and increased risk, and in asymptomatic pregnant women.

x) One (1) lifetime screening test for abdominal aortic aneurism (AAA) in men 65-75 years old who have ever been smokers.

y) Counseling regarding the use of aspirin in prevention of disease, for both men and women 45-79 years of age who are cardiovascular and colorectal cancer risks. The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged (50) to (59) years who have a (10)% or greater (10) year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least (10) years, and are willing to take low-dose aspirin daily for at least (10) years. For aspirin, prescription is required.

z) Counseling regarding folic acid supplements for women who may become pregnant. The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing (0.4) to (0.8) mg of folic acid. For folic acid, prescription is required.

aa) Hypothyroidism: Screening for congenital hypothyroidism in newborns.

bb) Screening for cervical dysplasia for sexually active females.

cc) Screening for sickle cell disease in newborns.

dd) Vision screening for all children at least once in all children between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.

ee) Screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up.

ff) Medical history: For all children throughout development.

gg) Behavioral Assessment for children of all ages. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

hh) Screening for this genetic disorder Phenylketonuria (PKU) in newborns.

ii) Obesity in children and adolescents: The USPSTF recommends that clinicians screen for obesity in children and adolescents (6) years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.

jj) Screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

kk) Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care. Also, is recommended repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at (24)-(28) weeks gestation, unless the biological father is known to be Rh (D)-negative.

ll) BRCA: Screening and risk assessment for women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.

mm) Screening for asymptomatic bacteriuria with urine culture for pregnant women at (12) to (16) weeks of gestation or at the first prenatal visit, if later.

nn) Screening for syphilis for all pregnant women and for any adolescent or adult who is at increased risk for infection.

oo) Screening for chlamydia and gonorrhea in sexually active women age (24) years or younger and in older women who are at increased risk for infection.

pp) Preventive medication for the eyes of all newborn for the prevention of gonorrhea.

qq) Skin cancer behavioral counseling The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.

rr) Preeclampsia prevention: aspirin, recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk. For aspirin, prescription is required.

ss) Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors: recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.

tt) Dental caries prevention: The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.

It is recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. The fluoride varnish is covered under the Dental Services Section.

uu) Oral health: Risk assessment for young children. Ages: (0) to (11) months, (1) to (4) years, (5) to (10) years.

vv) Lung cancer screening: recommends annual screening for lung cancer with low-dose computed tomography in adult ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

ww) Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. The USPSTF recommends exercise or physical therapy and vitamin D supplementation to prevent falls.

xx) Hepatitis B screening in persons at high risk for infection. Hepatitis B screening is also cover for pregnant women at their first prenatal visit.

yy) Hepatitis C virus infection screening: adults The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.

zz) Tuberculosis : Testing for children at higher risk of tuberculosis. Ages: (0) to (11) months, (1) to (4) years, (5) to (10) years, (11) to (14) years, (15) to (21) years.

aaa) Prevention of cardiovascular diseases: It is recommended that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.

bbb) Preeclampsia Screening in pregnant women with blood pressure measurements throughout pregnancy.

ccc) Tobacco Smoking cessation: The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.

ddd) Developmental Screening and Surveillance: Screening for children under age (3), and surveillance throughout childhood.

eee) Dyslipidemia: Screening for children at higher risk of lipid disorders. Ages: (1) to (4) years, (5) to (10) years, (11) to (14) years, (15) to (16) years.

fff) Hepatitis B virus infection: screening nonpregnant adolescents and adults The USPSTF recommends screening for hepatitis B virus (HBV) infection in persons at high risk for infection.

ggg) Tuberculosis latent infection screening: adults The USPSTF recommends screening for latent tuberculosis infection in populations at increased Risk.

2. Preventive services **covered at 100%** (without copay) when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF) and the Health Resources and Services Administration.

For more information and updates on preventive services, visit:
//www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

- Women's contraceptives and contraception counseling. All women's contraceptive methods approved by the Federal Drug Administration (FDA) by prescription are covered, including counseling, placement and removal of uterine devices, administration of medication and sterilization
- Any device insertion and removal of contraceptive methods is covered.

3. Preventive services **covered at 100%** (without copay) during and immediately following pregnancy when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF) and the Health Resources and Services Administration. For this service, insured has to call the *Humana Beginnings* program at 1-866-488-5992, for screening process. Humana recommends to participate in the Humana Beginnings Program starting the first trimester of gestation.

For more information and updates on preventive services, visit:
//www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

- Comprehensive breastfeeding support with guidance and counseling, during pregnancy and after birth, and the necessary breastfeeding equipment and supplies, including the breast pump with prescription.

4. Screening for Human Immunodeficiency Virus (HIV) covered at 100% (without co-payment or coinsurance), according to the recommendation of the Centers for Disease Control and Prevention (CDC) and in compliance to the Act No. 45 of May 16, 2016, as part of the routine testing of a medical evaluation at least once every five (5) years, based on the clinical criteria for adolescents and adults between the ages of thirteen (13) and Sixty-five (65) years of age at low risk. For people of high risk between the ages of thirteen (13) and sixty-five (65) is covered annually.

   Clinicians should screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown. For pregnant women, two tests are covered: 1) A first HIV test during the first trimester of pregnancy at the first prenatal visit, and 2) A second test during the third trimester of pregnancy (between the (28) and (34) weeks of pregnancy.

Hospital Services

Hospital admissions must be authorized by Humana and the services to be offered must be provided under the determinations of an attending physician. A member or his (her) responsible caretaker is responsible for the predetermined co-payment for any admission that so specifies.

Inpatient Care:	$150.00 per admission
Outpatient Surgery-Facility:	$75.00 per rendered service

1. Hospital services included in the contracted per diem:
   - Semi-private room or similar facility, unlimited. In cases in which an insured use the services of a private room, it is his/her responsibility to pay the difference between the cost of medical services billed and the contracted fees.
   - Specialized units for critical care services including: intensive care unit (ICU), intermediate care unit, coronary care unit (CCU), neonatal intensive care unit (NICU), and pediatric intensive care unit (PICU).
   - Operating, recovery, and maternity rooms.
   - Drugs prescribed by physician during hospital stay that are included in the per diem.
   - Oxygen and its administration.
   - Laboratory and radiology.
   - Disposable supplies.
   - Special and regular diets.
   - Regular hospital nursing service

2. Hyperalimentation services, unlimited
3. Universal Neonatal Hearing Screening according to Law No. 311 dated on December 19, 2003, which includes: hearing evaluations for the follow-up treatment needed by the patient.
4. Surgical procedures for benefits included under the basic coverage.
5. Anesthetic agents and their administration including sedation. Anesthesia services and hospitalization services, unlimited, in accordance with Act No. 352 of 1999; Pre-authorization is required. These services will

be available when the member has dental coverage with Humana and when at least one of the following scenarios occurs:

a. When a pediatric dentist, oral or maxillofacial surgeon member of the medical faculty of a hospital, licensed by the Government of Puerto Rico, determines that the member's condition is significantly complex in accordance with criteria established by the American Academy of Pediatric Dentistry.
b. When the patient due to age or disability is unable to resist or tolerate pain, or cooperate with the treatment indicated in dental procedures;
c. When the infant, child, adolescent or person with a physical or mental disability has a medical condition in which it is essential to carry out dental treatment under general anesthesia in an outpatient surgical center or hospital and which otherwise could represent a significant risk to the patient's health;
d. When local anesthesia is ineffective or contraindicated due to an acute infection, anatomical variation or allergic condition;

e. When the patient is an infant, child, adolescent, person with a physical or mental disability, and is in a state of fear or anxiety that prevents the dental treatment under traditional procedures of dental treatment and their condition Of such magnitude, that postponing or delaying treatment would result in pain, infection, loss of teeth or dental morbidity;
f. When a patient has received extensive and severe dental trauma where the use of local anesthesia would compromise the quality of services or be ineffective in managing pain and apprehension.

To evaluate the services, a medical order must be sent to Humana with the diagnosis of the insured, as well as the reasons that justify the use of general anesthesia and hospital. Humana will approve or deny the request, in accordance with the criteria previously established, within two (2) days as of the date on which the member submits all required documentation.

The documents are:

- Medical order with diagnostics.
- Justification in the medical order.

6. Sonogram, Computerized Tomography and Magnetic Resonance (MRI and MRA), unlimited
7. Electrocardiogram, unlimited
8. Nuclear medicine studies and digital angiography, unlimited.
9. Blood transfusions including autologous process, all components and compatibility tests.
10. Respiratory Therapy.
11. Physical Therapy, maximum of forty (40) therapy sessions per insured, per hospital stay.
12. Acute and chronic services related to End Stage Renal Disease, such as dialysis, hemodialysis and complications directly related to the disease are covered up to a maximum of ninety (90) days starting on the date on which the disease is diagnosed.
13. Treatment and services for morbid obesity as medically necessary. One (1) bariatric surgery using one of the following techniques, gastric bypass, and adjustable gastric band or sleeve gastrectomy per lifetime, according to Law No. 212 dated on August 9, 2008.
14. Surgical procedures in ambulatory surgery in a hospital, less applicable copayment or coinsurance.
15. Surgeon Assistant when medically necessary: pre-authorization required, less 30% coinsurance.

Transplant or Graft

Cornea transplant or bone, skin graft services received by the insured will be covered, less $150.00 copayment; pre-authorization is required. The covered transplant or graft includes pre-transplant, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation.

In-Home Services

In-Home Health Services, authorized by a main doctor and Humana.

Home health care must be provided by an agency that is dedicated, licensed and managed according to the regulations established by a group of medical professionals that keeps medical records of the patients and operates according to the laws of the Commonwealth of Puerto Rico. These services are covered if they begin within fourteen (14) days after release from a hospital or expert nursing facility due to a hospitalization of at least three (3) days, and are provided because of the same condition or in relation to the condition for which the patient was hospitalized.

If the patient is in the hospital, Home health services must be requested by the attending physician in the hospital. If the patient is out of the hospital, Home health services must be requested by the main doctor with medical justification. The doctor must present a care plan and estimated time of the duration of services, according to the individual needs of the patient. The program will provide education for the patient and family members responsible for his/her health care. This benefit will be covered for forty (40) days initially, and an additional twenty (20) days, subject to medical necessity certification.

In-home health services include:

1. Care by a nurse or under the supervision of a graduate nurse.
2. Respiratory therapy care, less $10.00 copayment
3. Collection of samples for lab tests, less 30% coinsurance
4. Care and maintenance of catheters.
5. Administration of intravenous antibiotics, subject to Humana's case management program.
6. Ulcer care through Humana's case management program.
7. Physical therapies, up to forty (40), less $10.00 copayment. For condition of autism, unlimited as mention in law No. 220 of September 4, 2012.
8. Occupational therapy for the purpose of training and aiding in the restoration of normal physical function and or prevent further deterioration of the same; resulting illness, from trauma, stroke or a surgical procedure while insured under the policy, unlimited for all conditions including autisms, less $15.00 copayment.
9. Speech therapy, when ordered by a physician and rendered by a licensed speech therapist; combined at the physician office or at home, up to a maximum of forty (40) therapy sessions per insured per policy year less $15.00 visit copayment. Speech therapies are unlimited for Autism and language as mention in Law No. 220 of September 4, 2012.
10. Hyperalimentation services, unlimited, less 30% coinsurance.

Skilled Nursing Facility

Skilled nursing facility covered up to a maximum of one hundred and twenty (120) days per insured per policy year, covered at 100%. These services will be covered if they begin within the fourteen (14) days following the release

from the hospital due to a hospitalization of at least three (3) days, and if they are rendered because of the same condition or in relation to the condition leading to the hospitalization.

If the patient is in the hospital, Home health services must be requested by the attending physician in the hospital. If the patient is out of the hospital, Home health services must be requested by the main doctor with medical justification. Pre-authorization is required.

Durable Medical Equipment, Supplies, Prosthesis, Orthosis and Implants

1. The purchase or rental of medically necessary Durable Medical Equipment, less 30% coinsurance. The cost or rental of durable medical equipment will be covered. If the cost of renting the equipment is more than an insured would pay to buy it, Humana will covered up to the amount of the purchased equipment. We do not pay for equipment or devices not specifically designed and intended for the treatment of an injury or sickness. Required pre-authorization. Including glucometer and insulin pump mention in Law No. 177 of August 13, 2016. Covered for children and adults.

   Pre-authorization is required. If the endocrinologist recommends a specific glucometer due to the treatment utilizes, or order a particular insulin pump due to the necessity of the member, the provider must submit to Humana a justification. Humana will then cover the equipment specifically ordered by the endocrinologist, whether it is a specific glucometer or insulin pump is required.

2. Initial placement of a medically necessary prosthesis and its supportive device, except for those excluded. We will also cover the replacement of such prosthesis if it is determined by the insured's physician to be necessary because of growth or change. Less 30% coinsurance. Required pre-authorization.

3. Orthotics (No cover pre-fabricated, over-the-counter - OTC) and supplemented (No cover over-the-counter - OTC), less 30% coinsurance. Requires pre-authorization.

4. Implants, less 30% coinsurance. Requires pre-authorization.

Ambulance Services

Also an emergency may arise from a call managed thru the 911 System which refer to a dedicated telephone system that is available 24/7 for receiving emergency calls that deal with public security. System 9-1-1 was created by virtue of Law No. 144 dated on December 22nd, 1994 as amended, known as the "Law for rapid response to emergency calls with Public Security" or "Law for calls 9-1-1.

1. Land transportation by an ambulance, between facilities, authorized by the Public Service Commission and the Health Department as mention in Law No. 183 of August 6, 2008, to a hospital or between health facilities, e.g. between a hospital and a radiology institute or between a skilled nursing facility and a hospital, and when ordered by a physician, including psychiatric emergencies. Services requested for psychiatric and medical emergencies through the 911 will be paid in full directly to the provider.
2. Land transportation by an ambulance authorized by the Public Service Commission and the Health Department as mention in Law No. 183 of August 6, 2008, including psychiatric emergencies, less $50.00 copayment per trip.
   a. from the insured residence or place of emergency to the Skilled Nursing Facilities or Hospice, when is medically necessaries.
   b. From the hospital to the residence, if the condition of the patient discharged requires.

3. Land ambulance services for psychiatric and medical emergencies through 911 will be paid in full by Humana directly to the provider. The service will only cover if the insured meets the following requirements:
    a. The patient suffered an illness or injury for which other types of transportation are not recommended;
    b. Psychiatric emergencies as mention in Law No. 183 of August 6, 2008;
    c. The health condition of the patient does not allow the use of other types of transportation;
    d. It is not a case covered by the Automobile Accident Compensation Administration (ACAA), the State Workmen's Compensation Fund (CFSE) or any other insurance with primary responsibility
4. The general hospital and the psychiatric hospital must both comply with all EMTALA regulations regarding the draft and preparation of a "Protocol for the Process of Transferring Patients" which is here requested and required."
5. Maritime and air transportation services by an ambulance within Puerto Rico, subject to medical need for it, less $50.00 copayment. Pre-authorization is required unless it is a life or death emergency.

Cancer Services and Treatments

1. Ambulatory services for the treatment of radiotherapy and/or chemotherapy, including intravenously, via injection or intrathecally, according to the instructions of the medical doctor or oncologist. Oral chemotherapy is cover under the Pharmacy Coverage Section covered 100%. This is, according to Law No. 107 dated on June 5, 2012.
2. Medically necessary oral and parenteral medication for pain management of patients suffering terminal cancer.
3. All the benefits, including radiotherapy and/or chemotherapy in the hospital services, less $150.00 hospital copayment.
4. Stoma care and maintenance: colostomy, gastrostomy and cystostomy.
5. For the insured who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, the coverage includes:
    a) all stages of reconstruction of the breast on which the mastectomy has been performed
    b) surgery and reconstruction of the other breast to produce a symmetrical appearance
    c) prosthesis and physical complications of mastectomy, including lymphedemas

According to Law No. 275 dated on September 27, 2012, patients with a diagnosis of cancer have the following rights:

- To know and understand their treatment and rehabilitation plans, and the pain management protocol specifically appropriate for their case. The patient with cancer has the right to priority treatment for his/her pain; and is entitled to aggressive pain management techniques based on scientific evidence and approved by the Food and Drug Administration (FDA).
- To receive a copy of their file in an expeditious manner when they wish a second medical opinion or a consultation with another provider.
- The right to information, counseling and guidance regarding the possible short and long term effects on fertility of the cancer itself, and of the diagnostic tests and treatments to be received.
- Continuity in medical care and other health services, such as diagnostic tests for early detection, and access to oncologists, radiation therapists and surgical specialists involved in the initial diagnosis, and in his/her management once regarded a cancer survivor; continuity is necessary for close monitoring against

recurrence and adverse effects of treatment, and to maintain physical and emotional health as a surviving patient with cancer.

- To be included in their employer's group healthcare insurance plan with no increase in their premium compared to all other members of the Group, and without exclusion of coverage because of a previous diagnosis of cancer.
- No private insurer can reduce benefits or terminate the policy of a patient with cancer, or that of a child who has survived cancer, as long as the health emergency lasts.
- Elderly patients who have a diagnosis of cancer or who are cancer survivors will be offered clear and up-to-date information about the prevention, detection and treatment of cancer taking into account conditions which might affect communication and their sensory, mobility or cognitive impairments. Elderly patients with a diagnosis of cancer will receive the support appropriate for their age, including but not limited to community support services and psychosocial and palliative services.
- Included as covered services will be pelvic examinations, and all type of vaginal cytology preparations which may be specifically required by medical order to detect, diagnose and treat early anomalies which might lead to cancer of the cervix.
- To provide extended coverage for the payment of studies and tests to monitor cancer of the breast, such as office visits to specialists, clinical breast examinations, mammography and digital mammography, magnetic resonance mammography and sono-mammography, and such treatments as, but not limited to, mastectomies, reconstructive surgery after mastectomy for the reconstruction of the removed breast, the reconstruction of the other breast to achieve a symmetrical appearance, breast prosthesis, treatment of complications at all stages of the mastectomy, including lymphedema (an inflammation which sometimes occurs after treatment for breast cancer), and any other reconstructive surgery after mastectomy which may be necessary for the physical and emotional recovery of the patient.

Maternity Services

The female employee, the wife or cohabitant, and the dependent daughter of any employee covered by the insurance plan for families or couples, will have maternity benefit coverage. The minimum hospital stay for both patient and newborn has been established by Law No. 248 of the Commonwealth of Puerto Rico dated on August 15, 1999, at 48 hours for a normal delivery, without complications, and 96 hours for a Cesarean-section delivery. Hospital discharges prior to length of stays stipulated by the law must have the consent of the patient. The maternity benefit covers a follow-up visit during the 48-hour period following discharge, at which time the newborn infant can also be checked. Services will include, but not be limited to support and physical care for the benefits of the minor, education to both parents on caring for the minor, support and training on breast feeding, orientation on support at home and the performance of any treatments and medicine test both for the infant and the mother.

Covered maternity benefits include the following services:

1. Hospitalization, less $150.00 copayment.
    a. Delivery, including Cesarean Section.
    b. Delivery and recovery rooms.
    c. Nursery and incubator.
    d. Neonatal intensive care unit (NICU)
    e. Fetal monitoring during delivery.
    f. Postpartum sterilization before discharge
2. Ambulatory (unlimited services)
    a. Pre-natal and post-natal care, less $15.00 copayment per visit

b. Genetic amniocentesis, less 30% coinsurance

c. Spontaneous abortion

d. Ambulatory fetal monitoring, less 30% coinsurance

e. Biophysical profile, unlimited.

3. Vaccines

   a. RhoGam Vaccine, less 30% of coinsurance
   b. Vaccine for the treatment of the Respiratory Syncytial Virus according to Law No. 165 dated on August 30, 2006 and protocol approved by Puerto Rico's Department of Health.

4. Ambulatory sterilization, covered at 100%.

Pediatric Services

1. Unlimited visits, less $15.00 copayment per visit.
2. Well Child Care, less $15.00 copayment per visit.
3. Universal Neonatal Hearing Screening, according to Law No. 311 dated on December 19, 2003, which includes: hearing evaluations for the follow-up treatment needed by the patient.
4. Annual exam according to Law No. 296 dated on September 1st, 2000, which includes: physical and mental evaluation, oral health, hearing and vision screening, and screenings recommended by the American Academy of Pediatrics.
5. Circumcision and dilatation for newborns before discharge from the hospital, at ambulatory facility, or physician office, less $75.00 copayment or $15.00 copayment.
6. Immunizations according to established medical practices and as recommended by the Advisory Committee on Immunization Practices (CDC) and the American Academy of Pediatrics, while included as insured under the policy, Human Papilloma Virus vaccine according to Law No. 255 dated on September 15, 2012. For children who have been sexually abused, the HPV vaccine (HPV) is covered beginning at age nine (9).
7. Coverage for technical equipment of ventilators for children which are vital for the maintenance of life, including children who depend on medical equipment such as respirators or supplemental oxygen, an 8-hour daily shift of a skilled nurse with experience in respiratory therapy or respiratory therapists with nursing experience, the necessary supplies to work with the technical equipment, physical and occupational therapy, laboratories, radiology, and prescribed medications which must be dispensed by a participating pharmacy of our network which is freely selected by our insured, all as authorized by the laws of Puerto Rico as outlined in Law No. 62 dated May 4, 2015, less copayment. For those who have started treatment as minors and become age 21, all the aforementioned services will continue to be covered. This benefit applies also to children who have had a tracheotomy to enable breathing and require home care because of the risk of airway obstruction; this requires a prescription by a physician.
8. Care and treatment of congenital defects and anomalies diagnosed by a doctor, without exclusion due to a preexisting condition. This covers newborns, recently adopted newborns or newborns recently placed for adoption. These services are subject to any applicable copayment or coinsurance.
9. Vaccine for the treatment of the Respiratory Syncytial Virus according to Law No. 165 dated August 30, 2006 and protocol approved by Puerto Rico's Department of Health. Pre-authorization required.

Urgent / Emergency Room Services

Services provided in Urgent / Emergency Rooms will be provided without prior-authorization or waiting period; will be provided regardless if the provider is a participating provider, according to the Law number 194 of August 25, 2000. For services provided in Urgent / Emergency Rooms of non-participant providers, the insured will pay to the provider the same amount as if a participating provider, as long as there is an important and justifiable medical reason for not transferring the patient to a contracted facility.

If Urgent / Emergency services are provided to a patient by a non-participant provider, the patient is not responsible for payment of services that exceed the applicable amount if it had received the services of a participant provider. Humana will compensate the provider that offers the service and it will be obligated to accept such compensation with an amount of not less than the contracted by Humana to offer the same services. In addition, under these circumstances, such Urgent / Emergency services will be provided regardless of the conditions by the health insurance.

If the patient receives health services posterior to the urgent / emergency services, or after being stabilized, and these would normally be covered services except for the fact that they are rendered by a non-participating provider, Humana will reimburse the patient for that part of the costs incurred that would be normally paid by the plan, as long as there is an important and justifiable reason for not transferring the patient to a contracted facility.

Emergencies handled by the 911 system – this refers to the public safety system of urgent / emergency calls through the number 9-1-1.

After the insured individual receives complete urgent / emergency care and stabilization, the facility will transfer the patient to a Humana or Choice Care facility as soon as it is medically possible. Such transfer must not in any way affect the treatment being given or harm the insured patient's health. Humana will assist in the coordination of this transfer, as stipulated in Law No. 194 dated on August 25, 2000.

1. Urgent / Emergency room services due to accidents are covered in full.
2. Urgent room services resulting from illness are covered, less $50.00 copayment
3. Emergency room services resulting from illness are covered, less $50.00 copayment
4. Urgent / Emergency room services' copayment or coinsurance will be waived if patient is admitted; in that case the hospital admission copayment or coinsurance will apply.

For examples of emergency conditions, refer to the definition "Condition of emergency".

Protocol to be followed in the process of transferring patients with psychiatric conditions from one health facility to another.

Regarding an in-patient who presents emotional disturbances in a general hospital or in an urgent / emergency room:

1. Screening and evaluation of the patient will be performed as stipulated in Law No. 35 of 1994 and EMTALA, including all the necessary tests to establish a diagnosis.

2. Organic disease must be ruled-out before reaching a psychiatric diagnosis.

3. During initial evaluation, the general hospital must consider and rule-out the possibility that the etiology of the symptoms of anxiety and agitation presented by the patient at the moment of the emergency are of organic origin.

4. The personnel of the general hospital must consult a mental-health professional to establish continuity of care and obtain permission for transfer from the family or a person properly authorized.

5. The patient is to be stabilized in regard to his/her physical condition or illness. The time spent at the general hospital will depend on the evaluations of organic conditions necessary to establish the state of health of the individual. In cases of poisoning, the general hospital will be responsible for contacting the Poison Control Center in order to determine how long it will take to eliminate the potentially toxic substance taken by the patient. That time-frame will become the minimal period of time for the patient to remain in the urgent / emergency room before transfer to a psychiatric facility.

6. Once the patient's physical condition is stabilized he/she can be transferred to a psychiatric hospital. Simultaneously, the emergency room must send a clear and concise summary to the psychiatric facility of all tests and treatment done, follow-up recommended and information on the physician who attended the patient in the emergency room.

7. The attending physician at the general hospital is responsible for communicating by telephone with the psychiatric facility in order to discuss the case in detail and explain the symptoms and signs presented by the patient to be transferred. At the same time the patient's transfer can be coordinated.

8. The psychiatric hospital must commit to accept the patient to be transferred for further care.

If the patient involved has the economic capacity to pay for the transportation by ambulance or other means necessary for transfer, or has insurance which covers this service, the transportation necessary for transfer will be paid by the patient or his insurance. In such cases the hospital will be paid directly, if it has actually paid for these services; the health insurance plan is responsible for this payment to the hospital. Cases in which the patient is covered for mental health services by the government health insurance. If necessary, and in the absence of other alternatives, transportation will be provided by the ambulances which service the public safety system of emergency calls through 9-1-1. Transportation will be covered from wherever the patient who needs the service is located to whatever hospital facility that can provide the care necessary. Ambulance transportation must comply with the requirements of Law No. 35 of 1994 and EMTALA.

The general hospital and the psychiatric hospital must both comply with all EMTALA regulations regarding the draft and preparation of a "Protocol for the Process of Transferring Patients" which is here requested and required.

NOTE: Urgencies / Emergencies which are secondary to accidents are covered 100%. The urgent / emergency room copayment or coinsurance does not apply if the patient insured is admitted to the hospital; in that case the co-payment of admission to hospital applies.

Psychiatric urgencies / emergencies will be covered with the applicable copayment or coinsurance.

Cardiovascular Procedures

1. Diagnostic Tests and treatment, including the invasive and non-invasive cardiovascular procedures, less 30% of coinsurance.

2. Physician services, less $15.00 office copayment
3. Surgical procedures, less $75.00 facility copayment
4. Repair or replacement of heart valves, pacemaker and any other applicable device, with $0.00 copayment. Defibrillator pacemaker required pre-authorization.

Neurological Procedures

1. Diagnostic tests and treatment, less 30% of coinsurance.
2. Physician services, less $15.00 office copayment
3. Surgical procedures, including neuroendovascular, less $75.00 facility copayment
4. Repair or replacement of valves, and any other medically necessary device, with $0.00 copayment.

Mental Health Services

1. Unlimited visits to professionals, psychology doctors and other providers who because of their education, training or experience, and the proper competency, are able to offer psychological health services, less $15.00 copayment
2. Unlimited office visits to psychiatrist and/or psychologist of children and teens/adults less $15.00 copayment
3. Group therapies, less $15.00 copayment
4. Collateral visits, less $15.00 copayment
5. Unlimited hospital services, less $150.00 admission copayment. Two (2) days of partial hospitalization are equivalent to one (1) day of regular hospitalization.

This service includes emergency psychiatric transportation by an ambulance authorized by the Service Public Commission (*Comisión de Servicio Público*) and the Health Department (*Departamento de Salud*), as stated in Article 4.20 (b) of Law No. 183 of 6 August 2008. Services requested for psychiatric emergencies through the 911 will be paid in full directly to the provider.

Alcoholism & Substance Abuse Services

1. Unlimited visits to professionals, psychology doctors and other providers who because of their education, training or experience, and the proper competency, are able to offer health services in substance abuse, less $15.00 copayment
2. Unlimited office visits to psychiatrist and/or psychologist of children and teens/adults, less $15.00 copayment
3. Unlimited therapies, treatment and follow-up at one or more service levels, which may combine multiple types of therapy, less $15.00 copayment
4. Unlimited residential treatment for alcoholism and substance abuse including detox, less $150.00 copayment.
5. Unlimited hospital services, less $150.00 admission copayment. Two (2) days of partial hospitalization are equivalent to one (1) day of regular hospitalization. Pre-authorization required.

Autism

Autism is recognized as physico-mental health condition. In compliance with Law of Puerto Rico No. 220 dated on September 4, 2012 with the Puerto Rico Department of Health and utilizing as reference the guidelines of the American Association of Pediatrics coverage for these conditions will include diagnostic and therapeutic services in persons diagnosed with disorders within the continuum of Autism.

Covered benefits include visits to physicians and other health providers and the ordered tests and procedures determined to be medically necessary. The specialized services most commonly utilized are related to neurology, psychotherapy, immunology, genetics, gastroenterology, nutrition, speech and language therapy, occupational and physical therapy. Coverage/benefits are not limited only to the previously mentioned services. These services are subject to any applicable copayment or coinsurance, except for the screening for autism for children up to 36 months.

Dental Services

The dental care benefits described below are available using Humana's provider network in Puerto Rico.

Preventive and Diagnostic Services

The following services will be **covered at 100%** In-network:

1. Initial oral examination, one (1) every three (3) years
2. Periodic examination, one (1) every six (6) months
3. Specific oral evaluation, one (1) every six (6) months
4. Complete series of radiographs (FMX), one (1) every three (3) years
5. Panoramic radiographs, up to one (1) every three (3) years
6. Periapical radiographs, one (1) and five (5) additional per policy year
7. Bitewing radiographs, one (1) set every twelve (12) months
8. Prophylaxis adult and child, one (1) every six (6) months
9. Application of fluoride to children up to nineteen (19) years, one (1) every six (6) months
10. Sealants application, limited to children up to fourteen (14) years, one (1) treatment per tooth per lifetime in permanent molars and premolars not previously restored.
11. Application of fluoride varnish for infants and children up to age 5 years, one (1) every six (6) months.
12. Space maintainers, to replace deciduous teeth that are lost permanently, one (1) per area per lifetime.
13. Pulp vitality test, one (1) per visit
14. Re-cementation of space maintainer
15. General anesthesia, administered by an anesthesiologist, and hospital services according to Law No. 352 of December 22, 1999.

Non-Contracted Dentists

If the insured uses the services of a non-participant dentist or facility, Humana will reimburse the insured the fee of the contracted dentist or facility (with the receipt of the payment made to the dentist that provided the service).

Pediatric Vision Care Services

The vision care benefits described below are available until the 21st birthday.

Lenses: One (1) set of lenses per insured, per policy year, with $0.00 copayment. Service is available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers.

- ✓ Lenses for eyeglasses: the lenses included the following selection:
  - CR-39 Plastic for single vision lenses, bi-focal lenses, or tri-focal lenses
  - Polycarbonate for single vision lenses

Frames: The insured can select any frame available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers throughout Puerto Rico with $0.00 copayment. The benefit includes frame from the collection. Coverage includes one (1) frame per policy year.

Contact lenses: Instead of eyeglass benefit (frame and lenses), the member may choose standard disposable contact lenses. The disposable contact lens benefit consists of two (2) boxes per policy year, with $0.00 copayment. Services are available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers.

One (1) pair of low vision eyeglasses or magnifiers as medically necessary for insured with significant loss of vision (low vision), but not total blindness using an exclusive network of Humana Insurance, less $15.00 copayment.

Pharmacy Coverage

What is the formulary?

A Formulary is a prescription drug list developed and approved by Humana and which is regularly evaluated to include or exclude prescription drugs, which is used to determine benefits covered under the pharmacy coverage. The formulary includes generic/bioequivalent, preferred brand, non-preferred brand, and specialty drugs.

The formulary is available in our webpage, Humana.com. There, you can also find information about your prescription medications that may have Utilization Management requirements and the authorization forms with the information required to evaluate them, if applicable. Humana will provide the insured a copy of the formulary, along with information about which prescription drugs are subject to Utilization Management requirements.

Humana will require that the Pharmacy and Therapeutics Committee has an established process, in writing, to consider and update changes in formulary or those that may require Utilization Management, on a timely manner and based on:

- New scientific medical evidence or any other prescription drug related information for covered, non-covered or those that may require Utilization Management, to determine if a change is needed in the formulary or the utilization management criteria;

- if applicable, any clinical information that Humana receives, related to an exception request that would allow the Pharmacy and Therapeutics Committee to determine if the drugs covered in the formulary or those that may require Utilization Management, meet the member's needs, and

- safety and effectiveness information for covered drugs or those that may require Utilization Management, information about prescription drugs that may be clinically similar or bioequivalent, but that are not covered in the formulary nor require Utilization Management, information that may arise from quality assurance activities in the insurance company or information from prescription drug claims received after the latest Pharmacy and Therapeutic meeting.

- Humana will require that the Pharmacy and Therapeutics Committee performs the evaluation of new prescription drugs approved by the Food and Drug Administration (FDA) in no more than a ninety (90) days period, from the FDA approval date. The Pharmacy and Therapeutics Committee should make a determination to include or not include a new prescription drug in the formulary, in a term no more than ninety (90) days from the date the drug is available on the market.

Humana guarantees that the Pharmacy and Therapeutics Committee establishes disclosure policies and requirements in which the identification of possible conflicts of interest between members of the committee and the developers or manufacturers of prescription drugs is contemplated. No member of the Pharmacy and Therapeutics Committee may have any relationship or interest, financial or otherwise, with the developers or manufacturers of the prescription drugs.

Humana guarantees that the Pharmacy and Therapeutics Committee will establish and comply with a written procedure to evaluate medical and scientific evidence related to the safety and efficacy of prescription medications, including information to compare similar prescription medications and bioequivalent, on deciding which prescription medications are to be included in the formulary and on developing other pharmacy benefit management processes. Humana also guarantees that the Pharmacy and Therapeutics Committee will establish protocols for the analysis, and possible inclusion in formulary, of medications for "off-label use" for those health conditions in which, through medical or scientific evidence, the efficacy of the medication has been established.

Pharmacy and Therapeutics Committees must document all their protocols and processes and present registers and documents to Humana upon request.

Humana may contract with other persons to perform the functions of the Pharmacy and Therapeutics Committee. Humana will be accountable to the Commissioner of Insurance for non-compliance and violations incurred by its' Pharmacy and Therapeutics Committee.

Humana will only be able to make changes in the formulary or the Utilization Management while the policy is active; if the change is because of safety, the drug is no longer available in the market, if a new prescription drug will be added in the formulary. If this happened, Humana will notify this no later than when the change is made, to:

- All covered members and
- participating pharmacies, only if the change is because a new prescription drug will be added to the formulary. In this case, Humana will notify thirty (30) days before the change is made.

Humana will meet the following requirements:

Humana will maintain and facilitate the information below to the members, prescribers and pharmacies, by electronic means and if requested by the member or the Pharmacy, written:

- The formulary (prescription drug list) organized by therapeutic categories and the list known as "Maximum Allowable Cost";
- Information about prescription drugs and those that may require Utilization Management, if applicable, which was developed and maintained according to the "Código de Seguros de Salud de Puerto Rico".
- Information about the documentation that may need to be presented by the insured or the personal representative to request a medical exception and the way in which to present this documentation. For details, see Section Application and Process Exception in this Certificate.

How do I use the formulary?

Drugs are listed in the formulary alphabetically.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage based on FDA indications and dosing, like gender, age, and dose limitations. Requirements and limits may include:

- **Prior Authorization (PA):** Humana requires you or your doctor to get prior authorization for certain drugs. This means that your doctor must contact Humana to get approval before you fill or refill a prescription for any drug that needs prior authorization. Your plan benefits won't cover this drug without prior authorization. You'll pay the entire cost of the drug if you decide to buy it.
- **Quantity limits (QL):** For certain drugs Humana limits the amount of the drug that we'll cover. Humana might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. Specialty drugs are limited to a 30-day supply regardless of drug-tier placement.
- **Specialty drugs (SP):** High-cost drugs, including high technology and self-administered injectable medications, requiring special monitoring.
- **This coverage focuses on the use of bioequivalent drugs as a first alternative; however, the insured has the option to choose between a brand drug or a bioequivalent**. If an insured chooses to purchase a brand drug, and an equivalent generic/bioequivalente is available, the insured must pay the difference in cost between the brand and the generic/bioequivalent, plus any applicable brand copay or coinsurance dispensed. If the insured chooses the bioequivalent drug, he or she will only pay the copayment or coinsurance for the bioequivalent drug dispensed. If there is no bioequivalent alternative on the market, the insured will pay the applicable copayment or coinsurance for the brand-name drug dispensed. However, if the physician orders a brand-name drug and writes a prescription as dispensed as written, the insured is responsible only for the copayment or coinsurance of the brand name drug.

What if my drug is not on the formulary?

If your drug isn't included in this printed list of covered drugs, you should visit **Humana.com** to see if your drug is covered. You can also contact Customer Care and ask if your drug is covered.

If Humana doesn't cover your drug, you have two options:

- You can ask Customer Care for a list of similar drugs that are covered by Humana. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Humana.
- You can ask Humana to make an exception and cover your drug. See below for information about how to request an exception.

You are responsible, when applicable, for all or some of the payments for the following:

- The copayment or coinsurance*; and

* If the charge from the pharmacy dispensing the medication is lower than the copayment or coinsurance, you will be responsible for the lesser amount. The amount we pay the pharmacy for the medication might not reflect the final cost to us. Your copayments or coinsurances are made according to the prescription or refill of the prescription and will not be adjusted if Humana gets a discount for volume or a sale on prescription medications.

Pharmacy Annual Deductible

Deductible	Individual	Family
Network Provider	$0	$0
Non-Network Provider	$0	$0

Pharmacy Annual Deductible is the amount that an Individual / Family must pay for calendar year before Humana provides payment for pharmacy covered benefits. The deductible will not apply to Tier 1 Drugs. Once the Individual member in an Individual policy meets the applicable Individual annual deductible, Humana shall provide payment for covered benefits.

For Individual coverage or Family coverage, there is a deductible pharmacy services in-network and a deductible for pharmacy services out-of-network. Pharmacy expenses of benefits you might incur for covered expenses provided by a network provider will apply to the network providers' deductible. Pharmacy expenses you might incur (as provider fee for in-network) for covered expenses provided by out of network will apply to the out of network providers' deductible.

The accumulation period will begin on the effective date of the policy and will end when the policy terminates. From there on, it will be from the renovation date until the policy year end.

Coverage Description

Covered Prescription Drugs List

The following drugs will be covered when prescribed by an authorized doctor:

1. Drugs, medicines or medications that under Federal or state law, may be dispensed only by prescription from a health care practitioner; this includes brand, generic, acute and maintenance medications;
2. Drugs, medicines or medications that are included on the drug list, including the drugs covered by the "Patient protection and Affordable Care Act", like contraceptives, breast cancer risk-reducing medications, among others.
3. Insulin and diabetes supplies;
4. Hypodermic needles or syringes when prescribed by a health care practitioner for use with insulin or self-administered injectable drugs (Hypodermic needles and syringes used in conjunction with covered drugs may be available at no cost to you);
5. Specialty drugs and Self-Administered Injectable Drugs approved by Humana;
6. Spacers and/or peak flow meters for the treatment of asthma;

7. Drugs, medicines or medications on the Women's Healthcare Drug List with a prescription from a health care practitioner;
8. Buprenorphine.

Humana provides for the dispensed of covered drug, regardless of the condition, illness, injury, condition or disease for which they are prescribed, if:

• The drug has FDA approval for at least one indication and

• the drug is recognized for treatment of the disease, illness, injury, condition or disease in question in one of the standard reference compendia or through peer-reviewed medical literature generally accepted.

This drug coverage also includes medically necessary services that are associated with drug administration.

If *you* request a *brand-name medication* when a *generic medication* is available, *your payment* is greater. *You* are responsible for the applicable *generic medication copayment* or coinsurance and 100% of the difference between the amount *we* would have paid the dispensing *pharmacy* for the *brand-name medication* and the amount *we* would have paid the dispensing *pharmacy* for the *generic medication*. If the prescribing *physician* determines that the *brand-name medication* is *medically necessary*, *you* are only responsible for the applicable *copayment or coinsurance* of a *brand-name medication*.

Drugs, Medicines or Medications on the Women's Healthcare Drug List from a N*etwork Pharmacy* are covered in Full (without cost-sharing)

Prescription Drugs Covered without cost sharing from a Network Pharmacy. For more details please refer to drugs list/ formulary.

1. Generic aspirin, for both men and women from 45 to 79 with cardiovascular risk and as prevention of pre-eclampsia: after 12 weeks of gestation in women who are at high risk of pre-eclampsia, both with a medical prescription.
2. Generic folic acid for women planning a pregnancy, with medical prescription.
3. Cancer treatment included within the pharmacy benefit and processed (including oral and auto-administered injectable) in a Network Pharmacy is covered in full, with medical prescription. Intravenously and intrathecally are covered under the Cancer Services and Treatment Section.
4. Breast cancer risk-reducing medications, with medical prescription such as tamoxifen or raloxifene for women who are at increased risk for breast cancer and at low risk of adverse effects to the drug.
5. Smoking cessation drugs, including over-the-counter (OTC), with medical prescription. Covers smoking cessation drugs for 90 consecutive days in an attempt and two (2) cessation attempts per year.
6. Statins in low- to moderate-dose statin for the prevention of cardiovascular disease events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater.

Immunizations for infants, children, and adults are covered through the Medical Coverage in accord with accepted medical practice and as recommended by the Advisory Committee for Immunization Practices (ACIP) of the Centers for Disease Control (CDC), the American Academy of Pediatrics, and are also covered under the vaccination schedule of the Puerto Rico Department of Health.

Benefit Program

The healthcare provider will be able to prescribe maintenance medications to the member with enough refills not to exceed 180 days, according to the plan limitations, when the medical history of the member permits it and no risk are identified.

Contracted/participant pharmacy

Contracted or participant pharmacies are pharmacies that are legally authorized by the relevant authorities, which has signed a contract with Humana to provide pharmacy benefits to its insured.

You are responsible of the following:

Retail Pharmacy / Specialty Pharmacy

Tier 1 Drugs means a category of generic prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 1 drugs.

Tier 2 Drugs means a category of preferred brand prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 2 drugs.

Tier 3 Drugs means a category of non-preferred brand prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 3 drugs.

Tier 3 Drugs: Specialty Drugs means a category of specialty prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 3 drugs.

Tier 1 drugs	$5.00 copayment per prescription or refill per 30-day supply
Tier 2 drugs	95% coinsurance per prescription or refill per 30-day supply
Tier 3 drugs	95% coinsurance per prescription or refill per 30-day supply
Tier 3 drugs: Specialty drugs	95% coinsurance per prescription or refill per 30-day supply

Specialty Drugs through Medical Coverage

Benefits:

A. When medically necessary, specialty drugs administered in a professional setting, including office or infusion center, are covered less the applicable copayment or coinsurance of the specialty drugs in the pharmacy coverage.
B. All utilization requirements of the pharmacy coverage, including but not limited to pre-authorization or quantity limits, shall apply.

90 days program

The retail pharmacies participate in our program which allows you to receive a 90-day supply of a prescription or refill. Your cost is 3 times the applicable copayment or coinsurance as outlined above. Self-administered injectable drugs and specialty drugs are limited to a 30-day supply from a retail pharmacy or specialty pharmacy.

Mail Order Pharmacy
This is a service that delivers medications by mail. It applies to prescriptions or refilled prescriptions covered in the policy.

For up to a 90-day supply of a prescription or refill	2 times the applicable copayment or coinsurance, as outlined above under Retail Pharmacy / Specialty Pharmacy

Mail Order Process:

Your health and well-being is very important to us. Please note that Humana Pharmacy can offer the value and services that you expect from your pharmacy. The routine process to be followed in procuring your maintenance medications by mail is easy and saves time.

The first time you use mail order to receive your medication, ask your doctor for two prescriptions. The first prescription should be written for a one-month supply that can be immediately filled at a participating retail pharmacy. The second prescription should be written for a 90-day supply of the medication with refills and the doctor will send it to Pharmacy Solution. You can use the service for all your maintenance medications.

1. Humana Pharmacy receives the request to fill your prescription. Your physician provider can actually send your prescription by fax (1-800-379-7617), through the telephone (1-800-833-1315-TTY: 711), by filling out a form designed for this purpose (Registration form for prescriptions by mail), onsite at HumanaParmacy.com, or by mail (Humana Pharmacy, PO Box 745099, Cincinnati, OH, 45274- 5099).
2. Humana Pharmacy verifies your pharmacy benefit coverage, enters your order and creates an exclusive shipping number.
3. The Humana pharmacist then reviews the order for a prescribed medication to verify that it is correct and complete. If it is incomplete or incorrect, it is returned with the reason for the rejection.
4. The Humana pharmacist approves the prescription.
5. After approved, the prescription then goes through the billing process.
6. An automated system fills your prescription and a pharmacist verifies that each medication is correct.
7. The prescription is filled in a period of seven (7) to ten (10) days of the time when Humana Pharmacy first received the request for your medications.

Out-Of-Network Pharmacy

When an *out-of-network pharmacy* is used, *you* must pay for the *prescription* or refill at the time it is dispensed. *You* must file a claim for reimbursement with *us*. In addition to any applicable *copayments coinsurances*, *prescription drug deductibles*, *you* are responsible for 30% of the *default rate* (the contracted fee that Humana agreed to pay a pharmacy within the network of providers for a drug) *and* the difference between the *default rate* and the *out-of-network pharmacy's* charge. Example: A pharmacy non-participant has a drug charge of $ 70.00 and the default rate is $75.00, the insured will be responsible for $ 15.00 (30% of the default rate-$ 50.00) plus $ 20.00 which is the price difference between the default rate ($75.00) and the charge of the drug in non-participating pharmacy ($70.00), plus the copayment that has that drug at a contracted pharmacy or coinsurance of the default rate. Any amount *you* pay over the *default rate* and any applicable *copayments*, coinsurances, *pharmacy annual deductible* and percentage amounts *you* pay to an *out-of-network pharmacy* do not apply toward *your maximum out-of-pocket* or any maximum *out-of-pocket*, if any. The charge received from an *out-of-network pharmacy* for a *prescription* or refill may be higher than the *default rate.*

Prior authorization

A prescription drug that is safe and effective for one person may not be safe and effective for another. This is why certain drugs must go through an evaluation and authorization process at Humana before they can be dispensed to members. This process is based on the evaluation of clinical standards for its safe use. The United States Food and Drug Administration (FDA) has recommended these drugs as safe and effective, but due to a high level of concern about their appropriate use, therapeutic indication, and cost, Humana's National Pharmacy and Therapeutics Committee has decided that a prior-authorization must be obtained for dispensing and use. To request coverage for a drug with prior authorization, the physician can contact the Humana Clinical Pharmacy Review (HCPR) at 1-866-488-5991 or by fax 1-855-681-8650

Prior authorization process:

The Humana Clinical Pharmacy Review (HCPR) will receive calls from providers requesting authorizations related to clinical review.

- Requests that require clinical review will be evaluated by the Humana Clinical Pharmacy Review (HCPR) staff. Decisions will be made according to approved clinical protocols established by the Humana's Pharmacy and Therapeutics Committee, as applicable.

- If the request is approved, the authorization is added on Humana's claim processing system. Then, the decision is notified to the person or entity who requested the authorization, whether the member, the physician, or personal representative.

- Requests that do not meet clinical criteria are denied and the decision is notified to the person or entity who has requested the authorization, whether the member, the physician, or the personal representative.

- If additional information is required to complete the evaluation of the request, a prior authorization form will be sent to physician's office by fax. If there is no fax available at physician's office it will be sent to pharmacy.

Humana Clinical Pharmacy Review (HCPR) will evaluate the request for authorization in a period not exceeding 72 hours after being received. In those cases where the physician requesting the case to be worked as expedited because the member's health could be affected, request will be evaluated in a period not exceeding 24 working hours.

Exception request and process

How do I request an exception to the formulary?

You, your physician, or your Personal Representative can contact Humana to ask for an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it's not on our formulary.
- You can ask us not to apply coverage restrictions or limits on your drug. For example, if your drug has a quantity limit, you can ask us not to apply the limit and to cover more.
- Continuum of coverage for a specific prescription drug that Humana will remove from the formulary for reasons other than health or because the drug is no longer available or because the manufacturer removed it from the market; or
- An exception to Utilization Management criteria that indicates the drug may not be covered in the prescribed quantity.

Your doctor should contact us to ask us for an initial coverage decision for a formulary or utilization restriction exception. We must make our decision within 72 hours of getting your prescribing doctor's supporting

statement. For controlled medicines, the term should not exceed thirty-six (36) hours after getting your prescribing doctor's supporting statement.

The member or your appointed representative will only be able to make a request in writing, if the physician or other prescriber has determined that the requested medication is medically necessary for the treatment of the disease of the member because:

a. There is no covered prescription drug in the plan's formulary that is a clinically accepted alternative to treat the member's disease:
b. The prescription drug alternative(s) listed on the formulary:
   i. Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
   ii. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
c. The number of doses available under a dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

The following information would be required as part of the supporting statement in an Exception request:

- Name , group number or policy ID, member ID;
- Patient's history
- Primary diagnosis, related to the requested prescription medication
- Reason why:
  - The covered prescription drug would not be an acceptable alternative for this member; or
  - The prescription drug alternative(s) listed on the formulary or required to be used in accordance with requirements would not be acceptable for this member; or
  - The number of doses available under a dose restriction for the requested prescription drug would not be acceptable;
- Reason why the Exception request is needed, for either the requested prescription drug or the limit of available doses.

Exception requests will be evaluated by appropriate healthcare professionals, according to the member's condition; who will consider specific facts and circumstances within each case and use clinical criteria that is:

- Based on scientific, clinical evidence based medicine; and
- If available, clinical practice guidelines, which may include, evidence based practice guidelines, clinical criteria developed by Humana's Pharmacy Committee or any other practice guidelines that may have been developed by the federal government, national associations or medical/pharmacy professional associations.

Experienced healthcare professionals will evaluate Exception requests according to the member's coverage - pharmacy benefit and exclusions.

If a medical exception is granted, Humana will provide coverage for the requested medication and will not require that the member requests an approval for a refill, nor for a new prescription, in order to continue using the same prescription drug after the refills of the first prescription run out. This is subject to the coverage terms and provided that:

a. The prescribing physician continues prescribing the medication for the same disease or medical condition;

b. The prescription drug continues being safe for the treatment of the member's disease or medical condition.

Humana will not establish a new or special formulary tier, copay for any other cost-sharing requirement that would only apply for the prescription drugs approved through the Exception process.

All denials for an exception request by Humana:

a. Will be notified to the member or the appointed representative, in writing, or by electronic means, if the member has agreed to receive the information that way;
b. Will notify, by electronic means, to the physician or other prescriber, as requested, in writing; and
c. It may be appealed through an appeal request, according to the Section Procedures to Address Complaints, Grievances and Appeals of the Policy.

The denial will describe in a comprehensible way for the member or the personal representative, if applicable:

a) The specific reason for the denial;

b) references to the evidence and documentation, which include the clinical criteria for evaluation and practice guidelines, clinical, medical and scientific evidence that was used and considered to make a denial determination for the request;

c) instructions on how to request a written statement for the clinical, medical and scientific justification of the denial; and

d) a description of the process and procedures to request an appeal for the decision, according to the Section Procedures to Address Complaints, Grievances and Appeals of the Policy, including the timeframes for these procedures.

If Humana does not make a decision with respect to the request for exception, or does not notify it in the above mentioned timeframe:

- The insured shall be entitled to be provided with the prescription drug that is the object of the request for up to thirty (30) days; and
- Humana shall make a decision with respect to the request for exception prior to that time when the insured finish the medication provided.
- If the insured finishes the medication provided, Humana shall maintain coverage under the same terms and in a continuous manner, so long as the same medication is prescribed to the insured and it is deemed safe for the treatment of the illness or medical condition, unless applicable limits to benefits have been exhausted.

If the member is not satisfied with Humana decision, he/she has the right to appeal it; following the Procedure to address Complaints, Grievances and Appeals that is part of the Policy and this Schedule of Benefits.

Other Benefits

Ambulatory Services

1. SPECT test, less 30% of coinsurance. Pre-authorization required.

2. Cardiovascular rehabilitation services at a dedicated center. Includes services by licensed physicians and registered nurses. Rehabilitation program must include education and supervised exercises that lead to risk factor recognition and management and improved exercise capacity. This benefit does not include maintenance exercise programs. Program must not exceed twelve (12) sessions in duration, less $150.00 copayment. Pre-authorization required.
3. Orthopedic devices: casts, splints, braces and crutches, with $0.00 copayment.
4. Laparoscopy, covered at ambulatory facility or at hospital, less $75.00 ambulatory facility copayment, $150.00 hospital copayment per rendered service.
5. Adult circumcision, less $15.00 office visit or $75.00 facility copayment.
6. Breast biopsies, unlimited, less $75.00 facility or $150.00 hospital copayment.
7. Allergy vaccines, up to a maximum of twenty (20) per insured, policy year, less 30% coinsurance.
8. Epidural blocks for pain management administered by medically qualified and recognized specialist, one (1) per anatomical region per insured per policy year, less $15.00 copayment.
9. Maxillofacial surgery, diagnostic and therapeutic services for accidental injuries, jaw fractures, neoplasms, injuries to natural teeth, including their replacement within a period of six months following an accident, provided the insured was covered by the policy when the accident occurred, less $150.00 copayment. Pre-authorization required.
10. Assistant Surgeon, when medically necessary: pre-notification required. Less applicable 30% coinsurance.
11. Reconstructive surgery for injuries due to an accident while the insured is covered under the policy and is not covered under any other program (ACAA, FSE, etc.), less $150.00 copayment.
12. Diagnostic tests and treatment associated with Hepatitis C, unlimited, less 30% coinsurance.
13. Diabetes paraphernalia for children and adults: lancets, syringes for insulin administration and glucometer strips up to a maximum of one hundred and fifty (150) of each one per month, less 30% coinsurance.
14. Hyperbaric Oxygenation treatment for people diagnosed with autism spectrum disorder, provided that it is recommended by a certified medical professional or health professional and the treatment is allowed by federal laws and regulations, as provided by Law 63 of July 19, 2019. Less $75.00 facility or $150.00 admission copayment.

Employee Assistance Program (EAP)

The program is offered by [Inspira, Lucy Lopez Roig, APS OptiMind] and includes the following:

1. Counseling, support, guidance and brief psychological therapy for life situations, including labor problems, emotional problems, relationships, and alcohol or drug abuse, covered at 100%, [Up to sixteen (16) sessions per policy year for each insured. Sessions are divided between the employee and dependents; eight (8) sessions for the employee and eight (8) sessions for dependents - Up to eight (8) visits per situation per insured – Unlimited]. Sessions may include the following:
    - crisis intervention
    - initial evaluation
    - marital or family counseling
    - referral to appropriate mental health resources when indicated for specialized treatment or assistance, including long-term therapy or psychiatric treatment.
2. Special crisis intervention services in case of catastrophic or traumatic events at the work-site.
3. Financial advice

4. Legal advice
5. Implementation orientation to administration and personnel
6. Workshops and orientations for employees
7. [Up to 10 occupational evaluations per employee]

Hospice

Hospice Care Program means a coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill insured and his or her insured family members, by providing palliative and supportive medical, nursing and other services through at-home or inpatient care. The hospice must be licensed according to the laws of the Commonwealth of Puerto Rico. It must provide a program of treatment for a person who have been medically diagnosed as having no reasonable prospect of cure for their illness and, as estimated by a physician, are expected to live less than six (6) months as a result of that illness.

Humana will pay benefits for charges for a hospice care program, which is submitted in writing and approved by us. The insured must submit in writing his or her intent to enroll in a hospice care program approved by us. Hospice benefits are subject to the applicable copayment. All the hospice services are subject to $150.00 admission copayment. All services must be received within a twelve (12) month period. Pre-authorization required.

Organ and Tissue Transplant

We will pay benefits of a Covered Organ Transplant as defined below, incurred by an insured for an organ transplant approved in advance by Humana, subject to those terms, conditions and limitations described below and contained in the group policy. These services are subject to any applicable copayment or coinsurance. Please contact the company's Transplant Management Department when in-need of these services.

Covered Organ Transplant means only the services, care, and treatment received for or in connection with the pre-approved transplant of the organs identified hereafter, which are determined by Humana to be medically necessary services and which are not experimental or investigational.

The covered organ transplant includes pre-transplant, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation of the following organs or procedures only:

a) Heart;
b) Lung(s);
c) Heart-lung;
d) Liver;
e) Kidney;
f) Bone Marrow;
g) Intestine;
h) Simultaneous pancreas/kidney;
i) Pancreas following kidney;
j) Any organ not listed above required by state or federal law.

The term bone marrow identified in the foregoing covered organ transplant definition refers to the transplant of human blood precursor cells which are administered to a patient following high dose, ablative or myelosuppresive chemotherapy. a) Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or

unrelated donor or cord blood. b) If chemotherapy is an integral part of the treatment involving a covered organ transplant of bone marrow, the term bone marrow includes the harvesting, the transplantation and the chemotherapy components. c) Storage of cord blood and stem cells will not be covered unless as an integral part of a covered organ transplant of bone marrow approved by Humana.

For a covered organ transplant procedure to be considered totally approved, a written authorization by Humana is required.

a. The insured or his/her physician must notify Humana in advance regarding the need for an evaluation to determine if the organ transplant will be covered. Within five working days of the receipt of this request, Human will contact the insured and his/her physician to clarify transplant benefits available under the insurance, if any.

b. If the product includes benefits of organ transplants, and once the insured has chosen the facility for transplant, Humana proceeds to approve a pre-transplant evaluation.

c. The transplant facility proceeds with the evaluation of the candidate for transplant and must submit to Humana for review seven (7) specific points or articles evaluated.

d. Humana then reviews the clinical results of the facility's evaluation, confirms eligibility, and proceeds to approval on the same day.

e. For solid organ transplants, no medical review is necessary by Humana; bone marrow transplants do require a medical review for final determination.

f. If the transplant is denied, the insured and the physician will receive oral and written explanations of their rights to appeal through the Complaints, Grievances and Appeals system of Humana.

Covered Services:

For approved covered Organ Transplants and all related complications, we will cover only the following expenses:

1. Hospital benefits shown in the schedule of benefits under the Hospital Services section of the group policy will be paid at: (a) 100% of reasonable charges if received at a participating hospital designated by us as an approved transplant facility; and (b) 70% of reasonable charges if received at non-participating hospital.

   Physician benefits shown in this Schedule of Benefits under the Ambulatory Services section of this group policy will be paid at (a) 100% of reasonable charges if received from a participating physician designated by us as an approved transplant provider; and (b) 70% of reasonable charges if received form a non-participating physician.

2. Organ acquisition and donor costs. (a) Except for Bone Marrow transplants, donor costs are not payable under the group policy if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. (b) Coverage for Bone Marrow transplant procedures will include costs associated with donor-patient to the same extent and limitations associated with the insured, except the reasonable costs of searching for the donor may be limited to the immediate family members and the National Bone Marrow Donor Program.

3. Direct non-medical costs* for the insured receiving the covered organ transplant will be paid for: (a) transportation to and from the hospital where the covered organ transplant is performed; and (b) temporary lodging at a prearranged location up to $75.00 per day when requested by the hospital and approved by Humana.

   Transportation costs for the insured to and from the hospital where the covered organ transplant is performed will be paid at: (a) 100% of the reasonable charges if the covered organ transplant is received at a

participating hospital designated by Humana as an approved transplant facility; or, (b) 70% of reasonable charges if the covered organ transplant is received at a non-participating hospital.

Coverage of *non-medical cost will be available only if the insured will travel to the United States for transplant.

4. Direct non-medical costs* for one member of the insured's immediate family (two members if the patient is under age 18 years) will be paid for: (a) transportation to and from the approved facility where the covered organ transplant is performed; and (b) temporary lodging at a prearranged location during the insured's confinement in a hospital, not to exceed $75.00 per day.

   Transportation costs for the insured's immediate family member(s) to and from the hospital where the covered organ transplant is received.

   Coverage of non-medical* will be available only if an immediate family member(s) accompanies the patient to the United States for a transplant.

*All direct non-medical expenses for the insured receiving the covered organ transplant and his/her family member(s) are limited to a combined maximum coverage of $10,000.

Exclusions:

No benefit is payable for or in connection with a covered organ transplant if:

1. We are not contacted for authorization prior to referral for evaluation of the covered organ transplant, unless such authorization is waived by Humana.
2. We do not approve coverage for the covered organ transplant, based on our established criteria.
3. Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received.
4. The expense related to the transplantation of any non-human organ or tissue, unless otherwise stated in the group policy.
5. The expense related to the donation or acquisition of an organ for a recipient who is not covered by Humana.
6. A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow up care, immunosuppressive drugs, and complications of such transplant.
7. The insured for whom a covered organ transplant is requested has not met pre-transplant criteria as established by Humana.

Once the covered organ transplant is approved, we will advise the insured's physician. Benefits are payable only if the pre-transplant services, the covered organ transplant and post-discharge services are approved by Humana.

Services Out of Puerto Rico

Services rendered on the United States of America:

If insured needs a procedure, treatment, test or office visit in the United States as a second opinion, follow up treatment or because the treatment is not available in Puerto Rico, can submit evidence of the incurred expenses, we will reimburse according the established rates for each treatment in Puerto Rico. Apply the copayment or coinsurance of the benefit described in the policy. Pre-authorization required.

These do not include benefits not available in Puerto Rico, available in the United States of America. For these benefits, refer to Section Service Not Available in Puerto Rico, Available in the United States.

Emergency Services Outside Puerto Rico

I. Emergency Services (Including emergency hospitalizations) received in the United States of America:

A. Services received in contracted Humana or ChoiceCare facilities:

1. Whenever possible emergency services should be received in a facility contracted with the Humana or ChoiceCare Networks.
2. Humana P.R. must receive notice of all emergency services within 72 hours of the insured receiving the services.
3. Payments for emergency services and related admissions provided by a contracted provider will be paid according to the Urgent / Emergency Room Services Section under this Schedule of Benefits, less $50.00 copayment.

B. Services received outside of contracted Humana or ChoiceCare facilities:

1. For services provided in emergency rooms of non-participating providers, payment will be the same as if a participating provider, less $50.00 copayment.
2. The physician must receive notice of all emergency services within 72 hours of the insured receiving the services.

   The attending physician may transfer the insured to a contracted facility as soon as medically feasible. Such transfer should in no way compromise or be detrimental to the insured's medical condition or treatment. Humana will assist in the coordination of such transfer.

II. Emergency Services received outside the United States of America or Puerto Rico:

A. The insured will be reimbursed 100% of the contracted fee for similar services by a provider in Puerto Rico or, billed charges, whichever is less, less $50.00 copayment.

1. If the insured requires hospitalization and cannot be transported to a contracted facility in Puerto Rico or the United States, Humana will attempt to negotiate the best possible fee with the non-participating facility for the benefit of the insured.

2. If the insured can be transported without risk to a participating facility in the United States or Puerto Rico, then the admission copayment or coinsurance only will apply from this point forward.

All claims for services rendered outside of Puerto Rico or the United States must be submitted to Humana with all supporting medical and financial records within a period of one (1) year from the date of service or date of discharge (whichever is later) to ensure reimbursement where applicable.

Ambulatory Services for Dependent Studying in College in the United States of America

Dependent studying in college in the United States of America, as included in the definition of direct dependent, (b) through (g), can receive coverage for covered services provided by contracted providers in the United States. To receive coverage the following conditions must be met:

- The dependent studying college degree, in accordance to the definition of dependent indent (b) through (g), must be eligible for coverage, under the Plan and the ambulatory services received in the United States must be covered services under the Humana PPO Policy.
- The insured university student must be a full-time student at an accredited university in the United States. For purposes of this requirement, it will be presumed that the student is full-time if he/she studies twelve (12) credits; six (6) credits in the case of students studying graduate studies. Any exception to this assumption of credit requirements must be certified by the university institution.
- The dependent college student must coordinate and obtain prior authorization from Humana P.R. for the services unless the services meet criteria for urgent or emergency treatment as set forth in the Policy.
- Services provided by a provider in the Humana or ChoiceCare provider network shall be paid according to the benefits under the Policy. Any copays, coinsurance and/or deductibles set forth in the policy applicable to the benefits shall apply.

If the service is rendered by a provider not participating in the Humana or ChoiceCare network, the service will the service will be reimbursed based on contracted fees for similar services in Puerto Rico, less applicable copayments, coinsurances and deductibles. The insured is responsible for the difference between the Humana contracted rate in Puerto Rico and the facility billed charges.

Important:

1. ChoiceCare is a network of providers, including physicians and hospitals, contracted by Humana in the United States. The insured does not need to contact ChoiceCare to access a covered service. The logo on the card will be the identifier to the provider. Since the services require pre-authorization and coordination, Humana will help the insured identify the appropriate provider or facility. A full ChoiceCare directory is available on the web at www.humana.com.
2. For coordination or pre-authorization the member should call Humana's Customer Service Department at 1-800-314-3121.

Services Not Available in Puerto Rico, Available in the United States of America

This benefit is for services not available in Puerto Rico, available in the United States of America, including equipment, treatment and facilities, among others.

A. Humana will cover such services only if the following five conditions are met.

   1. The Insured must be eligible for coverage under the Plan and the services requested must be Included this Schedule of Benefits.

   2. The provider referring must demonstrate that the equipment, treatment or facilities required to provide medically necessary covered services to the insured are unavailable in Puerto Rico**.** A service will not be deemed unavailable in Puerto Rico if the request for services to be provided outside of Puerto Rico involves a modification to the equipment, technique, or surgical approach available in Puerto Rico or is based on the reputation or recognition of any given provider.

   3. The service must be coordinated and pre-authorized with Humana in Puerto Rico at least five (5) working days prior to the date the service will be rendered.

   4. The service must be provided by Humana or ChoiceCare network providers/facilities.

   5. All services under this Section are subject to the applicable copayments and coinsurances for services as described in this Schedule of Benefits.

B. These services or treatments require pre-authorization with Humana, except in emergencies. If the service or treatment is not authorized by and coordinated with Humana in Puerto Rico, the insured will be responsible for the entire payment for such service or treatment. Humana will reimburse the patient based on the applicable Humana fee in Puerto Rico, less applicable copayments or coinsurances as described in this Schedule of benefits only if conditions A1, A2 are met. To receive reimbursement, the insured must provide Humana with all supporting medical and financial information within one (1) year of service or discharge.

Important Notes:

1. ChoiceCare is a network of providers, including physicians and hospitals, contracted by Humana in the United States. The insured does not need to contact ChoiceCare to access a covered service. The logo on the card will be the identifier to the provider. Since the services require pre-authorization and coordination, Humana will help the insured identify the appropriate provider or facility. A full ChoiceCare directory is available on the web at www.humana.com.

2. For coordination or pre-authorization the member should call Humana's Customer Service Department at 1-800-314-3121.

Telemedicine Service
(Virtual Medical Consultation)

Benefit:
Telemedicine service through virtual medical consultation to the insured allows you to receive access to health or minor emergency consultations with a certified primary care physician for the practice of Telemedicine in accordance with Act No. 168 of 2018. Less $20.00 copayment per virtual medical consultation. Through the following website: **www.mdlive.com/humanapr**.
As part of the services of this virtual platform, the insured can also share medical results of their studies.

In cases where the doctor understands that he or she needs medication use according to the insured's clinical picture, the prescription will be coordinated directly to the insured's preferred pharmacy through one of our contracted provider pharmacies.

This Telemedicine service does not replace your doctor, if you have an emergency, it is important that you call the emergency system at 911 or visit the nearest emergency room.

If the doctor determines that the condition by which the insured accesses the virtual consultation cannot be attended through this service, the insured will be immediately referred to an emergency room or personal doctor.

The insured is responsible for verifying their certificate of benefits, description of benefits and / or the medication form to verify if the service is covered.

Medical Exclusions

1. Procedures and/or health services in an experimental or research stage which are not supported by clinical evidence documented in the medical literature of the United States of America, except in connection with a life-threatening condition of the insured for which no effective treatment is available. Humana will pay only for the routine medical expenses associated with the order of such procedure or service which are not reimbursed by the entity conducting the service.
2. Expenses related to illness or injury resulting from war or uprisings.

3. Correspond Services be received, according to the State Workmen's' Compensation Fund Law (*Ley del Fondo de Seguro del Estado*), liability of the insured, private compensation plans at work, car accidents (Automobile Accident Compensation Administration (*Administración de Compensación por Accidentes de Automóviles*, ACAA, for its Spanish acronym).and other services available under state or federal laws. They will also be excluded such services when they are denied by government agencies concerning non-compliance or violation of the requirements or provisions of the above laws, although such failure or violation does not constitute a crime.
4. Expenses caused by military service, war, civil insurrection, international armed conflict, except in those cases where the services received are related to an injury sustained while the insured was active in the military (service connected), in which case Humana will collected such charges from the U.S. Department of Veterans Affairs.
5. Accidents occurring while the insured is participating in races such as: automobile, motorcycle, four-track, boats or other tests of speed, in areas set aside for such activities or any other place.
6. Services provided and/or covered pursuant to state or federal legislation for which the Insured is not legally required to pay.
7. Services received free of charge, rendered by the spouse, parents, siblings, or children of the Insured.
8. Hospitalizations for procedures which can be performed on an ambulatory basis.
9. Hospitalization for diagnostic purposes only; custodial, rest or convalescence services.
10. Services rendered at a time when the policy is not in effect.
11. Electronic prosthesis, including myoelectric arm and cochlear implant, and the removal or insertion of any device, and any other described as non-covered, except the breast prosthesis covered in case of mastectomy.
12. Services considered unreasonable or medically unnecessary for diagnosis or treatment of an illness or injury.
13. Expenses for custodial services, private nurses, personal commodity services such as telephone, television, etc. and all medical services or expenses in convalescence facilities, except for home healthcare services which have been authorized by Humana.
14. Music therapy
15. Cosmetic/esthetic maxillofacial and dental procedures.
16. Esthetic mammoplasty except as applicable in Woman's Rights Cancer Act, and the esthetic mammoplasty in accordance with the Law No. 275 dated on September 27, 2012.
17. Cosmetic/esthetic surgery, except septoplasty when medically justified and with prior authorization.
18. Repair or replacement of instruments or prosthetic devices due to normal wear and tear and impairment.
19. Corrective footwear.
20. Services, treatments, and therapies of alternative medicine by physicians or other certified trained professionals, except naturopathic physician visits.
21. Sports medicine.
22. Eyeglasses and contact lenses for adults, hearing aids.
23. Congenital or genetic deformities and metabolic deformities, except in newborns, recently adopted newborns or newborns recently placed for adoption.
24. All services and/or treatments related to infertility or impotence, except test to detect infertility.
25. Expenses for Physical Examinations to adults required by the employer or health certificates for any type of license and all diagnostic tests or services for these purposes. Except for the annual exam according to Law No. 296 dated on September 1st, 2000, which includes: physical and mental evaluation, oral health, hearing and vision screening, and screenings recommended by the American Academy of Pediatrics.
26. Elective abortions.

27. Acne surgery and acne treatment, including drugs.
28. Growth hormones and all related treatment.
29. Embryo transplantation.
30. Human chorionic gonadotropin (HCG) injections.
31. Vaccinations required for travel.
32. Tuboplasty, vasovasostomy, and any procedure or service for the purpose of fertility.
33. Sickness or injury caused by the insured engaging in an illegal occupation; or committing or attempting to commit a criminal act, except those injuries resulting from an act of domestic violence or medical condition.
34. Enrollment in a health, athletic, or similar club; or a weight loss or similar program.
35. Purchase or rental of supplies of common household use such as: exercise cycles; air purifiers; central or unit air conditioners; water purifiers; allergenic pillows or mattresses; or waterbeds. Except for technical equipment of ventilators for children which are vital for the maintenance of life, including children and those who have started treatment as minors and become age 21, who depend on medical equipment such as respirators or supplemental oxygen, as authorized by the laws of Puerto Rico as outlined in Law Number 62 dated May 4, 2015.
36. Purchase or rental of: motorized transportation equipment; escalators or elevators; saunas or attachment pools; professional medical equipment such as blood pressure kits; or supplies or attachments for any of these items.
37. Expert witness required by a Court that is not included under the benefits or requirements of the mental health law.
38. Services and supplies for treatment of temporomandibular joint disorder or dysfunction (TMJ) and craniomandibular jaw disorders (CMJ) which are recognized as dental procedures. This includes, but is not limited to, the extraction of teeth and the application of orthodontic devices and splints.
39. New diagnostic and therapeutic services/procedures that are done with approved FDA equipment/devices that become available posterior to the effective date of the policy. Unless, the insured suffers from a life-threatening condition for which there is no effective treatment. Humana would then pay for routine medical expenses of the patient which are not covered by the entity carrying out the study.
40. Epidural anesthesia during delivery.
41. Air and maritime ambulance services outside of Puerto Rico, except for dependent studying in the United States
42. Any and all services or treatments not specifically described as covered benefits, except for the services and benefits included in a law that are required to be included in the coverage.

Dental Coverage Exclusions

1. Services or treatments presented for beauty or cosmetic reasons.
2. Services received free of charge; services rendered by spouses, parents, brothers/sisters or children of the insured.
3. Experimental or investigative procedures and/or services, or the drugs related to them.
4. Services rendered before the effective date of the policy.
5. Expenses related to injuries caused by war or disturbances.

6. Illnesses or accidents covered by the State Insurance Fund law -*Ley del Fondo del Seguro del Estado* (FSE) and/or the Automobile Accidents Compensation Administration -*Administración de Compensaciones por Accidentes de Automóviles* (ACAA).
7. Any benefit or service not specified in the dental coverage.
8. Services not used during the policy year do not accumulate for the following year.

Vision Coverage Limitations and Exclusions

1. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
2. Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan
3. Services provided as a result of any worker's compensation law (*Ley del Fondo del Seguro del Estado* -FSE) and/or the Automobile Accidents Compensation Administration (*Administración de Compensaciones por Accidentes de Automóviles* - ACAA).
4. Lenses or vision devices that are not prescribed.
5. Unspecified contact lenses on the vision coverage.
6. Any other frame that is out of the collection.
7. Any treatment or service that is not specified on the vision coverage.

Pharmacy Coverage Limitations and Exclusions

1. Legend drugs which are not deemed medically necessary by us;
2. Any drug prescribed for a sickness or bodily injury not covered under the policy;
3. Any drug, medicine or medication labeled "Caution-limited by federal law to investigational use" or any experimental or investigational drug, medicine or medication, even though a charge is made to you; not covered:
    a. Medications used in research trials which have the sponsorship of manufacturers or government entities.
    b. Medications or services offered during research trials when the sponsor of such tests offers these services and medications at no cost to the participants
4. Allergen extracts(covered under the Medical Coverage);
5. Therapeutic devices or appliances including, but not limited to:
    A. Hypodermic needles and syringes (except needles and syringes for use with insulin, and self-administered injectable drugs whose coverage is approved by us);
    B. Support garments;
    C. Test reagents;

D. Mechanical pumps for delivery of medications; and

E. Other non-medical substances;

6. Dietary supplements; (except for formulas or low protein modified foods necessary for the treatment of phenylketonuria or certain other heritable diseases of amino and organic acids);
7. Nutritional products;
8. Minerals;
9. Herbs and vitamins, except Vitamin D, prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride, OTC Ferrous Sulfate which are covered for Women's Preventive Healthcare;
10. Anorectic or any drug used for the purpose of weight control;
11. Any drug used for cosmetic purposes, including but not limited to:
    A. Tretinoin;
    B. Dermatologicals or hair growth stimulants; or
    C. Pigmenting or de-pigmenting agents, e.g. Solaquin;
12. Any drug or medicine that is:
    a. Lawfully obtainable without a prescription (over the counter drugs), except insulin
13. Progesterone crystals or powder in any compounded dosage form;
14. Abortifacients (drugs used to induce abortions);
15. Infertility services including medications;
16. Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra;
17. Any drug, medicine or medication that is consumed or injected at the place where the prescription is given, or dispensed by the health care practitioner;
18. Prescriptions that are to be taken by or administered to you, in whole or in part, while you are a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
    A. Hospital;
    B. Skilled nursing facility; or
    C. Hospice facility;
    D. Physician office (unless coverage is approved by us)
19. Injectable drugs such as:
    A. Biological sera (covered under the Medical Coverage)
    B. Blood (covered under the Medical Coverage)
    C. Blood plasma (covered under the Medical Coverage)
20. Prescription refills:
    A. In excess of the number specified by the health care practitioner; or
    B. Dispensed more than one year from the date of the original order;

21. Any portion of a prescription or refill that exceeds a 90-day supply, received from a mail order pharmacy or a retail pharmacy that participates in our program which allows you to receive a 90-day supply of a prescription or refill;
22. Any portion of a prescription or refill that exceeds a 30-day supply, received from a retail pharmacy that does not participate in our program which allows you to receive a 90-day supply of a prescription or refill;

23. Any portion of a specialty drug or self-administered injectable drug received from a retail pharmacy or a specialty pharmacy that exceeds a 30-day supply, unless otherwise determined by us;
24. Any portion of a prescription or refill that:
    A. Exceeds our drug specific dispensing limit, e.g. IMITREX; or
    B. Is dispensed to an insured whose age is outside the drug specific age limits;
    C. Exceeds the duration-specific dispensing limit;
25. Any drug for which a charge is customarily not made;
26. Any drug, medicine or medication received by you:
    A. Before becoming covered under this rider; or
    B. After the date your coverage under this rider has ended;
27. Any costs related to the mailing, sending or delivery of prescription drugs;
28. Any intentional misuse (improper use)of this benefit, including prescriptions purchased for consumption by someone other than you;
29. Any prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
30. Drug delivery implants;
31. More than one prescription or refill for the same drug or therapeutic equivalent medication prescribed by one or more health care practitioners and dispensed by one or more pharmacies until you have used, or should have used, at least 75% of the previous prescription or refill, unless the drug or therapeutic equivalent medication is purchased through a mail order pharmacy, or a retail pharmacy that participates in our program which allows you to receive a 90-day supply of a prescription or refill, in which case you have used, or should have used 66% of the previous prescription. (Based on the dosage schedule prescribed by the health care practitioner);
32. Any copayment or coinsurance you paid for a prescription that has been filled, regardless of whether the prescription is revoked or changed due to adverse reaction or change in dosage or prescription;
33. Bulk Chemicals and Pain Patch not approved by the Food and Drug Administration (FDA)

34. When the FDA has determined that a medication is contraindicated for the condition for which it is prescribed.

These limitations and exclusions apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, service, treatment, supply, or prescription. This does not prevent your health care practitioner or pharmacist from providing or performing the procedure, service, treatment, supply, or prescription; however, the procedure, service, treatment, supply or prescription will not be a covered expense.

Humana Insurance of Puerto Rico, Inc.

(Hereinafter "the Company")

PPO Program Humana Complete
RX 3

19728PR0010

Schedule of Benefits Coverage

Schedule of Benefits

This schedule of benefits should be attached and made part of PPO Program Policy: Attachment I

Services and Benefits Procedures

1. Benefits and services are subject to the terms and conditions included in the group policy and to the exclusions and limitations described in this attachment.
2. Insured must receive services from participating facilities, contracted providers or under the order, direction and approval of the contracted provider upon presentation of the identification card issued by the Company. The Insured is responsible for paying applicable copayment, coinsurance or deductible.

Deductible

Deductible	Individual	Family
Network Provider	$0	$0
Non-Network Provider	$0	$0

Annual Maximum Out-of Pocket

Maximum out-of pocket limit	Individual	Family
Maximum out-of pocket limit ("MOOP") Network Provider	$6,350	$12,700
Maximum out-of pocket limit ("MOOP") Non-Network Provider	$19,050	$38,100

This includes copayments and coinsurance expenses of the Medical and Pharmacy coverage, in addition to accumulated expenses of the pharmacy benefits coverage deductibles.

Once the individual or family maximum out of pocket limit is met for the policy year for network providers, the percentage of benefits provided by network providers for covered expense will be paid at a rate of 100% for the rest of the policy year, subject to all terms, limits and exclusions of this Schedule of Benefits Coverage. Any expenses (medical and pharmacy) you might incur for covered expenses provided by a network provider will apply to the maximum out of pocket limit for network providers. Any expenses (medical and pharmacy) you might incur (as contracted fee for similar services by a provider in Puerto Rico) for covered expenses provided by out of network provider will apply to the maximum out of pocket limit for out of network providers.

The accumulation period will begin on the effective date of the policy and will end when the policy terminates. From there on, it will be from the renovation date until the policy year end.

The Maximum Out-of Pocket is based on the maximum amount allowed by the Office of the Commissioner of Insurance of Puerto Rico.

Essential Health Benefits

Ambulatory Services

The following services are covered, less any applicable co-insurance or copayment per visit:

1. Unlimited office visits to physicians, less applicable copayment or coinsurance:

   Generalists: $10.00

   Specialists: $15.00

   Sub-specialists: $15.00

2. Chiropractic Services, one (1) initial visit, one (1) follow-up visit, less $15.00 visit copayment or and up to twenty (20) manipulations per insured, per policy year. Physical therapies unlimited, less $10.00 copayment.
3. Six (6) Nutritionist consultations per insured per policy year, less $15.00 visit copayment or per visit.
4. Laboratories, X-rays and its reproduction, unlimited, less 30% of coinsurance. Genetic tests require pre-authorization, less 30% of coinsurance.
5. Electrocardiograms, unlimited, less 30% of coinsurance.
6. Sonograms, unlimited, less 30% of coinsurance.
7. Computerized tomography, unlimited, less 30% of coinsurance. Pre-authorization required.
8. Positron Emission Tomography (PET), unlimited, less 30% of coinsurance. Pre-authorization required.
9. Electroencephalogram, unlimited, less 30% of coinsurance.
10. Electromyogram, unlimited, less 30% of coinsurance.
11. Magnetic Resonance, including MRI and MRA, unlimited, less 30% of coinsurance. Preauthorization required.
12. One (1) sleep study or polysomnography covered per insured, per policy year, less 30% of coinsurance. Pre-authorization required.
13. Nuclear medicine tests, unlimited, less 30% of coinsurance.
14. Respiratory therapy, unlimited, less $10.00 copayment.
15. Physical therapy, including rehabilitation and habilitation, unlimited for all conditions including autisms, as prescribed and under the supervision of an orthopedist or a physical medicine specialist, less $10.00 copayment.

16. Speech therapy, combined at the physician office or at home, when ordered by a physician and rendered by a licensed speech therapist; up to a maximum of forty (40) therapies, per insured per policy year, less $15.00 copayment. Unlimited speech and language therapies for autism according to Law No. 220 of September 4, 2012.
17. Occupational therapy for the purpose of training and aiding in the restoration of normal physical function and or prevent further deterioration of the same; resulting illness, from trauma, stroke or a surgical procedure while insured under the policy, unlimited for all conditions including autisms, less $15.00 copayment.
18. Ambulatory surgery at ambulatory surgery facilities, including Mental Health, less $50.00 of copayment.
19. Endoscopies, diagnostic and therapeutic, unlimited, less $15.00 office copayment or less $50.00 facility copayment.
20. Lithotripsy, unlimited, less $50.00 ambulatory facility copayment per rendered service. Pre-authorization required.
21. Vasectomy at physician's office, less $15.00 office visit copayment.
22. Acute and chronic services related to End Stage Renal Disease, such as dialysis, hemodialysis and complications directly related to the disease are covered up to a maximum of ninety (90) days starting on the date on which the disease is diagnosed, In case of admission apply $100.00 copayment.
23. Allergy tests, including allergenic and biological extracts, drugs, patches and provocative tests, up to a maximum of fifty (50) tests per insured per policy year, less 30% coinsurance.
24. Intra-articular injections, unlimited, less $15.00 office copayment or less $50.00 facility copayment.
25. Audiologist visits according to Law No. 127 of September 27, 2007; Audiometry and tympanometry tests when ordered by a physician, one (1) of each test per insured, per policy year, less 30% of coinsurance.
26. Orthognathic surgery (mandibular or maxillary osteotomy - Le Fort). Expenses for implants related to orthognathic surgery are excluded, less $50.00 facility or $100.00 hospital copayment. Pre-authorization required.
27. Treatment and services for morbid obesity as medically necessary. One (1) bariatric surgery using one of the following techniques, gastric bypass, adjustable gastric band or sleeve gastrectomy per lifetime, according to Law 212 dated on August 9, 2008, less $100.00 copayment. Surgeries for removing excess skin (commonly known as folds) shall not be covered, unless the physician certifies that it is necessary to remove the excess skin because it affects the functions of any part of the body. Bariatric surgery requires pre-authorization.
28. In the event that an insured voluntarily enrolls in a research clinical trial, Humana will cover diagnostic tests which are usually associated with his condition as long as they are covered by his/her health insurance policy. These services are subject to the maximum limits specified under the policy, less $15.00 copayment or 30% coinsurance. Tests which are not covered by his/her policy, and which are strictly linked to the goal of the research, will not be reimbursed by Humana. The process and results of the investigation are the responsibility of the researcher and the insured.
29. Diagnostic tests and treatments associated with hemophilia, unlimited, less $15.00 copayment or 30% coinsurance.
30. Unlimited naturopathic physician visits according to Law 210 dated on December 14, 2007, less $15.00 copayment.
31. Eye refraction test by an ophthalmologist or optometrist, one (1) per insured per policy year within the Humana Insurance network, less $15.00 copayment.
32. Ophthalmic Diagnostic Tests, less $15.00 copayment.
33. Mammography, when they are not presented as a preventive test required by ACA, but as a follow up to a diagnosis or treatment of a condition, less $50.00 facility copayment.
34. Podiatry visits; Treatment of diseases and disorders of the foot and ankle, including injections and surgical procedures, less $15.00 visit copayment or $50.00 facility copayment.
35. Cervical Cryosurgery, less $15.00 copayment.

36. Nerve Conducting Velocity Test, unlimited, per policy year, less 30% coinsurance.

37. Humana will cover the Nutritional Supplement free of phenylalanine, based on low phenylalanine protein hydrolysates for patients diagnosed with the genetic disorder Phenylketonuria (PKU), without age limits, and for other recommended diagnostic, prevention and treatment of people with innate metabolic errors, in accordance to Act 139 of August 8, 2016. Covered at 100%.

38. Anesthesia services and hospitalization services, unlimited, in accordance with Act No. 352 of 1999; Pre-authorization is required. These services will be available when the member has dental coverage with Humana and when at least one of the following scenarios occurs:

    a. When a pediatric dentist, oral or maxillofacial surgeon member of the medical faculty of a hospital, licensed by the Government of Puerto Rico, determines that the member's condition is significantly complex in accordance with criteria established by the American Academy of Pediatric Dentistry.
    b. When the patient due to age or disability is unable to resist or tolerate pain, or cooperate with the treatment indicated in dental procedures;
    c. When the infant, child, adolescent or person with a physical or mental disability has a medical condition in which it is essential to carry out dental treatment under general anesthesia in an outpatient surgical center or hospital and which otherwise could represent a significant risk to the patient's health;
    d. When local anesthesia is ineffective or contraindicated due to an acute infection, anatomical variation or allergic condition;
    e. When the patient is an infant, child, adolescent, person with a physical or mental disability, and is in a state of fear or anxiety that prevents the dental treatment under traditional procedures of dental treatment and their condition Of such magnitude, that postponing or delaying treatment would result in pain, infection, loss of teeth or dental morbidity;
    f. When a patient has received extensive and severe dental trauma where the use of local anesthesia would compromise the quality of services or be ineffective in managing pain and apprehension.

To evaluate the services, a medical order must be sent to Humana with the diagnosis of the insured, as well as the reasons that justify the use of general anesthesia and hospital. Humana will approve or deny the request, in accordance with the criteria previously established, within two (2) days as of the date on which the member submits all required documentation.

The documents are:

- Medical order with diagnostics.
- Justification in the medical order.

Preventive Services

1. Annual preventive services are **covered at 100%** (without copayment or coinsurance) when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF), the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), The Health Resources and Services Administration, and the Puerto Rico Department of Health.

   For more information and updates on preventive services, visit: //www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

   a) Routine physical examination, including height, weight, and body mass index (BMI), for children and adults.

   b) High Blood pressure screening. The USPSTF recommends screening for high blood pressure in adults age (18) years and older. It is recommended obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.

   c) Cholesterol screening, for children and adults.

d) Screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults 40 years of age and older. The risks and benefits of these methods vary.

e) Screening for obesity, and counseling, for children and adults. The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of (30) kg/m2 or higher to intensive, multicomponent behavioral interventions.

f) Screening for Tobacco Use for all adult. The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA) approved pharmacotherapy for cessation to adults who use tobacco.

   The dispatch of FDA approved medication for smoke cessation is covered for (90) consecutive days in one intent and until (2) intents per year. Smoking cessation drugs are covered under the Pharmacy Coverage Section with prescription.

g) Tobacco use interventions: children and adolescents; recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

h) Screening for gestational diabetes mellitus (GDM) in asymptomatic pregnant women after (24) weeks of gestation and those at high risk of developing gestational diabetes.

i) Screening for abnormal blood glucose and Diabetes Mellitus Type 2 in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer, or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.

   In addition, it is recommended screening for diabetes type 2 in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than (135/80) mm Hg.

j) Screening for alcohol abuse, and behavioral counseling. It is recommended that clinicians screen adults aged (18) years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

k) Screening for tobacco, alcohol or drug use for children 11 to 21 years of age.

l) Immunizations for infants, children, and adults in accord with accepted medical practice and as recommended by the Advisory Committee for Immunization Practices (ACIP) of the Centers for Disease Control (CDC) and the American Academy of Pediatrics, as long as the individual is covered by this health insurance, including follow up (catch up).

   - Immunizations for Adults (21 years or older), including catch-ups – Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza (Flu Shot), Meningococcal, Measles/Mumps/Rubella, Pneumococcal, Tetanus/Diphtheria/Pertussis, Varicella

   - Immunizations for Children (less than 21 years old), including catch-ups – Haemophilus Influenzae Type b, Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza (Flu Shot), Meningococcal, Measles/Mumps/Rubella, Pneumococcal, Rotavirus, Tetanus/Diphtheria/Pertussis, Varicella, , inactivated poliovirus

m) Cervical cancer screening The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).

n) Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate. Office visits and consultations regarding checkups for healthy women (well-woman visits). Health and Human Services recognizes that several visits may be necessary to get all recommended preventive services, depending on the health status of women, their health needs and other risk factors.

o) Breast cancer mammography screenings every one (1) to two (2) years for insured over 40 years, biannual for insured between fifty (50) and seventy-four (74) years. This includes guidance and advice regarding chemoprevention, and the chemoprevention of breast cancer in women when indicated. Counseling for women at higher risk. The USPSTF recommends that clinicians engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk.

   For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk- reducing medications, such as tamoxifen or raloxifene.

p) Pap Smear

q) Prostatic Specific Antigen test (PSA) for men

r) Behavioral counseling regarding sexually transmitted diseases (STD's), for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs).

s) Screening for intimate partner violence (IPV), such as domestic violence, for women of childbearing age. Physicians shall also provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.

t) Screening for autism for children up to 36 months.

u) Osteoporosis screening: postmenopausal women younger than 65 years at increased risk of osteoporosis The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool. Osteoporosis screening: women 65 years and older. The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporosis fractures in women 65 years and older.

v) Screening for hearing loss all newborns infants.

w) Screening for elevated blood lead levels in children aged (1) to (6) years who are both at average and increased risk, and in asymptomatic pregnant women.

x) One (1) lifetime screening test for abdominal aortic aneurism (AAA) in men 65-75 years old who have ever been smokers.

y) Counseling regarding the use of aspirin in prevention of disease, for both men and women 45-79 years of age who are cardiovascular and colorectal cancer risks. The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged (50) to (59) years who have a (10)% or greater (10) year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least (10) years, and are willing to take low-dose aspirin daily for at least (10) years. For aspirin, prescription is required.

z) Counseling regarding folic acid supplements for women who may become pregnant. The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing (0.4) to (0.8) mg of folic acid. For folic acid, prescription is required.

aa) Hypothyroidism: Screening for congenital hypothyroidism in newborns.

bb) Screening for cervical dysplasia for sexually active females.

cc) Screening for sickle cell disease in newborns.

dd) Vision screening for all children at least once in all children between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.

ee) Screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up.

ff) Medical history: For all children throughout development.

gg) Behavioral Assessment for children of all ages. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

hh) Screening for this genetic disorder Phenylketonuria (PKU) in newborns.

ii) Obesity in children and adolescents: The USPSTF recommends that clinicians screen for obesity in children and adolescents (6) years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.

jj) Screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

kk) Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care. Also, is recommended repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at (24)-(28) weeks gestation, unless the biological father is known to be Rh (D)-negative.

ll) BRCA: Screening and risk assessment for women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.

mm) Screening for asymptomatic bacteriuria with urine culture for pregnant women at (12) to (16) weeks of gestation or at the first prenatal visit, if later.

nn) Screening for syphilis for all pregnant women and for any adolescent or adult who is at increased risk for infection.

oo) Screening for chlamydia and gonorrhea in sexually active women age (24) years or younger and in older women who are at increased risk for infection.

pp) Preventive medication for the eyes of all newborn for the prevention of gonorrhea.

qq) Skin cancer behavioral counseling The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.

rr) Preeclampsia prevention: aspirin, recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk. For aspirin, prescription is required.

ss) Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors: recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.

tt) Dental caries prevention: The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.

It is recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. The fluoride varnish is covered under the Dental Services Section.

uu) Oral health: Risk assessment for young children. Ages: (0) to (11) months, (1) to (4) years, (5) to (10) years.

vv) Lung cancer screening: recommends annual screening for lung cancer with low-dose computed tomography in adult ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

ww) Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. The USPSTF recommends exercise or physical therapy and vitamin D supplementation to prevent falls.

xx) Hepatitis B screening in persons at high risk for infection. Hepatitis B screening is also cover for pregnant women at their first prenatal visit.

yy) Hepatitis C virus infection screening: adults The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.

zz) Tuberculosis : Testing for children at higher risk of tuberculosis. Ages: (0) to (11) months, (1) to (4) years, (5) to (10) years, (11) to (14) years, (15) to (21) years.

aaa) Prevention of cardiovascular diseases: It is recommended that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.

bbb) Preeclampsia Screening in pregnant women with blood pressure measurements throughout pregnancy.

ccc) Tobacco Smoking cessation: The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.

ddd) Developmental Screening and Surveillance: Screening for children under age (3), and surveillance throughout childhood.

eee) Dyslipidemia: Screening for children at higher risk of lipid disorders. Ages: (1) to (4) years, (5) to (10) years, (11) to (14) years, (15) to (16) years.

fff) Hepatitis B virus infection: screening nonpregnant adolescents and adults The USPSTF recommends screening for hepatitis B virus (HBV) infection in persons at high risk for infection.

ggg) Tuberculosis latent infection screening: adults The USPSTF recommends screening for latent tuberculosis infection in populations at increased Risk

2. Preventive services **covered at 100%** (without copay) when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF) and the Health Resources and Services Administration.

For more information and updates on preventive services, visit:
//www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

- Women's contraceptives and contraception counseling. All women's contraceptive methods approved by the Federal Drug Administration (FDA) by prescription are covered, including counseling, placement and removal of uterine devices, administration of medication and sterilization
- Any device insertion and removal of contraceptive methods is covered.

3. Preventive services **covered at 100%** (without copay) during and immediately following pregnancy when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF) and the Health Resources and Services Administration. For this service, insured has to call the *Humana Beginnings* program at 1-866-488-5992, for screening process. Humana recommends to participate in the Humana Beginnings Program starting the first trimester of gestation.

For more information and updates on preventive services, visit:
//www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

- Comprehensive breastfeeding support with guidance and counseling, during pregnancy and after birth, and the necessary breastfeeding equipment and supplies, including the breast pump with prescription.

4. Screening for Human Immunodeficiency Virus (HIV) covered at 100% (without co-payment or coinsurance), according to the recommendation of the Centers for Disease Control and Prevention (CDC) and in compliance to the Act No. 45 of May 16, 2016, as part of the routine testing of a medical evaluation at least once every five (5) years, based on the clinical criteria for adolescents and adults between the ages of thirteen (13) and Sixty-five (65) years of age at low risk. For people of high risk between the ages of thirteen (13) and sixty-five (65) is covered annually.

   Clinicians should screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown. For pregnant women, two tests are covered: 1) A first HIV test during the first trimester of pregnancy at the first prenatal visit, and 2) A second test during the third trimester of pregnancy (between the (28) and (34) weeks of pregnancy.

Hospital Services

Hospital admissions must be authorized by Humana and the services to be offered must be provided under the determinations of an attending physician. A member or his (her) responsible caretaker is responsible for the predetermined co-payment for any admission that so specifies.

Inpatient Care:	$100.00 per admission
Outpatient Surgery-Facility:	$50.00 per rendered service

1. Hospital services included in the contracted per diem:
   - Semi-private room or similar facility, unlimited. In cases in which an insured use the services of a private room, it is his/her responsibility to pay the difference between the cost of medical services billed and the contracted fees.
   - Specialized units for critical care services including: intensive care unit (ICU), intermediate care unit, coronary care unit (CCU), neonatal intensive care unit (NICU), and pediatric intensive care unit (PICU).
   - Operating, recovery, and maternity rooms.
   - Drugs prescribed by physician during hospital stay that are included in the per diem.
   - Oxygen and its administration.
   - Laboratory and radiology.
   - Disposable supplies.
   - Special and regular diets.
   - Regular hospital nursing service

2. Hyperalimentation services, unlimited
3. Universal Neonatal Hearing Screening according to Law No. 311 dated on December 19, 2003, which includes: hearing evaluations for the follow-up treatment needed by the patient.
4. Surgical procedures for benefits included under the basic coverage.

5. Anesthetic agents and their administration including sedation. Anesthesia services and hospitalization services, unlimited, in accordance with Act No. 352 of 1999; Pre-authorization is required. These services will be available when the member has dental coverage with Humana and when at least one of the following scenarios occurs:

    a. When a pediatric dentist, oral or maxillofacial surgeon member of the medical faculty of a hospital, licensed by the Government of Puerto Rico, determines that the member's condition is significantly complex in accordance with criteria established by the American Academy of Pediatric Dentistry.
    b. When the patient due to age or disability is unable to resist or tolerate pain, or cooperate with the treatment indicated in dental procedures;
    c. When the infant, child, adolescent or person with a physical or mental disability has a medical condition in which it is essential to carry out dental treatment under general anesthesia in an outpatient surgical center or hospital and which otherwise could represent a significant risk to the patient's health;
    d. When local anesthesia is ineffective or contraindicated due to an acute infection, anatomical variation or allergic condition;

    e. When the patient is an infant, child, adolescent, person with a physical or mental disability, and is in a state of fear or anxiety that prevents the dental treatment under traditional procedures of dental treatment and their condition Of such magnitude, that postponing or delaying treatment would result in pain, infection, loss of teeth or dental morbidity;
    f. When a patient has received extensive and severe dental trauma where the use of local anesthesia would compromise the quality of services or be ineffective in managing pain and apprehension.

    To evaluate the services, a medical order must be sent to Humana with the diagnosis of the insured, as well as the reasons that justify the use of general anesthesia and hospital. Humana will approve or deny the request, in accordance with the criteria previously established, within two (2) days as of the date on which the member submits all required documentation.

    The documents are:

    - Medical order with diagnostics.
    - Justification in the medical order.

6. Sonogram, Computerized Tomography and Magnetic Resonance (MRI and MRA), unlimited
7. Electrocardiogram, unlimited
8. Nuclear medicine studies and digital angiography, unlimited.
9. Blood transfusions including autologous process, all components and compatibility tests.
10. Respiratory Therapy.
11. Physical Therapy, maximum of forty (40) therapy sessions per insured, per hospital stay.
12. Acute and chronic services related to End Stage Renal Disease, such as dialysis, hemodialysis and complications directly related to the disease are covered up to a maximum of ninety (90) days starting on the date on which the disease is diagnosed.
13. Treatment and services for morbid obesity as medically necessary. One (1) bariatric surgery using one of the following techniques, gastric bypass, and adjustable gastric band or sleeve gastrectomy per lifetime, according to Law No. 212 dated on August 9, 2008.
14. Surgical procedures in ambulatory surgery in a hospital, less applicable copayment or coinsurance.
15. Surgeon Assistant when medically necessary: pre-authorization required, less 30% coinsurance.

Transplant or Graft

Cornea transplant or bone, skin graft services received by the insured will be covered, less $100.00 copayment; pre-authorization is required. The covered transplant or graft includes pre-transplant, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation.

In-Home Services

In-Home Health Services, authorized by a main doctor and Humana.

Home health care must be provided by an agency that is dedicated, licensed and managed according to the regulations established by a group of medical professionals that keeps medical records of the patients and operates according to the laws of the Commonwealth of Puerto Rico. These services are covered if they begin within fourteen (14) days after release from a hospital or expert nursing facility due to a hospitalization of at least three (3) days, and are provided because of the same condition or in relation to the condition for which the patient was hospitalized.

If the patient is in the hospital, Home health services must be requested by the attending physician in the hospital. If the patient is out of the hospital, Home health services must be requested by the main doctor with medical justification. The doctor must present a care plan and estimated time of the duration of services, according to the individual needs of the patient. The program will provide education for the patient and family members responsible for his/her health care. This benefit will be covered for forty (40) days initially, and an additional twenty (20) days, subject to medical necessity certification.

In-home health services include:

1. Care by a nurse or under the supervision of a graduate nurse.
2. Respiratory therapy care, less $10.00 copayment
3. Collection of samples for lab tests, less 30% coinsurance
4. Care and maintenance of catheters.
5. Administration of intravenous antibiotics, subject to Humana's case management program.
6. Ulcer care through Humana's case management program.
7. Physical therapies, up to forty (40), less $10.00 copayment. For condition of autism, unlimited as mention in law No. 220 of September 4, 2012.
8. Occupational therapy for the purpose of training and aiding in the restoration of normal physical function and or prevent further deterioration of the same; resulting illness, from trauma, stroke or a surgical procedure while insured under the policy, unlimited for all conditions including autisms, less $15.00 copayment.
9. Speech therapy, when ordered by a physician and rendered by a licensed speech therapist; combined at the physician office or at home, up to a maximum of forty (40) therapy sessions per insured per policy year less $15.00 visit copayment. Speech therapies are unlimited for Autism and language as mention in Law No. 220 of September 4, 2012.
10. Hyperalimentation services, unlimited, less 30% coinsurance.

Skilled Nursing Facility

Skilled nursing facility covered up to a maximum of one hundred and twenty (120) days per insured per policy year, covered at 100%. These services will be covered if they begin within the fourteen (14) days following the release from the hospital due to a hospitalization of at least three (3) days, and if they are rendered because of the same condition or in relation to the condition leading to the hospitalization.

If the patient is in the hospital, Home health services must be requested by the attending physician in the hospital. If the patient is out of the hospital, Home health services must be requested by the main doctor with medical justification. Pre-authorization is required.

Durable Medical Equipment, Supplies, Prosthesis, Orthosis and Implants

1. The purchase or rental of medically necessary Durable Medical Equipment, less 30% coinsurance. The cost or rental of durable medical equipment will be covered. If the cost of renting the equipment is more than an insured would pay to buy it, Humana will covered up to the amount of the purchased equipment. We do not pay for equipment or devices not specifically designed and intended for the treatment of an injury or sickness. Required pre-authorization. Including glucometer and insulin pump mention in Law No. 177 of August 13, 2016. Covered for children and adults.

   Pre-authorization is required. If the endocrinologist recommends a specific glucometer due to the treatment utilizes, or order a particular insulin pump due to the necessity of the member, the provider must submit to Humana a justification. Humana will then cover the equipment specifically ordered by the endocrinologist, whether it is a specific glucometer or insulin pump is required.

2. Initial placement of a medically necessary prosthesis and its supportive device, except for those excluded. We will also cover the replacement of such prosthesis if it is determined by the insured's physician to be necessary because of growth or change. Less 30% coinsurance. Required pre-authorization.

3. Orthotics (No cover pre-fabricated, over-the-counter - OTC) and supplemented (No cover over-the-counter - OTC), less 30% coinsurance. Requires pre-authorization.

4. Implants, less 30% coinsurance. Requires pre-authorization.

Ambulance Services

Also an emergency may arise from a call managed thru the 911 System which refer to a dedicated telephone system that is available 24/7 for receiving emergency calls that deal with public security. System 9-1-1 was created by virtue of Law No. 144 dated on December 22nd, 1994 as amended, known as the "Law for rapid response to emergency calls with Public Security" or "Law for calls 9-1-1.

1. Land transportation by an ambulance, between facilities, authorized by the Public Service Commission and the Health Department as mention in Law No. 183 of August 6, 2008, to a hospital or between health facilities, e.g. between a hospital and a radiology institute or between a skilled nursing facility and a hospital, and when ordered by a physician, including psychiatric emergencies. Services requested for psychiatric and medical emergencies through the 911 will be paid in full directly to the provider.
2. Land transportation by an ambulance authorized by the Public Service Commission and the Health Department as mention in Law No. 183 of August 6, 2008, including psychiatric emergencies, less $50.00 copayment per trip.
   a. from the insured residence or place of emergency to the Skilled Nursing Facilities or Hospice, when is medically necessaries.
   b. From the hospital to the residence, if the condition of the patient discharged requires.
3. Land ambulance services for psychiatric and medical emergencies through 911 will be paid in full by Humana directly to the provider. The service will only cover if the insured meets the following requirements:

a. The patient suffered an illness or injury for which other types of transportation are not recommended;

b. Psychiatric emergencies as mention in Law No. 183 of August 6, 2008;

c. The health condition of the patient does not allow the use of other types of transportation;

d. It is not a case covered by the Automobile Accident Compensation Administration (ACAA), the State Workmen's Compensation Fund (CFSE) or any other insurance with primary responsibility

4. The general hospital and the psychiatric hospital must both comply with all EMTALA regulations regarding the draft and preparation of a "Protocol for the Process of Transferring Patients" which is here requested and required."

5. Maritime and air transportation services by an ambulance within Puerto Rico, subject to medical need for it, less $50.00 copayment. Pre-authorization is required unless it is a life or death emergency.

Cancer Services and Treatments

1. Ambulatory services for the treatment of radiotherapy and/or chemotherapy, including intravenously, via injection or intrathecally, according to the instructions of the medical doctor or oncologist. Oral chemotherapy is covered at 100% under the Pharmacy Coverage Section. This is, according to Law No. 107 dated on June 5, 2012.

2. Medically necessary oral and parenteral medication for pain management of patients suffering terminal cancer.

3. All the benefits, including radiotherapy and/or chemotherapy in the hospital services, less $100.00 hospital copayment.

4. Stoma care and maintenance: colostomy, gastrostomy and cystostomy.

5. For the insured who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, the coverage includes:

   a) all stages of reconstruction of the breast on which the mastectomy has been performed

   b) surgery and reconstruction of the other breast to produce a symmetrical appearance

   c) prosthesis and physical complications of mastectomy, including lymphedemas

According to Law No. 275 dated on September 27, 2012, patients with a diagnosis of cancer have the following rights:

- To know and understand their treatment and rehabilitation plans, and the pain management protocol specifically appropriate for their case. The patient with cancer has the right to priority treatment for his/her pain; and is entitled to aggressive pain management techniques based on scientific evidence and approved by the Food and Drug Administration (FDA).

- To receive a copy of their file in an expeditious manner when they wish a second medical opinion or a consultation with another provider.

- The right to information, counseling and guidance regarding the possible short and long term effects on fertility of the cancer itself, and of the diagnostic tests and treatments to be received.

- Continuity in medical care and other health services, such as diagnostic tests for early detection, and access to oncologists, radiation therapists and surgical specialists involved in the initial diagnosis, and in his/her management once regarded a cancer survivor; continuity is necessary for close monitoring against recurrence and adverse effects of treatment, and to maintain physical and emotional health as a surviving patient with cancer.

- To be included in their employer's group healthcare insurance plan with no increase in their premium compared to all other members of the Group, and without exclusion of coverage because of a previous diagnosis of cancer.
- No private insurer can reduce benefits or terminate the policy of a patient with cancer, or that of a child who has survived cancer, as long as the health emergency lasts.
- Elderly patients who have a diagnosis of cancer or who are cancer survivors will be offered clear and up-to-date information about the prevention, detection and treatment of cancer taking into account conditions which might affect communication and their sensory, mobility or cognitive impairments. Elderly patients with a diagnosis of cancer will receive the support appropriate for their age, including but not limited to community support services and psychosocial and palliative services.
- Included as covered services will be pelvic examinations, and all type of vaginal cytology preparations which may be specifically required by medical order to detect, diagnose and treat early anomalies which might lead to cancer of the cervix.

- To provide extended coverage for the payment of studies and tests to monitor cancer of the breast, such as office visits to specialists, clinical breast examinations, mammography and digital mammography, magnetic resonance mammography and sono-mammography, and such treatments as, but not limited to, mastectomies, reconstructive surgery after mastectomy for the reconstruction of the removed breast, the reconstruction of the other breast to achieve a symmetrical appearance, breast prosthesis, treatment of complications at all stages of the mastectomy, including lymphedema (an inflammation which sometimes occurs after treatment for breast cancer), and any other reconstructive surgery after mastectomy which may be necessary for the physical and emotional recovery of the patient.

Maternity Services

The female employee, the wife or cohabitant, and the dependent daughter of any employee covered by the insurance plan for families or couples, will have maternity benefit coverage. The minimum hospital stay for both patient and newborn has been established by Law No. 248 of the Commonwealth of Puerto Rico dated on August 15, 1999, at 48 hours for a normal delivery, without complications, and 96 hours for a Cesarean-section delivery. Hospital discharges prior to length of stays stipulated by the law must have the consent of the patient. The maternity benefit covers a follow-up visit during the 48-hour period following discharge, at which time the newborn infant can also be checked. Services will include, but not be limited to support and physical care for the benefits of the minor, education to both parents on caring for the minor, support and training on breast feeding, orientation on support at home and the performance of any treatments and medicine test both for the infant and the mother.

Covered maternity benefits include the following services:

1. Hospitalization, less $100.00 copayment.
    a. Delivery, including Cesarean Section.
    b. Delivery and recovery rooms.
    c. Nursery and incubator.
    d. Neonatal intensive care unit (NICU)
    e. Fetal monitoring during delivery.
    f. Postpartum sterilization before discharge
2. Ambulatory (unlimited services)
    a. Pre-natal and post-natal care, less $15.00 copayment per visit
    b. Genetic amniocentesis, less 30% coinsurance

c. Spontaneous abortion

d. Ambulatory fetal monitoring, less 30% coinsurance

e. Biophysical profile, unlimited.

3. Vaccines

   a. RhoGam Vaccine, less 30% of coinsurance
   b. Vaccine for the treatment of the Respiratory Syncytial Virus according to Law No. 165 dated on August 30, 2006 and protocol approved by Puerto Rico's Department of Health.

4. Ambulatory sterilization, covered at 100%.

Pediatric Services

1. Unlimited visits, less $15.00 copayment per visit.
2. Well Child Care, less $15.00 copayment per visit.
3. Universal Neonatal Hearing Screening, according to Law No. 311 dated on December 19, 2003, which includes: hearing evaluations for the follow-up treatment needed by the patient.
4. Annual exam according to Law No. 296 dated on September 1st, 2000, which includes: physical and mental evaluation, oral health, hearing and vision screening, and screenings recommended by the American Academy of Pediatrics.
5. Circumcision and dilatation for newborns before discharge from the hospital, at ambulatory facility, or physician office, less $50.00 copayment or $15.00 copayment.
6. Immunizations according to established medical practices and as recommended by the Advisory Committee on Immunization Practices (CDC) and the American Academy of Pediatrics, while included as insured under the policy, Human Papilloma Virus vaccine according to Law No. 255 dated on September 15, 2012. For children who have been sexually abused, the HPV vaccine (HPV) is covered beginning at age nine (9).
7. Coverage for technical equipment of ventilators for children which are vital for the maintenance of life, including children who depend on medical equipment such as respirators or supplemental oxygen, an 8-hour daily shift of a skilled nurse with experience in respiratory therapy or respiratory therapists with nursing experience, the necessary supplies to work with the technical equipment, physical and occupational therapy, laboratories, radiology, and prescribed medications which must be dispensed by a participating pharmacy of our network which is freely selected by our insured, all as authorized by the laws of Puerto Rico as outlined in Law No. 62 dated May 4, 2015, less copayment. For those who have started treatment as minors and become age 21, all the aforementioned services will continue to be covered. This benefit applies also to children who have had a tracheotomy to enable breathing and require home care because of the risk of airway obstruction; this requires a prescription by a physician.
8. Care and treatment of congenital defects and anomalies diagnosed by a doctor, without exclusion due to a preexisting condition. This covers newborns, recently adopted newborns or newborns recently placed for adoption. These services are subject to any applicable copayment or coinsurance.
9. Vaccine for the treatment of the Respiratory Syncytial Virus according to Law No. 165 dated August 30, 2006 and protocol approved by Puerto Rico's Department of Health. Pre-authorization required.

Urgent / Emergency Room Services

Services provided in Urgent / Emergency Rooms will be provided without prior-authorization or waiting period; will be provided regardless if the provider is a participating provider, according to the Law number 194 of August 25, 2000. For services provided in Urgent / Emergency Rooms of non-participant providers, the insured will pay to the provider the same amount as if a participating provider, as long as there is an important and justifiable medical reason for not transferring the patient to a contracted facility.

If Urgent / Emergency services are provided to a patient by a non-participant provider, the patient is not responsible for payment of services that exceed the applicable amount if it had received the services of a participant provider. Humana will compensate the provider that offers the service and it will be obligated to accept such compensation with an amount of not less than the contracted by Humana to offer the same services. In addition, under these circumstances, such Urgent / Emergency services will be provided regardless of the conditions by the health insurance.

If the patient receives health services posterior to the urgent / emergency services, or after being stabilized, and these would normally be covered services except for the fact that they are rendered by a non-participating provider, Humana will reimburse the patient for that part of the costs incurred that would be normally paid by the plan, as long as there is an important and justifiable reason for not transferring the patient to a contracted facility.

Emergencies handled by the 911 system – this refers to the public safety system of urgent / emergency calls through the number 9-1-1.

After the insured individual receives complete urgent / emergency care and stabilization, the facility will transfer the patient to a Humana or Choice Care facility as soon as it is medically possible. Such transfer must not in any way affect the treatment being given or harm the insured patient's health. Humana will assist in the coordination of this transfer, as stipulated in Law No. 194 dated on August 25, 2000.

1. Urgent / Emergency room services due to accidents are covered in full.
2. Urgent room services resulting from illness are covered, less $50.00 copayment
3. Emergency room services resulting from illness are covered, less $50.00 copayment
4. Urgent / Emergency room services' copayment or coinsurance will be waived if patient is admitted; in that case the hospital admission copayment or coinsurance will apply.

For examples of emergency conditions, refer to the definition "Condition of emergency".

Protocol to be followed in the process of transferring patients with psychiatric conditions from one health facility to another.

Regarding an in-patient who presents emotional disturbances in a general hospital or in an urgent / emergency room:

1. Screening and evaluation of the patient will be performed as stipulated in Law No. 35 of 1994 and EMTALA, including all the necessary tests to establish a diagnosis.

2. Organic disease must be ruled-out before reaching a psychiatric diagnosis.

3. During initial evaluation, the general hospital must consider and rule-out the possibility that the etiology of the symptoms of anxiety and agitation presented by the patient at the moment of the emergency are of organic origin.

4. The personnel of the general hospital must consult a mental-health professional to establish continuity of care and obtain permission for transfer from the family or a person properly authorized.

5. The patient is to be stabilized in regard to his/her physical condition or illness. The time spent at the general hospital will depend on the evaluations of organic conditions necessary to establish the state of health of the individual. In cases of poisoning, the general hospital will be responsible for contacting the Poison Control Center in order to determine how long it will take to eliminate the potentially toxic substance taken by the patient. That time-frame will become the minimal period of time for the patient to remain in the urgent / emergency room before transfer to a psychiatric facility.

6. Once the patient's physical condition is stabilized he/she can be transferred to a psychiatric hospital. Simultaneously, the emergency room must send a clear and concise summary to the psychiatric facility of all tests and treatment done, follow-up recommended and information on the physician who attended the patient in the emergency room.

7. The attending physician at the general hospital is responsible for communicating by telephone with the psychiatric facility in order to discuss the case in detail and explain the symptoms and signs presented by the patient to be transferred. At the same time the patient's transfer can be coordinated.

8. The psychiatric hospital must commit to accept the patient to be transferred for further care.

If the patient involved has the economic capacity to pay for the transportation by ambulance or other means necessary for transfer, or has insurance which covers this service, the transportation necessary for transfer will be paid by the patient or his insurance. In such cases the hospital will be paid directly, if it has actually paid for these services; the health insurance plan is responsible for this payment to the hospital. Cases in which the patient is covered for mental health services by the government health insurance. If necessary, and in the absence of other alternatives, transportation will be provided by the ambulances which service the public safety system of emergency calls through 9-1-1. Transportation will be covered from wherever the patient who needs the service is located to whatever hospital facility that can provide the care necessary. Ambulance transportation must comply with the requirements of Law No. 35 of 1994 and EMTALA.

The general hospital and the psychiatric hospital must both comply with all EMTALA regulations regarding the draft and preparation of a "Protocol for the Process of Transferring Patients" which is here requested and required.

NOTE: Urgencies / Emergencies which are secondary to accidents are covered 100%. The urgent / emergency room copayment or coinsurance does not apply if the patient insured is admitted to the hospital; in that case the co-payment of admission to hospital applies.

Psychiatric urgencies / emergencies will be covered with the applicable copayment or coinsurance.

Cardiovascular Procedures

1. Diagnostic Tests and treatment, including the invasive and non-invasive cardiovascular procedures, less 30% of coinsurance.

2. Physician services, less $15.00 office copayment
3. Surgical procedures, less $50.00 facility copayment
4. Repair or replacement of heart valves, pacemaker and any other applicable device, with $0.00 copayment. Defibrillator pacemaker required pre-authorization.

Neurological Procedures

1. Diagnostic tests and treatment, less 30% of coinsurance.
2. Physician services, less $15.00 office copayment
3. Surgical procedures, including neuroendovascular, less $50.00 facility copayment
4. Repair or replacement of valves, and any other medically necessary device, with $0.00 copayment.

Mental Health Services

1. Unlimited visits to professionals, psychology doctors and other providers who because of their education, training or experience, and the proper competency, are able to offer psychological health services, less $15.00 copayment
2. Unlimited office visits to psychiatrist and/or psychologist of children and teens/adults less $15.00 copayment
3. Group therapies, less $15.00 copayment
4. Collateral visits, less $15.00 copayment
5. Unlimited hospital services, less $100.00 admission copayment. Two (2) days of partial hospitalization are equivalent to one (1) day of regular hospitalization.

This service includes emergency psychiatric transportation by an ambulance authorized by the Service Public Commission (*Comisión de Servicio Público*) and the Health Department (*Departamento de Salud*), as stated in Article 4.20 (b) of Law No. 183 of 6 August 2008. Services requested for psychiatric emergencies through the 911 will be paid in full directly to the provider.

Alcoholism & Substance Abuse Services

1. Unlimited visits to professionals, psychology doctors and other providers who because of their education, training or experience, and the proper competency, are able to offer health services in substance abuse, less $15.00 copayment
2. Unlimited office visits to psychiatrist and/or psychologist of children and teens/adults, less $15.00 copayment
3. Unlimited therapies, treatment and follow-up at one or more service levels, which may combine multiple types of therapy, less $15.00 copayment
4. Unlimited residential treatment for alcoholism and substance abuse including detox, less $100.00 copayment.
5. Unlimited hospital services, less $100.00 admission copayment. Two (2) days of partial hospitalization are equivalent to one (1) day of regular hospitalization. Pre-authorization required.

Autism

Autism is recognized as physico-mental health condition. In compliance with Law of Puerto Rico No. 220 dated on September 4, 2012 with the Puerto Rico Department of Health and utilizing as reference the guidelines of the American Association of Pediatrics coverage for these conditions will include diagnostic and therapeutic services in persons diagnosed with disorders within the continuum of Autism.

Covered benefits include visits to physicians and other health providers and the ordered tests and procedures determined to be medically necessary. The specialized services most commonly utilized are related to neurology, psychotherapy, immunology, genetics, gastroenterology, nutrition, speech and language therapy, occupational and physical therapy. Coverage/benefits are not limited only to the previously mentioned services. These services are subject to any applicable copayment or coinsurance, except for the screening for autism for children up to 36 months.

Dental Services

The dental care benefits described below are available using Humana's provider network in Puerto Rico.

Preventive and Diagnostic Services

The following services will be **covered at 100%** In-network:

1. Initial oral examination, one (1) every three (3) years
2. Periodic examination, one (1) every six (6) months
3. Specific oral evaluation, one (1) every six (6) months
4. Complete series of radiographs (FMX), one (1) every three (3) years
5. Panoramic radiographs, up to one (1) every three (3) years
6. Periapical radiographs, one (1) and five (5) additional per policy year
7. Bitewing radiographs, one (1) set every twelve (12) months
8. Prophylaxis adult and child, one (1) every six (6) months
9. Application of fluoride to children up to nineteen (19) years, one (1) every six (6) months
10. Sealants application, limited to children up to fourteen (14) years, one (1) treatment per tooth per lifetime in permanent molars and premolars not previously restored.
11. Application of fluoride varnish for infants and children up to age 5 years, one (1) every six (6) months.
12. Space maintainers, to replace deciduous teeth that are lost permanently, one (1) per area per lifetime.
13. Pulp vitality test, one (1) per visit
14. Re-cementation of space maintainer
15. General anesthesia, administered by an anesthesiologist, and hospital services according to Law No. 352 of December 22, 1999.

Non-Contracted Dentists

If the insured uses the services of a non-participant dentist or facility, Humana will reimburse the insured the fee of the contracted dentist or facility (with the receipt of the payment made to the dentist that provided the service).

Pediatric Vision Care Services

The vision care benefits described below are available until the 21st birthday.

Lenses: One (1) set of lenses per insured, per policy year, with $0.00 copayment. Service is available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers.

- ✓ Lenses for eyeglasses: the lenses included the following selection:
  - CR-39 Plastic for single vision lenses, bi-focal lenses, or tri-focal lenses
  - Polycarbonate for single vision lenses

Frames: The insured can select any frame available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers throughout Puerto Rico with $0.00 copayment. The benefit includes frame from the collection. Coverage includes one (1) frame per policy year.

Contact lenses: Instead of eyeglass benefit (frame and lenses), the member may choose standard disposable contact lenses. The disposable contact lens benefit consists of two (2) boxes per policy year, with $0.00 copayment. Services are available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers.

One (1) pair of low vision eyeglasses or magnifiers as medically necessary for insured with significant loss of vision (low vision), but not total blindness using an exclusive network of Humana Insurance, less $15.00 copayment.

Pharmacy Coverage

What is the formulary?

A Formulary is a prescription drug list developed and approved by Humana and which is regularly evaluated to include or exclude prescription drugs, which is used to determine benefits covered under the pharmacy coverage. The formulary includes generic/bioequivalent, preferred brand, non-preferred brand, and specialty drugs.

The formulary is available in our webpage, Humana.com. There, you can also find information about your prescription medications that may have Utilization Management requirements and the authorization forms with the information required to evaluate them, if applicable. Humana will provide the insured a copy of the formulary, along with information about which prescription drugs are subject to Utilization Management requirements.

Humana will require that the Pharmacy and Therapeutics Committee has an established process, in writing, to consider and update changes in formulary or those that may require Utilization Management, on a timely manner and based on:

- New scientific medical evidence or any other prescription drug related information for covered, non-covered or those that may require Utilization Management, to determine if a change is needed in the formulary or the utilization management criteria;

- if applicable, any clinical information that Humana receives, related to an exception request that would allow the Pharmacy and Therapeutics Committee to determine if the drugs covered in the formulary or those that may require Utilization Management, meet the member's needs, and

- safety and effectiveness information for covered drugs or those that may require Utilization Management, information about prescription drugs that may be clinically similar or bioequivalent, but that are not covered in the formulary nor require Utilization Management, information that may arise from quality assurance activities in the insurance company or information from prescription drug claims received after the latest Pharmacy and Therapeutic meeting.

- Humana will require that the Pharmacy and Therapeutics Committee performs the evaluation of new prescription drugs approved by the Food and Drug Administration (FDA) in no more than a ninety (90) days period, from the FDA approval date. The Pharmacy and Therapeutics Committee should make a determination to include or not include a new prescription drug in the formulary, in a term no more than ninety (90) days from the date the drug is available on the market.

Humana guarantees that the Pharmacy and Therapeutics Committee establishes disclosure policies and requirements in which the identification of possible conflicts of interest between members of the committee and the developers or manufacturers of prescription drugs is contemplated. No member of the Pharmacy and Therapeutics Committee may have any relationship or interest, financial or otherwise, with the developers or manufacturers of the prescription drugs.

Humana guarantees that the Pharmacy and Therapeutics Committee will establish and comply with a written procedure to evaluate medical and scientific evidence related to the safety and efficacy of prescription medications, including information to compare similar prescription medications and bioequivalent, on deciding which prescription medications are to be included in the formulary and on developing other pharmacy benefit management processes. Humana also guarantees that the Pharmacy and Therapeutics Committee will establish protocols for the analysis, and possible inclusion in formulary, of medications for "off-label use" for those health conditions in which, through medical or scientific evidence, the efficacy of the medication has been established.

Pharmacy and Therapeutics Committees must document all their protocols and processes and present registers and documents to Humana upon request.

Humana may contract with other persons to perform the functions of the Pharmacy and Therapeutics Committee. Humana will be accountable to the Commissioner of Insurance for non-compliance and violations incurred by its' Pharmacy and Therapeutics Committee.

Humana will only be able to make changes in the formulary or the Utilization Management while the policy is active; if the change is because of safety, the drug is no longer available in the market, if a new prescription drug will be added in the formulary. If this happened, Humana will notify this no later than when the change is made, to:

- All covered members and
- participating pharmacies, only if the change is because a new prescription drug will be added to the formulary. In this case, Humana will notify thirty (30) days before the change is made.

Humana will meet the following requirements:

Humana will maintain and facilitate the information below to the members, prescribers and pharmacies, by electronic means and if requested by the member or the Pharmacy, written:

- The formulary (prescription drug list) organized by therapeutic categories and the list known as "Maximum Allowable Cost";
- Information about prescription drugs and those that may require Utilization Management, if applicable, which was developed and maintained according to the "Código de Seguros de Salud de Puerto Rico".
- Information about the documentation that may need to be presented by the insured or the personal representative to request a medical exception and the way in which to present this documentation. For details, see Section Application and Process Exception in this Certificate.

How do I use the formulary?

Drugs are listed in the formulary alphabetically.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage based on FDA indications and dosing, like gender, age, and dose limitations. Requirements and limits may include:

- **Prior Authorization (PA):** Humana requires you or your doctor to get prior authorization for certain drugs. This means that your doctor must contact Humana to get approval before you fill or refill a prescription for any drug that needs prior authorization. Your plan benefits won't cover this drug without prior authorization. You'll pay the entire cost of the drug if you decide to buy it.
- **Quantity limits (QL):** For certain drugs Humana limits the amount of the drug that we'll cover. Humana might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. Specialty drugs are limited to a 30-day supply regardless of drug-tier placement.
- **Specialty drugs (SP):** High-cost drugs, including high technology and self-administered injectable medications, requiring special monitoring.
- **This coverage focuses on the use of bioequivalent drugs as a first alternative; however, the insured has the option to choose between a brand drug or a bioequivalent**. If an insured chooses to purchase a brand drug, and an equivalent generic/bioequivalente is available, the insured must pay the difference in cost between the brand and the generic/bioequivalent, plus any applicable brand copay or coinsurance dispensed. If the insured chooses the bioequivalent drug, he or she will only pay the copayment or coinsurance for the bioequivalent drug dispensed. If there is no bioequivalent alternative on the market, the insured will pay the applicable copayment or coinsurance for the brand-name drug dispensed. However, if the physician orders a brand-name drug and writes a prescription as dispensed as written, the insured is responsible only for the copayment or coinsurance of the brand name drug.

What if my drug is not on the formulary?

If your drug isn't included in this printed list of covered drugs, you should visit **Humana.com** to see if your drug is covered. You can also contact Customer Care and ask if your drug is covered.

If Humana doesn't cover your drug, you have two options:

- You can ask Customer Care for a list of similar drugs that are covered by Humana. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Humana.
- You can ask Humana to make an exception and cover your drug. See below for information about how to request an exception.

You are responsible, when applicable, for all or some of the payments for the following:

- The copayment or coinsurance*; and

* If the charge from the pharmacy dispensing the medication is lower than the copayment or coinsurance, you will be responsible for the lesser amount. The amount we pay the pharmacy for the medication might not reflect the final cost to us. Your copayments or coinsurances are made according to the prescription or refill of the prescription and will not be adjusted if Humana gets a discount for volume or a sale on prescription medications.

Pharmacy Annual Deductible

Deductible	Individual	Family
Network Provider	$0	$0
Non-Network Provider	$0	$0

Pharmacy Annual Deductible is the amount that an Individual / Family must pay for calendar year before Humana provides payment for pharmacy covered benefits. The deductible will not apply to Tier 1 Drugs. Once the Individual member in an Individual policy meets the applicable Individual annual deductible, Humana shall provide payment for covered benefits.

For Individual coverage or Family coverage, there is a deductible pharmacy services in-network and a deductible for pharmacy services out-of-network. Pharmacy expenses of benefits you might incur for covered expenses provided by a network provider will apply to the network providers' deductible. Pharmacy expenses you might incur (as provider fee for in-network) for covered expenses provided by out of network will apply to the out of network providers' deductible.

The accumulation period will begin on the effective date of the policy and will end when the policy terminates. From there on, it will be from the renovation date until the policy year end.

Coverage Description

Covered Prescription Drugs List

The following drugs will be covered when prescribed by an authorized doctor:

1. Drugs, medicines or medications that under Federal or state law, may be dispensed only by prescription from a health care practitioner; this includes brand, generic, acute and maintenance medications;
2. Drugs, medicines or medications that are included on the drug list, including the drugs covered by the "Patient protection and Affordable Care Act", like contraceptives, breast cancer risk-reducing medications, among others.
3. Insulin and diabetes supplies;
4. Hypodermic needles or syringes when prescribed by a health care practitioner for use with insulin or self-administered injectable drugs (Hypodermic needles and syringes used in conjunction with covered drugs may be available at no cost to you);
5. Specialty drugs and Self-Administered Injectable Drugs approved by Humana;
6. Spacers and/or peak flow meters for the treatment of asthma;

7. Drugs, medicines or medications on the Women's Healthcare Drug List with a prescription from a health care practitioner;
8. Buprenorphine.

Humana provides for the dispensed of covered drug, regardless of the condition, illness, injury, condition or disease for which they are prescribed, if:

• The drug has FDA approval for at least one indication and

• the drug is recognized for treatment of the disease, illness, injury, condition or disease in question in one of the standard reference compendia or through peer-reviewed medical literature generally accepted.

This drug coverage also includes medically necessary services that are associated with drug administration.

If *you* request a *brand-name medication* when a *generic medication* is available, *your payment* is greater. *You* are responsible for the applicable *generic medication copayment* or coinsurance and 100% of the difference between the amount *we* would have paid the dispensing *pharmacy* for the *brand-name medication* and the amount *we* would have paid the dispensing *pharmacy* for the *generic medication*. If the prescribing *physician* determines that the *brand-name medication* is *medically necessary*, *you* are only responsible for the applicable *copayment or coinsurance* of a *brand-name medication*.

Drugs, Medicines or Medications on the Women's Healthcare Drug List from a N*etwork Pharmacy* are covered in Full (without cost-sharing)

Prescription Drugs Covered without cost sharing from a Network Pharmacy. For more details please refer to drugs list/ formulary.

1. Generic aspirin, for both men and women from 45 to 79 with cardiovascular risk and as prevention of pre-eclampsia: after 12 weeks of gestation in women who are at high risk of pre-eclampsia, both with a medical prescription.
2. Generic folic acid for women planning a pregnancy, with medical prescription.
3. Cancer treatment included within the pharmacy benefit and processed (including oral and auto-administered injectable) in a Network Pharmacy is covered in full, with medical prescription. Intravenously and intrathecally are covered under the Cancer Services and Treatment Section.
4. Breast cancer risk-reducing medications, with medical prescription such as tamoxifen or raloxifene for women who are at increased risk for breast cancer and at low risk of adverse effects to the drug.
5. Smoking cessation drugs, including over-the-counter (OTC), with medical prescription. Covers smoking cessation drugs for 90 consecutive days in an attempt and two (2) cessation attempts per year.
6. Statins in low- to moderate-dose statin for the prevention of cardiovascular disease events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater.

Immunizations for infants, children, and adults are covered through the Medical Coverage in accord with accepted medical practice and as recommended by the Advisory Committee for Immunization Practices (ACIP) of the Centers for Disease Control (CDC), the American Academy of Pediatrics, and are also covered under the vaccination schedule of the Puerto Rico Department of Health.

Benefit Program

The healthcare provider will be able to prescribe maintenance medications to the member with enough refills not to exceed 180 days, according to the plan limitations, when the medical history of the member permits it and no risk are identified.

Contracted/participant pharmacy

Contracted or participant pharmacies are pharmacies that are legally authorized by the relevant authorities, which has signed a contract with Humana to provide pharmacy benefits to its insured.

You are responsible of the following:

Retail Pharmacy / Specialty Pharmacy

Tier 1 Drugs means a category of generic prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 1 drugs.

Tier 2 Drugs means a category of preferred brand prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 2 drugs.

Tier 3 Drugs means a category of non-preferred brand prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 3 drugs.

Tier 3 Drugs: Specialty Drugs means a category of specialty prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 3 drugs.

Tier 1 drugs	$5.00 copayment per prescription or refill per 30-day supply
Tier 2 drugs	$15.00 copayment per prescription or refill per 30-day supply
Tier 3 drugs	20% coinsurance per prescription or refill per 30-day supply
Tier 3 drugs: Specialty drugs	20% coinsurance per prescription or refill per 30-day supply

Note: This plan has a Max Allowable Benefit of $1,200. After this monetary maximum for prescriptions has been reached in disbursements by Humana, the member will be responsible for a 95% coinsurance for all prescriptions until the end of the policy year.

Specialty Drugs through Medical Coverage

Benefits:

A. When medically necessary, specialty drugs administered in a professional setting, including office or infusion center, are covered less the applicable copayment or coinsurance of the specialty drugs in the pharmacy coverage.
B. All utilization requirements of the pharmacy coverage, including but not limited to pre-authorization or quantity limits, shall apply.

90 days program

The retail pharmacies participate in our program which allows you to receive a 90-day supply of a prescription or refill. Your cost is 3 times the applicable copayment or coinsurance as outlined above. Self-administered injectable drugs and specialty drugs are limited to a 30-day supply from a retail pharmacy or specialty pharmacy.

Mail Order Pharmacy
This is a service that delivers medications by mail. It applies to prescriptions or refilled prescriptions covered in the policy.

For up to a 90-day supply of a prescription or refill	2 times the applicable copayment or coinsurance, as outlined above under Retail Pharmacy / Specialty Pharmacy

Mail Order Process:

Your health and well-being is very important to us. Please note that Humana Pharmacy can offer the value and services that you expect from your pharmacy. The routine process to be followed in procuring your maintenance medications by mail is easy and saves time.

The first time you use mail order to receive your medication, ask your doctor for two prescriptions. The first prescription should be written for a one-month supply that can be immediately filled at a participating retail pharmacy. The second prescription should be written for a 90-day supply of the medication with refills and the doctor will send it to Pharmacy Solution. You can use the service for all your maintenance medications.

1. Humana Pharmacy receives the request to fill your prescription. Your physician provider can actually send your prescription by fax (1-800-379-7617), through the telephone (1-800-833-1315-TTY: 711), by filling out a form designed for this purpose (Registration form for prescriptions by mail), onsite at HumanaParmacy.com, or by mail (Humana Pharmacy, PO Box 745099, Cincinnati, OH, 45274- 5099).
2. Humana Pharmacy verifies your pharmacy benefit coverage, enters your order and creates an exclusive shipping number.
3. The Humana pharmacist then reviews the order for a prescribed medication to verify that it is correct and complete. If it is incomplete or incorrect, it is returned with the reason for the rejection.
4. The Humana pharmacist approves the prescription.
5. After approved, the prescription then goes through the billing process.
6. An automated system fills your prescription and a pharmacist verifies that each medication is correct.
7. The prescription is filled in a period of seven (7) to ten (10) days of the time when Humana Pharmacy first received the request for your medications.

Out-Of-Network Pharmacy

When an *out-of-network pharmacy* is used, *you* must pay for the *prescription* or refill at the time it is dispensed. *You* must file a claim for reimbursement with *us*. In addition to any applicable *copayments coinsurances*, *prescription drug deductibles*, *you* are responsible for 30% of the *default rate* (the contracted fee that Humana agreed to pay a pharmacy within the network of providers for a drug) *and* the difference between the *default rate* and the *out-of-network pharmacy's* charge. Example: A pharmacy non-participant has a drug charge of $ 70.00 and the default rate is $50.00, the insured will be responsible for $ 15.00 (30% of the default rate-$ 50.00) plus $ 20.00 which is the price difference between the default rate ($50.00) and the charge of the drug in non-participating pharmacy ($70.00), plus the copayment that has that drug at a contracted pharmacy or coinsurance of the default rate. Any amount *you* pay over the *default rate* and any applicable *copayments*, coinsurances, *pharmacy annual deductible* and percentage amounts *you* pay to an *out-of-network pharmacy* do not apply toward *your maximum out-of-pocket* or any maximum *out-of-pocket*, if any. The charge received from an *out-of-network pharmacy* for a *prescription* or refill may be higher than the *default rate.*

Prior authorization

A prescription drug that is safe and effective for one person may not be safe and effective for another. This is why certain drugs must go through an evaluation and authorization process at Humana before they can be dispensed to members. This process is based on the evaluation of clinical standards for its safe use. The United States Food and Drug Administration (FDA) has recommended these drugs as safe and effective, but due to a high level of concern about their appropriate use, therapeutic indication, and cost, Humana's National Pharmacy and Therapeutics Committee has decided that a prior-authorization must be obtained for dispensing and use. To request coverage for a drug with prior authorization, the physician can contact the Humana Clinical Pharmacy Review (HCPR) at 1-866-488-5991 or by fax 1-855-681-8650

Prior authorization process:

The Humana Clinical Pharmacy Review (HCPR) will receive calls from providers requesting authorizations related to clinical review.

- Requests that require clinical review will be evaluated by the Humana Clinical Pharmacy Review (HCPR) staff. Decisions will be made according to approved clinical protocols established by the Humana's Pharmacy and Therapeutics Committee, as applicable.

- If the request is approved, the authorization is added on Humana's claim processing system. Then, the decision is notified to the person or entity who requested the authorization, whether the member, the physician, or personal representative.

- Requests that do not meet clinical criteria are denied and the decision is notified to the person or entity who has requested the authorization, whether the member, the physician, or the personal representative.

- If additional information is required to complete the evaluation of the request, a prior authorization form will be sent to physician's office by fax. If there is no fax available at physician's office it will be sent to pharmacy.

Humana Clinical Pharmacy Review (HCPR) will evaluate the request for authorization in a period not exceeding 72 hours after being received. In those cases where the physician requesting the case to be worked as expedited because the member's health could be affected, request will be evaluated in a period not exceeding 24 working hours.

Exception request and process

How do I request an exception to the formulary?

You, your physician, or your Personal Representative can contact Humana to ask for an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it's not on our formulary.
- You can ask us not to apply coverage restrictions or limits on your drug. For example, if your drug has a quantity limit, you can ask us not to apply the limit and to cover more.
- Continuum of coverage for a specific prescription drug that Humana will remove from the formulary for reasons other than health or because the drug is no longer available or because the manufacturer removed it from the market; or
- An exception to Utilization Management criteria that indicates the drug may not be covered in the prescribed quantity.

Your doctor should contact us to ask us for an initial coverage decision for a formulary or utilization restriction exception. We must make our decision within 72 hours of getting your prescribing doctor's supporting statement. For controlled medicines, the term should not exceed thirty-six (36) hours after getting your prescribing doctor's supporting statement.

The member or your appointed representative will only be able to make a request in writing, if the physician or other prescriber has determined that the requested medication is medically necessary for the treatment of the disease of the member because:

a. There is no covered prescription drug in the plan's formulary that is a clinically accepted alternative to treat the member's disease:
b. The prescription drug alternative(s) listed on the formulary:
    i. Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
    ii. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
c. The number of doses available under a dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

The following information would be required as part of the supporting statement in an Exception request:

- Name , group number or policy ID, member ID;
- Patient's history
- Primary diagnosis, related to the requested prescription medication
- Reason why:
    - The covered prescription drug would not be an acceptable alternative for this member; or
    - The prescription drug alternative(s) listed on the formulary or required to be used in accordance with requirements would not be acceptable for this member; or
    - The number of doses available under a dose restriction for the requested prescription drug would not be acceptable;
- Reason why the Exception request is needed, for either the requested prescription drug or the limit of available doses.

Exception requests will be evaluated by appropriate healthcare professionals, according to the member's condition; who will consider specific facts and circumstances within each case and use clinical criteria that is:

- Based on scientific, clinical evidence based medicine; and
- If available, clinical practice guidelines, which may include, evidence based practice guidelines, clinical criteria developed by Humana's Pharmacy Committee or any other practice guidelines that may have been developed by the federal government, national associations or medical/pharmacy professional associations.

Experienced healthcare professionals will evaluate Exception requests according to the member's coverage - pharmacy benefit and exclusions.

If a medical exception is granted, Humana will provide coverage for the requested medication and will not require that the member requests an approval for a refill, nor for a new prescription, in order to continue using the same prescription drug after the refills of the first prescription run out. This is subject to the coverage terms and provided that:

a. The prescribing physician continues prescribing the medication for the same disease or medical condition;
b. The prescription drug continues being safe for the treatment of the member's disease or medical condition.

Humana will not establish a new or special formulary tier, copay for any other cost-sharing requirement that would only apply for the prescription drugs approved through the Exception process.

All denials for an exception request by Humana:

a. Will be notified to the member or the appointed representative, in writing, or by electronic means, if the member has agreed to receive the information that way;
b. Will notify, by electronic means, to the physician or other prescriber, as requested, in writing; and
c. It may be appealed through an appeal request, according to the Section Procedures to Address Complaints, Grievances and Appeals of the Policy.

The denial will describe in a comprehensible way for the member or the personal representative, if applicable:

a) The specific reason for the denial;

b) references to the evidence and documentation, which include the clinical criteria for evaluation and practice guidelines, clinical, medical and scientific evidence that was used and considered to make a denial determination for the request;

c) instructions on how to request a written statement for the clinical, medical and scientific justification of the denial; and

d) a description of the process and procedures to request an appeal for the decision, according to the Section Procedures to Address Complaints, Grievances and Appeals of the Policy, including the timeframes for these procedures.

If Humana does not make a decision with respect to the request for exception, or does not notify it in the above mentioned timeframe:

- The insured shall be entitled to be provided with the prescription drug that is the object of the request for up to thirty (30) days; and
- Humana shall make a decision with respect to the request for exception prior to that time when the insured finish the medication provided.
- If the insured finishes the medication provided, Humana shall maintain coverage under the same terms and in a continuous manner, so long as the same medication is prescribed to the insured and it is deemed safe for the treatment of the illness or medical condition, unless applicable limits to benefits have been exhausted.

If the member is not satisfied with Humana decision, he/she has the right to appeal it; following the Procedure to address Complaints, Grievances and Appeals that is part of the Policy and this Schedule of Benefits.

Other Benefits

Ambulatory Services

1. SPECT test, less 30% of coinsurance. Pre-authorization required.

2. Cardiovascular rehabilitation services at a dedicated center. Includes services by licensed physicians and registered nurses. Rehabilitation program must include education and supervised exercises that lead to risk factor recognition and management and improved exercise capacity. This benefit does not include maintenance exercise programs. Program must not exceed twelve (12) sessions in duration, less $100.00 copayment. Pre-authorization required.
3. Orthopedic devices: casts, splints, braces and crutches, with $0.00 copayment.
4. Laparoscopy, covered at ambulatory facility or at hospital, less $50.00 ambulatory facility copayment, $100.00 hospital copayment per rendered service.
5. Adult circumcision, less $15.00 office visit or $50.00 facility copayment.
6. Breast biopsies, unlimited, less $50.00 facility or $100.00 hospital copayment.
7. Allergy vaccines, up to a maximum of twenty (20) per insured, policy year, less 30% coinsurance.
8. Epidural blocks for pain management administered by medically qualified and recognized specialist, one (1) per anatomical region per insured per policy year, less $15.00 copayment.
9. Maxillofacial surgery, diagnostic and therapeutic services for accidental injuries, jaw fractures, neoplasms, injuries to natural teeth, including their replacement within a period of six months following an accident, provided the insured was covered by the policy when the accident occurred, less $100.00 copayment. Pre-authorization required.
10. Assistant Surgeon, when medically necessary: pre-notification required. Less applicable 30% coinsurance.
11. Reconstructive surgery for injuries due to an accident while the insured is covered under the policy and is not covered under any other program (ACAA, FSE, etc.), less $100.00 copayment.
12. Diagnostic tests and treatment associated with Hepatitis C, unlimited, less 30% coinsurance.
13. Diabetes paraphernalia for children and adults: lancets, syringes for insulin administration and glucometer strips up to a maximum of one hundred and fifty (150) of each one per month, less 30% coinsurance.
14. Hyperbaric Oxygenation treatment for people diagnosed with autism spectrum disorder, provided that it is recommended by a certified medical professional or health professional and the treatment is allowed by federal laws and regulations, as provided by Law 63 of July 19, 2019. Less $50.00 facility or $100.00 admission copayment.

Employee Assistance Program (EAP)

The program is offered by [Inspira, Lucy Lopez Roig, APS OptiMind] and includes the following:

1. Counseling, support, guidance and brief psychological therapy for life situations, including labor problems, emotional problems, relationships, and alcohol or drug abuse, covered at 100%, [Up to sixteen (16) sessions per policy year for each insured. Sessions are divided between the employee and dependents; eight (8) sessions for the employee and eight (8) sessions for dependents - Up to eight (8) visits per situation per insured – Unlimited]. Sessions may include the following:
    - crisis intervention
    - initial evaluation
    - marital or family counseling
    - referral to appropriate mental health resources when indicated for specialized treatment or assistance, including long-term therapy or psychiatric treatment.
2. Special crisis intervention services in case of catastrophic or traumatic events at the work-site.
3. Financial advice

4. Legal advice
5. Implementation orientation to administration and personnel
6. Workshops and orientations for employees
7. [Up to 10 occupational evaluations per employee]

Hospice

Hospice Care Program means a coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill insured and his or her insured family members, by providing palliative and supportive medical, nursing and other services through at-home or inpatient care. The hospice must be licensed according to the laws of the Commonwealth of Puerto Rico. It must provide a program of treatment for a person who have been medically diagnosed as having no reasonable prospect of cure for their illness and, as estimated by a physician, are expected to live less than six (6) months as a result of that illness.

Humana will pay benefits for charges for a hospice care program, which is submitted in writing and approved by us. The insured must submit in writing his or her intent to enroll in a hospice care program approved by us. Hospice benefits are subject to the applicable copayment. All the hospice services are subject to $100.00 admission copayment. All services must be received within a twelve (12) month period. Pre-authorization required.

Organ and Tissue Transplant

We will pay benefits of a Covered Organ Transplant as defined below, incurred by an insured for an organ transplant approved in advance by Humana, subject to those terms, conditions and limitations described below and contained in the group policy. These services are subject to any applicable copayment or coinsurance. Please contact the company's Transplant Management Department when in-need of these services.

Covered Organ Transplant means only the services, care, and treatment received for or in connection with the pre-approved transplant of the organs identified hereafter, which are determined by Humana to be medically necessary services and which are not experimental or investigational.

The covered organ transplant includes pre-transplant, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation of the following organs or procedures only:

a) Heart;
b) Lung(s);
c) Heart-lung;
d) Liver;
e) Kidney;
f) Bone Marrow;
g) Intestine;
h) Simultaneous pancreas/kidney;
i) Pancreas following kidney;
j) Any organ not listed above required by state or federal law.

The term bone marrow identified in the foregoing covered organ transplant definition refers to the transplant of human blood precursor cells which are administered to a patient following high dose, ablative or myelosuppresive chemotherapy. a) Such cells may be derived from bone marrow, circulating blood, or a combination of bone

marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. b) If chemotherapy is an integral part of the treatment involving a covered organ transplant of bone marrow, the term bone marrow includes the harvesting, the transplantation and the chemotherapy components. c) Storage of cord blood and stem cells will not be covered unless as an integral part of a covered organ transplant of bone marrow approved by Humana.

For a covered organ transplant procedure to be considered totally approved, a written authorization by Humana is required.

a. The insured or his/her physician must notify Humana in advance regarding the need for an evaluation to determine if the organ transplant will be covered. Within five working days of the receipt of this request, Human will contact the insured and his/her physician to clarify transplant benefits available under the insurance, if any.

b. If the product includes benefits of organ transplants, and once the insured has chosen the facility for transplant, Humana proceeds to approve a pre-transplant evaluation.

c. The transplant facility proceeds with the evaluation of the candidate for transplant and must submit to Humana for review seven (7) specific points or articles evaluated.

d. Humana then reviews the clinical results of the facility's evaluation, confirms eligibility, and proceeds to approval on the same day.

e. For solid organ transplants, no medical review is necessary by Humana; bone marrow transplants do require a medical review for final determination.

f. If the transplant is denied, the insured and the physician will receive oral and written explanations of their rights to appeal through the Complaints, Grievances and Appeals system of Humana.

Covered Services:

For approved covered Organ Transplants and all related complications, we will cover only the following expenses:

1. Hospital benefits shown in the schedule of benefits under the Hospital Services section of the group policy will be paid at: (a) 100% of reasonable charges if received at a participating hospital designated by us as an approved transplant facility; and (b) 70% of reasonable charges if received at non-participating hospital.

   Physician benefits shown in this Schedule of Benefits under the Ambulatory Services section of this group policy will be paid at (a) 100% of reasonable charges if received from a participating physician designated by us as an approved transplant provider; and (b) 70% of reasonable charges if received form a non-participating physician.

2. Organ acquisition and donor costs. (a) Except for Bone Marrow transplants, donor costs are not payable under the group policy if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. (b) Coverage for Bone Marrow transplant procedures will include costs associated with donor-patient to the same extent and limitations associated with the insured, except the reasonable costs of searching for the donor may be limited to the immediate family members and the National Bone Marrow Donor Program.

3. Direct non-medical costs* for the insured receiving the covered organ transplant will be paid for: (a) transportation to and from the hospital where the covered organ transplant is performed; and (b) temporary lodging at a prearranged location up to $75.00 per day when requested by the hospital and approved by Humana.

   Transportation costs for the insured to and from the hospital where the covered organ transplant is performed will be paid at: (a) 100% of the reasonable charges if the covered organ transplant is received at a

participating hospital designated by Humana as an approved transplant facility; or, (b) 70% of reasonable charges if the covered organ transplant is received at a non-participating hospital.

Coverage of *non-medical cost will be available only if the insured will travel to the United States for transplant.

4. Direct non-medical costs* for one member of the insured's immediate family (two members if the patient is under age 18 years) will be paid for: (a) transportation to and from the approved facility where the covered organ transplant is performed; and (b) temporary lodging at a prearranged location during the insured's confinement in a hospital, not to exceed $75.00 per day.

   Transportation costs for the insured's immediate family member(s) to and from the hospital where the covered organ transplant is received.

   Coverage of non-medical* will be available only if an immediate family member(s) accompanies the patient to the United States for a transplant.

*All direct non-medical expenses for the insured receiving the covered organ transplant and his/her family member(s) are limited to a combined maximum coverage of $10,000.

Exclusions:

No benefit is payable for or in connection with a covered organ transplant if:

1. We are not contacted for authorization prior to referral for evaluation of the covered organ transplant, unless such authorization is waived by Humana.
2. We do not approve coverage for the covered organ transplant, based on our established criteria.
3. Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received.
4. The expense related to the transplantation of any non-human organ or tissue, unless otherwise stated in the group policy.
5. The expense related to the donation or acquisition of an organ for a recipient who is not covered by Humana.
6. A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow up care, immunosuppressive drugs, and complications of such transplant.
7. The insured for whom a covered organ transplant is requested has not met pre-transplant criteria as established by Humana.

Once the covered organ transplant is approved, we will advise the insured's physician. Benefits are payable only if the pre-transplant services, the covered organ transplant and post-discharge services are approved by Humana.

Services Out of Puerto Rico

Services rendered on the United States of America:

If insured needs a procedure, treatment, test or office visit in the United States as a second opinion, follow up treatment or because the treatment is not available in Puerto Rico, can submit evidence of the incurred expenses, we will reimburse according the established rates for each treatment in Puerto Rico. Apply the copayment or coinsurance of the benefit described in the policy. Pre-authorization required.

These do not include benefits not available in Puerto Rico, available in the United States of America. For these benefits, refer to Section Service Not Available in Puerto Rico, Available in the United States.

Emergency Services Outside Puerto Rico

I. Emergency Services (Including emergency hospitalizations) received in the United States of America:

A. Services received in contracted Humana or ChoiceCare facilities:

1. Whenever possible emergency services should be received in a facility contracted with the Humana or ChoiceCare Networks.
2. Humana P.R. must receive notice of all emergency services within 72 hours of the insured receiving the services.
3. Payments for emergency services and related admissions provided by a contracted provider will be paid according to the Urgent / Emergency Room Services Section under this Schedule of Benefits, less $50.00 copayment.

B. Services received outside of contracted Humana or ChoiceCare facilities:

1. For services provided in emergency rooms of non-participating providers, payment will be the same as if a participating provider, less $50.00 copayment.
2. The physician must receive notice of all emergency services within 72 hours of the insured receiving the services.

   The attending physician may transfer the insured to a contracted facility as soon as medically feasible. Such transfer should in no way compromise or be detrimental to the insured's medical condition or treatment. Humana will assist in the coordination of such transfer.

II. Emergency Services received outside the United States of America or Puerto Rico:

A. The insured will be reimbursed 100% of the contracted fee for similar services by a provider in Puerto Rico or, billed charges, whichever is less, less $50.00 copayment.

1. If the insured requires hospitalization and cannot be transported to a contracted facility in Puerto Rico or the United States, Humana will attempt to negotiate the best possible fee with the non-participating facility for the benefit of the insured.

2. If the insured can be transported without risk to a participating facility in the United States or Puerto Rico, then the admission copayment or coinsurance only will apply from this point forward.

All claims for services rendered outside of Puerto Rico or the United States must be submitted to Humana with all supporting medical and financial records within a period of one (1) year from the date of service or date of discharge (whichever is later) to ensure reimbursement where applicable.

Ambulatory Services for Dependent Studying in College in the United States of America

Dependent studying in college in the United States of America, as included in the definition of direct dependent, (b) through (g), can receive coverage for covered services provided by contracted providers in the United States. To receive coverage the following conditions must be met:

- The dependent studying college degree, in accordance to the definition of dependent indent (b) through (g), must be eligible for coverage, under the Plan and the ambulatory services received in the United States must be covered services under the Humana PPO Policy.
- The insured university student must be a full-time student at an accredited university in the United States. For purposes of this requirement, it will be presumed that the student is full-time if he/she studies twelve (12) credits; six (6) credits in the case of students studying graduate studies. Any exception to this assumption of credit requirements must be certified by the university institution.
- The dependent college student must coordinate and obtain prior authorization from Humana P.R. for the services unless the services meet criteria for urgent or emergency treatment as set forth in the Policy.
- Services provided by a provider in the Humana or ChoiceCare provider network shall be paid according to the benefits under the Policy. Any copays, coinsurance and/or deductibles set forth in the policy applicable to the benefits shall apply.

If the service is rendered by a provider not participating in the Humana or ChoiceCare network, the service will the service will be reimbursed based on contracted fees for similar services in Puerto Rico, less applicable copayments, coinsurances and deductibles. The insured is responsible for the difference between the Humana contracted rate in Puerto Rico and the facility billed charges.

Important:

1. ChoiceCare is a network of providers, including physicians and hospitals, contracted by Humana in the United States. The insured does not need to contact ChoiceCare to access a covered service. The logo on the card will be the identifier to the provider. Since the services require pre-authorization and coordination, Humana will help the insured identify the appropriate provider or facility. A full ChoiceCare directory is available on the web at www.humana.com.
2. For coordination or pre-authorization the member should call Humana's Customer Service Department at 1-800-314-3121.

Services Not Available in Puerto Rico, Available in the United States of America

This benefit is for services not available in Puerto Rico, available in the United States of America, including equipment, treatment and facilities, among others.

A. Humana will cover such services only if the following five conditions are met.

   1. The Insured must be eligible for coverage under the Plan and the services requested must be Included this Schedule of Benefits.

   2. The provider referring must demonstrate that the equipment, treatment or facilities required to provide medically necessary covered services to the insured are unavailable in Puerto Rico**.** A service will not be deemed unavailable in Puerto Rico if the request for services to be provided outside of Puerto Rico involves a modification to the equipment, technique, or surgical approach available in Puerto Rico or is based on the reputation or recognition of any given provider.

   3. The service must be coordinated and pre-authorized with Humana in Puerto Rico at least five (5) working days prior to the date the service will be rendered.

   4. The service must be provided by Humana or ChoiceCare network providers/facilities.

   5. All services under this Section are subject to the applicable copayments and coinsurances for services as described in this Schedule of Benefits.

B. These services or treatments require pre-authorization with Humana, except in emergencies. If the service or treatment is not authorized by and coordinated with Humana in Puerto Rico, the insured will be responsible for the entire payment for such service or treatment. Humana will reimburse the patient based on the applicable Humana fee in Puerto Rico, less applicable copayments or coinsurances as described in this Schedule of benefits only if conditions A1, A2 are met. To receive reimbursement, the insured must provide Humana with all supporting medical and financial information within one (1) year of service or discharge.

Important Notes:

1. ChoiceCare is a network of providers, including physicians and hospitals, contracted by Humana in the United States. The insured does not need to contact ChoiceCare to access a covered service. The logo on the card will be the identifier to the provider. Since the services require pre-authorization and coordination, Humana will help the insured identify the appropriate provider or facility. A full ChoiceCare directory is available on the web at www.humana.com.

2. For coordination or pre-authorization the member should call Humana's Customer Service Department at 1-800-314-3121.

Telemedicine Service
(Virtual Medical Consultation)

Benefit:

Telemedicine service through virtual medical consultation to the insured allows you to receive access to health or minor emergency consultations with a certified primary care physician for the practice of Telemedicine in accordance with Act No. 168 of 2018. Less $20.00 copayment per virtual medical consultation. Through the following website: **www.mdlive.com/humanapr.**
As part of the services of this virtual platform, the insured can also share medical results of their studies.

In cases where the doctor understands that he or she needs medication use according to the insured's clinical picture, the prescription will be coordinated directly to the insured's preferred pharmacy through one of our contracted provider pharmacies.

This Telemedicine service does not replace your doctor, if you have an emergency, it is important that you call the emergency system at 911 or visit the nearest emergency room.

If the doctor determines that the condition by which the insured accesses the virtual consultation cannot be attended through this service, the insured will be immediately referred to an emergency room or personal doctor.

The insured is responsible for verifying their certificate of benefits, description of benefits and / or the medication form to verify if the service is covered.

Medical Exclusions

1. Procedures and/or health services in an experimental or research stage which are not supported by clinical evidence documented in the medical literature of the United States of America, except in connection with a life-threatening condition of the insured for which no effective treatment is available. Humana will pay only for the routine medical expenses associated with the order of such procedure or service which are not reimbursed by the entity conducting the service.
2. Expenses related to illness or injury resulting from war or uprisings.
3. Correspond Services be received, according to the State Workmen's' Compensation Fund Law (*Ley del Fondo de Seguro del Estado*), liability of the insured, private compensation plans at work, car accidents (Automobile Accident Compensation Administration (*Administración de Compensación por Accidentes de Automóviles*, ACAA, for its Spanish acronym).and other services available under state or federal laws. They will also be excluded such services when they are denied by government agencies concerning non-compliance or violation of the requirements or provisions of the above laws, although such failure or violation does not constitute a crime.
4. Expenses caused by military service, war, civil insurrection, international armed conflict, except in those cases where the services received are related to an injury sustained while the insured was active in the military (service connected), in which case Humana will collected such charges from the U.S. Department of Veterans Affairs.
5. Accidents occurring while the insured is participating in races such as: automobile, motorcycle, four-track, boats or other tests of speed, in areas set aside for such activities or any other place.
6. Services provided and/or covered pursuant to state or federal legislation for which the Insured is not legally required to pay.
7. Services received free of charge, rendered by the spouse, parents, siblings, or children of the Insured.
8. Hospitalizations for procedures which can be performed on an ambulatory basis.
9. Hospitalization for diagnostic purposes only; custodial, rest or convalescence services.
10. Services rendered at a time when the policy is not in effect.
11. Electronic prosthesis, including myoelectric arm and cochlear implant, and the removal or insertion of any device, and any other described as non-covered, except the breast prosthesis covered in case of mastectomy.
12. Services considered unreasonable or medically unnecessary for diagnosis or treatment of an illness or injury.
13. Expenses for custodial services, private nurses, personal commodity services such as telephone, television, etc. and all medical services or expenses in convalescence facilities, except for home healthcare services which have been authorized by Humana.
14. Music therapy
15. Cosmetic/esthetic maxillofacial and dental procedures.
16. Esthetic mammoplasty except as applicable in Woman's Rights Cancer Act, and the esthetic mammoplasty in accordance with the Law No. 275 dated on September 27, 2012.
17. Cosmetic/esthetic surgery, except septoplasty when medically justified and with prior authorization.
18. Repair or replacement of instruments or prosthetic devices due to normal wear and tear and impairment.
19. Corrective footwear.
20. Services, treatments, and therapies of alternative medicine by physicians or other certified trained professionals, except naturopathic physician visits.
21. Sports medicine.

22. Eyeglasses and contact lenses for adults, hearing aids.
23. Congenital or genetic deformities and metabolic deformities, except in newborns, recently adopted newborns or newborns recently placed for adoption.
24. All services and/or treatments related to infertility or impotence, except test to detect infertility.
25. Expenses for Physical Examinations to adults required by the employer or health certificates for any type of license and all diagnostic tests or services for these purposes. Except for the annual exam according to Law No. 296 dated on September 1st, 2000, which includes: physical and mental evaluation, oral health, hearing and vision screening, and screenings recommended by the American Academy of Pediatrics.
26. Elective abortions.
27. Acne surgery and acne treatment, including drugs.
28. Growth hormones and all related treatment.
29. Embryo transplantation.
30. Human chorionic gonadotropin (HCG) injections.
31. Vaccinations required for travel.
32. Tuboplasty, vasovasostomy, and any procedure or service for the purpose of fertility.
33. Sickness or injury caused by the insured engaging in an illegal occupation; or committing or attempting to commit a criminal act, except those injuries resulting from an act of domestic violence or medical condition.
34. Enrollment in a health, athletic, or similar club; or a weight loss or similar program.
35. Purchase or rental of supplies of common household use such as: exercise cycles; air purifiers; central or unit air conditioners; water purifiers; allergenic pillows or mattresses; or waterbeds. Except for technical equipment of ventilators for children which are vital for the maintenance of life, including children and those who have started treatment as minors and become age 21, who depend on medical equipment such as respirators or supplemental oxygen, as authorized by the laws of Puerto Rico as outlined in Law Number 62 dated May 4, 2015.
36. Purchase or rental of: motorized transportation equipment; escalators or elevators; saunas or attachment pools; professional medical equipment such as blood pressure kits; or supplies or attachments for any of these items.
37. Expert witness required by a Court that is not included under the benefits or requirements of the mental health law.
38. Services and supplies for treatment of temporomandibular joint disorder or dysfunction (TMJ) and craniomandibular jaw disorders (CMJ) which are recognized as dental procedures. This includes, but is not limited to, the extraction of teeth and the application of orthodontic devices and splints.
39. New diagnostic and therapeutic services/procedures that are done with approved FDA equipment/devices that become available posterior to the effective date of the policy. Unless, the insured suffers from a life-threatening condition for which there is no effective treatment. Humana would then pay for routine medical expenses of the patient which are not covered by the entity carrying out the study.
40. Epidural anesthesia during delivery.
41. Air and maritime ambulance services outside of Puerto Rico, except for dependent studying in the United States
42. Any and all services or treatments not specifically described as covered benefits, except for the services and benefits included in a law that are required to be included in the coverage.

Dental Coverage Exclusions

1. Services or treatments presented for beauty or cosmetic reasons.
2. Services received free of charge; services rendered by spouses, parents, brothers/sisters or children of the insured.
3. Experimental or investigative procedures and/or services, or the drugs related to them.
4. Services rendered before the effective date of the policy.
5. Expenses related to injuries caused by war or disturbances.
6. Illnesses or accidents covered by the State Insurance Fund law -*Ley del Fondo del Seguro del Estado* (FSE) and/or the Automobile Accidents Compensation Administration -*Administración de Compensaciones por Accidentes de Automóviles* (ACAA).
7. Any benefit or service not specified in the dental coverage.
8. Services not used during the policy year do not accumulate for the following year.

Vision Coverage Limitations and Exclusions

1. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
2. Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan
3. Services provided as a result of any worker's compensation law (*Ley del Fondo del Seguro del Estado* -FSE) and/or the Automobile Accidents Compensation Administration (*Administración de Compensaciones por Accidentes de Automóviles* - ACAA).
4. Lenses or vision devices that are not prescribed.
5. Unspecified contact lenses on the vision coverage.
6. Any other frame that is out of the collection.
7. Any treatment or service that is not specified on the vision coverage.

Pharmacy Coverage Limitations and Exclusions

1. Legend drugs which are not deemed medically necessary by us;
2. Any drug prescribed for a sickness or bodily injury not covered under the policy;
3. Any drug, medicine or medication labeled "Caution-limited by federal law to investigational use" or any experimental or investigational drug, medicine or medication, even though a charge is made to you; not covered:
    a. Medications used in research trials which have the sponsorship of manufacturers or government entities.
    b. Medications or services offered during research trials when the sponsor of such tests offers these services and medications at no cost to the participants

4. Allergen extracts(covered under the Medical Coverage);
5. Therapeutic devices or appliances including, but not limited to:
   A. Hypodermic needles and syringes (except needles and syringes for use with insulin, and self-administered injectable drugs whose coverage is approved by us);
   B. Support garments;
   C. Test reagents;
   D. Mechanical pumps for delivery of medications; and
   E. Other non-medical substances;
6. Dietary supplements; (except for formulas or low protein modified foods necessary for the treatment of phenylketonuria or certain other heritable diseases of amino and organic acids);
7. Nutritional products;
8. Minerals;
9. Herbs and vitamins, except Vitamin D, prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride, OTC Ferrous Sulfate which are covered for Women's Preventive Healthcare;
10. Anorectic or any drug used for the purpose of weight control;
11. Any drug used for cosmetic purposes, including but not limited to:
    A. Tretinoin;
    B. Dermatologicals or hair growth stimulants; or
    C. Pigmenting or de-pigmenting agents, e.g. Solaquin;
12. Any drug or medicine that is:
    a. Lawfully obtainable without a prescription (over the counter drugs), except insulin
13. Progesterone crystals or powder in any compounded dosage form;
14. Abortifacients (drugs used to induce abortions);
15. Infertility services including medications;
16. Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra;
17. Any drug, medicine or medication that is consumed or injected at the place where the prescription is given, or dispensed by the health care practitioner;
18. Prescriptions that are to be taken by or administered to you, in whole or in part, while you are a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
    A. Hospital;
    B. Skilled nursing facility; or
    C. Hospice facility;
    D. Physician office (unless coverage is approved by us)
19. Injectable drugs such as:
    A. Biological sera (covered under the Medical Coverage)
    B. Blood (covered under the Medical Coverage)

C. Blood plasma (covered under the Medical Coverage)

20. Prescription refills:
    A. In excess of the number specified by the health care practitioner; or
    B. Dispensed more than one year from the date of the original order;
21. Any portion of a prescription or refill that exceeds a 90-day supply, received from a mail order pharmacy or a retail pharmacy that participates in our program which allows you to receive a 90-day supply of a prescription or refill;
22. Any portion of a prescription or refill that exceeds a 30-day supply, received from a retail pharmacy that does not participate in our program which allows you to receive a 90-day supply of a prescription or refill;
23. Any portion of a specialty drug or self-administered injectable drug received from a retail pharmacy or a specialty pharmacy that exceeds a 30-day supply, unless otherwise determined by us;
24. Any portion of a prescription or refill that:
    A. Exceeds our drug specific dispensing limit, e.g. IMITREX; or
    B. Is dispensed to an insured whose age is outside the drug specific age limits;
    C. Exceeds the duration-specific dispensing limit;
25. Any drug for which a charge is customarily not made;
26. Any drug, medicine or medication received by you:
    A. Before becoming covered under this rider; or
    B. After the date your coverage under this rider has ended;
27. Any costs related to the mailing, sending or delivery of prescription drugs;
28. Any intentional misuse (improper use)of this benefit, including prescriptions purchased for consumption by someone other than you;
29. Any prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
30. Drug delivery implants;
31. More than one prescription or refill for the same drug or therapeutic equivalent medication prescribed by one or more health care practitioners and dispensed by one or more pharmacies until you have used, or should have used, at least 75% of the previous prescription or refill, unless the drug or therapeutic equivalent medication is purchased through a mail order pharmacy, or a retail pharmacy that participates in our program which allows you to receive a 90-day supply of a prescription or refill, in which case you have used, or should have used 66% of the previous prescription. (Based on the dosage schedule prescribed by the health care practitioner);
32. Any copayment or coinsurance you paid for a prescription that has been filled, regardless of whether the prescription is revoked or changed due to adverse reaction or change in dosage or prescription;
33. Bulk Chemicals and Pain Patch not approved by the Food and Drug Administration (FDA)
34. When the FDA has determined that a medication is contraindicated for the condition for which it is prescribed.

These limitations and exclusions apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, service, treatment, supply, or prescription. This does not prevent your health care

practitioner or pharmacist from providing or performing the procedure, service, treatment, supply, or prescription; however, the procedure, service, treatment, supply or prescription will not be a covered expense.

Humana Insurance of Puerto Rico, Inc.

(Hereinafter "the Company")

PPO Program Humana Complete
RX 3

19728PR0010

Schedule of Benefits Coverage

Schedule of Benefits

This schedule of benefits should be attached and made part of PPO Program Policy: Attachment I

Services and Benefits Procedures

1. Benefits and services are subject to the terms and conditions included in the group policy and to the exclusions and limitations described in this attachment.
2. Insured must receive services from participating facilities, contracted providers or under the order, direction and approval of the contracted provider upon presentation of the identification card issued by the Company. The Insured is responsible for paying applicable copayment, coinsurance or deductible.

Deductible

Deductible	Individual	Family
Network Provider	$0	$0
Non-Network Provider	$0	$0

Annual Maximum Out-of Pocket

Maximum out-of pocket limit	Individual	Family
Maximum out-of pocket limit ("MOOP") Network Provider	$6,350	$12,700
Maximum out-of pocket limit ("MOOP") Non-Network Provider	$19,050	$38,100

This includes copayments and coinsurance expenses of the Medical and Pharmacy coverage, in addition to accumulated expenses of the pharmacy benefits coverage deductibles.

Once the individual or family maximum out of pocket limit is met for the policy year for network providers, the percentage of benefits provided by network providers for covered expense will be paid at a rate of 100% for the rest of the policy year, subject to all terms, limits and exclusions of this Schedule of Benefits Coverage. Any expenses (medical and pharmacy) you might incur for covered expenses provided by a network provider will apply to the maximum out of pocket limit for network providers. Any expenses (medical and pharmacy) you might incur (as contracted fee for similar services by a provider in Puerto Rico) for covered expenses provided by out of network provider will apply to the maximum out of pocket limit for out of network providers.

The accumulation period will begin on the effective date of the policy and will end when the policy terminates. From there on, it will be from the renovation date until the policy year end.

The Maximum Out-of Pocket is based on the maximum amount allowed by the Office of the Commissioner of Insurance of Puerto Rico.

Essential Health Benefits

Ambulatory Services

The following services are covered, less any applicable co-insurance or copayment per visit:

1. Unlimited office visits to physicians, less applicable copayment or coinsurance:

   Generalists: $10.00

   Specialists: $20.00

   Sub-specialists: $20.00

2. Chiropractic Services, one (1) initial visit, one (1) follow-up visit, less $20.00 visit copayment or and up to twenty (20) manipulations per insured, per policy year. Physical therapies unlimited, less $10.00 copayment.
3. Six (6) Nutritionist consultations per insured per policy year, less $20.00 visit copayment or per visit.
4. Laboratories, X-rays and its reproduction, unlimited, less 40% of coinsurance. Genetic tests require pre-authorization, less 40% of coinsurance.
5. Electrocardiograms, unlimited, less 40% of coinsurance.
6. Sonograms, unlimited, less 40% of coinsurance.
7. Computerized tomography, unlimited, less 40% of coinsurance. Pre-authorization required.
8. Positron Emission Tomography (PET), unlimited, less 40% of coinsurance. Pre-authorization required.
9. Electroencephalogram, unlimited, less 40% of coinsurance.
10. Electromyogram, unlimited, less 40% of coinsurance.
11. Magnetic Resonance, including MRI and MRA, unlimited, less 40% of coinsurance. Preauthorization required.
12. One (1) sleep study or polysomnography covered per insured, per policy year, less 40% of coinsurance. Pre-authorization required.
13. Nuclear medicine tests, unlimited, less 40% of coinsurance.
14. Respiratory therapy, unlimited, less $10.00 copayment.

15. Physical therapy, including rehabilitation and habilitation, unlimited for all conditions including autisms, as prescribed and under the supervision of an orthopedist or a physical medicine specialist, less $10.00 copayment.
16. Speech therapy, combined at the physician office or at home, when ordered by a physician and rendered by a licensed speech therapist; up to a maximum of forty (40) therapies, per insured per policy year, less $20.00 copayment. Unlimited speech and language therapies for autism according to Law No. 220 of September 4, 2012.
17. Occupational therapy for the purpose of training and aiding in the restoration of normal physical function and or prevent further deterioration of the same; resulting illness, from trauma, stroke or a surgical procedure while insured under the policy, unlimited for all conditions including autisms, less $15.00 copayment.
18. Ambulatory surgery at ambulatory surgery facilities, including Mental Health, less $75.00 of copayment.
19. Endoscopies, diagnostic and therapeutic, unlimited, less $20.00 office copayment or less $75.00 facility copayment.
20. Lithotripsy, unlimited, less $75.00 ambulatory facility copayment per rendered service. Pre-authorization required.
21. Vasectomy at physician's office, less $20.00 office visit copayment.
22. Acute and chronic services related to End Stage Renal Disease, such as dialysis, hemodialysis and complications directly related to the disease are covered up to a maximum of ninety (90) days starting on the date on which the disease is diagnosed, In case of admission apply $150.00 copayment.
23. Allergy tests, including allergenic and biological extracts, drugs, patches and provocative tests, up to a maximum of fifty (50) tests per insured per policy year, less 40% coinsurance.
24. Intra-articular injections, unlimited, less $20.00 office copayment or less $75.00 facility copayment.
25. Audiologist visits according to Law No. 127 of September 27, 2007; Audiometry and tympanometry tests when ordered by a physician, one (1) of each test per insured, per policy year, less 40% of coinsurance.
26. Orthognathic surgery (mandibular or maxillary osteotomy - Le Fort). Expenses for implants related to orthognathic surgery are excluded, less $75.00 facility or $150.00 hospital copayment. Pre-authorization required.
27. Treatment and services for morbid obesity as medically necessary. One (1) bariatric surgery using one of the following techniques, gastric bypass, adjustable gastric band or sleeve gastrectomy per lifetime, according to Law 212 dated on August 9, 2008, less $150.00 copayment. Surgeries for removing excess skin (commonly known as folds) shall not be covered, unless the physician certifies that it is necessary to remove the excess skin because it affects the functions of any part of the body. Bariatric surgery requires pre-authorization.
28. In the event that an insured voluntarily enrolls in a research clinical trial, Humana will cover diagnostic tests which are usually associated with his condition as long as they are covered by his/her health insurance policy. These services are subject to the maximum limits specified under the policy, less $20.00 copayment or 40% coinsurance. Tests which are not covered by his/her policy, and which are strictly linked to the goal of the research, will not be reimbursed by Humana. The process and results of the investigation are the responsibility of the researcher and the insured.
29. Diagnostic tests and treatments associated with hemophilia, unlimited, less $20.00 copayment or 40% coinsurance.
30. Unlimited naturopathic physician visits according to Law 210 dated on December 14, 2007, less $20.00 copayment.
31. Eye refraction test by an ophthalmologist or optometrist, one (1) per insured per policy year within the Humana Insurance network, less $20.00 copayment.
32. Ophthalmic Diagnostic Tests, less $20.00 copayment.

33. Mammography, when they are not presented as a preventive test required by ACA, but as a follow up to a diagnosis or treatment of a condition, less $75.00 facility copayment.
34. Podiatry visits; Treatment of diseases and disorders of the foot and ankle, including injections and surgical procedures, less $20.00 visit copayment or $75.00 facility copayment.
35. Cervical Cryosurgery, less $20.00 copayment.
36. Nerve Conducting Velocity Test, unlimited, per policy year, less 40% coinsurance.
37. Humana will cover the Nutritional Supplement free of phenylalanine, based on low phenylalanine protein hydrolysates for patients diagnosed with the genetic disorder Phenylketonuria (PKU), without age limits, and for other recommended diagnostic, prevention and treatment of people with innate metabolic errors, in accordance to Act 139 of August 8, 2016. Covered at 100%.
38. Anesthesia services and hospitalization services, unlimited, in accordance with Act No. 352 of 1999; Pre-authorization is required. These services will be available when the member has dental coverage with Humana and when at least one of the following scenarios occurs:
    a. When a pediatric dentist, oral or maxillofacial surgeon member of the medical faculty of a hospital, licensed by the Government of Puerto Rico, determines that the member's condition is significantly complex in accordance with criteria established by the American Academy of Pediatric Dentistry.
    b. When the patient due to age or disability is unable to resist or tolerate pain, or cooperate with the treatment indicated in dental procedures;
    c. When the infant, child, adolescent or person with a physical or mental disability has a medical condition in which it is essential to carry out dental treatment under general anesthesia in an outpatient surgical center or hospital and which otherwise could represent a significant risk to the patient's health;
    d. When local anesthesia is ineffective or contraindicated due to an acute infection, anatomical variation or allergic condition;
    e. When the patient is an infant, child, adolescent, person with a physical or mental disability, and is in a state of fear or anxiety that prevents the dental treatment under traditional procedures of dental treatment and their condition Of such magnitude, that postponing or delaying treatment would result in pain, infection, loss of teeth or dental morbidity;
    f. When a patient has received extensive and severe dental trauma where the use of local anesthesia would compromise the quality of services or be ineffective in managing pain and apprehension.

To evaluate the services, a medical order must be sent to Humana with the diagnosis of the insured, as well as the reasons that justify the use of general anesthesia and hospital. Humana will approve or deny the request, in accordance with the criteria previously established, within two (2) days as of the date on which the member submits all required documentation.

The documents are:

- Medical order with diagnostics.
- Justification in the medical order.

Preventive Services

1. Annual preventive services are **covered at 100%** (without copayment or coinsurance) when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF), the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), The Health Resources and Services Administration, and the Puerto Rico Department of Health.

   For more information and updates on preventive services, visit: //www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

a) Routine physical examination, including height, weight, and body mass index (BMI), for children and adults.

b) High Blood pressure screening. The USPSTF recommends screening for high blood pressure in adults age (18) years and older. It is recommended obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.

c) Cholesterol screening, for children and adults.

d) Screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults 40 years of age and older. The risks and benefits of these methods vary.

e) Screening for obesity, and counseling, for children and adults. The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of (30) kg/m2 or higher to intensive, multicomponent behavioral interventions.

f) Screening for Tobacco Use for all adult. The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA) approved pharmacotherapy for cessation to adults who use tobacco.

   The dispatch of FDA approved medication for smoke cessation is covered for (90) consecutive days in one intent and until (2) intents per year. Smoking cessation drugs are covered under the Pharmacy Coverage Section with prescription.

g) Tobacco use interventions: children and adolescents; recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

h) Screening for gestational diabetes mellitus (GDM) in asymptomatic pregnant women after (24) weeks of gestation and those at high risk of developing gestational diabetes.

i) Screening for abnormal blood glucose and Diabetes Mellitus Type 2 in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer, or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.

   In addition, it is recommended screening for diabetes type 2 in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than (135/80) mm Hg.

j) Screening for alcohol abuse, and behavioral counseling. It is recommended that clinicians screen adults aged (18) years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

k) Screening for tobacco, alcohol or drug use for children 11 to 21 years of age.

l) Immunizations for infants, children, and adults in accord with accepted medical practice and as recommended by the Advisory Committee for Immunization Practices (ACIP) of the Centers for Disease Control (CDC) and the American Academy of Pediatrics, as long as the individual is covered by this health insurance, including follow up (catch up).

   - Immunizations for Adults (21 years or older), including catch-ups – Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza (Flu Shot), Meningococcal, Measles/Mumps/Rubella, Pneumococcal, Tetanus/Diphtheria/Pertussis, Varicella

   - Immunizations for Children (less than 21 years old), including catch-ups – Haemophilus Influenzae Type b, Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza (Flu Shot), Meningococcal, Measles/Mumps/Rubella, Pneumococcal, Rotavirus, Tetanus/Diphtheria/Pertussis, Varicella, , inactivated poliovirus

m) Cervical cancer screening The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).

n) Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate. Office visits and consultations regarding checkups for healthy women (well-woman visits). Health and Human Services recognizes that several visits may be necessary to get all recommended preventive services, depending on the health status of women, their health needs and other risk factors.

o) Breast cancer mammography screenings every one (1) to two (2) years for insured over 40 years, biannual for insured between fifty (50) and seventy-four (74) years. This includes guidance and advice regarding chemoprevention, and the chemoprevention of breast cancer in women when indicated. Counseling for women at higher risk. The USPSTF recommends that clinicians engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk.

   For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk- reducing medications, such as tamoxifen or raloxifene.

p) Pap Smear

q) Prostatic Specific Antigen test (PSA) for men

r) Behavioral counseling regarding sexually transmitted diseases (STD's), for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs).

s) Screening for intimate partner violence (IPV), such as domestic violence, for women of childbearing age. Physicians shall also provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.

t) Screening for autism for children up to 36 months.

u) Osteoporosis screening: postmenopausal women younger than 65 years at increased risk of osteoporosis The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool. Osteoporosis screening: women 65 years and older. The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporosis fractures in women 65 years and older.

v) Screening for hearing loss all newborns infants.

w) Screening for elevated blood lead levels in children aged (1) to (6) years who are both at average and increased risk, and in asymptomatic pregnant women.

x) One (1) lifetime screening test for abdominal aortic aneurism (AAA) in men 65-75 years old who have ever been smokers.

y) Counseling regarding the use of aspirin in prevention of disease, for both men and women 45-79 years of age who are cardiovascular and colorectal cancer risks. The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged (50) to (59) years who have a (10)% or greater (10) year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least (10) years, and are willing to take low-dose aspirin daily for at least (10) years. For aspirin, prescription is required.

z) Counseling regarding folic acid supplements for women who may become pregnant. The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing (0.4) to (0.8) mg of folic acid. For folic acid, prescription is required.

aa) Hypothyroidism: Screening for congenital hypothyroidism in newborns.

bb) Screening for cervical dysplasia for sexually active females.

cc) Screening for sickle cell disease in newborns.

dd) Vision screening for all children at least once in all children between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.

ee) Screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up.

ff) Medical history: For all children throughout development.

gg) Behavioral Assessment for children of all ages. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

hh) Screening for this genetic disorder Phenylketonuria (PKU) in newborns.

ii) Obesity in children and adolescents: The USPSTF recommends that clinicians screen for obesity in children and adolescents (6) years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.

jj) Screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

kk) Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care. Also, is recommended repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at (24)-(28) weeks gestation, unless the biological father is known to be Rh (D)-negative.

ll) BRCA: Screening and risk assessment for women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.

mm) Screening for asymptomatic bacteriuria with urine culture for pregnant women at (12) to (16) weeks of gestation or at the first prenatal visit, if later.

nn) Screening for syphilis for all pregnant women and for any adolescent or adult who is at increased risk for infection.

oo) Screening for chlamydia and gonorrhea in sexually active women age (24) years or younger and in older women who are at increased risk for infection.

pp) Preventive medication for the eyes of all newborn for the prevention of gonorrhea.

qq) Skin cancer behavioral counseling The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.

rr) Preeclampsia prevention: aspirin, recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk. For aspirin, prescription is required.

ss) Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors: recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.

tt) Dental caries prevention: The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.

It is recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. The fluoride varnish is covered under the Dental Services Section.

uu) Oral health: Risk assessment for young children. Ages: (0) to (11) months, (1) to (4) years, (5) to (10) years.

vv) Lung cancer screening: recommends annual screening for lung cancer with low-dose computed tomography in adult ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

ww) Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. The USPSTF recommends exercise or physical therapy and vitamin D supplementation to prevent falls.

xx) Hepatitis B screening in persons at high risk for infection. Hepatitis B screening is also cover for pregnant women at their first prenatal visit.

yy) Hepatitis C virus infection screening: adults The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.

zz) Tuberculosis : Testing for children at higher risk of tuberculosis. Ages: (0) to (11) months, (1) to (4) years, (5) to (10) years, (11) to (14) years, (15) to (21) years.

aaa) Prevention of cardiovascular diseases: It is recommended that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.

bbb) Preeclampsia Screening in pregnant women with blood pressure measurements throughout pregnancy.

ccc) Tobacco Smoking cessation: The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.

ddd) Developmental Screening and Surveillance: Screening for children under age (3), and surveillance throughout childhood.

eee) Dyslipidemia: Screening for children at higher risk of lipid disorders. Ages: (1) to (4) years, (5) to (10) years, (11) to (14) years, (15) to (16) years.

fff) Hepatitis B virus infection: screening nonpregnant adolescents and adults The USPSTF recommends screening for hepatitis B virus (HBV) infection in persons at high risk for infection.

Tuberculosis latent infection screening: adults The USPSTF recommends screening for latent tuberculosis infection in populations at increased Risk.

2. Preventive services **covered at 100%** (without copay) when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF) and the Health Resources and Services Administration.

For more information and updates on preventive services, visit:
//www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

- Women's contraceptives and contraception counseling. All women's contraceptive methods approved by the Federal Drug Administration (FDA) by prescription are covered, including counseling, placement and removal of uterine devices, administration of medication and sterilization
- Any device insertion and removal of contraceptive methods is covered.

3. Preventive services **covered at 100%** (without copay) during and immediately following pregnancy when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF) and the Health Resources and Services Administration. For this service, insured has to call the *Humana Beginnings* program at 1-866-488-5992, for screening process. Humana recommends to participate in the Humana Beginnings Program starting the first trimester of gestation.

For more information and updates on preventive services, visit:
//www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

- Comprehensive breastfeeding support with guidance and counseling, during pregnancy and after birth, and the necessary breastfeeding equipment and supplies, including the breast pump with prescription.

4. Screening for Human Immunodeficiency Virus (HIV) covered at 100% (without co-payment or coinsurance), according to the recommendation of the Centers for Disease Control and Prevention (CDC) and in compliance to the Act No. 45 of May 16, 2016, as part of the routine testing of a medical evaluation at least once every five (5) years, based on the clinical criteria for adolescents and adults between the ages of thirteen (13) and Sixty-five (65) years of age at low risk. For people of high risk between the ages of thirteen (13) and sixty-five (65) is covered annually.

   Clinicians should screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown. For pregnant women, two tests are covered: 1) A first HIV test during the first trimester of pregnancy at the first prenatal visit, and 2) A second test during the third trimester of pregnancy (between the (28) and (34) weeks of pregnancy.

Hospital Services

Hospital admissions must be authorized by Humana and the services to be offered must be provided under the determinations of an attending physician. A member or his (her) responsible caretaker is responsible for the predetermined co-payment for any admission that so specifies.

Inpatient Care:	$150.00 per admission
Outpatient Surgery-Facility:	$75.00 per rendered service

1. Hospital services included in the contracted per diem:

- Semi-private room or similar facility, unlimited. In cases in which an insured use the services of a private room, it is his/her responsibility to pay the difference between the cost of medical services billed and the contracted fees.
- Specialized units for critical care services including: intensive care unit (ICU), intermediate care unit, coronary care unit (CCU), neonatal intensive care unit (NICU), and pediatric intensive care unit (PICU).
- Operating, recovery, and maternity rooms.
- Drugs prescribed by physician during hospital stay that are included in the per diem.
- Oxygen and its administration.
- Laboratory and radiology.
- Disposable supplies.

- Special and regular diets.
- Regular hospital nursing service

2. Hyperalimentation services, unlimited
3. Universal Neonatal Hearing Screening according to Law No. 311 dated on December 19, 2003, which includes: hearing evaluations for the follow-up treatment needed by the patient.
4. Surgical procedures for benefits included under the basic coverage.
5. Anesthetic agents and their administration including sedation. Anesthesia services and hospitalization services, unlimited, in accordance with Act No. 352 of 1999; Pre-authorization is required. These services will be available when the member has dental coverage with Humana and when at least one of the following scenarios occurs:

    a. When a pediatric dentist, oral or maxillofacial surgeon member of the medical faculty of a hospital, licensed by the Government of Puerto Rico, determines that the member's condition is significantly complex in accordance with criteria established by the American Academy of Pediatric Dentistry.
    b. When the patient due to age or disability is unable to resist or tolerate pain, or cooperate with the treatment indicated in dental procedures;
    c. When the infant, child, adolescent or person with a physical or mental disability has a medical condition in which it is essential to carry out dental treatment under general anesthesia in an outpatient surgical center or hospital and which otherwise could represent a significant risk to the patient's health;
    d. When local anesthesia is ineffective or contraindicated due to an acute infection, anatomical variation or allergic condition;

    e. When the patient is an infant, child, adolescent, person with a physical or mental disability, and is in a state of fear or anxiety that prevents the dental treatment under traditional procedures of dental treatment and their condition Of such magnitude, that postponing or delaying treatment would result in pain, infection, loss of teeth or dental morbidity;
    f. When a patient has received extensive and severe dental trauma where the use of local anesthesia would compromise the quality of services or be ineffective in managing pain and apprehension.

    To evaluate the services, a medical order must be sent to Humana with the diagnosis of the insured, as well as the reasons that justify the use of general anesthesia and hospital. Humana will approve or deny the request, in accordance with the criteria previously established, within two (2) days as of the date on which the member submits all required documentation.

    The documents are:

    - Medical order with diagnostics.
    - Justification in the medical order.

6. Sonogram, Computerized Tomography and Magnetic Resonance (MRI and MRA), unlimited
7. Electrocardiogram, unlimited
8. Nuclear medicine studies and digital angiography, unlimited.
9. Blood transfusions including autologous process, all components and compatibility tests.
10. Respiratory Therapy.
11. Physical Therapy, maximum of forty (40) therapy sessions per insured, per hospital stay.

12. Acute and chronic services related to End Stage Renal Disease, such as dialysis, hemodialysis and complications directly related to the disease are covered up to a maximum of ninety (90) days starting on the date on which the disease is diagnosed.
13. Treatment and services for morbid obesity as medically necessary. One (1) bariatric surgery using one of the following techniques, gastric bypass, and adjustable gastric band or sleeve gastrectomy per lifetime, according to Law No. 212 dated on August 9, 2008.
14. Surgical procedures in ambulatory surgery in a hospital, less applicable copayment or coinsurance.
15. Surgeon Assistant when medically necessary: pre-authorization required, less 40% coinsurance.

Transplant or Graft

Cornea transplant or bone, skin graft services received by the insured will be covered, less $150.00 copayment; pre-authorization is required. The covered transplant or graft includes pre-transplant, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation.

In-Home Services

In-Home Health Services, authorized by a main doctor and Humana.

Home health care must be provided by an agency that is dedicated, licensed and managed according to the regulations established by a group of medical professionals that keeps medical records of the patients and operates according to the laws of the Commonwealth of Puerto Rico. These services are covered if they begin within fourteen (14) days after release from a hospital or expert nursing facility due to a hospitalization of at least three (3) days, and are provided because of the same condition or in relation to the condition for which the patient was hospitalized.

If the patient is in the hospital, Home health services must be requested by the attending physician in the hospital. If the patient is out of the hospital, Home health services must be requested by the main doctor with medical justification. The doctor must present a care plan and estimated time of the duration of services, according to the individual needs of the patient. The program will provide education for the patient and family members responsible for his/her health care. This benefit will be covered for forty (40) days initially, and an additional twenty (20) days, subject to medical necessity certification.

In-home health services include:

1. Care by a nurse or under the supervision of a graduate nurse.
2. Respiratory therapy care, less $10.00 copayment
3. Collection of samples for lab tests, less 40% coinsurance
4. Care and maintenance of catheters.
5. Administration of intravenous antibiotics, subject to Humana's case management program.
6. Ulcer care through Humana's case management program.
7. Physical therapies, up to forty (40), less $10.00 copayment. For condition of autism, unlimited as mention in law No. 220 of September 4, 2012.
8. Occupational therapy for the purpose of training and aiding in the restoration of normal physical function and or prevent further deterioration of the same; resulting illness, from trauma, stroke or a surgical procedure while insured under the policy, unlimited for all conditions including autisms, less $15.00 copayment.

9. Speech therapy, when ordered by a physician and rendered by a licensed speech therapist; combined at the physician office or at home, up to a maximum of forty (40) therapy sessions per insured per policy year less $20.00 visit copayment. Speech therapies are unlimited for Autism and language as mention in Law No. 220 of September 4, 2012.
10. Hyperalimentation services, unlimited, less 40% coinsurance.

Skilled Nursing Facility

Skilled nursing facility covered up to a maximum of one hundred and twenty (120) days per insured per policy year, covered at 100%. These services will be covered if they begin within the fourteen (14) days following the release from the hospital due to a hospitalization of at least three (3) days, and if they are rendered because of the same condition or in relation to the condition leading to the hospitalization.

If the patient is in the hospital, Home health services must be requested by the attending physician in the hospital. If the patient is out of the hospital, Home health services must be requested by the main doctor with medical justification. Pre-authorization is required.

Durable Medical Equipment, Supplies, Prosthesis, Orthosis and Implants

1. The purchase or rental of medically necessary Durable Medical Equipment, less 40% coinsurance. The cost or rental of durable medical equipment will be covered. If the cost of renting the equipment is more than an insured would pay to buy it, Humana will covered up to the amount of the purchased equipment. We do not pay for equipment or devices not specifically designed and intended for the treatment of an injury or sickness. Required pre-authorization. Including glucometer and insulin pump mention in Law No. 177 of August 13, 2016. Covered for children and adults.

   Pre-authorization is required. If the endocrinologist recommends a specific glucometer due to the treatment utilizes, or order a particular insulin pump due to the necessity of the member, the provider must submit to Humana a justification. Humana will then cover the equipment specifically ordered by the endocrinologist, whether it is a specific glucometer or insulin pump is required.

2. Initial placement of a medically necessary prosthesis and its supportive device, except for those excluded. We will also cover the replacement of such prosthesis if it is determined by the insured's physician to be necessary because of growth or change. Less 40% coinsurance. Required pre-authorization.

3. Orthotics (No cover pre-fabricated, over-the-counter - OTC) and supplemented (No cover over-the-counter - OTC), less 40% coinsurance. Requires pre-authorization.

4. Implants, less 40% coinsurance. Requires pre-authorization.

Ambulance Services

Also an emergency may arise from a call managed thru the 911 System which refer to a dedicated telephone system that is available 24/7 for receiving emergency calls that deal with public security. System 9-1-1 was created by virtue of Law No. 144 dated on December 22nd, 1994 as amended, known as the "Law for rapid response to emergency calls with Public Security" or "Law for calls 9-1-1.

1. Land transportation by an ambulance, between facilities, authorized by the Public Service Commission and the Health Department as mention in Law No. 183 of August 6, 2008, to a hospital or between health facilities, e.g. between a hospital and a radiology institute or between a skilled nursing facility and a hospital, and when ordered by a physician, including psychiatric emergencies. Services requested for psychiatric and medical emergencies through the 911 will be paid in full directly to the provider.
2. Land transportation by an ambulance authorized by the Public Service Commission and the Health Department as mention in Law No. 183 of August 6, 2008, including psychiatric emergencies, less $75.00 copayment per trip.
    a. from the insured residence or place of emergency to the Skilled Nursing Facilities or Hospice, when is medically necessaries.
    b. From the hospital to the residence, if the condition of the patient discharged requires.
3. Land ambulance services for psychiatric and medical emergencies through 911 will be paid in full by Humana directly to the provider. The service will only cover if the insured meets the following requirements:
    a. The patient suffered an illness or injury for which other types of transportation are not recommended;
    b. Psychiatric emergencies as mention in Law No. 183 of August 6, 2008;
    c. The health condition of the patient does not allow the use of other types of transportation;
    d. It is not a case covered by the Automobile Accident Compensation Administration (ACAA), the State Workmen's Compensation Fund (CFSE) or any other insurance with primary responsibility
4. The general hospital and the psychiatric hospital must both comply with all EMTALA regulations regarding the draft and preparation of a "Protocol for the Process of Transferring Patients" which is here requested and required."
5. Maritime and air transportation services by an ambulance within Puerto Rico, subject to medical need for it, less $75.00 copayment. Pre-authorization is required unless it is a life or death emergency.

Cancer Services and Treatments

1. Ambulatory services for the treatment of radiotherapy and/or chemotherapy, including intravenously, via injection or intrathecally, according to the instructions of the medical doctor or oncologist. Oral chemotherapy is cover under the Pharmacy Coverage Section covered 100%. This is, according to Law No. 107 dated on June 5, 2012.
2. Medically necessary oral and parenteral medication for pain management of patients suffering terminal cancer.
3. All the benefits, including radiotherapy and/or chemotherapy in the hospital services, less $150.00 hospital copayment.
4. Stoma care and maintenance: colostomy, gastrostomy and cystostomy.
5. For the insured who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, the coverage includes:
    a) all stages of reconstruction of the breast on which the mastectomy has been performed
    b) surgery and reconstruction of the other breast to produce a symmetrical appearance
    c) prosthesis and physical complications of mastectomy, including lymphedemas

According to Law No. 275 dated on September 27, 2012, patients with a diagnosis of cancer have the following rights:

- To know and understand their treatment and rehabilitation plans, and the pain management protocol specifically appropriate for their case. The patient with cancer has the right to priority treatment for his/her pain; and is entitled to aggressive pain management techniques based on scientific evidence and approved by the Food and Drug Administration (FDA).
- To receive a copy of their file in an expeditious manner when they wish a second medical opinion or a consultation with another provider.
- The right to information, counseling and guidance regarding the possible short and long term effects on fertility of the cancer itself, and of the diagnostic tests and treatments to be received.
- Continuity in medical care and other health services, such as diagnostic tests for early detection, and access to oncologists, radiation therapists and surgical specialists involved in the initial diagnosis, and in his/her management once regarded a cancer survivor; continuity is necessary for close monitoring against recurrence and adverse effects of treatment, and to maintain physical and emotional health as a surviving patient with cancer.
- To be included in their employer's group healthcare insurance plan with no increase in their premium compared to all other members of the Group, and without exclusion of coverage because of a previous diagnosis of cancer.
- No private insurer can reduce benefits or terminate the policy of a patient with cancer, or that of a child who has survived cancer, as long as the health emergency lasts.
- Elderly patients who have a diagnosis of cancer or who are cancer survivors will be offered clear and up-to-date information about the prevention, detection and treatment of cancer taking into account conditions which might affect communication and their sensory, mobility or cognitive impairments. Elderly patients with a diagnosis of cancer will receive the support appropriate for their age, including but not limited to community support services and psychosocial and palliative services.
- Included as covered services will be pelvic examinations, and all type of vaginal cytology preparations which may be specifically required by medical order to detect, diagnose and treat early anomalies which might lead to cancer of the cervix.
- To provide extended coverage for the payment of studies and tests to monitor cancer of the breast, such as office visits to specialists, clinical breast examinations, mammography and digital mammography, magnetic resonance mammography and sono-mammography, and such treatments as, but not limited to, mastectomies, reconstructive surgery after mastectomy for the reconstruction of the removed breast, the reconstruction of the other breast to achieve a symmetrical appearance, breast prosthesis, treatment of complications at all stages of the mastectomy, including lymphedema (an inflammation which sometimes occurs after treatment for breast cancer), and any other reconstructive surgery after mastectomy which may be necessary for the physical and emotional recovery of the patient.

Maternity Services

The female employee, the wife or cohabitant, and the dependent daughter of any employee covered by the insurance plan for families or couples, will have maternity benefit coverage. The minimum hospital stay for both patient and newborn has been established by Law No. 248 of the Commonwealth of Puerto Rico dated on August 15, 1999, at 48 hours for a normal delivery, without complications, and 96 hours for a Cesarean-section delivery. Hospital discharges prior to length of stays stipulated by the law must have the consent of the patient. The maternity benefit covers a follow-up visit during the 48-hour period following discharge, at which time the newborn infant can also be checked. Services will include, but not be limited to support and physical care for the benefits of the minor, education to both parents on caring for the minor, support and training on breast feeding,

orientation on support at home and the performance of any treatments and medicine test both for the infant and the mother.

Covered maternity benefits include the following services:

1. Hospitalization, less $150.00 copayment.
    a. Delivery, including Cesarean Section.
    b. Delivery and recovery rooms.
    c. Nursery and incubator.
    d. Neonatal intensive care unit (NICU)
    e. Fetal monitoring during delivery.
    f. Postpartum sterilization before discharge
2. Ambulatory (unlimited services)
    a. Pre-natal and post-natal care, less $20.00 copayment per visit
    b. Genetic amniocentesis, less 40% coinsurance
    c. Spontaneous abortion
    d. Ambulatory fetal monitoring, less 40% coinsurance
    e. Biophysical profile, unlimited.
3. Vaccines
    a. RhoGam Vaccine, less 40% of coinsurance
    b. Vaccine for the treatment of the Respiratory Syncytial Virus according to Law No. 165 dated on August 30, 2006 and protocol approved by Puerto Rico's Department of Health.
4. Ambulatory sterilization, covered at 100%.

Pediatric Services

1. Unlimited visits, less $20.00 copayment per visit.
2. Well Child Care, less $20.00 copayment per visit.
3. Universal Neonatal Hearing Screening, according to Law No. 311 dated on December 19, 2003, which includes: hearing evaluations for the follow-up treatment needed by the patient.
4. Annual exam according to Law No. 296 dated on September 1st, 2000, which includes: physical and mental evaluation, oral health, hearing and vision screening, and screenings recommended by the American Academy of Pediatrics.
5. Circumcision and dilatation for newborns before discharge from the hospital, at ambulatory facility, or physician office, less $75.00 copayment or $20.00 copayment.
6. Immunizations according to established medical practices and as recommended by the Advisory Committee on Immunization Practices (CDC) and the American Academy of Pediatrics, while included as insured under the policy, Human Papilloma Virus vaccine according to Law No. 255 dated on September 15, 2012. For children who have been sexually abused, the HPV vaccine (HPV) is covered beginning at age nine (9).
7. Coverage for technical equipment of ventilators for children which are vital for the maintenance of life, including children who depend on medical equipment such as respirators or supplemental oxygen, an 8-hour daily shift of a skilled nurse with experience in respiratory therapy or respiratory therapists with nursing experience, the necessary supplies to work with the technical equipment, physical and occupational therapy,

laboratories, radiology, and prescribed medications which must be dispensed by a participating pharmacy of our network which is freely selected by our insured, all as authorized by the laws of Puerto Rico as outlined in Law No. 62 dated May 4, 2015, less copayment. For those who have started treatment as minors and become age 21, all the aforementioned services will continue to be covered. This benefit applies also to children who have had a tracheotomy to enable breathing and require home care because of the risk of airway obstruction; this requires a prescription by a physician.

8. Care and treatment of congenital defects and anomalies diagnosed by a doctor, without exclusion due to a preexisting condition. This covers newborns, recently adopted newborns or newborns recently placed for adoption. These services are subject to any applicable copayment or coinsurance.
9. Vaccine for the treatment of the Respiratory Syncytial Virus according to Law No. 165 dated August 30, 2006 and protocol approved by Puerto Rico's Department of Health. Pre-authorization required.

Urgent / Emergency Room Services

Services provided in Urgent / Emergency Rooms will be provided without prior-authorization or waiting period; will be provided regardless if the provider is a participating provider, according to the Law number 194 of August 25, 2000. For services provided in Urgent / Emergency Rooms of non-participant providers, the insured will pay to the provider the same amount as if a participating provider, as long as there is an important and justifiable medical reason for not transferring the patient to a contracted facility.

If Urgent / Emergency services are provided to a patient by a non-participant provider, the patient is not responsible for payment of services that exceed the applicable amount if it had received the services of a participant provider. Humana will compensate the provider that offers the service and it will be obligated to accept such compensation with an amount of not less than the contracted by Humana to offer the same services. In addition, under these circumstances, such Urgent / Emergency services will be provided regardless of the conditions by the health insurance.

If the patient receives health services posterior to the urgent / emergency services, or after being stabilized, and these would normally be covered services except for the fact that they are rendered by a non-participating provider, Humana will reimburse the patient for that part of the costs incurred that would be normally paid by the plan, as long as there is an important and justifiable reason for not transferring the patient to a contracted facility.

Emergencies handled by the 911 system – this refers to the public safety system of urgent / emergency calls through the number 9-1-1.

After the insured individual receives complete urgent / emergency care and stabilization, the facility will transfer the patient to a Humana or Choice Care facility as soon as it is medically possible. Such transfer must not in any way affect the treatment being given or harm the insured patient's health. Humana will assist in the coordination of this transfer, as stipulated in Law No. 194 dated on August 25, 2000.

1. Urgent / Emergency room services due to accidents are covered in full.
2. Urgent room services resulting from illness are covered, less $75.00 copayment
3. Emergency room services resulting from illness are covered, less $75.00 copayment

4. Urgent / Emergency room services' copayment or coinsurance will be waived if patient is admitted; in that case the hospital admission copayment or coinsurance will apply.

For examples of emergency conditions, refer to the definition "Condition of emergency".

Protocol to be followed in the process of transferring patients with psychiatric conditions from one health facility to another.

Regarding an in-patient who presents emotional disturbances in a general hospital or in an urgent / emergency room:

1. Screening and evaluation of the patient will be performed as stipulated in Law No. 35 of 1994 and EMTALA, including all the necessary tests to establish a diagnosis.

2. Organic disease must be ruled-out before reaching a psychiatric diagnosis.

3. During initial evaluation, the general hospital must consider and rule-out the possibility that the etiology of the symptoms of anxiety and agitation presented by the patient at the moment of the emergency are of organic origin.

4. The personnel of the general hospital must consult a mental-health professional to establish continuity of care and obtain permission for transfer from the family or a person properly authorized.

5. The patient is to be stabilized in regard to his/her physical condition or illness. The time spent at the general hospital will depend on the evaluations of organic conditions necessary to establish the state of health of the individual. In cases of poisoning, the general hospital will be responsible for contacting the Poison Control Center in order to determine how long it will take to eliminate the potentially toxic substance taken by the patient. That time-frame will become the minimal period of time for the patient to remain in the urgent / emergency room before transfer to a psychiatric facility.

6. Once the patient's physical condition is stabilized he/she can be transferred to a psychiatric hospital. Simultaneously, the emergency room must send a clear and concise summary to the psychiatric facility of all tests and treatment done, follow-up recommended and information on the physician who attended the patient in the emergency room.

7. The attending physician at the general hospital is responsible for communicating by telephone with the psychiatric facility in order to discuss the case in detail and explain the symptoms and signs presented by the patient to be transferred. At the same time the patient's transfer can be coordinated.

8. The psychiatric hospital must commit to accept the patient to be transferred for further care.

If the patient involved has the economic capacity to pay for the transportation by ambulance or other means necessary for transfer, or has insurance which covers this service, the transportation necessary for transfer will be paid by the patient or his insurance. In such cases the hospital will be paid directly, if it has actually paid for these services; the health insurance plan is responsible for this payment to the hospital. Cases in which the patient is covered for mental health services by the government health insurance. If necessary, and in the absence of other alternatives, transportation will be provided by the ambulances which service the public safety system of emergency calls through 9-1-1. Transportation will be covered from wherever the patient who needs the service is located to whatever hospital facility that can provide the care necessary. Ambulance transportation must comply with the requirements of Law No. 35 of 1994 and EMTALA.

The general hospital and the psychiatric hospital must both comply with all EMTALA regulations regarding the draft and preparation of a "Protocol for the Process of Transferring Patients" which is here requested and required.

NOTE: Urgencies / Emergencies which are secondary to accidents are covered 100%. The urgent / emergency room copayment or coinsurance does not apply if the patient insured is admitted to the hospital; in that case the co-payment of admission to hospital applies.

Psychiatric urgencies / emergencies will be covered with the applicable copayment or coinsurance.

Cardiovascular Procedures

1. Diagnostic Tests and treatment, including the invasive and non-invasive cardiovascular procedures, less 40% of coinsurance.
2. Physician services, less $20.00 office copayment
3. Surgical procedures, less $75.00 facility copayment
4. Repair or replacement of heart valves, pacemaker and any other applicable device, with $0.00 copayment. Defibrillator pacemaker required pre-authorization.

Neurological Procedures

1. Diagnostic tests and treatment, less 40% of coinsurance.
2. Physician services, less $20.00 office copayment
3. Surgical procedures, including neuroendovascular, less $75.00 facility copayment
4. Repair or replacement of valves, and any other medically necessary device, with $0.00 copayment.

Mental Health Services

1. Unlimited visits to professionals, psychology doctors and other providers who because of their education, training or experience, and the proper competency, are able to offer psychological health services, less $20.00 copayment
2. Unlimited office visits to psychiatrist and/or psychologist of children and teens/adults less $20.00 copayment
3. Group therapies, less $20.00 copayment
4. Collateral visits, less $20.00 copayment

5. Unlimited hospital services, less $150.00 admission copayment. Two (2) days of partial hospitalization are equivalent to one (1) day of regular hospitalization.

This service includes emergency psychiatric transportation by an ambulance authorized by the Service Public Commission (*Comisión de Servicio Público*) and the Health Department (*Departamento de Salud*), as stated in Article 4.20 (b) of Law No. 183 of 6 August 2008. Services requested for psychiatric emergencies through the 911 will be paid in full directly to the provider.

Alcoholism & Substance Abuse Services

1. Unlimited visits to professionals, psychology doctors and other providers who because of their education, training or experience, and the proper competency, are able to offer health services in substance abuse, less $20.00 copayment
2. Unlimited office visits to psychiatrist and/or psychologist of children and teens/adults, less $20.00 copayment
3. Unlimited therapies, treatment and follow-up at one or more service levels, which may combine multiple types of therapy, less $20.00 copayment
4. Unlimited residential treatment for alcoholism and substance abuse including detox, less $150.00 copayment.
5. Unlimited hospital services, less $150.00 admission copayment. Two (2) days of partial hospitalization are equivalent to one (1) day of regular hospitalization. Pre-authorization required.

Autism

Autism is recognized as physico-mental health condition. In compliance with Law of Puerto Rico No. 220 dated on September 4, 2012 with the Puerto Rico Department of Health and utilizing as reference the guidelines of the American Association of Pediatrics coverage for these conditions will include diagnostic and therapeutic services in persons diagnosed with disorders within the continuum of Autism.

Covered benefits include visits to physicians and other health providers and the ordered tests and procedures determined to be medically necessary. The specialized services most commonly utilized are related to neurology, psychotherapy, immunology, genetics, gastroenterology, nutrition, speech and language therapy, occupational and physical therapy. Coverage/benefits are not limited only to the previously mentioned services. These services are subject to any applicable copayment or coinsurance, except for the screening for autism for children up to 36 months.

Dental Services

The dental care benefits described below are available using Humana's provider network in Puerto Rico.

Preventive and Diagnostic Services

The following services will be **covered at 100%** In-network:

1. Initial oral examination, one (1) every three (3) years
2. Periodic examination, one (1) every six (6) months
3. Specific oral evaluation, one (1) every six (6) months
4. Complete series of radiographs (FMX), one (1) every three (3) years
5. Panoramic radiographs, up to one (1) every three (3) years
6. Periapical radiographs, one (1) and five (5) additional per policy year
7. Bitewing radiographs, one (1) set every twelve (12) months
8. Prophylaxis adult and child, one (1) every six (6) months
9. Application of fluoride to children up to nineteen (19) years, one (1) every six (6) months
10. Sealants application, limited to children up to fourteen (14) years, one (1) treatment per tooth per lifetime in permanent molars and premolars not previously restored.
11. Application of fluoride varnish for infants and children up to age 5 years, one (1) every six (6) months.
12. Space maintainers, to replace deciduous teeth that are lost permanently, one (1) per area per lifetime.
13. Pulp vitality test, one (1) per visit
14. Re-cementation of space maintainer
15. General anesthesia, administered by an anesthesiologist, and hospital services according to Law No. 352 of December 22, 1999.

Non-Contracted Dentists

If the insured uses the services of a non-participant dentist or facility, Humana will reimburse the insured the fee of the contracted dentist or facility (with the receipt of the payment made to the dentist that provided the service).

Pediatric Vision Care Services

The vision care benefits described below are available until the 21st birthday.

Lenses: One (1) set of lenses per insured, per policy year, with $0.00 copayment. Service is available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers.

- ✓ Lenses for eyeglasses: the lenses included the following selection:
  - CR-39 Plastic for single vision lenses, bi-focal lenses, or tri-focal lenses
  - Polycarbonate for single vision lenses

Frames: The insured can select any frame available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers throughout Puerto Rico with $0.00 copayment. The benefit includes frame from the collection. Coverage includes one (1) frame per policy year.

Contact lenses: Instead of eyeglass benefit (frame and lenses), the member may choose standard disposable contact lenses. The disposable contact lens benefit consists of two (2) boxes per policy year, with $0.00 copayment. Services are available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers.

One (1) pair of low vision eyeglasses or magnifiers as medically necessary for insured with significant loss of vision (low vision), but not total blindness using an exclusive network of Humana Insurance, less $20.00 copayment.

Pharmacy Coverage

What is the formulary?

A Formulary is a prescription drug list developed and approved by Humana and which is regularly evaluated to include or exclude prescription drugs, which is used to determine benefits covered under the pharmacy coverage. The formulary includes generic/bioequivalent, preferred brand, non-preferred brand, and specialty drugs.

The formulary is available in our webpage, Humana.com. There, you can also find information about your prescription medications that may have Utilization Management requirements and the authorization forms with the information required to evaluate them, if applicable. Humana will provide the insured a copy of the formulary, along with information about which prescription drugs are subject to Utilization Management requirements.

Humana will require that the Pharmacy and Therapeutics Committee has an established process, in writing, to consider and update changes in formulary or those that may require Utilization Management, on a timely manner and based on:

- New scientific medical evidence or any other prescription drug related information for covered, non-covered or those that may require Utilization Management, to determine if a change is needed in the formulary or the utilization management criteria;

- if applicable, any clinical information that Humana receives, related to an exception request that would allow the Pharmacy and Therapeutics Committee to determine if the drugs covered in the formulary or those that may require Utilization Management, meet the member's needs, and

- safety and effectiveness information for covered drugs or those that may require Utilization Management, information about prescription drugs that may be clinically similar or bioequivalent, but that are not covered in the formulary nor require Utilization Management, information that may arise from quality assurance activities in the insurance company or information from prescription drug claims received after the latest Pharmacy and Therapeutic meeting.

- Humana will require that the Pharmacy and Therapeutics Committee performs the evaluation of new prescription drugs approved by the Food and Drug Administration (FDA) in no more than a ninety (90) days period, from the FDA approval date. The Pharmacy and Therapeutics Committee should make a determination to include or not include a new prescription drug in the formulary, in a term no more than ninety (90) days from the date the drug is available on the market.

Humana guarantees that the Pharmacy and Therapeutics Committee establishes disclosure policies and requirements in which the identification of possible conflicts of interest between members of the committee and the developers or manufacturers of prescription drugs is contemplated. No member of the Pharmacy and Therapeutics Committee may have any relationship or interest, financial or otherwise, with the developers or manufacturers of the prescription drugs.

Humana guarantees that the Pharmacy and Therapeutics Committee will establish and comply with a written procedure to evaluate medical and scientific evidence related to the safety and efficacy of prescription medications, including information to compare similar prescription medications and bioequivalent, on deciding which prescription medications are to be included in the formulary and on developing other pharmacy benefit

management processes. Humana also guarantees that the Pharmacy and Therapeutics Committee will establish protocols for the analysis, and possible inclusion in formulary, of medications for "off-label use" for those health conditions in which, through medical or scientific evidence, the efficacy of the medication has been established.

Pharmacy and Therapeutics Committees must document all their protocols and processes and present registers and documents to Humana upon request.

Humana may contract with other persons to perform the functions of the Pharmacy and Therapeutics Committee. Humana will be accountable to the Commissioner of Insurance for non-compliance and violations incurred by its' Pharmacy and Therapeutics Committee.

Humana will only be able to make changes in the formulary or the Utilization Management while the policy is active; if the change is because of safety, the drug is no longer available in the market, if a new prescription drug will be added in the formulary. If this happened, Humana will notify this no later than when the change is made, to:

- All covered members and
- participating pharmacies, only if the change is because a new prescription drug will be added to the formulary. In this case, Humana will notify thirty (30) days before the change is made.

Humana will meet the following requirements:

Humana will maintain and facilitate the information below to the members, prescribers and pharmacies, by electronic means and if requested by the member or the Pharmacy, written:

- The formulary (prescription drug list) organized by therapeutic categories and the list known as "Maximum Allowable Cost";
- Information about prescription drugs and those that may require Utilization Management, if applicable, which was developed and maintained according to the "Código de Seguros de Salud de Puerto Rico".
- Information about the documentation that may need to be presented by the insured or the personal representative to request a medical exception and the way in which to present this documentation. For details, see Section Application and Process Exception in this Certificate.

How do I use the formulary?

Drugs are listed in the formulary alphabetically.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage based on FDA indications and dosing, like gender, age, and dose limitations. Requirements and limits may include:

- **Prior Authorization (PA):** Humana requires you or your doctor to get prior authorization for certain drugs. This means that your doctor must contact Humana to get approval before you fill or refill a prescription for any drug that needs prior authorization. Your plan benefits won't cover this drug without prior authorization. You'll pay the entire cost of the drug if you decide to buy it.
- **Quantity limits (QL):** For certain drugs Humana limits the amount of the drug that we'll cover. Humana might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a

certain drug, we may limit coverage for your prescription to no more than one pill per day. Specialty drugs are limited to a 30-day supply regardless of drug-tier placement.

- **Specialty drugs (SP):** High-cost drugs, including high technology and self-administered injectable medications, requiring special monitoring.

- **This coverage focuses on the use of bioequivalent drugs as a first alternative; however, the insured has the option to choose between a brand drug or a bioequivalent**. If an insured chooses to purchase a brand drug, and an equivalent generic/bioequivalente is available, the insured must pay the difference in cost between the brand and the generic/bioequivalent, plus any applicable brand copay or coinsurance dispensed. If the insured chooses the bioequivalent drug, he or she will only pay the copayment or coinsurance for the bioequivalent drug dispensed. If there is no bioequivalent alternative on the market, the insured will pay the applicable copayment or coinsurance for the brand-name drug dispensed. However, if the physician orders a brand-name drug and writes a prescription as dispensed as written, the insured is responsible only for the copayment or coinsurance of the brand name drug.

What if my drug is not on the formulary?

If your drug isn't included in this printed list of covered drugs, you should visit **Humana.com** to see if your drug is covered. You can also contact Customer Care and ask if your drug is covered.

If Humana doesn't cover your drug, you have two options:

- You can ask Customer Care for a list of similar drugs that are covered by Humana. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Humana.
- You can ask Humana to make an exception and cover your drug. See below for information about how to request an exception.

You are responsible, when applicable, for all or some of the payments for the following:

- The copayment or coinsurance*; and

* If the charge from the pharmacy dispensing the medication is lower than the copayment or coinsurance, you will be responsible for the lesser amount. The amount we pay the pharmacy for the medication might not reflect the final cost to us. Your copayments or coinsurances are made according to the prescription or refill of the prescription and will not be adjusted if Humana gets a discount for volume or a sale on prescription medications.

Pharmacy Annual Deductible

Deductible	Individual	Family
Network Provider	$0	$0
Non-Network Provider	$0	$0

Pharmacy Annual Deductible is the amount that an Individual / Family must pay for calendar year before Humana provides payment for pharmacy covered benefits. The deductible will not apply to Tier 1 Drugs. Once the Individual member in an Individual policy meets the applicable Individual annual deductible, Humana shall provide payment for covered benefits.

For Individual coverage or Family coverage, there is a deductible pharmacy services in-network and a deductible for pharmacy services out-of-network. Pharmacy expenses of benefits you might incur for covered expenses provided by a network provider will apply to the network providers' deductible. Pharmacy expenses you might incur (as provider fee for in-network) for covered expenses provided by out of network will apply to the out of network providers' deductible.

The accumulation period will begin on the effective date of the policy and will end when the policy terminates. From there on, it will be from the renovation date until the policy year end.

Coverage Description

Covered Prescription Drugs List

The following drugs will be covered when prescribed by an authorized doctor:

1. Drugs, medicines or medications that under Federal or state law, may be dispensed only by prescription from a health care practitioner; this includes brand, generic, acute and maintenance medications;
2. Drugs, medicines or medications that are included on the drug list, including the drugs covered by the "Patient protection and Affordable Care Act", like contraceptives, breast cancer risk-reducing medications, among others.
3. Insulin and diabetes supplies;
4. Hypodermic needles or syringes when prescribed by a health care practitioner for use with insulin or self-administered injectable drugs (Hypodermic needles and syringes used in conjunction with covered drugs may be available at no cost to you);
5. Specialty drugs and Self-Administered Injectable Drugs approved by Humana;
6. Spacers and/or peak flow meters for the treatment of asthma;
7. Drugs, medicines or medications on the Women's Healthcare Drug List with a prescription from a health care practitioner;
8. Buprenorphine.

Humana provides for the dispensed of covered drug, regardless of the condition, illness, injury, condition or disease for which they are prescribed, if:

• The drug has FDA approval for at least one indication and

• the drug is recognized for treatment of the disease, illness, injury, condition or disease in question in one of the standard reference compendia or through peer-reviewed medical literature generally accepted.

This drug coverage also includes medically necessary services that are associated with drug administration.

If *you* request a *brand-name medication* when a *generic medication* is available, *your payment* is greater. *You* are responsible for the applicable *generic medication copayment* or coinsurance and 100% of the difference between the amount *we* would have paid the dispensing *pharmacy* for the *brand-name medication* and the amount *we* would have paid the dispensing *pharmacy* for the *generic medication*. If the prescribing *physician* determines that the *brand-name medication* is *medically necessary*, *you* are only responsible for the applicable *copayment or coinsurance* of a *brand-name medication*.

Drugs, Medicines or Medications on the Women's Healthcare Drug List from a N*etwork Pharmacy* are covered in Full (without cost-sharing)

Prescription Drugs Covered without cost sharing from a Network Pharmacy. For more details please refer to drugs list/ formulary.

1. Generic aspirin, for both men and women from 45 to 79 with cardiovascular risk and as prevention of pre-eclampsia: after 12 weeks of gestation in women who are at high risk of pre-eclampsia, both with a medical prescription.
2. Generic folic acid for women planning a pregnancy, with medical prescription.
3. Cancer treatment included within the pharmacy benefit and processed (including oral and auto-administered injectable) in a Network Pharmacy is covered in full, with medical prescription. Intravenously and intrathecally are covered under the Cancer Services and Treatment Section.
4. Breast cancer risk-reducing medications, with medical prescription such as tamoxifen or raloxifene for women who are at increased risk for breast cancer and at low risk of adverse effects to the drug.
5. Smoking cessation drugs, including over-the-counter (OTC), with medical prescription. Covers smoking cessation drugs for 90 consecutive days in an attempt and two (2) cessation attempts per year.
6. Statins in low- to moderate-dose statin for the prevention of cardiovascular disease events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater.

Immunizations for infants, children, and adults are covered through the Medical Coverage in accord with accepted medical practice and as recommended by the Advisory Committee for Immunization Practices (ACIP) of the Centers for Disease Control (CDC), the American Academy of Pediatrics, and are also covered under the vaccination schedule of the Puerto Rico Department of Health.

Benefit Program

The healthcare provider will be able to prescribe maintenance medications to the member with enough refills not to exceed 180 days, according to the plan limitations, when the medical history of the member permits it and no risk are identified.

Contracted/participant pharmacy

Contracted or participant pharmacies are pharmacies that are legally authorized by the relevant authorities, which has signed a contract with Humana to provide pharmacy benefits to its insured.

You are responsible of the following:

Retail Pharmacy / Specialty Pharmacy

Tier 1 Drugs means a category of generic prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 1 drugs.

Tier 2 Drugs means a category of preferred brand prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 2 drugs.

Tier 3 Drugs means a category of non-preferred brand prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 3 drugs.

Tier 3 Drugs: Specialty Drugs means a category of specialty prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 3 drugs.

Tier 1 drugs	$10.00 copayment per prescription or refill per 30-day supply

Tier 2 drugs	$25.00 copayment per prescription or refill per 30-day supply
Tier 3 drugs	20% coinsurance per prescription or refill per 30-day supply
Tier 3 drugs: Specialty drugs	20% coinsurance per prescription or refill per 30-day supply

Note: This plan has a Max Allowable Benefit of $1,500. After this monetary maximum for prescriptions has been reached in disbursements by Humana, the member will be responsible for a 75% coinsurance for all prescriptions until the end of the policy year.

Specialty Drugs through Medical Coverage

Benefits:

A. When medically necessary, specialty drugs administered in a professional setting, including office or infusion center, are covered less the applicable copayment or coinsurance of the specialty drugs in the pharmacy coverage.
B. All utilization requirements of the pharmacy coverage, including but not limited to pre-authorization or quantity limits, shall apply.

90 days program

The retail pharmacies participate in our program which allows you to receive a 90-day supply of a prescription or refill. Your cost is 3 times the applicable copayment or coinsurance as outlined above. Self-administered injectable drugs and specialty drugs are limited to a 30-day supply from a retail pharmacy or specialty pharmacy.

Mail Order Pharmacy

This is a service that delivers medications by mail. It applies to prescriptions or refilled prescriptions covered in the policy.

For up to a 90-day supply of a prescription or refill	2 times the applicable copayment or coinsurance, as outlined above under Retail Pharmacy / Specialty Pharmacy

Mail Order Process:

Your health and well-being is very important to us. Please note that Humana Pharmacy can offer the value and services that you expect from your pharmacy. The routine process to be followed in procuring your maintenance medications by mail is easy and saves time.

The first time you use mail order to receive your medication, ask your doctor for two prescriptions. The first prescription should be written for a one-month supply that can be immediately filled at a participating retail pharmacy. The second prescription should be written for a 90-day supply of the medication with refills and the doctor will send it to Pharmacy Solution. You can use the service for all your maintenance medications.

1. Humana Pharmacy receives the request to fill your prescription. Your physician provider can actually send your prescription by fax (1-800-379-7617), through the telephone (1-800-833-1315-TTY: 711), by filling out a form designed for this purpose (Registration form for prescriptions by mail), onsite at HumanaParmacy.com, or by mail (Humana Pharmacy, PO Box 745099, Cincinnati, OH, 45274- 5099).
2. Humana Pharmacy verifies your pharmacy benefit coverage, enters your order and creates an exclusive shipping number.
3. The Humana pharmacist then reviews the order for a prescribed medication to verify that it is correct and complete. If it is incomplete or incorrect, it is returned with the reason for the rejection.
4. The Humana pharmacist approves the prescription.
5. After approved, the prescription then goes through the billing process.
6. An automated system fills your prescription and a pharmacist verifies that each medication is correct.
7. The prescription is filled in a period of seven (7) to ten (10) days of the time when Humana Pharmacy first received the request for your medications.

Out-Of-Network Pharmacy

When an *out-of-network pharmacy* is used, *you* must pay for the *prescription* or refill at the time it is dispensed. *You* must file a claim for reimbursement with *us*. In addition to any applicable *copayments coinsurances*, *prescription drug deductibles*, *you* are responsible for 40% of the *default rate* (the contracted fee that Humana agreed to pay a pharmacy within the network of providers for a drug) *and* the difference between the *default rate* and the *out-of-network pharmacy's* charge. Example: A pharmacy non-participant has a drug charge of $ 70.00 and the default rate is $75.00, the insured will be responsible for $ 15.00 (40% of the default rate-$ 50.00) plus $ 20.00 which is the price difference between the default rate ($75.00) and the charge of the drug in non-participating pharmacy ($70.00), plus the copayment that has that drug at a contracted pharmacy or coinsurance of the default rate. Any amount *you* pay over the *default rate* and any applicable *copayments*, coinsurances, *pharmacy annual deductible* and percentage amounts *you* pay to an *out-of-network pharmacy* do not apply toward *your maximum out-of-pocket* or any maximum *out-of-pocket*, if any. The charge received from an *out-of-network pharmacy* for a *prescription* or refill may be higher than the *default rate.*

Prior authorization

A prescription drug that is safe and effective for one person may not be safe and effective for another. This is why certain drugs must go through an evaluation and authorization process at Humana before they can be dispensed to members. This process is based on the evaluation of clinical standards for its safe use. The United States Food and Drug Administration (FDA) has recommended these drugs as safe and effective, but due to a high level of concern about their appropriate use, therapeutic indication, and cost, Humana's National Pharmacy and Therapeutics Committee has decided that a prior-authorization must be obtained for dispensing and use. To request coverage for a drug with prior authorization, the physician can contact the Humana Clinical Pharmacy Review (HCPR) at 1-866-488-5991 or by fax 1-855-681-8650

Prior authorization process:

The Humana Clinical Pharmacy Review (HCPR) will receive calls from providers requesting authorizations related to clinical review.

- Requests that require clinical review will be evaluated by the Humana Clinical Pharmacy Review (HCPR) staff. Decisions will be made according to approved clinical protocols established by the Humana's Pharmacy and Therapeutics Committee, as applicable.

- If the request is approved, the authorization is added on Humana's claim processing system. Then, the decision is notified to the person or entity who requested the authorization, whether the member, the physician, or personal representative.

- Requests that do not meet clinical criteria are denied and the decision is notified to the person or entity who has requested the authorization, whether the member, the physician, or the personal representative.

- If additional information is required to complete the evaluation of the request, a prior authorization form will be sent to physician's office by fax. If there is no fax available at physician's office it will be sent to pharmacy.

Humana Clinical Pharmacy Review (HCPR) will evaluate the request for authorization in a period not exceeding 72 hours after being received. In those cases where the physician requesting the case to be worked as expedited because the member's health could be affected, request will be evaluated in a period not exceeding 24 working hours.

Exception request and process

How do I request an exception to the formulary?

You, your physician, or your Personal Representative can contact Humana to ask for an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it's not on our formulary.
- You can ask us not to apply coverage restrictions or limits on your drug. For example, if your drug has a quantity limit, you can ask us not to apply the limit and to cover more.
- Continuum of coverage for a specific prescription drug that Humana will remove from the formulary for reasons other than health or because the drug is no longer available or because the manufacturer removed it from the market; or
- An exception to Utilization Management criteria that indicates the drug may not be covered in the prescribed quantity.

Your doctor should contact us to ask us for an initial coverage decision for a formulary or utilization restriction exception. We must make our decision within 72 hours of getting your prescribing doctor's supporting statement. For controlled medicines, the term should not exceed thirty-six (36) hours after getting your prescribing doctor's supporting statement.

The member or your appointed representative will only be able to make a request in writing, if the physician or other prescriber has determined that the requested medication is medically necessary for the treatment of the disease of the member because:

a. There is no covered prescription drug in the plan's formulary that is a clinically accepted alternative to treat the member's disease:
b. The prescription drug alternative(s) listed on the formulary:
   i. Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
   ii. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
c. The number of doses available under a dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and

medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

The following information would be required as part of the supporting statement in an Exception request:

- Name , group number or policy ID, member ID;
- Patient's history
- Primary diagnosis, related to the requested prescription medication
- Reason why:
    - The covered prescription drug would not be an acceptable alternative for this member; or
    - The prescription drug alternative(s) listed on the formulary or required to be used in accordance with requirements would not be acceptable for this member; or
    - The number of doses available under a dose restriction for the requested prescription drug would not be acceptable;
- Reason why the Exception request is needed, for either the requested prescription drug or the limit of available doses.

Exception requests will be evaluated by appropriate healthcare professionals, according to the member's condition; who will consider specific facts and circumstances within each case and use clinical criteria that is:

- Based on scientific, clinical evidence based medicine; and
- If available, clinical practice guidelines, which may include, evidence based practice guidelines, clinical criteria developed by Humana's Pharmacy Committee or any other practice guidelines that may have been developed by the federal government, national associations or medical/pharmacy professional associations.

Experienced healthcare professionals will evaluate Exception requests according to the member's coverage - pharmacy benefit and exclusions.

If a medical exception is granted, Humana will provide coverage for the requested medication and will not require that the member requests an approval for a refill, nor for a new prescription, in order to continue using the same prescription drug after the refills of the first prescription run out. This is subject to the coverage terms and provided that:

a. The prescribing physician continues prescribing the medication for the same disease or medical condition;
b. The prescription drug continues being safe for the treatment of the member's disease or medical condition.

Humana will not establish a new or special formulary tier, copay for any other cost-sharing requirement that would only apply for the prescription drugs approved through the Exception process.

All denials for an exception request by Humana:

a. Will be notified to the member or the appointed representative, in writing, or by electronic means, if the member has agreed to receive the information that way;
b. Will notify, by electronic means, to the physician or other prescriber, as requested, in writing; and
c. It may be appealed through an appeal request, according to the Section Procedures to Address Complaints, Grievances and Appeals of the Policy.

The denial will describe in a comprehensible way for the member or the personal representative, if applicable:

a) The specific reason for the denial;

b) references to the evidence and documentation, which include the clinical criteria for evaluation and practice guidelines, clinical, medical and scientific evidence that was used and considered to make a denial determination for the request;

c) instructions on how to request a written statement for the clinical, medical and scientific justification of the denial; and

d) a description of the process and procedures to request an appeal for the decision, according to the Section Procedures to Address Complaints, Grievances and Appeals of the Policy, including the timeframes for these procedures.

If Humana does not make a decision with respect to the request for exception, or does not notify it in the above mentioned timeframe:

- The insured shall be entitled to be provided with the prescription drug that is the object of the request for up to thirty (30) days; and
- Humana shall make a decision with respect to the request for exception prior to that time when the insured finish the medication provided.
- If the insured finishes the medication provided, Humana shall maintain coverage under the same terms and in a continuous manner, so long as the same medication is prescribed to the insured and it is deemed safe for the treatment of the illness or medical condition, unless applicable limits to benefits have been exhausted.

If the member is not satisfied with Humana decision, he/she has the right to appeal it; following the Procedure to address Complaints, Grievances and Appeals that is part of the Policy and this Schedule of Benefits.

Other Benefits

Ambulatory Services

1. SPECT test, less 40% of coinsurance. Pre-authorization required.
2. Cardiovascular rehabilitation services at a dedicated center. Includes services by licensed physicians and registered nurses. Rehabilitation program must include education and supervised exercises that lead to risk factor recognition and management and improved exercise capacity. This benefit does not include maintenance exercise programs. Program must not exceed twelve (12) sessions in duration, less $150.00 copayment. Pre-authorization required.
3. Orthopedic devices: casts, splints, braces and crutches, with $0.00 copayment.
4. Laparoscopy, covered at ambulatory facility or at hospital, less $75.00 ambulatory facility copayment, $150.00 hospital copayment per rendered service.
5. Adult circumcision, less $20.00 office visit or $75.00 facility copayment.
6. Breast biopsies, unlimited, less $75.00 facility or $150.00 hospital copayment.
7. Allergy vaccines, up to a maximum of twenty (20) per insured, policy year, less 40% coinsurance.
8. Epidural blocks for pain management administered by medically qualified and recognized specialist, one (1) per anatomical region per insured per policy year, less $20.00 copayment.
9. Maxillofacial surgery, diagnostic and therapeutic services for accidental injuries, jaw fractures, neoplasms, injuries to natural teeth, including their replacement within a period of six months following an accident,

provided the insured was covered by the policy when the accident occurred, less $150.00 copayment. Pre-authorization required.

10. Assistant Surgeon, when medically necessary: pre-notification required. Less applicable 40% coinsurance
11. Reconstructive surgery for injuries due to an accident while the insured is covered under the policy and is not covered under any other program (ACAA, FSE, etc.), less $150.00 copayment.
12. Diagnostic tests and treatment associated with Hepatitis C, unlimited, less 40% coinsurance.
13. Diabetes paraphernalia for children and adults: lancets, syringes for insulin administration and glucometer strips up to a maximum of one hundred and fifty (150) of each one per month, less 40% coinsurance.
14. Hyperbaric Oxygenation treatment for people diagnosed with autism spectrum disorder, provided that it is recommended by a certified medical professional or health professional and the treatment is allowed by federal laws and regulations, as provided by Law 63 of July 19, 2019. Less $75.00 facility or $150.00 admission copayment.

Employee Assistance Program (EAP)

The program is offered by [Inspira, Lucy Lopez Roig, APS OptiMind] and includes the following:

1. Counseling, support, guidance and brief psychological therapy for life situations, including labor problems, emotional problems, relationships, and alcohol or drug abuse, covered at 100%, [Up to sixteen (16) sessions per policy year for each insured. Sessions are divided between the employee and dependents; eight (8) sessions for the employee and eight (8) sessions for dependents - Up to eight (8) visits per situation per insured – Unlimited]. Sessions may include the following:
    - crisis intervention
    - initial evaluation
    - marital or family counseling
    - referral to appropriate mental health resources when indicated for specialized treatment or assistance, including long-term therapy or psychiatric treatment.
2. Special crisis intervention services in case of catastrophic or traumatic events at the work-site.
3. Financial advice
4. Legal advice
5. Implementation orientation to administration and personnel
6. Workshops and orientations for employees
7. [Up to 10 occupational evaluations per employee]

Hospice

Hospice Care Program means a coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill insured and his or her insured family members, by providing palliative and supportive medical, nursing and other services through at-home or inpatient care. The hospice must be licensed according to the laws of the Commonwealth of Puerto Rico. It must provide a program of treatment for a person who have been medically diagnosed as having no reasonable prospect of cure for their illness and, as estimated by a physician, are expected to live less than six (6) months as a result of that illness.

Humana will pay benefits for charges for a hospice care program, which is submitted in writing and approved by us. The insured must submit in writing his or her intent to enroll in a hospice care program approved by us. Hospice benefits are subject to the applicable copayment. All the hospice services are subject to $150.00 admission copayment. All services must be received within a twelve (12) month period. Pre-authorization required.

Organ and Tissue Transplant

We will pay benefits of a Covered Organ Transplant as defined below, incurred by an insured for an organ transplant approved in advance by Humana, subject to those terms, conditions and limitations described below and contained in the group policy. These services are subject to any applicable copayment or coinsurance. Please contact the company's Transplant Management Department when in-need of these services.

Covered Organ Transplant means only the services, care, and treatment received for or in connection with the pre-approved transplant of the organs identified hereafter, which are determined by Humana to be medically necessary services and which are not experimental or investigational.

The covered organ transplant includes pre-transplant, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation of the following organs or procedures only:

a) Heart;
b) Lung(s);
c) Heart-lung;
d) Liver;
e) Kidney;
f) Bone Marrow;
g) Intestine;
h) Simultaneous pancreas/kidney;
i) Pancreas following kidney;
j) Any organ not listed above required by state or federal law.

The term bone marrow identified in the foregoing covered organ transplant definition refers to the transplant of human blood precursor cells which are administered to a patient following high dose, ablative or myelosuppresive chemotherapy. a) Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. b) If chemotherapy is an integral part of the treatment involving a covered organ transplant of bone marrow, the term bone marrow includes the harvesting, the transplantation and the chemotherapy components. c) Storage of cord blood and stem cells will not be covered unless as an integral part of a covered organ transplant of bone marrow approved by Humana.

For a covered organ transplant procedure to be considered totally approved, a written authorization by Humana is required.

a. The insured or his/her physician must notify Humana in advance regarding the need for an evaluation to determine if the organ transplant will be covered. Within five working days of the receipt of this request, Human will contact the insured and his/her physician to clarify transplant benefits available under the insurance, if any.

b. If the product includes benefits of organ transplants, and once the insured has chosen the facility for transplant, Humana proceeds to approve a pre-transplant evaluation.

c. The transplant facility proceeds with the evaluation of the candidate for transplant and must submit to Humana for review seven (7) specific points or articles evaluated.

d. Humana then reviews the clinical results of the facility's evaluation, confirms eligibility, and proceeds to approval on the same day.

e. For solid organ transplants, no medical review is necessary by Humana; bone marrow transplants do require a medical review for final determination.

f. If the transplant is denied, the insured and the physician will receive oral and written explanations of their rights to appeal through the Complaints, Grievances and Appeals system of Humana.

Covered Services:

For approved covered Organ Transplants and all related complications, we will cover only the following expenses:

1. Hospital benefits shown in the schedule of benefits under the Hospital Services section of the group policy will be paid at: (a) 100% of reasonable charges if received at a participating hospital designated by us as an approved transplant facility; and (b) 70% of reasonable charges if received at non-participating hospital.

   Physician benefits shown in this Schedule of Benefits under the Ambulatory Services section of this group policy will be paid at (a) 100% of reasonable charges if received from a participating physician designated by us as an approved transplant provider; and (b) 70% of reasonable charges if received form a non-participating physician.

2. Organ acquisition and donor costs. (a) Except for Bone Marrow transplants, donor costs are not payable under the group policy if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. (b) Coverage for Bone Marrow transplant procedures will include costs associated with donor-patient to the same extent and limitations associated with the insured, except the reasonable costs of searching for the donor may be limited to the immediate family members and the National Bone Marrow Donor Program.

3. Direct non-medical costs* for the insured receiving the covered organ transplant will be paid for: (a) transportation to and from the hospital where the covered organ transplant is performed; and (b) temporary lodging at a prearranged location up to $75.00 per day when requested by the hospital and approved by Humana.

   Transportation costs for the insured to and from the hospital where the covered organ transplant is performed will be paid at: (a) 100% of the reasonable charges if the covered organ transplant is received at a participating hospital designated by Humana as an approved transplant facility; or, (b) 70% of reasonable charges if the covered organ transplant is received at a non-participating hospital.

   Coverage of *non-medical cost will be available only if the insured will travel to the United States for transplant.

4. Direct non-medical costs* for one member of the insured's immediate family (two members if the patient is under age 18 years) will be paid for: (a) transportation to and from the approved facility where the covered organ transplant is performed; and (b) temporary lodging at a prearranged location during the insured's confinement in a hospital, not to exceed $75.00 per day.

Transportation costs for the insured's immediate family member(s) to and from the hospital where the covered organ transplant is received.

Coverage of non-medical* will be available only if an immediate family member(s) accompanies the patient to the United States for a transplant.

*All direct non-medical expenses for the insured receiving the covered organ transplant and his/her family member(s) are limited to a combined maximum coverage of $10,000.

Exclusions:

No benefit is payable for or in connection with a covered organ transplant if:

1. We are not contacted for authorization prior to referral for evaluation of the covered organ transplant, unless such authorization is waived by Humana.
2. We do not approve coverage for the covered organ transplant, based on our established criteria.
3. Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received.
4. The expense related to the transplantation of any non-human organ or tissue, unless otherwise stated in the group policy.
5. The expense related to the donation or acquisition of an organ for a recipient who is not covered by Humana.
6. A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow up care, immunosuppressive drugs, and complications of such transplant.
7. The insured for whom a covered organ transplant is requested has not met pre-transplant criteria as established by Humana.

Once the covered organ transplant is approved, we will advise the insured's physician. Benefits are payable only if the pre-transplant services, the covered organ transplant and post-discharge services are approved by Humana.

Services Out of Puerto Rico

Services rendered on the United States of America:

If insured needs a procedure, treatment, test or office visit in the United States as a second opinion, follow up treatment or because the treatment is not available in Puerto Rico, can submit evidence of the incurred expenses, we will reimburse according the established rates for each treatment in Puerto Rico. Apply the copayment or coinsurance of the benefit described in the policy. Pre-authorization required.

These do not include benefits not available in Puerto Rico, available in the United States of America. For these benefits, refer to Section Service Not Available in Puerto Rico, Available in the United States.

Emergency Services Outside Puerto Rico

I. Emergency Services (Including emergency hospitalizations) received in the United States of America:

A. <u>Services received in contracted Humana or ChoiceCare facilities:</u>

1. Whenever possible emergency services should be received in a facility contracted with the Humana or ChoiceCare Networks.
2. Humana P.R. must receive notice of all emergency services within 72 hours of the insured receiving the services.
3. Payments for emergency services and related admissions provided by a contracted provider will be paid according to the Urgent / Emergency Room Services Section under this Schedule of Benefits, less $75.00 copayment.

B. Services received outside of contracted Humana or ChoiceCare facilities:

1. For services provided in emergency rooms of non-participating providers, payment will be the same as if a participating provider, less $75.00 copayment.
2. The physician must receive notice of all emergency services within 72 hours of the insured receiving the services.

   The attending physician may transfer the insured to a contracted facility as soon as medically feasible. Such transfer should in no way compromise or be detrimental to the insured's medical condition or treatment. Humana will assist in the coordination of such transfer.

II. Emergency Services received outside the United States of America or Puerto Rico:

A. The insured will be reimbursed 100% of the contracted fee for similar services by a provider in Puerto Rico or, billed charges, whichever is less, less $75.00 copayment.

1. If the insured requires hospitalization and cannot be transported to a contracted facility in Puerto Rico or the United States, Humana will attempt to negotiate the best possible fee with the non-participating facility for the benefit of the insured.

2. If the insured can be transported without risk to a participating facility in the United States or Puerto Rico, then the admission copayment or coinsurance only will apply from this point forward.

All claims for services rendered outside of Puerto Rico or the United States must be submitted to Humana with all supporting medical and financial records within a period of one (1) year from the date of service or date of discharge (whichever is later) to ensure reimbursement where applicable.

Ambulatory Services for Dependent Studying in College in the United States of America

Dependent studying in college in the United States of America, as included in the definition of direct dependent, (b) through (g), can receive coverage for covered services provided by contracted providers in the United States. To receive coverage the following conditions must be met:

- The dependent studying college degree, in accordance to the definition of dependent indent (b) through (g), must be eligible for coverage, under the Plan and the ambulatory services received in the United States must be covered services under the Humana PPO Policy.
- The insured university student must be a full-time student at an accredited university in the United States. For purposes of this requirement, it will be presumed that the student is full-time if he/she studies twelve (12) credits; six (6) credits in the case of students studying graduate studies. Any exception to this assumption of credit requirements must be certified by the university institution.
- The dependent college student must coordinate and obtain prior authorization from Humana P.R. for the services unless the services meet criteria for urgent or emergency treatment as set forth in the Policy.

- Services provided by a provider in the Humana or ChoiceCare provider network shall be paid according to the benefits under the Policy. Any copays, coinsurance and/or deductibles set forth in the policy applicable to the benefits shall apply.

If the service is rendered by a provider not participating in the Humana or ChoiceCare network, the service will the service will be reimbursed based on contracted fees for similar services in Puerto Rico, less applicable copayments, coinsurances and deductibles. The insured is responsible for the difference between the Humana contracted rate in Puerto Rico and the facility billed charges.

Important:

1. ChoiceCare is a network of providers, including physicians and hospitals, contracted by Humana in the United States. The insured does not need to contact ChoiceCare to access a covered service. The logo on the card will be the identifier to the provider. Since the services require pre-authorization and coordination, Humana will help the insured identify the appropriate provider or facility. A full ChoiceCare directory is available on the web at www.humana.com.
2. For coordination or pre-authorization the member should call Humana's Customer Service Department at 1-800-314-3121.

Services Not Available in Puerto Rico, Available in the United States of America

This benefit is for services not available in Puerto Rico, available in the United States of America, including equipment, treatment and facilities, among others.

A. Humana will cover such services only if the following five conditions are met.

   1. The Insured must be eligible for coverage under the Plan and the services requested must be Included this Schedule of Benefits.

   2. The provider referring must demonstrate that the equipment, treatment or facilities required to provide medically necessary covered services to the insured are unavailable in Puerto Rico**.** A service will not be deemed unavailable in Puerto Rico if the request for services to be provided outside of Puerto Rico involves a modification to the equipment, technique, or surgical approach available in Puerto Rico or is based on the reputation or recognition of any given provider.

   3. The service must be coordinated and pre-authorized with Humana in Puerto Rico at least five (5) working days prior to the date the service will be rendered.

   4. The service must be provided by Humana or ChoiceCare network providers/facilities.

   5. All services under this Section are subject to the applicable copayments and coinsurances for services as described in this Schedule of Benefits.

B. These services or treatments require pre-authorization with Humana, except in emergencies**.** If the service or treatment is not authorized by and coordinated with Humana in Puerto Rico, the insured will be responsible for the entire payment for such service or treatment. Humana will reimburse the patient based on the applicable Humana fee in Puerto Rico, less applicable copayments or coinsurances as described in this Schedule of benefits only if conditions A1, A2 are met. To receive reimbursement, the insured must provide Humana with all supporting medical and financial information within one (1) year of service or discharge.

Important Notes:

1. ChoiceCare is a network of providers, including physicians and hospitals, contracted by Humana in the United States. The insured does not need to contact ChoiceCare to access a covered service. The logo on the card will be the identifier to the provider. Since the services require pre-authorization and coordination, Humana will help the insured identify the appropriate provider or facility. A full ChoiceCare directory is available on the web at www.humana.com.

2. For coordination or pre-authorization the member should call Humana's Customer Service Department at 1-800-314-3121.

Telemedicine Service
(Virtual Medical Consultation)

Benefit:

Telemedicine service through virtual medical consultation to the insured allows you to receive access to health or minor emergency consultations with a certified primary care physician for the practice of Telemedicine in accordance with Act No. 168 of 2018. Less $20.00 copayment per virtual medical consultation. Through the following website: **www.mdlive.com/humanapr.**
As part of the services of this virtual platform, the insured can also share medical results of their studies.

In cases where the doctor understands that he or she needs medication use according to the insured's clinical picture, the prescription will be coordinated directly to the insured's preferred pharmacy through one of our contracted provider pharmacies.

This Telemedicine service does not replace your doctor, if you have an emergency, it is important that you call the emergency system at 911 or visit the nearest emergency room.

If the doctor determines that the condition by which the insured accesses the virtual consultation cannot be attended through this service, the insured will be immediately referred to an emergency room or personal doctor.

The insured is responsible for verifying their certificate of benefits, description of benefits and / or the medication form to verify if the service is covered.

Medical Exclusions

1. Procedures and/or health services in an experimental or research stage which are not supported by clinical evidence documented in the medical literature of the United States of America, except in connection with a life-threatening condition of the insured for which no effective treatment is available. Humana will pay only for the routine medical expenses associated with the order of such procedure or service which are not reimbursed by the entity conducting the service.
2. Expenses related to illness or injury resulting from war or uprisings.

3. Correspond Services be received, according to the State Workmen's' Compensation Fund Law (*Ley del Fondo de Seguro del Estado*), liability of the insured, private compensation plans at work, car accidents (Automobile Accident Compensation Administration (*Administración de Compensación por Accidentes de Automóviles*, ACAA, for its Spanish acronym).and other services available under state or federal laws. They will also be excluded such services when they are denied by government agencies concerning non-compliance or violation of the requirements or provisions of the above laws, although such failure or violation does not constitute a crime.
4. Expenses caused by military service, war, civil insurrection, international armed conflict, except in those cases where the services received are related to an injury sustained while the insured was active in the military (service connected), in which case Humana will collected such charges from the U.S. Department of Veterans Affairs.
5. Accidents occurring while the insured is participating in races such as: automobile, motorcycle, four-track, boats or other tests of speed, in areas set aside for such activities or any other place.
6. Services provided and/or covered pursuant to state or federal legislation for which the Insured is not legally required to pay.
7. Services received free of charge, rendered by the spouse, parents, siblings, or children of the Insured.
8. Hospitalizations for procedures which can be performed on an ambulatory basis.
9. Hospitalization for diagnostic purposes only; custodial, rest or convalescence services.
10. Services rendered at a time when the policy is not in effect.
11. Electronic prosthesis, including myoelectric arm and cochlear implant, and the removal or insertion of any device, and any other described as non-covered, except the breast prosthesis covered in case of mastectomy.
12. Services considered unreasonable or medically unnecessary for diagnosis or treatment of an illness or injury.
13. Expenses for custodial services, private nurses, personal commodity services such as telephone, television, etc. and all medical services or expenses in convalescence facilities, except for home healthcare services which have been authorized by Humana.
14. Music therapy
15. Cosmetic/esthetic maxillofacial and dental procedures.
16. Esthetic mammoplasty except as applicable in Woman's Rights Cancer Act, and the esthetic mammoplasty in accordance with the Law No. 275 dated on September 27, 2012.
17. Cosmetic/esthetic surgery, except septoplasty when medically justified and with prior authorization.
18. Repair or replacement of instruments or prosthetic devices due to normal wear and tear and impairment.
19. Corrective footwear.
20. Services, treatments, and therapies of alternative medicine by physicians or other certified trained professionals, except naturopathic physician visits.
21. Sports medicine.
22. Eyeglasses and contact lenses for adults, hearing aids.
23. Congenital or genetic deformities and metabolic deformities, except in newborns, recently adopted newborns or newborns recently placed for adoption.
24. All services and/or treatments related to infertility or impotence, except test to detect infertility.
25. Expenses for Physical Examinations to adults required by the employer or health certificates for any type of license and all diagnostic tests or services for these purposes. Except for the annual exam according to Law No. 296 dated on September 1st, 2000, which includes: physical and mental evaluation, oral health, hearing and vision screening, and screenings recommended by the American Academy of Pediatrics.
26. Elective abortions.

27. Acne surgery and acne treatment, including drugs.
28. Growth hormones and all related treatment.
29. Embryo transplantation.
30. Human chorionic gonadotropin (HCG) injections.
31. Vaccinations required for travel.
32. Tuboplasty, vasovasostomy, and any procedure or service for the purpose of fertility.
33. Sickness or injury caused by the insured engaging in an illegal occupation; or committing or attempting to commit a criminal act, except those injuries resulting from an act of domestic violence or medical condition.
34. Enrollment in a health, athletic, or similar club; or a weight loss or similar program.
35. Purchase or rental of supplies of common household use such as: exercise cycles; air purifiers; central or unit air conditioners; water purifiers; allergenic pillows or mattresses; or waterbeds. Except for technical equipment of ventilators for children which are vital for the maintenance of life, including children and those who have started treatment as minors and become age 21, who depend on medical equipment such as respirators or supplemental oxygen, as authorized by the laws of Puerto Rico as outlined in Law Number 62 dated May 4, 2015.
36. Purchase or rental of: motorized transportation equipment; escalators or elevators; saunas or attachment pools; professional medical equipment such as blood pressure kits; or supplies or attachments for any of these items.
37. Expert witness required by a Court that is not included under the benefits or requirements of the mental health law.
38. Services and supplies for treatment of temporomandibular joint disorder or dysfunction (TMJ) and craniomandibular jaw disorders (CMJ) which are recognized as dental procedures. This includes, but is not limited to, the extraction of teeth and the application of orthodontic devices and splints.
39. New diagnostic and therapeutic services/procedures that are done with approved FDA equipment/devices that become available posterior to the effective date of the policy. Unless, the insured suffers from a life-threatening condition for which there is no effective treatment. Humana would then pay for routine medical expenses of the patient which are not covered by the entity carrying out the study.
40. Epidural anesthesia during delivery.
41. Air and maritime ambulance services outside of Puerto Rico, except for dependent studying in the United States
42. Any and all services or treatments not specifically described as covered benefits, except for the services and benefits included in a law that are required to be included in the coverage.

Dental Coverage Exclusions

1. Services or treatments presented for beauty or cosmetic reasons.
2. Services received free of charge; services rendered by spouses, parents, brothers/sisters or children of the insured.
3. Experimental or investigative procedures and/or services, or the drugs related to them.
4. Services rendered before the effective date of the policy.
5. Expenses related to injuries caused by war or disturbances.

6. Illnesses or accidents covered by the State Insurance Fund law -*Ley del Fondo del Seguro del Estado* (FSE) and/or the Automobile Accidents Compensation Administration -*Administración de Compensaciones por Accidentes de Automóviles* (ACAA).
7. Any benefit or service not specified in the dental coverage.
8. Services not used during the policy year do not accumulate for the following year.

Vision Coverage Limitations and Exclusions

1. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
2. Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan
3. Services provided as a result of any worker's compensation law (*Ley del Fondo del Seguro del Estado* -FSE) and/or the Automobile Accidents Compensation Administration (*Administración de Compensaciones por Accidentes de Automóviles* - ACAA).
4. Lenses or vision devices that are not prescribed.
5. Unspecified contact lenses on the vision coverage.
6. Any other frame that is out of the collection.
7. Any treatment or service that is not specified on the vision coverage.

Pharmacy Coverage Limitations and Exclusions

1. Legend drugs which are not deemed medically necessary by us;
2. Any drug prescribed for a sickness or bodily injury not covered under the policy;
3. Any drug, medicine or medication labeled "Caution-limited by federal law to investigational use" or any experimental or investigational drug, medicine or medication, even though a charge is made to you; not covered:
    a. Medications used in research trials which have the sponsorship of manufacturers or government entities.
    b. Medications or services offered during research trials when the sponsor of such tests offers these services and medications at no cost to the participants
4. Allergen extracts(covered under the Medical Coverage);
5. Therapeutic devices or appliances including, but not limited to:
    A. Hypodermic needles and syringes (except needles and syringes for use with insulin, and self-administered injectable drugs whose coverage is approved by us);
    B. Support garments;
    C. Test reagents;

D. Mechanical pumps for delivery of medications; and

E. Other non-medical substances;

6. Dietary supplements; (except for formulas or low protein modified foods necessary for the treatment of phenylketonuria or certain other heritable diseases of amino and organic acids);
7. Nutritional products;
8. Minerals;
9. Herbs and vitamins, except Vitamin D, prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride, OTC Ferrous Sulfate which are covered for Women's Preventive Healthcare;
10. Anorectic or any drug used for the purpose of weight control;
11. Any drug used for cosmetic purposes, including but not limited to:

    A. Tretinoin;

    B. Dermatologicals or hair growth stimulants; or

    C. Pigmenting or de-pigmenting agents, e.g. Solaquin;
12. Any drug or medicine that is:

    a. Lawfully obtainable without a prescription (over the counter drugs), except insulin
13. Progesterone crystals or powder in any compounded dosage form;
14. Abortifacients (drugs used to induce abortions);
15. Infertility services including medications;
16. Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra;
17. Any drug, medicine or medication that is consumed or injected at the place where the prescription is given, or dispensed by the health care practitioner;
18. Prescriptions that are to be taken by or administered to you, in whole or in part, while you are a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:

    A. Hospital;

    B. Skilled nursing facility; or

    C. Hospice facility;

    D. Physician office (unless coverage is approved by us)
19. Injectable drugs such as:

    A. Biological sera (covered under the Medical Coverage)
    B. Blood (covered under the Medical Coverage)
    C. Blood plasma (covered under the Medical Coverage)
20. Prescription refills:

    A. In excess of the number specified by the health care practitioner; or

    B. Dispensed more than one year from the date of the original order;

21. Any portion of a prescription or refill that exceeds a 90-day supply, received from a mail order pharmacy or a retail pharmacy that participates in our program which allows you to receive a 90-day supply of a prescription or refill;
22. Any portion of a prescription or refill that exceeds a 30-day supply, received from a retail pharmacy that does not participate in our program which allows you to receive a 90-day supply of a prescription or refill;

23. Any portion of a specialty drug or self-administered injectable drug received from a retail pharmacy or a specialty pharmacy that exceeds a 30-day supply, unless otherwise determined by us;
24. Any portion of a prescription or refill that:
    A. Exceeds our drug specific dispensing limit, e.g. IMITREX; or
    B. Is dispensed to an insured whose age is outside the drug specific age limits;
    C. Exceeds the duration-specific dispensing limit;
25. Any drug for which a charge is customarily not made;
26. Any drug, medicine or medication received by you:
    A. Before becoming covered under this rider; or
    B. After the date your coverage under this rider has ended;
27. Any costs related to the mailing, sending or delivery of prescription drugs;
28. Any intentional misuse (improper use)of this benefit, including prescriptions purchased for consumption by someone other than you;
29. Any prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
30. Drug delivery implants;
31. More than one prescription or refill for the same drug or therapeutic equivalent medication prescribed by one or more health care practitioners and dispensed by one or more pharmacies until you have used, or should have used, at least 75% of the previous prescription or refill, unless the drug or therapeutic equivalent medication is purchased through a mail order pharmacy, or a retail pharmacy that participates in our program which allows you to receive a 90-day supply of a prescription or refill, in which case you have used, or should have used 66% of the previous prescription. (Based on the dosage schedule prescribed by the health care practitioner);
32. Any copayment or coinsurance you paid for a prescription that has been filled, regardless of whether the prescription is revoked or changed due to adverse reaction or change in dosage or prescription;
33. Bulk Chemicals and Pain Patch not approved by the Food and Drug Administration (FDA)

34. When the FDA has determined that a medication is contraindicated for the condition for which it is prescribed.

These limitations and exclusions apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, service, treatment, supply, or prescription. This does not prevent your health care practitioner or pharmacist from providing or performing the procedure, service, treatment, supply, or prescription; however, the procedure, service, treatment, supply or prescription will not be a covered expense.

Humana Insurance of Puerto Rico, Inc.

(Hereinafter "the Company")

PPO Program Humana Complete
RX 3

19728PR0010

Schedule of Benefits Coverage

Schedule of Benefits

This schedule of benefits should be attached and made part of PPO Program Policy: Attachment I

Services and Benefits Procedures

1. Benefits and services are subject to the terms and conditions included in the group policy and to the exclusions and limitations described in this attachment.
2. Insured must receive services from participating facilities, contracted providers or under the order, direction and approval of the contracted provider upon presentation of the identification card issued by the Company. The Insured is responsible for paying applicable copayment, coinsurance or deductible.

Deductible

Deductible	Individual	Family
Network Provider	$0	$0
Non-Network Provider	$0	$0

Annual Maximum Out-of Pocket

Maximum out-of pocket limit	Individual	Family
Maximum out-of pocket limit ("MOOP") Network Provider	$6,350	$12,700
Maximum out-of pocket limit ("MOOP") Non-Network Provider	$19,050	$38,100

This includes copayments and coinsurance expenses of the Medical and Pharmacy coverage, in addition to accumulated expenses of the pharmacy benefits coverage deductibles.

Once the individual or family maximum out of pocket limit is met for the policy year for network providers, the percentage of benefits provided by network providers for covered expense will be paid at a rate of 100% for the rest of the policy year, subject to all terms, limits and exclusions of this Schedule of Benefits Coverage. Any expenses (medical and pharmacy) you might incur for covered expenses provided by a network provider will apply to the maximum out of pocket limit for network providers. Any expenses (medical and pharmacy) you might incur (as contracted fee for similar services by a provider in Puerto Rico) for covered expenses provided by out of network provider will apply to the maximum out of pocket limit for out of network providers.

The accumulation period will begin on the effective date of the policy and will end when the policy terminates. From there on, it will be from the renovation date until the policy year end.

The Maximum Out-of Pocket is based on the maximum amount allowed by the Office of the Commissioner of Insurance of Puerto Rico.

Essential Health Benefits

Ambulatory Services

The following services are covered, less any applicable co-insurance or copayment per visit:

1. Unlimited office visits to physicians, less applicable copayment or coinsurance:

   Generalists: $5.00

   Specialists: $10.00

   Sub-specialists: $10.00

2. Chiropractic Services, one (1) initial visit, one (1) follow-up visit, less $10.00 visit copayment or and up to twenty (20) manipulations per insured, per policy year. Physical therapies unlimited, less $5.00 copayment.
3. Six (6) Nutritionist consultations per insured per policy year, less $10.00 visit copayment or per visit.
4. Laboratories, X-rays and its reproduction, unlimited, less 25% of coinsurance. Genetic tests require pre-authorization, less 25% of coinsurance.
5. Electrocardiograms, unlimited, less 25% of coinsurance.
6. Sonograms, unlimited, less 25% of coinsurance.
7. Computerized tomography, unlimited, less 25% of coinsurance. Pre-authorization required.
8. Positron Emission Tomography (PET), unlimited, less 25% of coinsurance. Pre-authorization required.
9. Electroencephalogram, unlimited, less 25% of coinsurance.
10. Electromyogram, unlimited, less 25% of coinsurance.
11. Magnetic Resonance, including MRI and MRA, unlimited, less 25% of coinsurance. Preauthorization required.
12. One (1) sleep study or polysomnography covered per insured, per policy year, less 25% of coinsurance. Pre-authorization required.
13. Nuclear medicine tests, unlimited, less 25% of coinsurance.
14. Respiratory therapy, unlimited, less $5.00 copayment.
15. Physical therapy, including rehabilitation and habilitation, unlimited for all conditions including autisms, as prescribed and under the supervision of an orthopedist or a physical medicine specialist, less $5.00 copayment.

16. Speech therapy, combined at the physician office or at home, when ordered by a physician and rendered by a licensed speech therapist; up to a maximum of forty (40) therapies, per insured per policy year, less $10.00 copayment. Unlimited speech and language therapies for autism according to Law No. 220 of September 4, 2012.
17. Occupational therapy for the purpose of training and aiding in the restoration of normal physical function and or prevent further deterioration of the same; resulting illness, from trauma, stroke or a surgical procedure while insured under the policy, unlimited for all conditions including autisms, less $10.00 copayment.
18. Ambulatory surgery at ambulatory surgery facilities, including Mental Health, less $50.00 of copayment.
19. Endoscopies, diagnostic and therapeutic, unlimited, less $10.00 office copayment or less $50.00 facility copayment.
20. Lithotripsy, unlimited, less $50.00 ambulatory facility copayment per rendered service. Pre-authorization required.
21. Vasectomy at physician's office, less $10.00 office visit copayment.
22. Acute and chronic services related to End Stage Renal Disease, such as dialysis, hemodialysis and complications directly related to the disease are covered up to a maximum of ninety (90) days starting on the date on which the disease is diagnosed, In case of admission apply $100.00 copayment.
23. Allergy tests, including allergenic and biological extracts, drugs, patches and provocative tests, up to a maximum of fifty (50) tests per insured per policy year, less 25% coinsurance.
24. Intra-articular injections, unlimited, less $10.00 office copayment or less $50.00 facility copayment.
25. Audiologist visits according to Law No. 127 of September 27, 2007; Audiometry and tympanometry tests when ordered by a physician, one (1) of each test per insured, per policy year, less 25% of coinsurance.
26. Orthognathic surgery (mandibular or maxillary osteotomy - Le Fort). Expenses for implants related to orthognathic surgery are excluded, less $50.00 facility or $100.00 hospital copayment. Pre-authorization required.
27. Treatment and services for morbid obesity as medically necessary. One (1) bariatric surgery using one of the following techniques, gastric bypass, adjustable gastric band or sleeve gastrectomy per lifetime, according to Law 212 dated on August 9, 2008, less $100.00 copayment. Surgeries for removing excess skin (commonly known as folds) shall not be covered, unless the physician certifies that it is necessary to remove the excess skin because it affects the functions of any part of the body. Bariatric surgery requires pre-authorization.
28. In the event that an insured voluntarily enrolls in a research clinical trial, Humana will cover diagnostic tests which are usually associated with his condition as long as they are covered by his/her health insurance policy. These services are subject to the maximum limits specified under the policy, less $10.00 copayment or 25% coinsurance. Tests which are not covered by his/her policy, and which are strictly linked to the goal of the research, will not be reimbursed by Humana. The process and results of the investigation are the responsibility of the researcher and the insured.
29. Diagnostic tests and treatments associated with hemophilia, unlimited, less $10.00 copayment or 25% coinsurance.
30. Unlimited naturopathic physician visits according to Law 210 dated on December 14, 2007, less $10.00 copayment.
31. Eye refraction test by an ophthalmologist or optometrist, one (1) per insured per policy year within the Humana Insurance network, less $10.00 copayment.
32. Ophthalmic Diagnostic Tests, less $10.00 copayment.
33. Mammography, when they are not presented as a preventive test required by ACA, but as a follow up to a diagnosis or treatment of a condition, less $50.00 facility copayment.
34. Podiatry visits; Treatment of diseases and disorders of the foot and ankle, including injections and surgical procedures, less $10.00 visit copayment or $50.00 facility copayment.
35. Cervical Cryosurgery, less $10.00 copayment.

36. Nerve Conducting Velocity Test, unlimited, per policy year, less 25% coinsurance.

37. Humana will cover the Nutritional Supplement free of phenylalanine, based on low phenylalanine protein hydrolysates for patients diagnosed with the genetic disorder Phenylketonuria (PKU), without age limits, and for other recommended diagnostic, prevention and treatment of people with innate metabolic errors, in accordance to Act 139 of August 8, 2016. Covered at 100%.

38. Anesthesia services and hospitalization services, unlimited, in accordance with Act No. 352 of 1999; Pre-authorization is required. These services will be available when the member has dental coverage with Humana and when at least one of the following scenarios occurs:

    a. When a pediatric dentist, oral or maxillofacial surgeon member of the medical faculty of a hospital, licensed by the Government of Puerto Rico, determines that the member's condition is significantly complex in accordance with criteria established by the American Academy of Pediatric Dentistry.
    b. When the patient due to age or disability is unable to resist or tolerate pain, or cooperate with the treatment indicated in dental procedures;
    c. When the infant, child, adolescent or person with a physical or mental disability has a medical condition in which it is essential to carry out dental treatment under general anesthesia in an outpatient surgical center or hospital and which otherwise could represent a significant risk to the patient's health;
    d. When local anesthesia is ineffective or contraindicated due to an acute infection, anatomical variation or allergic condition;
    e. When the patient is an infant, child, adolescent, person with a physical or mental disability, and is in a state of fear or anxiety that prevents the dental treatment under traditional procedures of dental treatment and their condition Of such magnitude, that postponing or delaying treatment would result in pain, infection, loss of teeth or dental morbidity;
    f. When a patient has received extensive and severe dental trauma where the use of local anesthesia would compromise the quality of services or be ineffective in managing pain and apprehension.

To evaluate the services, a medical order must be sent to Humana with the diagnosis of the insured, as well as the reasons that justify the use of general anesthesia and hospital. Humana will approve or deny the request, in accordance with the criteria previously established, within two (2) days as of the date on which the member submits all required documentation.

The documents are:

- Medical order with diagnostics.
- Justification in the medical order.

Preventive Services

1. Annual preventive services are **covered at 100%** (without copayment or coinsurance) when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF), the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), The Health Resources and Services Administration, and the Puerto Rico Department of Health.

   For more information and updates on preventive services, visit: //www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

   a) Routine physical examination, including height, weight, and body mass index (BMI), for children and adults.

   b) High Blood pressure screening. The USPSTF recommends screening for high blood pressure in adults age (18) years and older. It is recommended obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.

   c) Cholesterol screening, for children and adults.

d) Screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults 40 years of age and older. The risks and benefits of these methods vary.

e) Screening for obesity, and counseling, for children and adults. The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of (30) kg/m2 or higher to intensive, multicomponent behavioral interventions.

f) Screening for Tobacco Use for all adult. The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA) approved pharmacotherapy for cessation to adults who use tobacco.

   The dispatch of FDA approved medication for smoke cessation is covered for (90) consecutive days in one intent and until (2) intents per year. Smoking cessation drugs are covered under the Pharmacy Coverage Section with prescription.

g) Tobacco use interventions: children and adolescents; recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

h) Screening for gestational diabetes mellitus (GDM) in asymptomatic pregnant women after (24) weeks of gestation and those at high risk of developing gestational diabetes.

i) Screening for abnormal blood glucose and Diabetes Mellitus Type 2 in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer, or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.

   In addition, it is recommended screening for diabetes type 2 in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than (135/80) mm Hg.

j) Screening for alcohol abuse, and behavioral counseling. It is recommended that clinicians screen adults aged (18) years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

k) Screening for tobacco, alcohol or drug use for children 11 to 21 years of age.

l) Immunizations for infants, children, and adults in accord with accepted medical practice and as recommended by the Advisory Committee for Immunization Practices (ACIP) of the Centers for Disease Control (CDC) and the American Academy of Pediatrics, as long as the individual is covered by this health insurance, including follow up (catch up).

   - Immunizations for Adults (21 years or older), including catch-ups – Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza (Flu Shot), Meningococcal, Measles/Mumps/Rubella, Pneumococcal, Tetanus/Diphtheria/Pertussis, Varicella

   - Immunizations for Children (less than 21 years old), including catch-ups – Haemophilus Influenzae Type b, Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza (Flu Shot), Meningococcal, Measles/Mumps/Rubella, Pneumococcal, Rotavirus, Tetanus/Diphtheria/Pertussis, Varicella, , inactivated poliovirus

m) Cervical cancer screening The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).

n) Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate. Office visits and consultations regarding checkups for healthy women (well-woman visits). Health and Human Services recognizes that several visits may be necessary to get all recommended preventive services, depending on the health status of women, their health needs and other risk factors.

o) Breast cancer mammography screenings every one (1) to two (2) years for insured over 40 years, biannual for insured between fifty (50) and seventy-four (74) years. This includes guidance and advice regarding chemoprevention, and the chemoprevention of breast cancer in women when indicated. Counseling for women at higher risk. The USPSTF recommends that clinicians engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk.

   For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk- reducing medications, such as tamoxifen or raloxifene.

p) Pap Smear

q) Prostatic Specific Antigen test (PSA) for men

r) Behavioral counseling regarding sexually transmitted diseases (STD's), for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs).

s) Screening for intimate partner violence (IPV), such as domestic violence, for women of childbearing age. Physicians shall also provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.

t) Screening for autism for children up to 36 months.

u) Osteoporosis screening: postmenopausal women younger than 65 years at increased risk of osteoporosis The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool. Osteoporosis screening: women 65 years and older. The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporosis fractures in women 65 years and older.

v) Screening for hearing loss all newborns infants.

w) Screening for elevated blood lead levels in children aged (1) to (6) years who are both at average and increased risk, and in asymptomatic pregnant women.

x) One (1) lifetime screening test for abdominal aortic aneurism (AAA) in men 65-75 years old who have ever been smokers.

y) Counseling regarding the use of aspirin in prevention of disease, for both men and women 45-79 years of age who are cardiovascular and colorectal cancer risks. The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged (50) to (59) years who have a (10)% or greater (10) year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least (10) years, and are willing to take low-dose aspirin daily for at least (10) years. For aspirin, prescription is required.

z) Counseling regarding folic acid supplements for women who may become pregnant. The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing (0.4) to (0.8) mg of folic acid. For folic acid, prescription is required.

aa) Hypothyroidism: Screening for congenital hypothyroidism in newborns.

bb) Screening for cervical dysplasia for sexually active females.

cc) Screening for sickle cell disease in newborns.

dd) Vision screening for all children at least once in all children between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.

ee) Screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up.

ff) Medical history: For all children throughout development.

gg) Behavioral Assessment for children of all ages. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

hh) Screening for this genetic disorder Phenylketonuria (PKU) in newborns.

ii) Obesity in children and adolescents: The USPSTF recommends that clinicians screen for obesity in children and adolescents (6) years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.

jj) Screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

kk) Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care. Also, is recommended repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at (24)-(28) weeks gestation, unless the biological father is known to be Rh (D)-negative.

ll) BRCA: Screening and risk assessment for women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.

mm) Screening for asymptomatic bacteriuria with urine culture for pregnant women at (12) to (16) weeks of gestation or at the first prenatal visit, if later.

nn) Screening for syphilis for all pregnant women and for any adolescent or adult who is at increased risk for infection.

oo) Screening for chlamydia and gonorrhea in sexually active women age (24) years or younger and in older women who are at increased risk for infection.

pp) Preventive medication for the eyes of all newborn for the prevention of gonorrhea.

qq) Skin cancer behavioral counseling The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.

rr) Preeclampsia prevention: aspirin, recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk. For aspirin, prescription is required.

ss) Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors: recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.

tt) Dental caries prevention: The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.

It is recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. The fluoride varnish is covered under the Dental Services Section.

uu) Oral health: Risk assessment for young children. Ages: (0) to (11) months, (1) to (4) years, (5) to (10) years.

vv) Lung cancer screening: recommends annual screening for lung cancer with low-dose computed tomography in adult ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

ww) Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. The USPSTF recommends exercise or physical therapy and vitamin D supplementation to prevent falls.

xx) Hepatitis B screening in persons at high risk for infection. Hepatitis B screening is also cover for pregnant women at their first prenatal visit.

yy) Hepatitis C virus infection screening: adults The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.

zz) Tuberculosis : Testing for children at higher risk of tuberculosis. Ages: (0) to (11) months, (1) to (4) years, (5) to (10) years, (11) to (14) years, (15) to (21) years.

aaa) Prevention of cardiovascular diseases: It is recommended that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.

bbb) Preeclampsia Screening in pregnant women with blood pressure measurements throughout pregnancy.

ccc) Tobacco Smoking cessation: The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.

ddd) Developmental Screening and Surveillance: Screening for children under age (3), and surveillance throughout childhood.

eee) Dyslipidemia: Screening for children at higher risk of lipid disorders. Ages: (1) to (4) years, (5) to (10) years, (11) to (14) years, (15) to (16) years.

fff) Hepatitis B virus infection: screening nonpregnant adolescents and adults The USPSTF recommends screening for hepatitis B virus (HBV) infection in persons at high risk for infection.

ggg) Tuberculosis latent infection screening: adults The USPSTF recommends screening for latent tuberculosis infection in populations at increased Risk.

2. Preventive services **covered at 100%** (without copay) when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF) and the Health Resources and Services Administration.

For more information and updates on preventive services, visit:
//www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

- Women's contraceptives and contraception counseling. All women's contraceptive methods approved by the Federal Drug Administration (FDA) by prescription are covered, including counseling, placement and removal of uterine devices, administration of medication and sterilization
- Any device insertion and removal of contraceptive methods is covered.

3. Preventive services **covered at 100%** (without copay) during and immediately following pregnancy when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF) and the Health Resources and Services Administration. For this service, insured has to call the *Humana Beginnings* program at 1-866-488-5992, for screening process. Humana recommends to participate in the Humana Beginnings Program starting the first trimester of gestation.

For more information and updates on preventive services, visit:
//www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

- Comprehensive breastfeeding support with guidance and counseling, during pregnancy and after birth, and the necessary breastfeeding equipment and supplies, including the breast pump with prescription.

4. Screening for Human Immunodeficiency Virus (HIV) covered at 100% (without co-payment or coinsurance), according to the recommendation of the Centers for Disease Control and Prevention (CDC) and in compliance to the Act No. 45 of May 16, 2016, as part of the routine testing of a medical evaluation at least once every five (5) years, based on the clinical criteria for adolescents and adults between the ages of thirteen (13) and Sixty-five (65) years of age at low risk. For people of high risk between the ages of thirteen (13) and sixty-five (65) is covered annually.

   Clinicians should screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown. For pregnant women, two tests are covered: 1) A first HIV test during the first trimester of pregnancy at the first prenatal visit, and 2) A second test during the third trimester of pregnancy (between the (28) and (34) weeks of pregnancy.

Hospital Services

Hospital admissions must be authorized by Humana and the services to be offered must be provided under the determinations of an attending physician. A member or his (her) responsible caretaker is responsible for the predetermined co-payment for any admission that so specifies.

Inpatient Care:	$100.00 per admission
Outpatient Surgery-Facility:	$50.00 per rendered service

1. Hospital services included in the contracted per diem:
   - Semi-private room or similar facility, unlimited. In cases in which an insured use the services of a private room, it is his/her responsibility to pay the difference between the cost of medical services billed and the contracted fees.
   - Specialized units for critical care services including: intensive care unit (ICU), intermediate care unit, coronary care unit (CCU), neonatal intensive care unit (NICU), and pediatric intensive care unit (PICU).
   - Operating, recovery, and maternity rooms.
   - Drugs prescribed by physician during hospital stay that are included in the per diem.
   - Oxygen and its administration.
   - Laboratory and radiology.
   - Disposable supplies.
   - Special and regular diets.
   - Regular hospital nursing service

2. Hyperalimentation services, unlimited
3. Universal Neonatal Hearing Screening according to Law No. 311 dated on December 19, 2003, which includes: hearing evaluations for the follow-up treatment needed by the patient.
4. Surgical procedures for benefits included under the basic coverage.

5. Anesthetic agents and their administration including sedation. Anesthesia services and hospitalization services, unlimited, in accordance with Act No. 352 of 1999; Pre-authorization is required. These services will be available when the member has dental coverage with Humana and when at least one of the following scenarios occurs:

    a. When a pediatric dentist, oral or maxillofacial surgeon member of the medical faculty of a hospital, licensed by the Government of Puerto Rico, determines that the member's condition is significantly complex in accordance with criteria established by the American Academy of Pediatric Dentistry.
    b. When the patient due to age or disability is unable to resist or tolerate pain, or cooperate with the treatment indicated in dental procedures;
    c. When the infant, child, adolescent or person with a physical or mental disability has a medical condition in which it is essential to carry out dental treatment under general anesthesia in an outpatient surgical center or hospital and which otherwise could represent a significant risk to the patient's health;
    d. When local anesthesia is ineffective or contraindicated due to an acute infection, anatomical variation or allergic condition;
    e. When the patient is an infant, child, adolescent, person with a physical or mental disability, and is in a state of fear or anxiety that prevents the dental treatment under traditional procedures of dental treatment and their condition Of such magnitude, that postponing or delaying treatment would result in pain, infection, loss of teeth or dental morbidity;
    f. When a patient has received extensive and severe dental trauma where the use of local anesthesia would compromise the quality of services or be ineffective in managing pain and apprehension.

    To evaluate the services, a medical order must be sent to Humana with the diagnosis of the insured, as well as the reasons that justify the use of general anesthesia and hospital. Humana will approve or deny the request, in accordance with the criteria previously established, within two (2) days as of the date on which the member submits all required documentation.

    The documents are:

    - Medical order with diagnostics.
    - Justification in the medical order.

6. Sonogram, Computerized Tomography and Magnetic Resonance (MRI and MRA), unlimited
7. Electrocardiogram, unlimited
8. Nuclear medicine studies and digital angiography, unlimited.
9. Blood transfusions including autologous process, all components and compatibility tests.
10. Respiratory Therapy.
11. Physical Therapy, maximum of forty (40) therapy sessions per insured, per hospital stay.
12. Acute and chronic services related to End Stage Renal Disease, such as dialysis, hemodialysis and complications directly related to the disease are covered up to a maximum of ninety (90) days starting on the date on which the disease is diagnosed.
13. Treatment and services for morbid obesity as medically necessary. One (1) bariatric surgery using one of the following techniques, gastric bypass, and adjustable gastric band or sleeve gastrectomy per lifetime, according to Law No. 212 dated on August 9, 2008.
14. Surgical procedures in ambulatory surgery in a hospital, less applicable copayment or coinsurance.
15. Surgeon Assistant when medically necessary: pre-authorization required, less 25% coinsurance.

Transplant or Graft

Cornea transplant or bone, skin graft services received by the insured will be covered, less $100.00 copayment; pre-authorization is required. The covered transplant or graft includes pre-transplant, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation.

In-Home Services

In-Home Health Services, authorized by a main doctor and Humana.

Home health care must be provided by an agency that is dedicated, licensed and managed according to the regulations established by a group of medical professionals that keeps medical records of the patients and operates according to the laws of the Commonwealth of Puerto Rico. These services are covered if they begin within fourteen (14) days after release from a hospital or expert nursing facility due to a hospitalization of at least three (3) days, and are provided because of the same condition or in relation to the condition for which the patient was hospitalized.

If the patient is in the hospital, Home health services must be requested by the attending physician in the hospital. If the patient is out of the hospital, Home health services must be requested by the main doctor with medical justification. The doctor must present a care plan and estimated time of the duration of services, according to the individual needs of the patient. The program will provide education for the patient and family members responsible for his/her health care. This benefit will be covered for forty (40) days initially, and an additional twenty (20) days, subject to medical necessity certification.

In-home health services include:

1. Care by a nurse or under the supervision of a graduate nurse.
2. Respiratory therapy care, less $5.00 copayment
3. Collection of samples for lab tests, less 25% coinsurance
4. Care and maintenance of catheters.
5. Administration of intravenous antibiotics, subject to Humana's case management program.
6. Ulcer care through Humana's case management program.
7. Physical therapies, up to forty (40), less $5.00 copayment. For condition of autism, unlimited as mention in law No. 220 of September 4, 2012.
8. Occupational therapy for the purpose of training and aiding in the restoration of normal physical function and or prevent further deterioration of the same; resulting illness, from trauma, stroke or a surgical procedure while insured under the policy, unlimited for all conditions including autisms, less $10.00 copayment.
9. Speech therapy, when ordered by a physician and rendered by a licensed speech therapist; combined at the physician office or at home, up to a maximum of forty (40) therapy sessions per insured per policy year less $10.00 visit copayment. Speech therapies are unlimited for Autism and language as mention in Law No. 220 of September 4, 2012.
10. Hyperalimentation services, unlimited, less 25% coinsurance.

Skilled Nursing Facility

Skilled nursing facility covered up to a maximum of one hundred and twenty (120) days per insured per policy year, covered at 100%. These services will be covered if they begin within the fourteen (14) days following the release from the hospital due to a hospitalization of at least three (3) days, and if they are rendered because of the same condition or in relation to the condition leading to the hospitalization.

If the patient is in the hospital, Home health services must be requested by the attending physician in the hospital. If the patient is out of the hospital, Home health services must be requested by the main doctor with medical justification. Pre-authorization is required.

Durable Medical Equipment, Supplies, Prosthesis, Orthosis and Implants

1. The purchase or rental of medically necessary Durable Medical Equipment, less 25% coinsurance. The cost or rental of durable medical equipment will be covered. If the cost of renting the equipment is more than an insured would pay to buy it, Humana will covered up to the amount of the purchased equipment. We do not pay for equipment or devices not specifically designed and intended for the treatment of an injury or sickness. Required pre-authorization. Including glucometer and insulin pump mention in Law No. 177 of August 13, 2016. Covered for children and adults.

   Pre-authorization is required. If the endocrinologist recommends a specific glucometer due to the treatment utilizes, or order a particular insulin pump due to the necessity of the member, the provider must submit to Humana a justification. Humana will then cover the equipment specifically ordered by the endocrinologist, whether it is a specific glucometer or insulin pump is required.

2. Initial placement of a medically necessary prosthesis and its supportive device, except for those excluded. We will also cover the replacement of such prosthesis if it is determined by the insured's physician to be necessary because of growth or change. Less 25% coinsurance. Required pre-authorization.

3. Orthotics (No cover pre-fabricated, over-the-counter - OTC) and supplemented (No cover over-the-counter - OTC), less 25% coinsurance. Requires pre-authorization.

4. Implants, less 25% coinsurance. Requires pre-authorization.

Ambulance Services

Also an emergency may arise from a call managed thru the 911 System which refer to a dedicated telephone system that is available 24/7 for receiving emergency calls that deal with public security. System 9-1-1 was created by virtue of Law No. 144 dated on December 22nd, 1994 as amended, known as the "Law for rapid response to emergency calls with Public Security" or "Law for calls 9-1-1.

1. Land transportation by an ambulance, between facilities, authorized by the Public Service Commission and the Health Department as mention in Law No. 183 of August 6, 2008, to a hospital or between health facilities, e.g. between a hospital and a radiology institute or between a skilled nursing facility and a hospital, and when ordered by a physician, including psychiatric emergencies. Services requested for psychiatric and medical emergencies through the 911 will be paid in full directly to the provider.
2. Land transportation by an ambulance authorized by the Public Service Commission and the Health Department as mention in Law No. 183 of August 6, 2008, including psychiatric emergencies, less $50.00 copayment per trip.

a. from the insured residence or place of emergency to the Skilled Nursing Facilities or Hospice, when is medically necessaries.

b. From the hospital to the residence, if the condition of the patient discharged requires.

3. Land ambulance services for psychiatric and medical emergencies through 911 will be paid in full by Humana directly to the provider. The service will only cover if the insured meets the following requirements:

   a. The patient suffered an illness or injury for which other types of transportation are not recommended;

   b. Psychiatric emergencies as mention in Law No. 183 of August 6, 2008;

   c. The health condition of the patient does not allow the use of other types of transportation;

   d. It is not a case covered by the Automobile Accident Compensation Administration (ACAA), the State Workmen's Compensation Fund (CFSE) or any other insurance with primary responsibility

4. The general hospital and the psychiatric hospital must both comply with all EMTALA regulations regarding the draft and preparation of a "Protocol for the Process of Transferring Patients" which is here requested and required."

5. Maritime and air transportation services by an ambulance within Puerto Rico, subject to medical need for it, less $50.00 copayment. Pre-authorization is required unless it is a life or death emergency.

Cancer Services and Treatments

1. Ambulatory services for the treatment of radiotherapy and/or chemotherapy, including intravenously, via injection or intrathecally, according to the instructions of the medical doctor or oncologist. Oral chemotherapy is cover under the Pharmacy Coverage Section covered 100%. This is, according to Law No. 107 dated on June 5, 2012.

2. Medically necessary oral and parenteral medication for pain management of patients suffering terminal cancer.

3. All the benefits, including radiotherapy and/or chemotherapy in the hospital services, less $100.00 hospital copayment.

4. Stoma care and maintenance: colostomy, gastrostomy and cystostomy.

5. For the insured who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, the coverage includes:

   a) all stages of reconstruction of the breast on which the mastectomy has been performed

   b) surgery and reconstruction of the other breast to produce a symmetrical appearance

   c) prosthesis and physical complications of mastectomy, including lymphedemas

According to Law No. 275 dated on September 27, 2012, patients with a diagnosis of cancer have the following rights:

- To know and understand their treatment and rehabilitation plans, and the pain management protocol specifically appropriate for their case. The patient with cancer has the right to priority treatment for his/her pain; and is entitled to aggressive pain management techniques based on scientific evidence and approved by the Food and Drug Administration (FDA).

- To receive a copy of their file in an expeditious manner when they wish a second medical opinion or a consultation with another provider.

- The right to information, counseling and guidance regarding the possible short and long term effects on fertility of the cancer itself, and of the diagnostic tests and treatments to be received.

- Continuity in medical care and other health services, such as diagnostic tests for early detection, and access to oncologists, radiation therapists and surgical specialists involved in the initial diagnosis, and in his/her management once regarded a cancer survivor; continuity is necessary for close monitoring against recurrence and adverse effects of treatment, and to maintain physical and emotional health as a surviving patient with cancer.
- To be included in their employer's group healthcare insurance plan with no increase in their premium compared to all other members of the Group, and without exclusion of coverage because of a previous diagnosis of cancer.
- No private insurer can reduce benefits or terminate the policy of a patient with cancer, or that of a child who has survived cancer, as long as the health emergency lasts.
- Elderly patients who have a diagnosis of cancer or who are cancer survivors will be offered clear and up-to-date information about the prevention, detection and treatment of cancer taking into account conditions which might affect communication and their sensory, mobility or cognitive impairments. Elderly patients with a diagnosis of cancer will receive the support appropriate for their age, including but not limited to community support services and psychosocial and palliative services.
- Included as covered services will be pelvic examinations, and all type of vaginal cytology preparations which may be specifically required by medical order to detect, diagnose and treat early anomalies which might lead to cancer of the cervix.
- To provide extended coverage for the payment of studies and tests to monitor cancer of the breast, such as office visits to specialists, clinical breast examinations, mammography and digital mammography, magnetic resonance mammography and sono-mammography, and such treatments as, but not limited to, mastectomies, reconstructive surgery after mastectomy for the reconstruction of the removed breast, the reconstruction of the other breast to achieve a symmetrical appearance, breast prosthesis, treatment of complications at all stages of the mastectomy, including lymphedema (an inflammation which sometimes occurs after treatment for breast cancer), and any other reconstructive surgery after mastectomy which may be necessary for the physical and emotional recovery of the patient.

Maternity Services

The female employee, the wife or cohabitant, and the dependent daughter of any employee covered by the insurance plan for families or couples, will have maternity benefit coverage. The minimum hospital stay for both patient and newborn has been established by Law No. 248 of the Commonwealth of Puerto Rico dated on August 15, 1999, at 48 hours for a normal delivery, without complications, and 96 hours for a Cesarean-section delivery. Hospital discharges prior to length of stays stipulated by the law must have the consent of the patient. The maternity benefit covers a follow-up visit during the 48-hour period following discharge, at which time the newborn infant can also be checked. Services will include, but not be limited to support and physical care for the benefits of the minor, education to both parents on caring for the minor, support and training on breast feeding, orientation on support at home and the performance of any treatments and medicine test both for the infant and the mother.

Covered maternity benefits include the following services:

1. Hospitalization, less $100.00 copayment.
    a. Delivery, including Cesarean Section.
    b. Delivery and recovery rooms.
    c. Nursery and incubator.
    d. Neonatal intensive care unit (NICU)
    e. Fetal monitoring during delivery.
    f. Postpartum sterilization before discharge

2. Ambulatory (unlimited services)
    a. Pre-natal and post-natal care, less $10.00 copayment per visit
    b. Genetic amniocentesis, less 25% coinsurance
    c. Spontaneous abortion
    d. Ambulatory fetal monitoring, less 25% coinsurance
    e. Biophysical profile, unlimited.
3. Vaccines
    a. RhoGam Vaccine, less 25% of coinsurance
    b. Vaccine for the treatment of the Respiratory Syncytial Virus according to Law No. 165 dated on August 30, 2006 and protocol approved by Puerto Rico's Department of Health.
4. Ambulatory sterilization, covered at 100%.

Pediatric Services

1. Unlimited visits, less $10.00 copayment per visit.
2. Well Child Care, less $10.00 copayment per visit.
3. Universal Neonatal Hearing Screening, according to Law No. 311 dated on December 19, 2003, which includes: hearing evaluations for the follow-up treatment needed by the patient.
4. Annual exam according to Law No. 296 dated on September 1st, 2000, which includes: physical and mental evaluation, oral health, hearing and vision screening, and screenings recommended by the American Academy of Pediatrics.
5. Circumcision and dilatation for newborns before discharge from the hospital, at ambulatory facility, or physician office, less $50.00 copayment or $10.00 copayment.
6. Immunizations according to established medical practices and as recommended by the Advisory Committee on Immunization Practices (CDC) and the American Academy of Pediatrics, while included as insured under the policy, Human Papilloma Virus vaccine according to Law No. 255 dated on September 15, 2012. For children who have been sexually abused, the HPV vaccine (HPV) is covered beginning at age nine (9).
7. Coverage for technical equipment of ventilators for children which are vital for the maintenance of life, including children who depend on medical equipment such as respirators or supplemental oxygen, an 8-hour daily shift of a skilled nurse with experience in respiratory therapy or respiratory therapists with nursing experience, the necessary supplies to work with the technical equipment, physical and occupational therapy, laboratories, radiology, and prescribed medications which must be dispensed by a participating pharmacy of our network which is freely selected by our insured, all as authorized by the laws of Puerto Rico as outlined in Law No. 62 dated May 4, 2015, less copayment. For those who have started treatment as minors and become age 21, all the aforementioned services will continue to be covered. This benefit applies also to children who have had a tracheotomy to enable breathing and require home care because of the risk of airway obstruction; this requires a prescription by a physician.
8. Care and treatment of congenital defects and anomalies diagnosed by a doctor, without exclusion due to a preexisting condition. This covers newborns, recently adopted newborns or newborns recently placed for adoption. These services are subject to any applicable copayment or coinsurance.
9. Vaccine for the treatment of the Respiratory Syncytial Virus according to Law No. 165 dated August 30, 2006 and protocol approved by Puerto Rico's Department of Health. Pre-authorization required.

Urgent / Emergency Room Services

Services provided in Urgent / Emergency Rooms will be provided without prior-authorization or waiting period; will be provided regardless if the provider is a participating provider, according to the Law number 194 of August 25, 2000. For services provided in Urgent / Emergency Rooms of non-participant providers, the insured will pay to the provider the same amount as if a participating provider, as long as there is an important and justifiable medical reason for not transferring the patient to a contracted facility.

If Urgent / Emergency services are provided to a patient by a non-participant provider, the patient is not responsible for payment of services that exceed the applicable amount if it had received the services of a participant provider. Humana will compensate the provider that offers the service and it will be obligated to accept such compensation with an amount of not less than the contracted by Humana to offer the same services. In addition, under these circumstances, such Urgent / Emergency services will be provided regardless of the conditions by the health insurance.

If the patient receives health services posterior to the urgent / emergency services, or after being stabilized, and these would normally be covered services except for the fact that they are rendered by a non-participating provider, Humana will reimburse the patient for that part of the costs incurred that would be normally paid by the plan, as long as there is an important and justifiable reason for not transferring the patient to a contracted facility.

Emergencies handled by the 911 system – this refers to the public safety system of urgent / emergency calls through the number 9-1-1.

After the insured individual receives complete urgent / emergency care and stabilization, the facility will transfer the patient to a Humana or Choice Care facility as soon as it is medically possible. Such transfer must not in any way affect the treatment being given or harm the insured patient's health. Humana will assist in the coordination of this transfer, as stipulated in Law No. 194 dated on August 25, 2000.

1. Urgent / Emergency room services due to accidents are covered in full.
2. Urgent room services resulting from illness are covered, less $50.00 copayment
3. Emergency room services resulting from illness are covered, less $50.00 copayment
4. Urgent / Emergency room services' copayment or coinsurance will be waived if patient is admitted; in that case the hospital admission copayment or coinsurance will apply.

For examples of emergency conditions, refer to the definition "Condition of emergency".

Protocol to be followed in the process of transferring patients with psychiatric conditions from one health facility to another.

Regarding an in-patient who presents emotional disturbances in a general hospital or in an urgent / emergency room:

1. Screening and evaluation of the patient will be performed as stipulated in Law No. 35 of 1994 and EMTALA, including all the necessary tests to establish a diagnosis.

2. Organic disease must be ruled-out before reaching a psychiatric diagnosis.

3. During initial evaluation, the general hospital must consider and rule-out the possibility that the etiology of the symptoms of anxiety and agitation presented by the patient at the moment of the emergency are of organic origin.

4. The personnel of the general hospital must consult a mental-health professional to establish continuity of care and obtain permission for transfer from the family or a person properly authorized.

5. The patient is to be stabilized in regard to his/her physical condition or illness. The time spent at the general hospital will depend on the evaluations of organic conditions necessary to establish the state of health of the individual. In cases of poisoning, the general hospital will be responsible for contacting the Poison Control Center in order to determine how long it will take to eliminate the potentially toxic substance taken by the patient. That time-frame will become the minimal period of time for the patient to remain in the urgent / emergency room before transfer to a psychiatric facility.

6. Once the patient's physical condition is stabilized he/she can be transferred to a psychiatric hospital. Simultaneously, the emergency room must send a clear and concise summary to the psychiatric facility of all tests and treatment done, follow-up recommended and information on the physician who attended the patient in the emergency room.

7. The attending physician at the general hospital is responsible for communicating by telephone with the psychiatric facility in order to discuss the case in detail and explain the symptoms and signs presented by the patient to be transferred. At the same time the patient's transfer can be coordinated.

8. The psychiatric hospital must commit to accept the patient to be transferred for further care.

If the patient involved has the economic capacity to pay for the transportation by ambulance or other means necessary for transfer, or has insurance which covers this service, the transportation necessary for transfer will be paid by the patient or his insurance. In such cases the hospital will be paid directly, if it has actually paid for these services; the health insurance plan is responsible for this payment to the hospital. Cases in which the patient is covered for mental health services by the government health insurance. If necessary, and in the absence of other alternatives, transportation will be provided by the ambulances which service the public safety system of emergency calls through 9-1-1. Transportation will be covered from wherever the patient who needs the service is located to whatever hospital facility that can provide the care necessary. Ambulance transportation must comply with the requirements of Law No. 35 of 1994 and EMTALA.

The general hospital and the psychiatric hospital must both comply with all EMTALA regulations regarding the draft and preparation of a "Protocol for the Process of Transferring Patients" which is here requested and required.

NOTE: Urgencies / Emergencies which are secondary to accidents are covered 100%. The urgent / emergency room copayment or coinsurance does not apply if the patient insured is admitted to the hospital; in that case the co-payment of admission to hospital applies.

Psychiatric urgencies / emergencies will be covered with the applicable copayment or coinsurance.

Cardiovascular Procedures

1. Diagnostic Tests and treatment, including the invasive and non-invasive cardiovascular procedures, less 25% of coinsurance.

2. Physician services, less $10.00 office copayment
3. Surgical procedures, less $50.00 facility copayment
4. Repair or replacement of heart valves, pacemaker and any other applicable device, with $0.00 copayment. Defibrillator pacemaker required pre-authorization.

Neurological Procedures

1. Diagnostic tests and treatment, less 25% of coinsurance.
2. Physician services, less $10.00 office copayment
3. Surgical procedures, including neuroendovascular, less $50.00 facility copayment
4. Repair or replacement of valves, and any other medically necessary device, with $0.00 copayment.

Mental Health Services

1. Unlimited visits to professionals, psychology doctors and other providers who because of their education, training or experience, and the proper competency, are able to offer psychological health services, less $10.00 copayment
2. Unlimited office visits to psychiatrist and/or psychologist of children and teens/adults less $10.00 copayment
3. Group therapies, less $10.00 copayment
4. Collateral visits, less $10.00 copayment
5. Unlimited hospital services, less $100.00 admission copayment. Two (2) days of partial hospitalization are equivalent to one (1) day of regular hospitalization.

This service includes emergency psychiatric transportation by an ambulance authorized by the Service Public Commission (*Comisión de Servicio Público*) and the Health Department (*Departamento de Salud*), as stated in Article 4.20 (b) of Law No. 183 of 6 August 2008. Services requested for psychiatric emergencies through the 911 will be paid in full directly to the provider.

Alcoholism & Substance Abuse Services

1. Unlimited visits to professionals, psychology doctors and other providers who because of their education, training or experience, and the proper competency, are able to offer health services in substance abuse, less $10.00 copayment
2. Unlimited office visits to psychiatrist and/or psychologist of children and teens/adults, less $10.00 copayment
3. Unlimited therapies, treatment and follow-up at one or more service levels, which may combine multiple types of therapy, less $10.00 copayment
4. Unlimited residential treatment for alcoholism and substance abuse including detox, less $100.00 copayment.
5. Unlimited hospital services, less $100.00 admission copayment. Two (2) days of partial hospitalization are equivalent to one (1) day of regular hospitalization. Pre-authorization required.

Autism

Autism is recognized as physico-mental health condition. In compliance with Law of Puerto Rico No. 220 dated on September 4, 2012 with the Puerto Rico Department of Health and utilizing as reference the guidelines of the American Association of Pediatrics coverage for these conditions will include diagnostic and therapeutic services in persons diagnosed with disorders within the continuum of Autism.

Covered benefits include visits to physicians and other health providers and the ordered tests and procedures determined to be medically necessary. The specialized services most commonly utilized are related to neurology, psychotherapy, immunology, genetics, gastroenterology, nutrition, speech and language therapy, occupational and physical therapy. Coverage/benefits are not limited only to the previously mentioned services. These services are subject to any applicable copayment or coinsurance, except for the screening for autism for children up to 36 months.

Dental Services

The dental care benefits described below are available using Humana's provider network in Puerto Rico.

Preventive and Diagnostic Services

The following services will be **covered at 100%** In-network:

1. Initial oral examination, one (1) every three (3) years
2. Periodic examination, one (1) every six (6) months
3. Specific oral evaluation, one (1) every six (6) months
4. Complete series of radiographs (FMX), one (1) every three (3) years
5. Panoramic radiographs, up to one (1) every three (3) years
6. Periapical radiographs, one (1) and five (5) additional per policy year
7. Bitewing radiographs, one (1) set every twelve (12) months
8. Prophylaxis adult and child, one (1) every six (6) months
9. Application of fluoride to children up to nineteen (19) years, one (1) every six (6) months
10. Sealants application, limited to children up to fourteen (14) years, one (1) treatment per tooth per lifetime in permanent molars and premolars not previously restored.
11. Application of fluoride varnish for infants and children up to age 5 years, one (1) every six (6) months.
12. Space maintainers, to replace deciduous teeth that are lost permanently, one (1) per area per lifetime.
13. Pulp vitality test, one (1) per visit
14. Re-cementation of space maintainer
15. General anesthesia, administered by an anesthesiologist, and hospital services according to Law No. 352 of December 22, 1999.

Non-Contracted Dentists

If the insured uses the services of a non-participant dentist or facility, Humana will reimburse the insured the fee of the contracted dentist or facility (with the receipt of the payment made to the dentist that provided the service).

Pediatric Vision Care Services

The vision care benefits described below are available until the 21st birthday.

Lenses: One (1) set of lenses per insured, per policy year, with $0.00 copayment. Service is available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers.

- ✓ Lenses for eyeglasses: the lenses included the following selection:
  - CR-39 Plastic for single vision lenses, bi-focal lenses, or tri-focal lenses
  - Polycarbonate for single vision lenses

Frames: The insured can select any frame available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers throughout Puerto Rico with $0.00 copayment. The benefit includes frame from the collection. Coverage includes one (1) frame per policy year.

Contact lenses: Instead of eyeglass benefit (frame and lenses), the member may choose standard disposable contact lenses. The disposable contact lens benefit consists of two (2) boxes per policy year, with $0.00 copayment. Services are available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers.

One (1) pair of low vision eyeglasses or magnifiers as medically necessary for insured with significant loss of vision (low vision), but not total blindness using an exclusive network of Humana Insurance, less $10.00 copayment.

Pharmacy Coverage

What is the formulary?

A Formulary is a prescription drug list developed and approved by Humana and which is regularly evaluated to include or exclude prescription drugs, which is used to determine benefits covered under the pharmacy coverage. The formulary includes generic/bioequivalent, preferred brand, non-preferred brand, and specialty drugs.

The formulary is available in our webpage, Humana.com. There, you can also find information about your prescription medications that may have Utilization Management requirements and the authorization forms with the information required to evaluate them, if applicable. Humana will provide the insured a copy of the formulary, along with information about which prescription drugs are subject to Utilization Management requirements.

Humana will require that the Pharmacy and Therapeutics Committee has an established process, in writing, to consider and update changes in formulary or those that may require Utilization Management, on a timely manner and based on:

- New scientific medical evidence or any other prescription drug related information for covered, non-covered or those that may require Utilization Management, to determine if a change is needed in the formulary or the utilization management criteria;

- if applicable, any clinical information that Humana receives, related to an exception request that would allow the Pharmacy and Therapeutics Committee to determine if the drugs covered in the formulary or those that may require Utilization Management, meet the member's needs, and

- safety and effectiveness information for covered drugs or those that may require Utilization Management, information about prescription drugs that may be clinically similar or bioequivalent, but that are not covered in the formulary nor require Utilization Management, information that may arise from quality assurance activities in the insurance company or information from prescription drug claims received after the latest Pharmacy and Therapeutic meeting.

- Humana will require that the Pharmacy and Therapeutics Committee performs the evaluation of new prescription drugs approved by the Food and Drug Administration (FDA) in no more than a ninety (90) days period, from the FDA approval date. The Pharmacy and Therapeutics Committee should make a determination to include or not include a new prescription drug in the formulary, in a term no more than ninety (90) days from the date the drug is available on the market.

Humana guarantees that the Pharmacy and Therapeutics Committee establishes disclosure policies and requirements in which the identification of possible conflicts of interest between members of the committee and the developers or manufacturers of prescription drugs is contemplated. No member of the Pharmacy and Therapeutics Committee may have any relationship or interest, financial or otherwise, with the developers or manufacturers of the prescription drugs.

Humana guarantees that the Pharmacy and Therapeutics Committee will establish and comply with a written procedure to evaluate medical and scientific evidence related to the safety and efficacy of prescription medications, including information to compare similar prescription medications and bioequivalent, on deciding which prescription medications are to be included in the formulary and on developing other pharmacy benefit management processes. Humana also guarantees that the Pharmacy and Therapeutics Committee will establish protocols for the analysis, and possible inclusion in formulary, of medications for "off-label use" for those health conditions in which, through medical or scientific evidence, the efficacy of the medication has been established.

Pharmacy and Therapeutics Committees must document all their protocols and processes and present registers and documents to Humana upon request.

Humana may contract with other persons to perform the functions of the Pharmacy and Therapeutics Committee. Humana will be accountable to the Commissioner of Insurance for non-compliance and violations incurred by its' Pharmacy and Therapeutics Committee.

Humana will only be able to make changes in the formulary or the Utilization Management while the policy is active; if the change is because of safety, the drug is no longer available in the market, if a new prescription drug will be added in the formulary. If this happened, Humana will notify this no later than when the change is made, to:

- All covered members and
- participating pharmacies, only if the change is because a new prescription drug will be added to the formulary. In this case, Humana will notify thirty (30) days before the change is made.

Humana will meet the following requirements:

Humana will maintain and facilitate the information below to the members, prescribers and pharmacies, by electronic means and if requested by the member or the Pharmacy, written:

- The formulary (prescription drug list) organized by therapeutic categories and the list known as "Maximum Allowable Cost";
- Information about prescription drugs and those that may require Utilization Management, if applicable, which was developed and maintained according to the "Código de Seguros de Salud de Puerto Rico".
- Information about the documentation that may need to be presented by the insured or the personal representative to request a medical exception and the way in which to present this documentation. For details, see Section Application and Process Exception in this Certificate.

How do I use the formulary?

Drugs are listed in the formulary alphabetically.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage based on FDA indications and dosing, like gender, age, and dose limitations. Requirements and limits may include:

- **Prior Authorization (PA):** Humana requires you or your doctor to get prior authorization for certain drugs. This means that your doctor must contact Humana to get approval before you fill or refill a prescription for any drug that needs prior authorization. Your plan benefits won't cover this drug without prior authorization. You'll pay the entire cost of the drug if you decide to buy it.
- **Quantity limits (QL):** For certain drugs Humana limits the amount of the drug that we'll cover. Humana might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. Specialty drugs are limited to a 30-day supply regardless of drug-tier placement.
- **Specialty drugs (SP):** High-cost drugs, including high technology and self-administered injectable medications, requiring special monitoring.
- **This coverage focuses on the use of bioequivalent drugs as a first alternative; however, the insured has the option to choose between a brand drug or a bioequivalent**. If an insured chooses to purchase a brand drug, and an equivalent generic/bioequivalente is available, the insured must pay the difference in cost between the brand and the generic/bioequivalent, plus any applicable brand copay or coinsurance dispensed. If the insured chooses the bioequivalent drug, he or she will only pay the copayment or coinsurance for the bioequivalent drug dispensed. If there is no bioequivalent alternative on the market, the insured will pay the applicable copayment or coinsurance for the brand-name drug dispensed. However, if the physician orders a brand-name drug and writes a prescription as dispensed as written, the insured is responsible only for the copayment or coinsurance of the brand name drug.

What if my drug is not on the formulary?

If your drug isn't included in this printed list of covered drugs, you should visit **Humana.com** to see if your drug is covered. You can also contact Customer Care and ask if your drug is covered.

If Humana doesn't cover your drug, you have two options:

- You can ask Customer Care for a list of similar drugs that are covered by Humana. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Humana.
- You can ask Humana to make an exception and cover your drug. See below for information about how to request an exception.

You are responsible, when applicable, for all or some of the payments for the following:

- The copayment or coinsurance*; and

* If the charge from the pharmacy dispensing the medication is lower than the copayment or coinsurance, you will be responsible for the lesser amount. The amount we pay the pharmacy for the medication might not reflect the final cost to us. Your copayments or coinsurances are made according to the prescription or refill of the prescription and will not be adjusted if Humana gets a discount for volume or a sale on prescription medications.

Pharmacy Annual Deductible

Deductible	Individual	Family
Network Provider	$0	$0
Non-Network Provider	$0	$0

Pharmacy Annual Deductible is the amount that an Individual / Family must pay for calendar year before Humana provides payment for pharmacy covered benefits. The deductible will not apply to Tier 1 Drugs. Once the Individual member in an Individual policy meets the applicable Individual annual deductible, Humana shall provide payment for covered benefits.

For Individual coverage or Family coverage, there is a deductible pharmacy services in-network and a deductible for pharmacy services out-of-network. Pharmacy expenses of benefits you might incur for covered expenses provided by a network provider will apply to the network providers' deductible. Pharmacy expenses you might incur (as provider fee for in-network) for covered expenses provided by out of network will apply to the out of network providers' deductible.

The accumulation period will begin on the effective date of the policy and will end when the policy terminates. From there on, it will be from the renovation date until the policy year end.

Coverage Description

Covered Prescription Drugs List

The following drugs will be covered when prescribed by an authorized doctor:

1. Drugs, medicines or medications that under Federal or state law, may be dispensed only by prescription from a health care practitioner; this includes brand, generic, acute and maintenance medications;
2. Drugs, medicines or medications that are included on the drug list, including the drugs covered by the "Patient protection and Affordable Care Act", like contraceptives, breast cancer risk-reducing medications, among others.

3. Insulin and diabetes supplies;
4. Hypodermic needles or syringes when prescribed by a health care practitioner for use with insulin or self-administered injectable drugs (Hypodermic needles and syringes used in conjunction with covered drugs may be available at no cost to you);
5. Specialty drugs and Self-Administered Injectable Drugs approved by Humana;
6. Spacers and/or peak flow meters for the treatment of asthma;
7. Drugs, medicines or medications on the Women's Healthcare Drug List with a prescription from a health care practitioner;
8. Buprenorphine.

Humana provides for the dispensed of covered drug, regardless of the condition, illness, injury, condition or disease for which they are prescribed, if:

• The drug has FDA approval for at least one indication and

• the drug is recognized for treatment of the disease, illness, injury, condition or disease in question in one of the standard reference compendia or through peer-reviewed medical literature generally accepted.

This drug coverage also includes medically necessary services that are associated with drug administration.

If *you* request a *brand-name medication* when a *generic medication* is available, *your payment* is greater. *You* are responsible for the applicable *generic medication copayment* or coinsurance and 100% of the difference between the amount *we* would have paid the dispensing *pharmacy* for the *brand-name medication* and the amount *we* would have paid the dispensing *pharmacy* for the *generic medication*. If the prescribing *physician* determines that the *brand-name medication* is *medically necessary*, *you* are only responsible for the applicable *copayment or coinsurance* of a *brand-name medication*.

Drugs, Medicines or Medications on the Women's Healthcare Drug List from a N*etwork Pharmacy* are covered in Full (without cost-sharing)

Prescription Drugs Covered without cost sharing from a Network Pharmacy. For more details please refer to drugs list/ formulary.

1. Generic aspirin, for both men and women from 45 to 79 with cardiovascular risk and as prevention of pre-eclampsia: after 12 weeks of gestation in women who are at high risk of pre-eclampsia, both with a medical prescription.
2. Generic folic acid for women planning a pregnancy, with medical prescription.
3. Cancer treatment included within the pharmacy benefit and processed (including oral and auto-administered injectable) in a Network Pharmacy is covered in full, with medical prescription. Intravenously and intrathecally are covered under the Cancer Services and Treatment Section.
4. Breast cancer risk-reducing medications, with medical prescription such as tamoxifen or raloxifene for women who are at increased risk for breast cancer and at low risk of adverse effects to the drug.
5. Smoking cessation drugs, including over-the-counter (OTC), with medical prescription. Covers smoking cessation drugs for 90 consecutive days in an attempt and two (2) cessation attempts per year.
6. Statins in low- to moderate-dose statin for the prevention of cardiovascular disease events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater.

Immunizations for infants, children, and adults are covered through the Medical Coverage in accord with accepted medical practice and as recommended by the Advisory Committee for Immunization Practices (ACIP) of the Centers for Disease Control (CDC), the American Academy of Pediatrics, and are also covered under the vaccination schedule of the Puerto Rico Department of Health.

Benefit Program

The healthcare provider will be able to prescribe maintenance medications to the member with enough refills not to exceed 180 days, according to the plan limitations, when the medical history of the member permits it and no risk are identified.

Contracted/participant pharmacy

Contracted or participant pharmacies are pharmacies that are legally authorized by the relevant authorities, which has signed a contract with Humana to provide pharmacy benefits to its insured.

You are responsible of the following:

Retail Pharmacy / Specialty Pharmacy

Tier 1 Drugs means a category of generic prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 1 drugs.

Tier 2 Drugs means a category of preferred brand prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 2 drugs.

Tier 3 Drugs means a category of non-preferred brand prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 3 drugs.

Tier 3 Drugs: Specialty Drugs means a category of specialty prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 3 drugs.

Tier 1 drugs	$5.00 copayment per prescription or refill per 30-day supply
Tier 2 drugs	15% coinsurance per prescription or refill per 30-day supply with a minimum of $15
Tier 3 drugs	30% coinsurance per prescription or refill per 30-day supply with a minimum of $30
Tier 3 drugs: Specialty drugs	30% coinsurance per prescription or refill per 30-day supply with a minimum of $30

Note: This plan has a Max Allowable Benefit of $1,200. After this monetary maximum for prescriptions has been reached in disbursements by Humana, the member will be responsible for a 95% coinsurance for all prescriptions until the end of the policy year.

Specialty Drugs through Medical Coverage

Benefits:

A. When medically necessary, specialty drugs administered in a professional setting, including office or infusion center, are covered less the applicable copayment or coinsurance of the specialty drugs in the pharmacy coverage.
B. All utilization requirements of the pharmacy coverage, including but not limited to pre-authorization or quantity limits, shall apply.

90 days program

The retail pharmacies participate in our program which allows you to receive a 90-day supply of a prescription or refill. Your cost is 3 times the applicable copayment or coinsurance as outlined above. Self-administered injectable drugs and specialty drugs are limited to a 30-day supply from a retail pharmacy or specialty pharmacy.

Mail Order Pharmacy

This is a service that delivers medications by mail. It applies to prescriptions or refilled prescriptions covered in the policy.

For up to a 90-day supply of a prescription or refill	2 times the applicable copayment or coinsurance, as outlined above under Retail Pharmacy / Specialty Pharmacy

Mail Order Process:

Your health and well-being is very important to us. Please note that Humana Pharmacy can offer the value and services that you expect from your pharmacy. The routine process to be followed in procuring your maintenance medications by mail is easy and saves time.

The first time you use mail order to receive your medication, ask your doctor for two prescriptions. The first prescription should be written for a one-month supply that can be immediately filled at a participating retail pharmacy. The second prescription should be written for a 90-day supply of the medication with refills and the doctor will send it to Pharmacy Solution. You can use the service for all your maintenance medications.

1. Humana Pharmacy receives the request to fill your prescription. Your physician provider can actually send your prescription by fax (1-800-379-7617), through the telephone (1-800-833-1315-TTY: 711), by filling out a form designed for this purpose (Registration form for prescriptions by mail), onsite at HumanaParmacy.com, or by mail (Humana Pharmacy, PO Box 745099, Cincinnati, OH, 45274- 5099).
2. Humana Pharmacy verifies your pharmacy benefit coverage, enters your order and creates an exclusive shipping number.
3. The Humana pharmacist then reviews the order for a prescribed medication to verify that it is correct and complete. If it is incomplete or incorrect, it is returned with the reason for the rejection.
4. The Humana pharmacist approves the prescription.
5. After approved, the prescription then goes through the billing process.
6. An automated system fills your prescription and a pharmacist verifies that each medication is correct.
7. The prescription is filled in a period of seven (7) to ten (10) days of the time when Humana Pharmacy first received the request for your medications.

Out-Of-Network Pharmacy

When an *out-of-network pharmacy* is used, *you* must pay for the *prescription* or refill at the time it is dispensed. *You* must file a claim for reimbursement with *us*. In addition to any applicable *copayments coinsurances*, *prescription drug deductibles*, *you* are responsible for 30% of the *default rate* (the contracted fee that Humana agreed to pay a pharmacy within the network of providers for a drug) *and* the difference between the *default rate* and the *out-of-network pharmacy's* charge. Example: A pharmacy non-participant has a drug charge of $ 70.00 and the default rate is $50.00, the insured will be responsible for $ 15.00 (30% of the default rate-$ 50.00) plus $ 20.00 which is the price difference between the default rate ($50.00) and the charge of the drug in non-participating

pharmacy ($70.00), plus the copayment that has that drug at a contracted pharmacy or coinsurance of the default rate. Any amount *you* pay over the *default rate* and any applicable *copayments*, coinsurances, *pharmacy annual deductible* and percentage amounts *you* pay to an *out-of-network pharmacy* do not apply toward *your maximum out-of-pocket* or any maximum *out-of-pocket*, if any. The charge received from an *out-of-network pharmacy* for a *prescription* or refill may be higher than the *default rate.*

Prior authorization

A prescription drug that is safe and effective for one person may not be safe and effective for another. This is why certain drugs must go through an evaluation and authorization process at Humana before they can be dispensed to members. This process is based on the evaluation of clinical standards for its safe use. The United States Food and Drug Administration (FDA) has recommended these drugs as safe and effective, but due to a high level of concern about their appropriate use, therapeutic indication, and cost, Humana's National Pharmacy and Therapeutics Committee has decided that a prior-authorization must be obtained for dispensing and use. To request coverage for a drug with prior authorization, the physician can contact the Humana Clinical Pharmacy Review (HCPR) at 1-866-488-5991 or by fax 1-855-681-8650

Prior authorization process:

The Humana Clinical Pharmacy Review (HCPR) will receive calls from providers requesting authorizations related to clinical review.

- Requests that require clinical review will be evaluated by the Humana Clinical Pharmacy Review (HCPR) staff. Decisions will be made according to approved clinical protocols established by the Humana's Pharmacy and Therapeutics Committee, as applicable.

- If the request is approved, the authorization is added on Humana's claim processing system. Then, the decision is notified to the person or entity who requested the authorization, whether the member, the physician, or personal representative.

- Requests that do not meet clinical criteria are denied and the decision is notified to the person or entity who has requested the authorization, whether the member, the physician, or the personal representative.

- If additional information is required to complete the evaluation of the request, a prior authorization form will be sent to physician's office by fax. If there is no fax available at physician's office it will be sent to pharmacy.

Humana Clinical Pharmacy Review (HCPR) will evaluate the request for authorization in a period not exceeding 72 hours after being received. In those cases where the physician requesting the case to be worked as expedited because the member's health could be affected, request will be evaluated in a period not exceeding 24 working hours.

Exception request and process

How do I request an exception to the formulary?

You, your physician, or your Personal Representative can contact Humana to ask for an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it's not on our formulary.
- You can ask us not to apply coverage restrictions or limits on your drug. For example, if your drug has a quantity limit, you can ask us not to apply the limit and to cover more.

- Continuum of coverage for a specific prescription drug that Humana will remove from the formulary for reasons other than health or because the drug is no longer available or because the manufacturer removed it from the market; or
- An exception to Utilization Management criteria that indicates the drug may not be covered in the prescribed quantity.

Your doctor should contact us to ask us for an initial coverage decision for a formulary or utilization restriction exception. We must make our decision within 72 hours of getting your prescribing doctor's supporting statement. For controlled medicines, the term should not exceed thirty-six (36) hours after getting your prescribing doctor's supporting statement.

The member or your appointed representative will only be able to make a request in writing, if the physician or other prescriber has determined that the requested medication is medically necessary for the treatment of the disease of the member because:

a. There is no covered prescription drug in the plan's formulary that is a clinically accepted alternative to treat the member's disease:
b. The prescription drug alternative(s) listed on the formulary:
    i. Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
    ii. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
c. The number of doses available under a dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

The following information would be required as part of the supporting statement in an Exception request:

- Name , group number or policy ID, member ID;
- Patient's history
- Primary diagnosis, related to the requested prescription medication
- Reason why:
    - The covered prescription drug would not be an acceptable alternative for this member; or
    - The prescription drug alternative(s) listed on the formulary or required to be used in accordance with requirements would not be acceptable for this member; or
    - The number of doses available under a dose restriction for the requested prescription drug would not be acceptable;
- Reason why the Exception request is needed, for either the requested prescription drug or the limit of available doses.

Exception requests will be evaluated by appropriate healthcare professionals, according to the member's condition; who will consider specific facts and circumstances within each case and use clinical criteria that is:

- Based on scientific, clinical evidence based medicine; and
- If available, clinical practice guidelines, which may include, evidence based practice guidelines, clinical criteria developed by Humana's Pharmacy Committee or any other practice guidelines that may have been developed by the federal government, national associations or medical/pharmacy professional associations.

Experienced healthcare professionals will evaluate Exception requests according to the member's coverage - pharmacy benefit and exclusions.

If a medical exception is granted, Humana will provide coverage for the requested medication and will not require that the member requests an approval for a refill, nor for a new prescription, in order to continue using the same prescription drug after the refills of the first prescription run out. This is subject to the coverage terms and provided that:

a. The prescribing physician continues prescribing the medication for the same disease or medical condition;
b. The prescription drug continues being safe for the treatment of the member's disease or medical condition.

Humana will not establish a new or special formulary tier, copay for any other cost-sharing requirement that would only apply for the prescription drugs approved through the Exception process.

All denials for an exception request by Humana:

a. Will be notified to the member or the appointed representative, in writing, or by electronic means, if the member has agreed to receive the information that way;
b. Will notify, by electronic means, to the physician or other prescriber, as requested, in writing; and
c. It may be appealed through an appeal request, according to the Section Procedures to Address Complaints, Grievances and Appeals of the Policy.

The denial will describe in a comprehensible way for the member or the personal representative, if applicable:

a) The specific reason for the denial;

b) references to the evidence and documentation, which include the clinical criteria for evaluation and practice guidelines, clinical, medical and scientific evidence that was used and considered to make a denial determination for the request;

c) instructions on how to request a written statement for the clinical, medical and scientific justification of the denial; and

d) a description of the process and procedures to request an appeal for the decision, according to the Section Procedures to Address Complaints, Grievances and Appeals of the Policy, including the timeframes for these procedures.

If Humana does not make a decision with respect to the request for exception, or does not notify it in the above mentioned timeframe:

- The insured shall be entitled to be provided with the prescription drug that is the object of the request for up to thirty (30) days; and
- Humana shall make a decision with respect to the request for exception prior to that time when the insured finish the medication provided.
- If the insured finishes the medication provided, Humana shall maintain coverage under the same terms and in a continuous manner, so long as the same medication is prescribed to the insured and it is deemed safe for the treatment of the illness or medical condition, unless applicable limits to benefits have been exhausted.

If the member is not satisfied with Humana decision, he/she has the right to appeal it; following the Procedure to address Complaints, Grievances and Appeals that is part of the Policy and this Schedule of Benefits.

Other Benefits

Ambulatory Services

1. SPECT test, less 25% of coinsurance. Pre-authorization required.
2. Cardiovascular rehabilitation services at a dedicated center. Includes services by licensed physicians and registered nurses. Rehabilitation program must include education and supervised exercises that lead to risk factor recognition and management and improved exercise capacity. This benefit does not include maintenance exercise programs. Program must not exceed twelve (12) sessions in duration, less $100.00 copayment. Pre-authorization required.
3. Orthopedic devices: casts, splints, braces and crutches, with $0.00 copayment.
4. Laparoscopy, covered at ambulatory facility or at hospital, less $50.00 ambulatory facility copayment, $100.00 hospital copayment per rendered service.
5. Adult circumcision, less $10.00 office visit or $50.00 facility copayment.
6. Breast biopsies, unlimited, less $50.00 facility or $100.00 hospital copayment.
7. Allergy vaccines, up to a maximum of twenty (20) per insured, policy year, less 25% coinsurance.
8. Epidural blocks for pain management administered by medically qualified and recognized specialist, one (1) per anatomical region per insured per policy year, less $10.00 copayment.
9. Maxillofacial surgery, diagnostic and therapeutic services for accidental injuries, jaw fractures, neoplasms, injuries to natural teeth, including their replacement within a period of six months following an accident, provided the insured was covered by the policy when the accident occurred, less $100.00 copayment. Pre-authorization required.
10. Assistant Surgeon, when medically necessary: pre-notification required. Less applicable 25% coinsurance.
11. Reconstructive surgery for injuries due to an accident while the insured is covered under the policy and is not covered under any other program (ACAA, FSE, etc.), less $100.00 copayment.
12. Diagnostic tests and treatment associated with Hepatitis C, unlimited, less 25% coinsurance.
13. Diabetes paraphernalia for children and adults: lancets, syringes for insulin administration and glucometer strips up to a maximum of one hundred and fifty (150) of each one per month, less 25% coinsurance.
14. Hyperbaric Oxygenation treatment for people diagnosed with autism spectrum disorder, provided that it is recommended by a certified medical professional or health professional and the treatment is allowed by federal laws and regulations, as provided by Law 63 of July 19, 2019. Less $50.00 facility or $100.00 admission copayment.

Employee Assistance Program (EAP)

The program is offered by [Inspira, Lucy Lopez Roig, APS OptiMind] and includes the following:

1. Counseling, support, guidance and brief psychological therapy for life situations, including labor problems, emotional problems, relationships, and alcohol or drug abuse, covered at 100%, [Up to sixteen (16) sessions per policy year for each insured. Sessions are divided between the employee and dependents; eight (8) sessions for the employee and eight (8) sessions for dependents - Up to eight (8) visits per situation per insured – Unlimited]. Sessions may include the following:
    - crisis intervention

- initial evaluation
- marital or family counseling
- referral to appropriate mental health resources when indicated for specialized treatment or assistance, including long-term therapy or psychiatric treatment.

2. Special crisis intervention services in case of catastrophic or traumatic events at the work-site.
3. Financial advice
4. Legal advice
5. Implementation orientation to administration and personnel
6. Workshops and orientations for employees
7. [Up to 10 occupational evaluations per employee]

Hospice

Hospice Care Program means a coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill insured and his or her insured family members, by providing palliative and supportive medical, nursing and other services through at-home or inpatient care. The hospice must be licensed according to the laws of the Commonwealth of Puerto Rico. It must provide a program of treatment for a person who have been medically diagnosed as having no reasonable prospect of cure for their illness and, as estimated by a physician, are expected to live less than six (6) months as a result of that illness.

Humana will pay benefits for charges for a hospice care program, which is submitted in writing and approved by us. The insured must submit in writing his or her intent to enroll in a hospice care program approved by us. Hospice benefits are subject to the applicable copayment. All the hospice services are subject to $100.00 admission copayment. All services must be received within a twelve (12) month period. Pre-authorization required.

Organ and Tissue Transplant

We will pay benefits of a Covered Organ Transplant as defined below, incurred by an insured for an organ transplant approved in advance by Humana, subject to those terms, conditions and limitations described below and contained in the group policy. These services are subject to any applicable copayment or coinsurance. Please contact the company's Transplant Management Department when in-need of these services.

Covered Organ Transplant means only the services, care, and treatment received for or in connection with the pre-approved transplant of the organs identified hereafter, which are determined by Humana to be medically necessary services and which are not experimental or investigational.

The covered organ transplant includes pre-transplant, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation of the following organs or procedures only:

a) Heart;
b) Lung(s);
c) Heart-lung;
d) Liver;
e) Kidney;
f) Bone Marrow;
g) Intestine;

h) Simultaneous pancreas/kidney;
i) Pancreas following kidney;
j) Any organ not listed above required by state or federal law.

The term bone marrow identified in the foregoing covered organ transplant definition refers to the transplant of human blood precursor cells which are administered to a patient following high dose, ablative or myelosuppresive chemotherapy. a) Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. b) If chemotherapy is an integral part of the treatment involving a covered organ transplant of bone marrow, the term bone marrow includes the harvesting, the transplantation and the chemotherapy components. c) Storage of cord blood and stem cells will not be covered unless as an integral part of a covered organ transplant of bone marrow approved by Humana.

For a covered organ transplant procedure to be considered totally approved, a written authorization by Humana is required.

a. The insured or his/her physician must notify Humana in advance regarding the need for an evaluation to determine if the organ transplant will be covered. Within five working days of the receipt of this request, Human will contact the insured and his/her physician to clarify transplant benefits available under the insurance, if any.

b. If the product includes benefits of organ transplants, and once the insured has chosen the facility for transplant, Humana proceeds to approve a pre-transplant evaluation.

c. The transplant facility proceeds with the evaluation of the candidate for transplant and must submit to Humana for review seven (7) specific points or articles evaluated.
d. Humana then reviews the clinical results of the facility's evaluation, confirms eligibility, and proceeds to approval on the same day.

e. For solid organ transplants, no medical review is necessary by Humana; bone marrow transplants do require a medical review for final determination.

f. If the transplant is denied, the insured and the physician will receive oral and written explanations of their rights to appeal through the Complaints, Grievances and Appeals system of Humana.

Covered Services:

For approved covered Organ Transplants and all related complications, we will cover only the following expenses:

1. Hospital benefits shown in the schedule of benefits under the Hospital Services section of the group policy will be paid at: (a) 100% of reasonable charges if received at a participating hospital designated by us as an approved transplant facility; and (b) 70% of reasonable charges if received at non-participating hospital.

   Physician benefits shown in this Schedule of Benefits under the Ambulatory Services section of this group policy will be paid at (a) 100% of reasonable charges if received from a participating physician designated by us as an approved transplant provider; and (b) 70% of reasonable charges if received form a non-participating physician.
2. Organ acquisition and donor costs. (a) Except for Bone Marrow transplants, donor costs are not payable under the group policy if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. (b) Coverage for Bone Marrow transplant procedures will include costs associated with donor-patient to the same extent and limitations associated with

the insured, except the reasonable costs of searching for the donor may be limited to the immediate family members and the National Bone Marrow Donor Program.

3. Direct non-medical costs* for the insured receiving the covered organ transplant will be paid for: (a) transportation to and from the hospital where the covered organ transplant is performed; and (b) temporary lodging at a prearranged location up to $75.00 per day when requested by the hospital and approved by Humana.

   Transportation costs for the insured to and from the hospital where the covered organ transplant is performed will be paid at: (a) 100% of the reasonable charges if the covered organ transplant is received at a participating hospital designated by Humana as an approved transplant facility; or, (b) 70% of reasonable charges if the covered organ transplant is received at a non-participating hospital.

   Coverage of *non-medical cost will be available only if the insured will travel to the United States for transplant.

4. Direct non-medical costs* for one member of the insured's immediate family (two members if the patient is under age 18 years) will be paid for: (a) transportation to and from the approved facility where the covered organ transplant is performed; and (b) temporary lodging at a prearranged location during the insured's confinement in a hospital, not to exceed $75.00 per day.

   Transportation costs for the insured's immediate family member(s) to and from the hospital where the covered organ transplant is received.

   Coverage of non-medical* will be available only if an immediate family member(s) accompanies the patient to the United States for a transplant.

*All direct non-medical expenses for the insured receiving the covered organ transplant and his/her family member(s) are limited to a combined maximum coverage of $10,000.

Exclusions:

No benefit is payable for or in connection with a covered organ transplant if:

1. We are not contacted for authorization prior to referral for evaluation of the covered organ transplant, unless such authorization is waived by Humana.
2. We do not approve coverage for the covered organ transplant, based on our established criteria.
3. Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received.
4. The expense related to the transplantation of any non-human organ or tissue, unless otherwise stated in the group policy.
5. The expense related to the donation or acquisition of an organ for a recipient who is not covered by Humana.
6. A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow up care, immunosuppressive drugs, and complications of such transplant.
7. The insured for whom a covered organ transplant is requested has not met pre-transplant criteria as established by Humana.

Once the covered organ transplant is approved, we will advise the insured's physician. Benefits are payable only if the pre-transplant services, the covered organ transplant and post-discharge services are approved by Humana.

Services Out of Puerto Rico

Services rendered on the United States of America:

If insured needs a procedure, treatment, test or office visit in the United States as a second opinion, follow up treatment or because the treatment is not available in Puerto Rico, can submit evidence of the incurred expenses, we will reimburse according the established rates for each treatment in Puerto Rico. Apply the copayment or coinsurance of the benefit described in the policy. Pre-authorization required.

These do not include benefits not available in Puerto Rico, available in the United States of America. For these benefits, refer to Section Service Not Available in Puerto Rico, Available in the United States.

Emergency Services Outside Puerto Rico

I. Emergency Services (Including emergency hospitalizations) received in the United States of America:

A. Services received in contracted Humana or ChoiceCare facilities:

1. Whenever possible emergency services should be received in a facility contracted with the Humana or ChoiceCare Networks.
2. Humana P.R. must receive notice of all emergency services within 72 hours of the insured receiving the services.
3. Payments for emergency services and related admissions provided by a contracted provider will be paid according to the Urgent / Emergency Room Services Section under this Schedule of Benefits, less $50.00 copayment.

B. Services received outside of contracted Humana or ChoiceCare facilities:

1. For services provided in emergency rooms of non-participating providers, payment will be the same as if a participating provider, less $50.00 copayment.
2. The physician must receive notice of all emergency services within 72 hours of the insured receiving the services.

   The attending physician may transfer the insured to a contracted facility as soon as medically feasible. Such transfer should in no way compromise or be detrimental to the insured's medical condition or treatment. Humana will assist in the coordination of such transfer.

II. Emergency Services received outside the United States of America or Puerto Rico:

A. The insured will be reimbursed 100% of the contracted fee for similar services by a provider in Puerto Rico or, billed charges, whichever is less, less $50.00 copayment.

1. If the insured requires hospitalization and cannot be transported to a contracted facility in Puerto Rico or the United States, Humana will attempt to negotiate the best possible fee with the non-participating facility for the benefit of the insured.

2. If the insured can be transported without risk to a participating facility in the United States or Puerto Rico, then the admission copayment or coinsurance only will apply from this point forward.

All claims for services rendered outside of Puerto Rico or the United States must be submitted to Humana with all supporting medical and financial records within a period of one (1) year from the date of service or date of discharge (whichever is later) to ensure reimbursement where applicable.

Ambulatory Services for Dependent Studying in College in the United States of America

Dependent studying in college in the United States of America, as included in the definition of direct dependent, (b) through (g), can receive coverage for covered services provided by contracted providers in the United States. To receive coverage the following conditions must be met:

- The dependent studying college degree, in accordance to the definition of dependent indent (b) through (g), must be eligible for coverage, under the Plan and the ambulatory services received in the United States must be covered services under the Humana PPO Policy.
- The insured university student must be a full-time student at an accredited university in the United States. For purposes of this requirement, it will be presumed that the student is full-time if he/she studies twelve (12) credits; six (6) credits in the case of students studying graduate studies. Any exception to this assumption of credit requirements must be certified by the university institution.
- The dependent college student must coordinate and obtain prior authorization from Humana P.R. for the services unless the services meet criteria for urgent or emergency treatment as set forth in the Policy.
- Services provided by a provider in the Humana or ChoiceCare provider network shall be paid according to the benefits under the Policy. Any copays, coinsurance and/or deductibles set forth in the policy applicable to the benefits shall apply.

If the service is rendered by a provider not participating in the Humana or ChoiceCare network, the service will the service will be reimbursed based on contracted fees for similar services in Puerto Rico, less applicable copayments, coinsurances and deductibles. The insured is responsible for the difference between the Humana contracted rate in Puerto Rico and the facility billed charges.

Important:

1. ChoiceCare is a network of providers, including physicians and hospitals, contracted by Humana in the United States. The insured does not need to contact ChoiceCare to access a covered service. The logo on the card will be the identifier to the provider. Since the services require pre-authorization and coordination, Humana will help the insured identify the appropriate provider or facility. A full ChoiceCare directory is available on the web at www.humana.com.
2. For coordination or pre-authorization the member should call Humana's Customer Service Department at 1-800-314-3121.

Services Not Available in Puerto Rico, Available in the United States of America

This benefit is for services not available in Puerto Rico, available in the United States of America, including equipment, treatment and facilities, among others.

A. Humana will cover such services only if the following five conditions are met.

   1. The Insured must be eligible for coverage under the Plan and the services requested must be Included this Schedule of Benefits.

   2. The provider referring must demonstrate that the equipment, treatment or facilities required to provide medically necessary covered services to the insured are unavailable in Puerto Rico**.** A service will not be deemed unavailable in Puerto Rico if the request for services to be provided outside of Puerto Rico involves a modification to the equipment, technique, or surgical approach

available in Puerto Rico or is based on the reputation or recognition of any given provider.

3. The service must be coordinated and pre-authorized with Humana in Puerto Rico at least five (5) working days prior to the date the service will be rendered.

4. The service must be provided by Humana or ChoiceCare network providers/facilities.

5. All services under this Section are subject to the applicable copayments and coinsurances for services as described in this Schedule of Benefits.

B. These services or treatments require pre-authorization with Humana, except in emergencies. If the service or treatment is not authorized by and coordinated with Humana in Puerto Rico, the insured will be responsible for the entire payment for such service or treatment. Humana will reimburse the patient based on the applicable Humana fee in Puerto Rico, less applicable copayments or coinsurances as described in this Schedule of benefits only if conditions A1, A2 are met. To receive reimbursement, the insured must provide Humana with all supporting medical and financial information within one (1) year of service or discharge.

Important Notes:

1. ChoiceCare is a network of providers, including physicians and hospitals, contracted by Humana in the United States. The insured does not need to contact ChoiceCare to access a covered service. The logo on the card will be the identifier to the provider. Since the services require pre-authorization and coordination, Humana will help the insured identify the appropriate provider or facility. A full ChoiceCare directory is available on the web at www.humana.com.

2. For coordination or pre-authorization the member should call Humana's Customer Service Department at 1-800-314-3121.

Telemedicine Service
(Virtual Medical Consultation)

Benefit:
Telemedicine service through virtual medical consultation to the insured allows you to receive access to health or minor emergency consultations with a certified primary care physician for the practice of Telemedicine in accordance with Act No. 168 of 2018. Less $20.00 copayment per virtual medical consultation. Through the following website: **www.mdlive.com/humanapr.**
As part of the services of this virtual platform, the insured can also share medical results of their studies.

In cases where the doctor understands that he or she needs medication use according to the insured's clinical picture, the prescription will be coordinated directly to the insured's preferred pharmacy through one of our contracted provider pharmacies.

This Telemedicine service does not replace your doctor, if you have an emergency, it is important that you call the emergency system at 911 or visit the nearest emergency room.

If the doctor determines that the condition by which the insured accesses the virtual consultation cannot be attended through this service, the insured will be immediately referred to an emergency room or personal doctor.

The insured is responsible for verifying their certificate of benefits, description of benefits and / or the medication form to verify if the service is covered.

Medical Exclusions

1. Procedures and/or health services in an experimental or research stage which are not supported by clinical evidence documented in the medical literature of the United States of America, except in connection with a life-threatening condition of the insured for which no effective treatment is available. Humana will pay only for the routine medical expenses associated with the order of such procedure or service which are not reimbursed by the entity conducting the service.
2. Expenses related to illness or injury resulting from war or uprisings.
3. Correspond Services be received, according to the State Workmen's' Compensation Fund Law (*Ley del Fondo de Seguro del Estado*), liability of the insured, private compensation plans at work, car accidents (Automobile Accident Compensation Administration (*Administración de Compensación por Accidentes de Automóviles*, ACAA, for its Spanish acronym).and other services available under state or federal laws. They will also be excluded such services when they are denied by government agencies concerning non-compliance or violation of the requirements or provisions of the above laws, although such failure or violation does not constitute a crime.
4. Expenses caused by military service, war, civil insurrection, international armed conflict, except in those cases where the services received are related to an injury sustained while the insured was active in the military (service connected), in which case Humana will collected such charges from the U.S. Department of Veterans Affairs.
5. Accidents occurring while the insured is participating in races such as: automobile, motorcycle, four-track, boats or other tests of speed, in areas set aside for such activities or any other place.
6. Services provided and/or covered pursuant to state or federal legislation for which the Insured is not legally required to pay.
7. Services received free of charge, rendered by the spouse, parents, siblings, or children of the Insured.
8. Hospitalizations for procedures which can be performed on an ambulatory basis.
9. Hospitalization for diagnostic purposes only; custodial, rest or convalescence services.
10. Services rendered at a time when the policy is not in effect.
11. Electronic prosthesis, including myoelectric arm and cochlear implant, and the removal or insertion of any device, and any other described as non-covered, except the breast prosthesis covered in case of mastectomy.
12. Services considered unreasonable or medically unnecessary for diagnosis or treatment of an illness or injury.
13. Expenses for custodial services, private nurses, personal commodity services such as telephone, television, etc. and all medical services or expenses in convalescence facilities, except for home healthcare services which have been authorized by Humana.
14. Music therapy
15. Cosmetic/esthetic maxillofacial and dental procedures.
16. Esthetic mammoplasty except as applicable in Woman's Rights Cancer Act, and the esthetic mammoplasty in accordance with the Law No. 275 dated on September 27, 2012.

17. Cosmetic/esthetic surgery, except septoplasty when medically justified and with prior authorization.
18. Repair or replacement of instruments or prosthetic devices due to normal wear and tear and impairment.
19. Corrective footwear.
20. Services, treatments, and therapies of alternative medicine by physicians or other certified trained professionals, except naturopathic physician visits.
21. Sports medicine.
22. Eyeglasses and contact lenses for adults, hearing aids.
23. Congenital or genetic deformities and metabolic deformities, except in newborns, recently adopted newborns or newborns recently placed for adoption.
24. All services and/or treatments related to infertility or impotence, except test to detect infertility.
25. Expenses for Physical Examinations to adults required by the employer or health certificates for any type of license and all diagnostic tests or services for these purposes. Except for the annual exam according to Law No. 296 dated on September 1st, 2000, which includes: physical and mental evaluation, oral health, hearing and vision screening, and screenings recommended by the American Academy of Pediatrics.
26. Elective abortions.
27. Acne surgery and acne treatment, including drugs.
28. Growth hormones and all related treatment.
29. Embryo transplantation.
30. Human chorionic gonadotropin (HCG) injections.
31. Vaccinations required for travel.
32. Tuboplasty, vasovasostomy, and any procedure or service for the purpose of fertility.
33. Sickness or injury caused by the insured engaging in an illegal occupation; or committing or attempting to commit a criminal act, except those injuries resulting from an act of domestic violence or medical condition.
34. Enrollment in a health, athletic, or similar club; or a weight loss or similar program.
35. Purchase or rental of supplies of common household use such as: exercise cycles; air purifiers; central or unit air conditioners; water purifiers; allergenic pillows or mattresses; or waterbeds. Except for technical equipment of ventilators for children which are vital for the maintenance of life, including children and those who have started treatment as minors and become age 21, who depend on medical equipment such as respirators or supplemental oxygen, as authorized by the laws of Puerto Rico as outlined in Law Number 62 dated May 4, 2015.
36. Purchase or rental of: motorized transportation equipment; escalators or elevators; saunas or attachment pools; professional medical equipment such as blood pressure kits; or supplies or attachments for any of these items.
37. Expert witness required by a Court that is not included under the benefits or requirements of the mental health law.
38. Services and supplies for treatment of temporomandibular joint disorder or dysfunction (TMJ) and craniomandibular jaw disorders (CMJ) which are recognized as dental procedures. This includes, but is not limited to, the extraction of teeth and the application of orthodontic devices and splints.
39. New diagnostic and therapeutic services/procedures that are done with approved FDA equipment/devices that become available posterior to the effective date of the policy. Unless, the insured suffers from a life-threatening condition for which there is no effective treatment. Humana would then pay for routine medical expenses of the patient which are not covered by the entity carrying out the study.
40. Epidural anesthesia during delivery.

41. Air and maritime ambulance services outside of Puerto Rico, except for dependent studying in the United States
42. Any and all services or treatments not specifically described as covered benefits, except for the services and benefits included in a law that are required to be included in the coverage.

Dental Coverage Exclusions

1. Services or treatments presented for beauty or cosmetic reasons.
2. Services received free of charge; services rendered by spouses, parents, brothers/sisters or children of the insured.
3. Experimental or investigative procedures and/or services, or the drugs related to them.
4. Services rendered before the effective date of the policy.
5. Expenses related to injuries caused by war or disturbances.
6. Illnesses or accidents covered by the State Insurance Fund law -*Ley del Fondo del Seguro del Estado* (FSE) and/or the Automobile Accidents Compensation Administration -*Administración de Compensaciones por Accidentes de Automóviles* (ACAA).
7. Any benefit or service not specified in the dental coverage.
8. Services not used during the policy year do not accumulate for the following year.

Vision Coverage Limitations and Exclusions

1. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
2. Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan
3. Services provided as a result of any worker's compensation law (*Ley del Fondo del Seguro del Estado* -FSE) and/or the Automobile Accidents Compensation Administration (*Administración de Compensaciones por Accidentes de Automóviles* - ACAA).
4. Lenses or vision devices that are not prescribed.
5. Unspecified contact lenses on the vision coverage.
6. Any other frame that is out of the collection.
7. Any treatment or service that is not specified on the vision coverage.

Pharmacy Coverage Limitations and Exclusions

1. Legend drugs which are not deemed medically necessary by us;
2. Any drug prescribed for a sickness or bodily injury not covered under the policy;

3. Any drug, medicine or medication labeled "Caution-limited by federal law to investigational use" or any experimental or investigational drug, medicine or medication, even though a charge is made to you; not covered:
    a. Medications used in research trials which have the sponsorship of manufacturers or government entities.
    b. Medications or services offered during research trials when the sponsor of such tests offers these services and medications at no cost to the participants
4. Allergen extracts(covered under the Medical Coverage);
5. Therapeutic devices or appliances including, but not limited to:
    A. Hypodermic needles and syringes (except needles and syringes for use with insulin, and self-administered injectable drugs whose coverage is approved by us);
    B. Support garments;
    C. Test reagents;
    D. Mechanical pumps for delivery of medications; and
    E. Other non-medical substances;
6. Dietary supplements; (except for formulas or low protein modified foods necessary for the treatment of phenylketonuria or certain other heritable diseases of amino and organic acids);
7. Nutritional products;
8. Minerals;
9. Herbs and vitamins, except Vitamin D, prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride, OTC Ferrous Sulfate which are covered for Women's Preventive Healthcare;
10. Anorectic or any drug used for the purpose of weight control;
11. Any drug used for cosmetic purposes, including but not limited to:
    A. Tretinoin;
    B. Dermatologicals or hair growth stimulants; or
    C. Pigmenting or de-pigmenting agents, e.g. Solaquin;
12. Any drug or medicine that is:
    a. Lawfully obtainable without a prescription (over the counter drugs), except insulin
13. Progesterone crystals or powder in any compounded dosage form;
14. Abortifacients (drugs used to induce abortions);
15. Infertility services including medications;
16. Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra;
17. Any drug, medicine or medication that is consumed or injected at the place where the prescription is given, or dispensed by the health care practitioner;
18. Prescriptions that are to be taken by or administered to you, in whole or in part, while you are a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:

A. Hospital;

B. Skilled nursing facility; or

C. Hospice facility;

D. Physician office (unless coverage is approved by us)

19. Injectable drugs such as:

    A. Biological sera (covered under the Medical Coverage)
    B. Blood (covered under the Medical Coverage)
    C. Blood plasma (covered under the Medical Coverage)

20. Prescription refills:

    A. In excess of the number specified by the health care practitioner; or

    B. Dispensed more than one year from the date of the original order;

21. Any portion of a prescription or refill that exceeds a 90-day supply, received from a mail order pharmacy or a retail pharmacy that participates in our program which allows you to receive a 90-day supply of a prescription or refill;

22. Any portion of a prescription or refill that exceeds a 30-day supply, received from a retail pharmacy that does <u>not</u> participate in our program which allows you to receive a 90-day supply of a prescription or refill;

23. Any portion of a specialty drug or self-administered injectable drug received from a retail pharmacy or a specialty pharmacy that exceeds a 30-day supply, unless otherwise determined by us;

24. Any portion of a prescription or refill that:

    A. Exceeds our drug specific dispensing limit, e.g. IMITREX; or

    B. Is dispensed to an insured whose age is outside the drug specific age limits;

    C. Exceeds the duration-specific dispensing limit;

25. Any drug for which a charge is customarily not made;

26. Any drug, medicine or medication received by you:

    A. Before becoming covered under this rider; or

    B. After the date your coverage under this rider has ended;

27. Any costs related to the mailing, sending or delivery of prescription drugs;

28. Any intentional misuse (improper use)of this benefit, including prescriptions purchased for consumption by someone other than you;

29. Any prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;

30. Drug delivery implants;

31. More than one prescription or refill for the same drug or therapeutic equivalent medication prescribed by one or more health care practitioners and dispensed by one or more pharmacies until you have used, or should have used, at least 75% of the previous prescription or refill, unless the drug or therapeutic equivalent medication is purchased through a mail order pharmacy, or a retail pharmacy that participates in our program which allows you to receive a 90-day supply of a prescription or refill, in which case you have used, or should have used 66% of the previous prescription. (Based on the dosage schedule prescribed by the health care practitioner);

32. Any copayment or coinsurance you paid for a prescription that has been filled, regardless of whether the prescription is revoked or changed due to adverse reaction or change in dosage or prescription;
33. Bulk Chemicals and Pain Patch not approved by the Food and Drug Administration (FDA)
34. When the FDA has determined that a medication is contraindicated for the condition for which it is prescribed.

These limitations and exclusions apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, service, treatment, supply, or prescription. This does not prevent your health care practitioner or pharmacist from providing or performing the procedure, service, treatment, supply, or prescription; however, the procedure, service, treatment, supply or prescription will not be a covered expense.

Humana Insurance of Puerto Rico, Inc.

(Hereinafter "the Company")

PPO Program Humana Complete
RX 3

19728PR0010

Schedule of Benefits Coverage

Schedule of Benefits

This schedule of benefits should be attached and made part of PPO Program Policy: Attachment I

Services and Benefits Procedures

1. Benefits and services are subject to the terms and conditions included in the group policy and to the exclusions and limitations described in this attachment.
2. Insured must receive services from participating facilities, contracted providers or under the order, direction and approval of the contracted provider upon presentation of the identification card issued by the Company. The Insured is responsible for paying applicable copayment, coinsurance or deductible.

Deductible

Deductible	Individual	Family
Network Provider	$0	$0
Non-Network Provider	$0	$0

Annual Maximum Out-of Pocket

Maximum out-of pocket limit	Individual	Family
Maximum out-of pocket limit ("MOOP") Network Provider	$6,350	$12,700
Maximum out-of pocket limit ("MOOP") Non-Network Provider	$19,050	$38,100

This includes copayments and coinsurance expenses of the Medical and Pharmacy coverage, in addition to accumulated expenses of the pharmacy benefits coverage deductibles.

Once the individual or family maximum out of pocket limit is met for the policy year for network providers, the percentage of benefits provided by network providers for covered expense will be paid at a rate of 100% for the rest of the policy year, subject to all terms, limits and exclusions of this Schedule of Benefits Coverage. Any expenses (medical and pharmacy) you might incur for covered expenses provided by a network provider will apply to the maximum out of pocket limit for network providers. Any expenses (medical and pharmacy) you might incur (as contracted fee for similar services by a provider in Puerto Rico) for covered expenses provided by out of network provider will apply to the maximum out of pocket limit for out of network providers.

The accumulation period will begin on the effective date of the policy and will end when the policy terminates. From there on, it will be from the renovation date until the policy year end.

The Maximum Out-of Pocket is based on the maximum amount allowed by the Office of the Commissioner of Insurance of Puerto Rico.

Essential Health Benefits

Ambulatory Services

The following services are covered, less any applicable co-insurance or copayment per visit:

1. Unlimited office visits to physicians, less applicable copayment or coinsurance:

   Generalists: $5.00

   Specialists: $20.00

   Sub-specialists: $20.00

2. Chiropractic Services, one (1) initial visit, one (1) follow-up visit, less $20.00 visit copayment or and up to twenty (20) manipulations per insured, per policy year. Physical therapies unlimited, less $5.00 copayment.
3. Six (6) Nutritionist consultations per insured per policy year, less $20.00 visit copayment or per visit.
4. Laboratories, X-rays and its reproduction, unlimited, less 35% of coinsurance. Genetic tests require pre-authorization, less 35% of coinsurance.
5. Electrocardiograms, unlimited, less 35% of coinsurance.
6. Sonograms, unlimited, less 35% of coinsurance.
7. Computerized tomography, unlimited, less 35% of coinsurance. Pre-authorization required.
8. Positron Emission Tomography (PET), unlimited, less 35% of coinsurance. Pre-authorization required.
9. Electroencephalogram, unlimited, less 35% of coinsurance.
10. Electromyogram, unlimited, less 35% of coinsurance.
11. Magnetic Resonance, including MRI and MRA, unlimited, less 35% of coinsurance. Preauthorization required.
12. One (1) sleep study or polysomnography covered per insured, per policy year, less 35% of coinsurance. Pre-authorization required.
13. Nuclear medicine tests, unlimited, less 35% of coinsurance.
14. Respiratory therapy, unlimited, less $5.00 copayment.
15. Physical therapy, including rehabilitation and habilitation, unlimited for all conditions including autisms, as prescribed and under the supervision of an orthopedist or a physical medicine specialist, less $5.00 copayment.

16. Speech therapy, combined at the physician office or at home, when ordered by a physician and rendered by a licensed speech therapist; up to a maximum of forty (40) therapies, per insured per policy year, less $20.00 copayment. Unlimited speech and language therapies for autism according to Law No. 220 of September 4, 2012.
17. Occupational therapy for the purpose of training and aiding in the restoration of normal physical function and or prevent further deterioration of the same; resulting illness, from trauma, stroke or a surgical procedure while insured under the policy, unlimited for all conditions including autisms, less $20.00 copayment.
18. Ambulatory surgery at ambulatory surgery facilities, including Mental Health, less $125.00 of copayment.
19. Endoscopies, diagnostic and therapeutic, unlimited, less $20.00 office copayment or less $125.00 facility copayment.
20. Lithotripsy, unlimited, less $125.00 ambulatory facility copayment per rendered service. Pre-authorization required.
21. Vasectomy at physician's office, less $20.00 office visit copayment.
22. Acute and chronic services related to End Stage Renal Disease, such as dialysis, hemodialysis and complications directly related to the disease are covered up to a maximum of ninety (90) days starting on the date on which the disease is diagnosed, In case of admission apply $250.00 copayment.
23. Allergy tests, including allergenic and biological extracts, drugs, patches and provocative tests, up to a maximum of fifty (50) tests per insured per policy year, less 35% coinsurance.
24. Intra-articular injections, unlimited, less $20.00 office copayment or less $125.00 facility copayment.
25. Audiologist visits according to Law No. 127 of September 27, 2007; Audiometry and tympanometry tests when ordered by a physician, one (1) of each test per insured, per policy year, less 35% of coinsurance.
26. Orthognathic surgery (mandibular or maxillary osteotomy - Le Fort). Expenses for implants related to orthognathic surgery are excluded, less $125.00 facility or $250.00 hospital copayment. Pre-authorization required.
27. Treatment and services for morbid obesity as medically necessary. One (1) bariatric surgery using one of the following techniques, gastric bypass, adjustable gastric band or sleeve gastrectomy per lifetime, according to Law 212 dated on August 9, 2008, less $250.00 copayment. Surgeries for removing excess skin (commonly known as folds) shall not be covered, unless the physician certifies that it is necessary to remove the excess skin because it affects the functions of any part of the body. Bariatric surgery requires pre-authorization.
28. In the event that an insured voluntarily enrolls in a research clinical trial, Humana will cover diagnostic tests which are usually associated with his condition as long as they are covered by his/her health insurance policy. These services are subject to the maximum limits specified under the policy, less $20.00 copayment or 35% coinsurance. Tests which are not covered by his/her policy, and which are strictly linked to the goal of the research, will not be reimbursed by Humana. The process and results of the investigation are the responsibility of the researcher and the insured.
29. Diagnostic tests and treatments associated with hemophilia, unlimited, less $20.00 copayment or 35% coinsurance.
30. Unlimited naturopathic physician visits according to Law 210 dated on December 14, 2007, less $20.00 copayment.
31. Eye refraction test by an ophthalmologist or optometrist, one (1) per insured per policy year within the Humana Insurance network, less $20.00 copayment.
32. Ophthalmic Diagnostic Tests, less $20.00 copayment.
33. Mammography, when they are not presented as a preventive test required by ACA, but as a follow up to a diagnosis or treatment of a condition, less $125.00 facility copayment.
34. Podiatry visits; Treatment of diseases and disorders of the foot and ankle, including injections and surgical procedures, less $20.00 visit copayment or $125.00 facility copayment.
35. Cervical Cryosurgery, less $20.00 copayment.

36. Nerve Conducting Velocity Test, unlimited, per policy year, less 35% coinsurance.

37. Humana will cover the Nutritional Supplement free of phenylalanine, based on low phenylalanine protein hydrolysates for patients diagnosed with the genetic disorder Phenylketonuria (PKU), without age limits, and for other recommended diagnostic, prevention and treatment of people with innate metabolic errors, in accordance to Act 139 of August 8, 2016. Covered at 100%.

38. Anesthesia services and hospitalization services, unlimited, in accordance with Act No. 352 of 1999; Pre-authorization is required. These services will be available when the member has dental coverage with Humana and when at least one of the following scenarios occurs:

    a. When a pediatric dentist, oral or maxillofacial surgeon member of the medical faculty of a hospital, licensed by the Government of Puerto Rico, determines that the member's condition is significantly complex in accordance with criteria established by the American Academy of Pediatric Dentistry.
    b. When the patient due to age or disability is unable to resist or tolerate pain, or cooperate with the treatment indicated in dental procedures;
    c. When the infant, child, adolescent or person with a physical or mental disability has a medical condition in which it is essential to carry out dental treatment under general anesthesia in an outpatient surgical center or hospital and which otherwise could represent a significant risk to the patient's health;
    d. When local anesthesia is ineffective or contraindicated due to an acute infection, anatomical variation or allergic condition;
    e. When the patient is an infant, child, adolescent, person with a physical or mental disability, and is in a state of fear or anxiety that prevents the dental treatment under traditional procedures of dental treatment and their condition Of such magnitude, that postponing or delaying treatment would result in pain, infection, loss of teeth or dental morbidity;
    f. When a patient has received extensive and severe dental trauma where the use of local anesthesia would compromise the quality of services or be ineffective in managing pain and apprehension.

To evaluate the services, a medical order must be sent to Humana with the diagnosis of the insured, as well as the reasons that justify the use of general anesthesia and hospital. Humana will approve or deny the request, in accordance with the criteria previously established, within two (2) days as of the date on which the member submits all required documentation.

The documents are:

- Medical order with diagnostics.
- Justification in the medical order.

Preventive Services

1. Annual preventive services are **covered at 100%** (without copayment or coinsurance) when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF), the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), The Health Resources and Services Administration, and the Puerto Rico Department of Health.

   For more information and updates on preventive services, visit: //www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

   a) Routine physical examination, including height, weight, and body mass index (BMI), for children and adults.

   b) High Blood pressure screening. The USPSTF recommends screening for high blood pressure in adults age (18) years and older. It is recommended obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.

   c) Cholesterol screening, for children and adults.

d) Screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults 40 years of age and older. The risks and benefits of these methods vary.

e) Screening for obesity, and counseling, for children and adults. The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of (30) kg/m2 or higher to intensive, multicomponent behavioral interventions.

f) Screening for Tobacco Use for all adult. The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA) approved pharmacotherapy for cessation to adults who use tobacco.

   The dispatch of FDA approved medication for smoke cessation is covered for (90) consecutive days in one intent and until (2) intents per year. Smoking cessation drugs are covered under the Pharmacy Coverage Section with prescription.

g) Tobacco use interventions: children and adolescents; recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

h) Screening for gestational diabetes mellitus (GDM) in asymptomatic pregnant women after (24) weeks of gestation and those at high risk of developing gestational diabetes.

i) Screening for abnormal blood glucose and Diabetes Mellitus Type 2 in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer, or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.

   In addition, it is recommended screening for diabetes type 2 in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than (135/80) mm Hg.

j) Screening for alcohol abuse, and behavioral counseling. It is recommended that clinicians screen adults aged (18) years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

k) Screening for tobacco, alcohol or drug use for children 11 to 21 years of age.

l) Immunizations for infants, children, and adults in accord with accepted medical practice and as recommended by the Advisory Committee for Immunization Practices (ACIP) of the Centers for Disease Control (CDC) and the American Academy of Pediatrics, as long as the individual is covered by this health insurance, including follow up (catch up).

   - Immunizations for Adults (21 years or older), including catch-ups – Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza (Flu Shot), Meningococcal, Measles/Mumps/Rubella, Pneumococcal, Tetanus/Diphtheria/Pertussis, Varicella

   - Immunizations for Children (less than 21 years old), including catch-ups – Haemophilus Influenzae Type b, Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza (Flu Shot), Meningococcal, Measles/Mumps/Rubella, Pneumococcal, Rotavirus, Tetanus/Diphtheria/Pertussis, Varicella, , inactivated poliovirus

m) Cervical cancer screening The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).

n) Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate. Office visits and consultations regarding checkups for healthy women (well-woman visits). Health and Human Services recognizes that several visits may be necessary to get all recommended preventive services, depending on the health status of women, their health needs and other risk factors.

o) Breast cancer mammography screenings every one (1) to two (2) years for insured over 40 years, biannual for insured between fifty (50) and seventy-four (74) years. This includes guidance and advice regarding chemoprevention, and the chemoprevention of breast cancer in women when indicated. Counseling for women at higher risk. The USPSTF recommends that clinicians engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk.

For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk- reducing medications, such as tamoxifen or raloxifene.

p) Pap Smear

q) Prostatic Specific Antigen test (PSA) for men

r) Behavioral counseling regarding sexually transmitted diseases (STD's), for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs).

s) Screening for intimate partner violence (IPV), such as domestic violence, for women of childbearing age. Physicians shall also provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.

t) Screening for autism for children up to 36 months.

u) Osteoporosis screening: postmenopausal women younger than 65 years at increased risk of osteoporosis The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool. Osteoporosis screening: women 65 years and older. The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporosis fractures in women 65 years and older.

v) Screening for hearing loss all newborns infants.

w) Screening for elevated blood lead levels in children aged (1) to (6) years who are both at average and increased risk, and in asymptomatic pregnant women.

x) One (1) lifetime screening test for abdominal aortic aneurism (AAA) in men 65-75 years old who have ever been smokers.

y) Counseling regarding the use of aspirin in prevention of disease, for both men and women 45-79 years of age who are cardiovascular and colorectal cancer risks. The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged (50) to (59) years who have a (10)% or greater (10) year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least (10) years, and are willing to take low-dose aspirin daily for at least (10) years. For aspirin, prescription is required.

z) Counseling regarding folic acid supplements for women who may become pregnant. The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing (0.4) to (0.8) mg of folic acid. For folic acid, prescription is required.

aa) Hypothyroidism: Screening for congenital hypothyroidism in newborns.

bb) Screening for cervical dysplasia for sexually active females.

cc) Screening for sickle cell disease in newborns.

dd) Vision screening for all children at least once in all children between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.

ee) Screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up.

ff) Medical history: For all children throughout development.

gg) Behavioral Assessment for children of all ages. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

hh) Screening for this genetic disorder Phenylketonuria (PKU) in newborns.

ii) Obesity in children and adolescents: The USPSTF recommends that clinicians screen for obesity in children and adolescents (6) years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.

jj) Screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

kk) Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care. Also, is recommended repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at (24)-(28) weeks gestation, unless the biological father is known to be Rh (D)-negative.

ll) BRCA: Screening and risk assessment for women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.

mm) Screening for asymptomatic bacteriuria with urine culture for pregnant women at (12) to (16) weeks of gestation or at the first prenatal visit, if later.

nn) Screening for syphilis for all pregnant women and for any adolescent or adult who is at increased risk for infection.

oo) Screening for chlamydia and gonorrhea in sexually active women age (24) years or younger and in older women who are at increased risk for infection.

pp) Preventive medication for the eyes of all newborn for the prevention of gonorrhea.

qq) Skin cancer behavioral counseling The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.

rr) Preeclampsia prevention: aspirin, recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk. For aspirin, prescription is required.

ss) Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors: recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.

tt) Dental caries prevention: The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.

It is recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. The fluoride varnish is covered under the Dental Services Section.

uu) Oral health: Risk assessment for young children. Ages: (0) to (11) months, (1) to (4) years, (5) to (10) years.

vv) Lung cancer screening: recommends annual screening for lung cancer with low-dose computed tomography in adult ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

ww) Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. The USPSTF recommends exercise or physical therapy and vitamin D supplementation to prevent falls.

xx) Hepatitis B screening in persons at high risk for infection. Hepatitis B screening is also cover for pregnant women at their first prenatal visit.

yy) Hepatitis C virus infection screening: adults The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.

zz) Tuberculosis : Testing for children at higher risk of tuberculosis. Ages: (0) to (11) months, (1) to (4) years, (5) to (10) years, (11) to (14) years, (15) to (21) years.

aaa) Prevention of cardiovascular diseases: It is recommended that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.

bbb) Preeclampsia Screening in pregnant women with blood pressure measurements throughout pregnancy.

ccc) Tobacco Smoking cessation: The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.

ddd) Developmental Screening and Surveillance: Screening for children under age (3), and surveillance throughout childhood.

eee) Dyslipidemia: Screening for children at higher risk of lipid disorders. Ages: (1) to (4) years, (5) to (10) years, (11) to (14) years, (15) to (16) years.

fff) Hepatitis B virus infection: screening nonpregnant adolescents and adults The USPSTF recommends screening for hepatitis B virus (HBV) infection in persons at high risk for infection.

ggg) Tuberculosis latent infection screening: adults The USPSTF recommends screening for latent tuberculosis infection in populations at increased Risk.

2. Preventive services **covered at 100%** (without copay) when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF) and the Health Resources and Services Administration.

For more information and updates on preventive services, visit:
//www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

- Women's contraceptives and contraception counseling. All women's contraceptive methods approved by the Federal Drug Administration (FDA) by prescription are covered, including counseling, placement and removal of uterine devices, administration of medication and sterilization
- Any device insertion and removal of contraceptive methods is covered.

3. Preventive services **covered at 100%** (without copay) during and immediately following pregnancy when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF) and the Health Resources and Services Administration. For this service, insured has to call the *Humana Beginnings* program at 1-866-488-5992, for screening process. Humana recommends to participate in the Humana Beginnings Program starting the first trimester of gestation.

For more information and updates on preventive services, visit:
//www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

- Comprehensive breastfeeding support with guidance and counseling, during pregnancy and after birth, and the necessary breastfeeding equipment and supplies, including the breast pump with prescription.

4. Screening for Human Immunodeficiency Virus (HIV) covered at 100% (without co-payment or coinsurance), according to the recommendation of the Centers for Disease Control and Prevention (CDC) and in compliance to the Act No. 45 of May 16, 2016, as part of the routine testing of a medical evaluation at least once every five (5) years, based on the clinical criteria for adolescents and adults between the ages of thirteen (13) and Sixty-five (65) years of age at low risk. For people of high risk between the ages of thirteen (13) and sixty-five (65) is covered annually.

   Clinicians should screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown. For pregnant women, two tests are covered: 1) A first HIV test during the first trimester of pregnancy at the first prenatal visit, and 2) A second test during the third trimester of pregnancy (between the (28) and (34) weeks of pregnancy.

Hospital Services

Hospital admissions must be authorized by Humana and the services to be offered must be provided under the determinations of an attending physician. A member or his (her) responsible caretaker is responsible for the predetermined co-payment for any admission that so specifies.

Inpatient Care:	$250.00 per admission
Outpatient Surgery-Facility:	$125.00 per rendered service

1. Hospital services included in the contracted per diem:
   - Semi-private room or similar facility, unlimited. In cases in which an insured use the services of a private room, it is his/her responsibility to pay the difference between the cost of medical services billed and the contracted fees.
   - Specialized units for critical care services including: intensive care unit (ICU), intermediate care unit, coronary care unit (CCU), neonatal intensive care unit (NICU), and pediatric intensive care unit (PICU).
   - Operating, recovery, and maternity rooms.
   - Drugs prescribed by physician during hospital stay that are included in the per diem.
   - Oxygen and its administration.
   - Laboratory and radiology.
   - Disposable supplies.
   - Special and regular diets.
   - Regular hospital nursing service

2. Hyperalimentation services, unlimited
3. Universal Neonatal Hearing Screening according to Law No. 311 dated on December 19, 2003, which includes: hearing evaluations for the follow-up treatment needed by the patient.
4. Surgical procedures for benefits included under the basic coverage.

5. Anesthetic agents and their administration including sedation. Anesthesia services and hospitalization services, unlimited, in accordance with Act No. 352 of 1999; Pre-authorization is required. These services will be available when the member has dental coverage with Humana and when at least one of the following scenarios occurs:

    a. When a pediatric dentist, oral or maxillofacial surgeon member of the medical faculty of a hospital, licensed by the Government of Puerto Rico, determines that the member's condition is significantly complex in accordance with criteria established by the American Academy of Pediatric Dentistry.
    b. When the patient due to age or disability is unable to resist or tolerate pain, or cooperate with the treatment indicated in dental procedures;
    c. When the infant, child, adolescent or person with a physical or mental disability has a medical condition in which it is essential to carry out dental treatment under general anesthesia in an outpatient surgical center or hospital and which otherwise could represent a significant risk to the patient's health;
    d. When local anesthesia is ineffective or contraindicated due to an acute infection, anatomical variation or allergic condition;

    e. When the patient is an infant, child, adolescent, person with a physical or mental disability, and is in a state of fear or anxiety that prevents the dental treatment under traditional procedures of dental treatment and their condition Of such magnitude, that postponing or delaying treatment would result in pain, infection, loss of teeth or dental morbidity;
    f. When a patient has received extensive and severe dental trauma where the use of local anesthesia would compromise the quality of services or be ineffective in managing pain and apprehension.

    To evaluate the services, a medical order must be sent to Humana with the diagnosis of the insured, as well as the reasons that justify the use of general anesthesia and hospital. Humana will approve or deny the request, in accordance with the criteria previously established, within two (2) days as of the date on which the member submits all required documentation.

    The documents are:

    - Medical order with diagnostics.
    - Justification in the medical order.

6. Sonogram, Computerized Tomography and Magnetic Resonance (MRI and MRA), unlimited
7. Electrocardiogram, unlimited
8. Nuclear medicine studies and digital angiography, unlimited.
9. Blood transfusions including autologous process, all components and compatibility tests.
10. Respiratory Therapy.
11. Physical Therapy, maximum of forty (40) therapy sessions per insured, per hospital stay.
12. Acute and chronic services related to End Stage Renal Disease, such as dialysis, hemodialysis and complications directly related to the disease are covered up to a maximum of ninety (90) days starting on the date on which the disease is diagnosed.
13. Treatment and services for morbid obesity as medically necessary. One (1) bariatric surgery using one of the following techniques, gastric bypass, and adjustable gastric band or sleeve gastrectomy per lifetime, according to Law No. 212 dated on August 9, 2008.
14. Surgical procedures in ambulatory surgery in a hospital, less applicable copayment or coinsurance.
15. Surgeon Assistant when medically necessary: pre-authorization required, less 35% coinsurance.

Transplant or Graft

Cornea transplant or bone, skin graft services received by the insured will be covered, less $250.00 copayment; pre-authorization is required. The covered transplant or graft includes pre-transplant, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation.

In-Home Services

In-Home Health Services, authorized by a main doctor and Humana.

Home health care must be provided by an agency that is dedicated, licensed and managed according to the regulations established by a group of medical professionals that keeps medical records of the patients and operates according to the laws of the Commonwealth of Puerto Rico. These services are covered if they begin within fourteen (14) days after release from a hospital or expert nursing facility due to a hospitalization of at least three (3) days, and are provided because of the same condition or in relation to the condition for which the patient was hospitalized.

If the patient is in the hospital, Home health services must be requested by the attending physician in the hospital. If the patient is out of the hospital, Home health services must be requested by the main doctor with medical justification. The doctor must present a care plan and estimated time of the duration of services, according to the individual needs of the patient. The program will provide education for the patient and family members responsible for his/her health care. This benefit will be covered for forty (40) days initially, and an additional twenty (20) days, subject to medical necessity certification.

In-home health services include:

1. Care by a nurse or under the supervision of a graduate nurse.
2. Respiratory therapy care, less $5.00 copayment
3. Collection of samples for lab tests, less 35% coinsurance
4. Care and maintenance of catheters.
5. Administration of intravenous antibiotics, subject to Humana's case management program.
6. Ulcer care through Humana's case management program.
7. Physical therapies, up to forty (40), less $5.00 copayment. For condition of autism, unlimited as mention in law No. 220 of September 4, 2012.
8. Occupational therapy for the purpose of training and aiding in the restoration of normal physical function and or prevent further deterioration of the same; resulting illness, from trauma, stroke or a surgical procedure while insured under the policy, unlimited for all conditions including autisms, less $20.00 copayment.
9. Speech therapy, when ordered by a physician and rendered by a licensed speech therapist; combined at the physician office or at home, up to a maximum of forty (40) therapy sessions per insured per policy year less $20.00 visit copayment. Speech therapies are unlimited for Autism and language as mention in Law No. 220 of September 4, 2012.
10. Hyperalimentation services, unlimited, less 35% coinsurance.

Skilled Nursing Facility

Skilled nursing facility covered up to a maximum of one hundred and twenty (120) days per insured per policy year, covered at 100%. These services will be covered if they begin within the fourteen (14) days following the release from the hospital due to a hospitalization of at least three (3) days, and if they are rendered because of the same condition or in relation to the condition leading to the hospitalization.

If the patient is in the hospital, Home health services must be requested by the attending physician in the hospital. If the patient is out of the hospital, Home health services must be requested by the main doctor with medical justification. Pre-authorization is required.

Durable Medical Equipment, Supplies, Prosthesis, Orthosis and Implants

1. The purchase or rental of medically necessary Durable Medical Equipment, less 35% coinsurance. The cost or rental of durable medical equipment will be covered. If the cost of renting the equipment is more than an insured would pay to buy it, Humana will covered up to the amount of the purchased equipment. We do not pay for equipment or devices not specifically designed and intended for the treatment of an injury or sickness. Required pre-authorization. Including glucometer and insulin pump mention in Law No. 177 of August 13, 2016. Covered for children and adults.

   Pre-authorization is required. If the endocrinologist recommends a specific glucometer due to the treatment utilizes, or order a particular insulin pump due to the necessity of the member, the provider must submit to Humana a justification. Humana will then cover the equipment specifically ordered by the endocrinologist, whether it is a specific glucometer or insulin pump is required.

2. Initial placement of a medically necessary prosthesis and its supportive device, except for those excluded. We will also cover the replacement of such prosthesis if it is determined by the insured's physician to be necessary because of growth or change. Less 35% coinsurance. Required pre-authorization.

3. Orthotics (No cover pre-fabricated, over-the-counter - OTC) and supplemented (No cover over-the-counter - OTC), less 35% coinsurance. Requires pre-authorization.

4. Implants, less 35% coinsurance. Requires pre-authorization.

Ambulance Services

Also an emergency may arise from a call managed thru the 911 System which refer to a dedicated telephone system that is available 24/7 for receiving emergency calls that deal with public security. System 9-1-1 was created by virtue of Law No. 144 dated on December 22nd, 1994 as amended, known as the "Law for rapid response to emergency calls with Public Security" or "Law for calls 9-1-1.

1. Land transportation by an ambulance, between facilities, authorized by the Public Service Commission and the Health Department as mention in Law No. 183 of August 6, 2008, to a hospital or between health facilities, e.g. between a hospital and a radiology institute or between a skilled nursing facility and a hospital, and when ordered by a physician, including psychiatric emergencies. Services requested for psychiatric and medical emergencies through the 911 will be paid in full directly to the provider.
2. Land transportation by an ambulance authorized by the Public Service Commission and the Health Department as mention in Law No. 183 of August 6, 2008, including psychiatric emergencies, less $75.00 copayment per trip.
   a. from the insured residence or place of emergency to the Skilled Nursing Facilities or Hospice, when is medically necessaries.

b. From the hospital to the residence, if the condition of the patient discharged requires.

3. Land ambulance services for psychiatric and medical emergencies through 911 will be paid in full by Humana directly to the provider. The service will only cover if the insured meets the following requirements:

    a. The patient suffered an illness or injury for which other types of transportation are not recommended;

    b. Psychiatric emergencies as mention in Law No. 183 of August 6, 2008;

    c. The health condition of the patient does not allow the use of other types of transportation;

    d. It is not a case covered by the Automobile Accident Compensation Administration (ACAA), the State Workmen's Compensation Fund (CFSE) or any other insurance with primary responsibility

4. The general hospital and the psychiatric hospital must both comply with all EMTALA regulations regarding the draft and preparation of a "Protocol for the Process of Transferring Patients" which is here requested and required."

5. Maritime and air transportation services by an ambulance within Puerto Rico, subject to medical need for it, less $75.00 copayment. Pre-authorization is required unless it is a life or death emergency.

Cancer Services and Treatments

1. Ambulatory services for the treatment of radiotherapy and/or chemotherapy, including intravenously, via injection or intrathecally, according to the instructions of the medical doctor or oncologist. Oral chemotherapy is cover under the Pharmacy Coverage Section covered 100%. This is, according to Law No. 107 dated on June 5, 2012.

2. Medically necessary oral and parenteral medication for pain management of patients suffering terminal cancer.

3. All the benefits, including radiotherapy and/or chemotherapy in the hospital services, less $250.00 hospital copayment.

4. Stoma care and maintenance: colostomy, gastrostomy and cystostomy.

5. For the insured who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, the coverage includes:

    a) all stages of reconstruction of the breast on which the mastectomy has been performed

    b) surgery and reconstruction of the other breast to produce a symmetrical appearance

    c) prosthesis and physical complications of mastectomy, including lymphedemas

According to Law No. 275 dated on September 27, 2012, patients with a diagnosis of cancer have the following rights:

- To know and understand their treatment and rehabilitation plans, and the pain management protocol specifically appropriate for their case. The patient with cancer has the right to priority treatment for his/her pain; and is entitled to aggressive pain management techniques based on scientific evidence and approved by the Food and Drug Administration (FDA).

- To receive a copy of their file in an expeditious manner when they wish a second medical opinion or a consultation with another provider.

- The right to information, counseling and guidance regarding the possible short and long term effects on fertility of the cancer itself, and of the diagnostic tests and treatments to be received.

- Continuity in medical care and other health services, such as diagnostic tests for early detection, and access to oncologists, radiation therapists and surgical specialists involved in the initial diagnosis, and in

his/her management once regarded a cancer survivor; continuity is necessary for close monitoring against recurrence and adverse effects of treatment, and to maintain physical and emotional health as a surviving patient with cancer.

- To be included in their employer's group healthcare insurance plan with no increase in their premium compared to all other members of the Group, and without exclusion of coverage because of a previous diagnosis of cancer.
- No private insurer can reduce benefits or terminate the policy of a patient with cancer, or that of a child who has survived cancer, as long as the health emergency lasts.
- Elderly patients who have a diagnosis of cancer or who are cancer survivors will be offered clear and up-to-date information about the prevention, detection and treatment of cancer taking into account conditions which might affect communication and their sensory, mobility or cognitive impairments. Elderly patients with a diagnosis of cancer will receive the support appropriate for their age, including but not limited to community support services and psychosocial and palliative services.
- Included as covered services will be pelvic examinations, and all type of vaginal cytology preparations which may be specifically required by medical order to detect, diagnose and treat early anomalies which might lead to cancer of the cervix.
- To provide extended coverage for the payment of studies and tests to monitor cancer of the breast, such as office visits to specialists, clinical breast examinations, mammography and digital mammography, magnetic resonance mammography and sono-mammography, and such treatments as, but not limited to, mastectomies, reconstructive surgery after mastectomy for the reconstruction of the removed breast, the reconstruction of the other breast to achieve a symmetrical appearance, breast prosthesis, treatment of complications at all stages of the mastectomy, including lymphedema (an inflammation which sometimes occurs after treatment for breast cancer), and any other reconstructive surgery after mastectomy which may be necessary for the physical and emotional recovery of the patient.

Maternity Services

The female employee, the wife or cohabitant, and the dependent daughter of any employee covered by the insurance plan for families or couples, will have maternity benefit coverage. The minimum hospital stay for both patient and newborn has been established by Law No. 248 of the Commonwealth of Puerto Rico dated on August 15, 1999, at 48 hours for a normal delivery, without complications, and 96 hours for a Cesarean-section delivery. Hospital discharges prior to length of stays stipulated by the law must have the consent of the patient. The maternity benefit covers a follow-up visit during the 48-hour period following discharge, at which time the newborn infant can also be checked. Services will include, but not be limited to support and physical care for the benefits of the minor, education to both parents on caring for the minor, support and training on breast feeding, orientation on support at home and the performance of any treatments and medicine test both for the infant and the mother.

Covered maternity benefits include the following services:

1. Hospitalization, less $250.00 copayment.
    a. Delivery, including Cesarean Section.
    b. Delivery and recovery rooms.
    c. Nursery and incubator.
    d. Neonatal intensive care unit (NICU)
    e. Fetal monitoring during delivery.
    f. Postpartum sterilization before discharge
2. Ambulatory (unlimited services)
    a. Pre-natal and post-natal care, less $20.00 copayment per visit

b. Genetic amniocentesis, less 35% coinsurance

c. Spontaneous abortion

d. Ambulatory fetal monitoring, less 35% coinsurance

e. Biophysical profile, unlimited.

3. Vaccines

   a. RhoGam Vaccine, less 35% of coinsurance
   b. Vaccine for the treatment of the Respiratory Syncytial Virus according to Law No. 165 dated on August 30, 2006 and protocol approved by Puerto Rico's Department of Health.

4. Ambulatory sterilization, covered at 100%.

Pediatric Services

1. Unlimited visits, less $20.00 copayment per visit.
2. Well Child Care, less $20.00 copayment per visit.
3. Universal Neonatal Hearing Screening, according to Law No. 311 dated on December 19, 2003, which includes: hearing evaluations for the follow-up treatment needed by the patient.
4. Annual exam according to Law No. 296 dated on September 1st, 2000, which includes: physical and mental evaluation, oral health, hearing and vision screening, and screenings recommended by the American Academy of Pediatrics.
5. Circumcision and dilatation for newborns before discharge from the hospital, at ambulatory facility, or physician office, less $125.00 copayment or $20.00 copayment.
6. Immunizations according to established medical practices and as recommended by the Advisory Committee on Immunization Practices (CDC) and the American Academy of Pediatrics, while included as insured under the policy, Human Papilloma Virus vaccine according to Law No. 255 dated on September 15, 2012. For children who have been sexually abused, the HPV vaccine (HPV) is covered beginning at age nine (9).
7. Coverage for technical equipment of ventilators for children which are vital for the maintenance of life, including children who depend on medical equipment such as respirators or supplemental oxygen, an 8-hour daily shift of a skilled nurse with experience in respiratory therapy or respiratory therapists with nursing experience, the necessary supplies to work with the technical equipment, physical and occupational therapy, laboratories, radiology, and prescribed medications which must be dispensed by a participating pharmacy of our network which is freely selected by our insured, all as authorized by the laws of Puerto Rico as outlined in Law No. 62 dated May 4, 2015, less copayment. For those who have started treatment as minors and become age 21, all the aforementioned services will continue to be covered. This benefit applies also to children who have had a tracheotomy to enable breathing and require home care because of the risk of airway obstruction; this requires a prescription by a physician.
8. Care and treatment of congenital defects and anomalies diagnosed by a doctor, without exclusion due to a preexisting condition. This covers newborns, recently adopted newborns or newborns recently placed for adoption. These services are subject to any applicable copayment or coinsurance.
9. Vaccine for the treatment of the Respiratory Syncytial Virus according to Law No. 165 dated August 30, 2006 and protocol approved by Puerto Rico's Department of Health. Pre-authorization required.

Urgent / Emergency Room Services

Services provided in Urgent / Emergency Rooms will be provided without prior-authorization or waiting period; will be provided regardless if the provider is a participating provider, according to the Law number 194 of August 25, 2000. For services provided in Urgent / Emergency Rooms of non-participant providers, the insured will pay to the provider the same amount as if a participating provider, as long as there is an important and justifiable medical reason for not transferring the patient to a contracted facility.

If Urgent / Emergency services are provided to a patient by a non-participant provider, the patient is not responsible for payment of services that exceed the applicable amount if it had received the services of a participant provider. Humana will compensate the provider that offers the service and it will be obligated to accept such compensation with an amount of not less than the contracted by Humana to offer the same services. In addition, under these circumstances, such Urgent / Emergency services will be provided regardless of the conditions by the health insurance.

If the patient receives health services posterior to the urgent / emergency services, or after being stabilized, and these would normally be covered services except for the fact that they are rendered by a non-participating provider, Humana will reimburse the patient for that part of the costs incurred that would be normally paid by the plan, as long as there is an important and justifiable reason for not transferring the patient to a contracted facility.

Emergencies handled by the 911 system – this refers to the public safety system of urgent / emergency calls through the number 9-1-1.

After the insured individual receives complete urgent / emergency care and stabilization, the facility will transfer the patient to a Humana or Choice Care facility as soon as it is medically possible. Such transfer must not in any way affect the treatment being given or harm the insured patient's health. Humana will assist in the coordination of this transfer, as stipulated in Law No. 194 dated on August 25, 2000.

1. Urgent / Emergency room services due to accidents are covered in full.
2. Urgent room services resulting from illness are covered, less $75.00 copayment
3. Emergency room services resulting from illness are covered, less $75.00 copayment
4. Urgent / Emergency room services' copayment or coinsurance will be waived if patient is admitted; in that case the hospital admission copayment or coinsurance will apply.

For examples of emergency conditions, refer to the definition "Condition of emergency".

Protocol to be followed in the process of transferring patients with psychiatric conditions from one health facility to another.

Regarding an in-patient who presents emotional disturbances in a general hospital or in an urgent / emergency room:

1. Screening and evaluation of the patient will be performed as stipulated in Law No. 35 of 1994 and EMTALA, including all the necessary tests to establish a diagnosis.

2. Organic disease must be ruled-out before reaching a psychiatric diagnosis.

3. During initial evaluation, the general hospital must consider and rule-out the possibility that the etiology of the symptoms of anxiety and agitation presented by the patient at the moment of the emergency are of organic origin.

4. The personnel of the general hospital must consult a mental-health professional to establish continuity of care and obtain permission for transfer from the family or a person properly authorized.

5. The patient is to be stabilized in regard to his/her physical condition or illness. The time spent at the general hospital will depend on the evaluations of organic conditions necessary to establish the state of health of the individual. In cases of poisoning, the general hospital will be responsible for contacting the Poison Control Center in order to determine how long it will take to eliminate the potentially toxic substance taken by the patient. That time-frame will become the minimal period of time for the patient to remain in the urgent / emergency room before transfer to a psychiatric facility.

6. Once the patient's physical condition is stabilized he/she can be transferred to a psychiatric hospital. Simultaneously, the emergency room must send a clear and concise summary to the psychiatric facility of all tests and treatment done, follow-up recommended and information on the physician who attended the patient in the emergency room.

7. The attending physician at the general hospital is responsible for communicating by telephone with the psychiatric facility in order to discuss the case in detail and explain the symptoms and signs presented by the patient to be transferred. At the same time the patient's transfer can be coordinated.

8. The psychiatric hospital must commit to accept the patient to be transferred for further care.

If the patient involved has the economic capacity to pay for the transportation by ambulance or other means necessary for transfer, or has insurance which covers this service, the transportation necessary for transfer will be paid by the patient or his insurance. In such cases the hospital will be paid directly, if it has actually paid for these services; the health insurance plan is responsible for this payment to the hospital. Cases in which the patient is covered for mental health services by the government health insurance. If necessary, and in the absence of other alternatives, transportation will be provided by the ambulances which service the public safety system of emergency calls through 9-1-1. Transportation will be covered from wherever the patient who needs the service is located to whatever hospital facility that can provide the care necessary. Ambulance transportation must comply with the requirements of Law No. 35 of 1994 and EMTALA.

The general hospital and the psychiatric hospital must both comply with all EMTALA regulations regarding the draft and preparation of a "Protocol for the Process of Transferring Patients" which is here requested and required.

NOTE: Urgencies / Emergencies which are secondary to accidents are covered 100%. The urgent / emergency room copayment or coinsurance does not apply if the patient insured is admitted to the hospital; in that case the co-payment of admission to hospital applies.

Psychiatric urgencies / emergencies will be covered with the applicable copayment or coinsurance.

Cardiovascular Procedures

1. Diagnostic Tests and treatment, including the invasive and non-invasive cardiovascular procedures, less 35% of coinsurance.

2. Physician services, less $20.00 office copayment
3. Surgical procedures, less $125.00 facility copayment
4. Repair or replacement of heart valves, pacemaker and any other applicable device, with $0.00 copayment. Defibrillator pacemaker required pre-authorization.

Neurological Procedures

1. Diagnostic tests and treatment, less 35% of coinsurance.
2. Physician services, less $20.00 office copayment
3. Surgical procedures, including neuroendovascular, less $125.00 facility copayment
4. Repair or replacement of valves, and any other medically necessary device, with $0.00 copayment.

Mental Health Services

1. Unlimited visits to professionals, psychology doctors and other providers who because of their education, training or experience, and the proper competency, are able to offer psychological health services, less $20.00 copayment
2. Unlimited office visits to psychiatrist and/or psychologist of children and teens/adults less $20.00 copayment
3. Group therapies, less $20.00 copayment
4. Collateral visits, less $20.00 copayment
5. Unlimited hospital services, less $250.00 admission copayment. Two (2) days of partial hospitalization are equivalent to one (1) day of regular hospitalization.

This service includes emergency psychiatric transportation by an ambulance authorized by the Service Public Commission (*Comisión de Servicio Público*) and the Health Department (*Departamento de Salud*), as stated in Article 4.20 (b) of Law No. 183 of 6 August 2008. Services requested for psychiatric emergencies through the 911 will be paid in full directly to the provider.

Alcoholism & Substance Abuse Services

1. Unlimited visits to professionals, psychology doctors and other providers who because of their education, training or experience, and the proper competency, are able to offer health services in substance abuse, less $20.00 copayment
2. Unlimited office visits to psychiatrist and/or psychologist of children and teens/adults, less $20.00 copayment
3. Unlimited therapies, treatment and follow-up at one or more service levels, which may combine multiple types of therapy, less $20.00 copayment

4. Unlimited residential treatment for alcoholism and substance abuse including detox, less $250.00 copayment.
5. Unlimited hospital services, less $250.00 admission copayment. Two (2) days of partial hospitalization are equivalent to one (1) day of regular hospitalization. Pre-authorization required.

Autism

Autism is recognized as physico-mental health condition. In compliance with Law of Puerto Rico No. 220 dated on September 4, 2012 with the Puerto Rico Department of Health and utilizing as reference the guidelines of the American Association of Pediatrics coverage for these conditions will include diagnostic and therapeutic services in persons diagnosed with disorders within the continuum of Autism.

Covered benefits include visits to physicians and other health providers and the ordered tests and procedures determined to be medically necessary. The specialized services most commonly utilized are related to neurology, psychotherapy, immunology, genetics, gastroenterology, nutrition, speech and language therapy, occupational and physical therapy. Coverage/benefits are not limited only to the previously mentioned services. These services are subject to any applicable copayment or coinsurance, except for the screening for autism for children up to 36 months.

Dental Services

The dental care benefits described below are available using Humana's provider network in Puerto Rico.

Preventive and Diagnostic Services

The following services will be **covered at 100%** In-network:

1. Initial oral examination, one (1) every three (3) years
2. Periodic examination, one (1) every six (6) months
3. Specific oral evaluation, one (1) every six (6) months
4. Complete series of radiographs (FMX), one (1) every three (3) years
5. Panoramic radiographs, up to one (1) every three (3) years
6. Periapical radiographs, one (1) and five (5) additional per policy year
7. Bitewing radiographs, one (1) set every twelve (12) months
8. Prophylaxis adult and child, one (1) every six (6) months
9. Application of fluoride to children up to nineteen (19) years, one (1) every six (6) months
10. Sealants application, limited to children up to fourteen (14) years, one (1) treatment per tooth per lifetime in permanent molars and premolars not previously restored.
11. Application of fluoride varnish for infants and children up to age 5 years, one (1) every six (6) months.
12. Space maintainers, to replace deciduous teeth that are lost permanently, one (1) per area per lifetime.
13. Pulp vitality test, one (1) per visit
14. Re-cementation of space maintainer

15. General anesthesia, administered by an anesthesiologist, and hospital services according to Law No. 352 of December 22, 1999.

Non-Contracted Dentists

If the insured uses the services of a non-participant dentist or facility, Humana will reimburse the insured the fee of the contracted dentist or facility (with the receipt of the payment made to the dentist that provided the service).

Pediatric Vision Care Services

The vision care benefits described below are available until the 21st birthday.

Lenses: One (1) set of lenses per insured, per policy year, with $0.00 copayment. Service is available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers.

- ✓ Lenses for eyeglasses: the lenses included the following selection:
  - CR-39 Plastic for single vision lenses, bi-focal lenses, or tri-focal lenses
  - Polycarbonate for single vision lenses

Frames: The insured can select any frame available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers throughout Puerto Rico with $0.00 copayment. The benefit includes frame from the collection. Coverage includes one (1) frame per policy year.

Contact lenses: Instead of eyeglass benefit (frame and lenses), the member may choose standard disposable contact lenses. The disposable contact lens benefit consists of two (2) boxes per policy year, with $0.00 copayment. Services are available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers.

One (1) pair of low vision eyeglasses or magnifiers as medically necessary for insured with significant loss of vision (low vision), but not total blindness using an exclusive network of Humana Insurance, less $20.00 copayment.

Pharmacy Coverage

What is the formulary?

A Formulary is a prescription drug list developed and approved by Humana and which is regularly evaluated to include or exclude prescription drugs, which is used to determine benefits covered under the pharmacy coverage. The formulary includes generic/bioequivalent, preferred brand, non-preferred brand, and specialty drugs.

The formulary is available in our webpage, Humana.com. There, you can also find information about your prescription medications that may have Utilization Management requirements and the authorization forms with the information required to evaluate them, if applicable. Humana will provide the insured a copy of the formulary, along with information about which prescription drugs are subject to Utilization Management requirements.

Humana will require that the Pharmacy and Therapeutics Committee has an established process, in writing, to consider and update changes in formulary or those that may require Utilization Management, on a timely manner and based on:

- New scientific medical evidence or any other prescription drug related information for covered, non-covered or those that may require Utilization Management, to determine if a change is needed in the formulary or the utilization management criteria;

- if applicable, any clinical information that Humana receives, related to an exception request that would allow the Pharmacy and Therapeutics Committee to determine if the drugs covered in the formulary or those that may require Utilization Management, meet the member's needs, and

- safety and effectiveness information for covered drugs or those that may require Utilization Management, information about prescription drugs that may be clinically similar or bioequivalent, but that are not covered in the formulary nor require Utilization Management, information that may arise from quality assurance activities in the insurance company or information from prescription drug claims received after the latest Pharmacy and Therapeutic meeting.

- Humana will require that the Pharmacy and Therapeutics Committee performs the evaluation of new prescription drugs approved by the Food and Drug Administration (FDA) in no more than a ninety (90) days period, from the FDA approval date. The Pharmacy and Therapeutics Committee should make a determination to include or not include a new prescription drug in the formulary, in a term no more than ninety (90) days from the date the drug is available on the market.

Humana guarantees that the Pharmacy and Therapeutics Committee establishes disclosure policies and requirements in which the identification of possible conflicts of interest between members of the committee and the developers or manufacturers of prescription drugs is contemplated. No member of the Pharmacy and Therapeutics Committee may have any relationship or interest, financial or otherwise, with the developers or manufacturers of the prescription drugs.

Humana guarantees that the Pharmacy and Therapeutics Committee will establish and comply with a written procedure to evaluate medical and scientific evidence related to the safety and efficacy of prescription medications, including information to compare similar prescription medications and bioequivalent, on deciding which prescription medications are to be included in the formulary and on developing other pharmacy benefit management processes. Humana also guarantees that the Pharmacy and Therapeutics Committee will establish protocols for the analysis, and possible inclusion in formulary, of medications for "off-label use" for those health conditions in which, through medical or scientific evidence, the efficacy of the medication has been established.

Pharmacy and Therapeutics Committees must document all their protocols and processes and present registers and documents to Humana upon request.

Humana may contract with other persons to perform the functions of the Pharmacy and Therapeutics Committee. Humana will be accountable to the Commissioner of Insurance for non-compliance and violations incurred by its' Pharmacy and Therapeutics Committee.

Humana will only be able to make changes in the formulary or the Utilization Management while the policy is active; if the change is because of safety, the drug is no longer available in the market, if a new prescription drug will be added in the formulary. If this happened, Humana will notify this no later than when the change is made, to:

- All covered members and
- participating pharmacies, only if the change is because a new prescription drug will be added to the formulary. In this case, Humana will notify thirty (30) days before the change is made.

Humana will meet the following requirements:

Humana will maintain and facilitate the information below to the members, prescribers and pharmacies, by electronic means and if requested by the member or the Pharmacy, written:

- The formulary (prescription drug list) organized by therapeutic categories and the list known as "Maximum Allowable Cost";
- Information about prescription drugs and those that may require Utilization Management, if applicable, which was developed and maintained according to the "Código de Seguros de Salud de Puerto Rico".
- Information about the documentation that may need to be presented by the insured or the personal representative to request a medical exception and the way in which to present this documentation. For details, see Section Application and Process Exception in this Certificate.

How do I use the formulary?

Drugs are listed in the formulary alphabetically.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage based on FDA indications and dosing, like gender, age, and dose limitations. Requirements and limits may include:

- **Prior Authorization (PA):** Humana requires you or your doctor to get prior authorization for certain drugs. This means that your doctor must contact Humana to get approval before you fill or refill a prescription for any drug that needs prior authorization. Your plan benefits won't cover this drug without prior authorization. You'll pay the entire cost of the drug if you decide to buy it.
- **Quantity limits (QL):** For certain drugs Humana limits the amount of the drug that we'll cover. Humana might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. Specialty drugs are limited to a 30-day supply regardless of drug-tier placement.
- **Specialty drugs (SP):** High-cost drugs, including high technology and self-administered injectable medications, requiring special monitoring.
- **This coverage focuses on the use of bioequivalent drugs as a first alternative; however, the insured has the option to choose between a brand drug or a bioequivalent**. If an insured chooses to purchase a brand drug, and an equivalent generic/bioequivalente is available, the insured must pay the difference in cost between the brand and the generic/bioequivalent, plus any applicable brand copay or coinsurance dispensed. If the insured chooses the bioequivalent drug, he or she will only pay the copayment or coinsurance for the bioequivalent drug dispensed. If there is no bioequivalent alternative on the market, the insured will pay the applicable copayment or coinsurance for the brand-name drug dispensed. However, if the physician orders a brand-name drug and writes a prescription as dispensed as written, the insured is responsible only for the copayment or coinsurance of the brand name drug.

What if my drug is not on the formulary?

If your drug isn't included in this printed list of covered drugs, you should visit **Humana.com** to see if your drug is covered. You can also contact Customer Care and ask if your drug is covered.

If Humana doesn't cover your drug, you have two options:

- You can ask Customer Care for a list of similar drugs that are covered by Humana. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Humana.
- You can ask Humana to make an exception and cover your drug. See below for information about how to request an exception.

You are responsible, when applicable, for all or some of the payments for the following:

- The copayment or coinsurance*; and

* If the charge from the pharmacy dispensing the medication is lower than the copayment or coinsurance, you will be responsible for the lesser amount. The amount we pay the pharmacy for the medication might not reflect the final cost to us. Your copayments or coinsurances are made according to the prescription or refill of the prescription and will not be adjusted if Humana gets a discount for volume or a sale on prescription medications.

Pharmacy Annual Deductible

Deductible	Individual	Family
Network Provider	$0	$0
Non-Network Provider	$0	$0

Pharmacy Annual Deductible is the amount that an Individual / Family must pay for calendar year before Humana provides payment for pharmacy covered benefits. The deductible will not apply to Tier 1 Drugs. Once the Individual member in an Individual policy meets the applicable Individual annual deductible, Humana shall provide payment for covered benefits.

For Individual coverage or Family coverage, there is a deductible pharmacy services in-network and a deductible for pharmacy services out-of-network. Pharmacy expenses of benefits you might incur for covered expenses provided by a network provider will apply to the network providers' deductible. Pharmacy expenses you might incur (as provider fee for in-network) for covered expenses provided by out of network will apply to the out of network providers' deductible.

The accumulation period will begin on the effective date of the policy and will end when the policy terminates. From there on, it will be from the renovation date until the policy year end.

Coverage Description

Covered Prescription Drugs List

The following drugs will be covered when prescribed by an authorized doctor:

1. Drugs, medicines or medications that under Federal or state law, may be dispensed only by prescription from a health care practitioner; this includes brand, generic, acute and maintenance medications;
2. Drugs, medicines or medications that are included on the drug list, including the drugs covered by the "Patient protection and Affordable Care Act", like contraceptives, breast cancer risk-reducing medications, among others.
3. Insulin and diabetes supplies;
4. Hypodermic needles or syringes when prescribed by a health care practitioner for use with insulin or self-administered injectable drugs (Hypodermic needles and syringes used in conjunction with covered drugs may be available at no cost to you);
5. Specialty drugs and Self-Administered Injectable Drugs approved by Humana;
6. Spacers and/or peak flow meters for the treatment of asthma;

7. Drugs, medicines or medications on the Women's Healthcare Drug List with a prescription from a health care practitioner;
8. Buprenorphine.

Humana provides for the dispensed of covered drug, regardless of the condition, illness, injury, condition or disease for which they are prescribed, if:

• The drug has FDA approval for at least one indication and

• the drug is recognized for treatment of the disease, illness, injury, condition or disease in question in one of the standard reference compendia or through peer-reviewed medical literature generally accepted.

This drug coverage also includes medically necessary services that are associated with drug administration.

If *you* request a *brand-name medication* when a *generic medication* is available, *your payment* is greater. *You* are responsible for the applicable *generic medication copayment* or coinsurance and 100% of the difference between the amount *we* would have paid the dispensing *pharmacy* for the *brand-name medication* and the amount *we* would have paid the dispensing *pharmacy* for the *generic medication*. If the prescribing *physician* determines that the *brand-name medication* is *medically necessary*, *you* are only responsible for the applicable *copayment or coinsurance* of a *brand-name medication*.

Drugs, Medicines or Medications on the Women's Healthcare Drug List from a N*etwork Pharmacy* are covered in Full (without cost-sharing)

Prescription Drugs Covered without cost sharing from a Network Pharmacy. For more details please refer to drugs list/ formulary.

1. Generic aspirin, for both men and women from 45 to 79 with cardiovascular risk and as prevention of pre-eclampsia: after 12 weeks of gestation in women who are at high risk of pre-eclampsia, both with a medical prescription.
2. Generic folic acid for women planning a pregnancy, with medical prescription.
3. Cancer treatment included within the pharmacy benefit and processed (including oral and auto-administered injectable) in a Network Pharmacy is covered in full, with medical prescription. Intravenously and intrathecally are covered under the Cancer Services and Treatment Section.
4. Breast cancer risk-reducing medications, with medical prescription such as tamoxifen or raloxifene for women who are at increased risk for breast cancer and at low risk of adverse effects to the drug.
5. Smoking cessation drugs, including over-the-counter (OTC), with medical prescription. Covers smoking cessation drugs for 90 consecutive days in an attempt and two (2) cessation attempts per year.
6. Statins in low- to moderate-dose statin for the prevention of cardiovascular disease events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater.

Immunizations for infants, children, and adults are covered through the Medical Coverage in accord with accepted medical practice and as recommended by the Advisory Committee for Immunization Practices (ACIP) of the Centers for Disease Control (CDC), the American Academy of Pediatrics, and are also covered under the vaccination schedule of the Puerto Rico Department of Health.

Benefit Program

The healthcare provider will be able to prescribe maintenance medications to the member with enough refills not to exceed 180 days, according to the plan limitations, when the medical history of the member permits it and no risk are identified.

Contracted/participant pharmacy

Contracted or participant pharmacies are pharmacies that are legally authorized by the relevant authorities, which has signed a contract with Humana to provide pharmacy benefits to its insured.

You are responsible of the following:

Retail Pharmacy / Specialty Pharmacy

Tier 1 Drugs means a category of generic prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 1 drugs.

Tier 2 Drugs means a category of preferred brand prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 2 drugs.

Tier 3 Drugs means a category of non-preferred brand prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 3 drugs.

Tier 3 Drugs: Specialty Drugs means a category of specialty prescription drugs, medicines or medications drugs within the drug list that are designated by us as level 3 drugs.

Tier 1 drugs	$5.00 copayment per prescription or refill per 30-day supply
Tier 2 drugs	$15.00 copayment per prescription or refill per 30-day supply
Tier 3 drugs	20% coinsurance per prescription or refill per 30-day supply
Tier 3 drugs: Specialty drugs	20% coinsurance per prescription or refill per 30-day supply

Note: This plan has a Max Allowable Benefit of $1,200. After this monetary maximum for prescriptions has been reached in disbursements by Humana, the member will be responsible for a 95% coinsurance for all prescriptions until the end of the policy year.

Specialty Drugs through Medical Coverage

Benefits:

A. When medically necessary, specialty drugs administered in a professional setting, including office or infusion center, are covered less the applicable copayment or coinsurance of the specialty drugs in the pharmacy coverage.
B. All utilization requirements of the pharmacy coverage, including but not limited to pre-authorization or quantity limits, shall apply.

90 days program

The retail pharmacies participate in our program which allows you to receive a 90-day supply of a prescription or refill. Your cost is 3 times the applicable copayment or coinsurance as outlined above. Self-administered injectable drugs and specialty drugs are limited to a 30-day supply from a retail pharmacy or specialty pharmacy.

Mail Order Pharmacy
This is a service that delivers medications by mail. It applies to prescriptions or refilled prescriptions covered in the policy.

For up to a 90-day supply of a prescription or refill	2 times the applicable copayment or coinsurance, as outlined above under Retail Pharmacy / Specialty Pharmacy

Mail Order Process:

Your health and well-being is very important to us. Please note that Humana Pharmacy can offer the value and services that you expect from your pharmacy. The routine process to be followed in procuring your maintenance medications by mail is easy and saves time.

The first time you use mail order to receive your medication, ask your doctor for two prescriptions. The first prescription should be written for a one-month supply that can be immediately filled at a participating retail pharmacy. The second prescription should be written for a 90-day supply of the medication with refills and the doctor will send it to Pharmacy Solution. You can use the service for all your maintenance medications.

1. Humana Pharmacy receives the request to fill your prescription. Your physician provider can actually send your prescription by fax (1-800-379-7617), through the telephone (1-800-833-1315-TTY: 711), by filling out a form designed for this purpose (Registration form for prescriptions by mail), onsite at HumanaParmacy.com, or by mail (Humana Pharmacy, PO Box 745099, Cincinnati, OH, 45274- 5099).
2. Humana Pharmacy verifies your pharmacy benefit coverage, enters your order and creates an exclusive shipping number.
3. The Humana pharmacist then reviews the order for a prescribed medication to verify that it is correct and complete. If it is incomplete or incorrect, it is returned with the reason for the rejection.
4. The Humana pharmacist approves the prescription.
5. After approved, the prescription then goes through the billing process.
6. An automated system fills your prescription and a pharmacist verifies that each medication is correct.
7. The prescription is filled in a period of seven (7) to ten (10) days of the time when Humana Pharmacy first received the request for your medications.

Out-Of-Network Pharmacy

When an *out-of-network pharmacy* is used, *you* must pay for the *prescription* or refill at the time it is dispensed. *You* must file a claim for reimbursement with *us*. In addition to any applicable *copayments coinsurances*, *prescription drug deductibles*, *you* are responsible for 35% of the *default rate* (the contracted fee that Humana agreed to pay a pharmacy within the network of providers for a drug) *and* the difference between the *default rate* and the *out-of-network pharmacy's* charge. Example: A pharmacy non-participant has a drug charge of $ 70.00 and the default rate is $125.00, the insured will be responsible for $ 15.00 (35% of the default rate-$ 50.00) plus $ 20.00 which is the price difference between the default rate ($125.00) and the charge of the drug in non-participating pharmacy ($70.00), plus the copayment that has that drug at a contracted pharmacy or coinsurance of the default rate. Any amount *you* pay over the *default rate* and any applicable *copayments*, coinsurances, *pharmacy annual deductible* and percentage amounts *you* pay to an *out-of-network pharmacy* do not apply toward *your maximum out-of-pocket* or any maximum *out-of-pocket*, if any. The charge received from an *out-of-network pharmacy* for a *prescription* or refill may be higher than the *default rate.*

Prior authorization

A prescription drug that is safe and effective for one person may not be safe and effective for another. This is why certain drugs must go through an evaluation and authorization process at Humana before they can be dispensed to members. This process is based on the evaluation of clinical standards for its safe use. The United States Food and Drug Administration (FDA) has recommended these drugs as safe and effective, but due to a high level of concern about their appropriate use, therapeutic indication, and cost, Humana's National Pharmacy and Therapeutics Committee has decided that a prior-authorization must be obtained for dispensing and use. To request coverage for a drug with prior authorization, the physician can contact the Humana Clinical Pharmacy Review (HCPR) at 1-866-488-5991 or by fax 1-855-681-8650

Prior authorization process:

The Humana Clinical Pharmacy Review (HCPR) will receive calls from providers requesting authorizations related to clinical review.

- Requests that require clinical review will be evaluated by the Humana Clinical Pharmacy Review (HCPR) staff. Decisions will be made according to approved clinical protocols established by the Humana's Pharmacy and Therapeutics Committee, as applicable.

- If the request is approved, the authorization is added on Humana's claim processing system. Then, the decision is notified to the person or entity who requested the authorization, whether the member, the physician, or personal representative.

- Requests that do not meet clinical criteria are denied and the decision is notified to the person or entity who has requested the authorization, whether the member, the physician, or the personal representative.

- If additional information is required to complete the evaluation of the request, a prior authorization form will be sent to physician's office by fax. If there is no fax available at physician's office it will be sent to pharmacy.

Humana Clinical Pharmacy Review (HCPR) will evaluate the request for authorization in a period not exceeding 72 hours after being received. In those cases where the physician requesting the case to be worked as expedited because the member's health could be affected, request will be evaluated in a period not exceeding 24 working hours.

Exception request and process

How do I request an exception to the formulary?

You, your physician, or your Personal Representative can contact Humana to ask for an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it's not on our formulary.
- You can ask us not to apply coverage restrictions or limits on your drug. For example, if your drug has a quantity limit, you can ask us not to apply the limit and to cover more.
- Continuum of coverage for a specific prescription drug that Humana will remove from the formulary for reasons other than health or because the drug is no longer available or because the manufacturer removed it from the market; or
- An exception to Utilization Management criteria that indicates the drug may not be covered in the prescribed quantity.

Your doctor should contact us to ask us for an initial coverage decision for a formulary or utilization restriction exception. We must make our decision within 72 hours of getting your prescribing doctor's supporting

statement. For controlled medicines, the term should not exceed thirty-six (36) hours after getting your prescribing doctor's supporting statement.

The member or your appointed representative will only be able to make a request in writing, if the physician or other prescriber has determined that the requested medication is medically necessary for the treatment of the disease of the member because:

a. There is no covered prescription drug in the plan's formulary that is a clinically accepted alternative to treat the member's disease:
b. The prescription drug alternative(s) listed on the formulary:
    i. Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
    ii. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
c. The number of doses available under a dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

The following information would be required as part of the supporting statement in an Exception request:

- Name , group number or policy ID, member ID;
- Patient's history
- Primary diagnosis, related to the requested prescription medication
- Reason why:
    - The covered prescription drug would not be an acceptable alternative for this member; or
    - The prescription drug alternative(s) listed on the formulary or required to be used in accordance with requirements would not be acceptable for this member; or
    - The number of doses available under a dose restriction for the requested prescription drug would not be acceptable;
- Reason why the Exception request is needed, for either the requested prescription drug or the limit of available doses.

Exception requests will be evaluated by appropriate healthcare professionals, according to the member's condition; who will consider specific facts and circumstances within each case and use clinical criteria that is:

- Based on scientific, clinical evidence based medicine; and
- If available, clinical practice guidelines, which may include, evidence based practice guidelines, clinical criteria developed by Humana's Pharmacy Committee or any other practice guidelines that may have been developed by the federal government, national associations or medical/pharmacy professional associations.

Experienced healthcare professionals will evaluate Exception requests according to the member's coverage - pharmacy benefit and exclusions.

If a medical exception is granted, Humana will provide coverage for the requested medication and will not require that the member requests an approval for a refill, nor for a new prescription, in order to continue using the same prescription drug after the refills of the first prescription run out. This is subject to the coverage terms and provided that:

a. The prescribing physician continues prescribing the medication for the same disease or medical condition;

b. The prescription drug continues being safe for the treatment of the member's disease or medical condition.

Humana will not establish a new or special formulary tier, copay for any other cost-sharing requirement that would only apply for the prescription drugs approved through the Exception process.

All denials for an exception request by Humana:

a. Will be notified to the member or the appointed representative, in writing, or by electronic means, if the member has agreed to receive the information that way;
b. Will notify, by electronic means, to the physician or other prescriber, as requested, in writing; and
c. It may be appealed through an appeal request, according to the Section Procedures to Address Complaints, Grievances and Appeals of the Policy.

The denial will describe in a comprehensible way for the member or the personal representative, if applicable:

a) The specific reason for the denial;

b) references to the evidence and documentation, which include the clinical criteria for evaluation and practice guidelines, clinical, medical and scientific evidence that was used and considered to make a denial determination for the request;

c) instructions on how to request a written statement for the clinical, medical and scientific justification of the denial; and

d) a description of the process and procedures to request an appeal for the decision, according to the Section Procedures to Address Complaints, Grievances and Appeals of the Policy, including the timeframes for these procedures.

If Humana does not make a decision with respect to the request for exception, or does not notify it in the above mentioned timeframe:

- The insured shall be entitled to be provided with the prescription drug that is the object of the request for up to thirty (30) days; and
- Humana shall make a decision with respect to the request for exception prior to that time when the insured finish the medication provided.
- If the insured finishes the medication provided, Humana shall maintain coverage under the same terms and in a continuous manner, so long as the same medication is prescribed to the insured and it is deemed safe for the treatment of the illness or medical condition, unless applicable limits to benefits have been exhausted.

If the member is not satisfied with Humana decision, he/she has the right to appeal it; following the Procedure to address Complaints, Grievances and Appeals that is part of the Policy and this Schedule of Benefits.

Other Benefits

Ambulatory Services

1. SPECT test, less 35% of coinsurance. Pre-authorization required.

2. Cardiovascular rehabilitation services at a dedicated center. Includes services by licensed physicians and registered nurses. Rehabilitation program must include education and supervised exercises that lead to risk

factor recognition and management and improved exercise capacity. This benefit does not include maintenance exercise programs. Program must not exceed twelve (12) sessions in duration, less $250.00 copayment. Pre-authorization required.

3. Orthopedic devices: casts, splints, braces and crutches, with $0.00 copayment.
4. Laparoscopy, covered at ambulatory facility or at hospital, less $125.00 ambulatory facility copayment, $250.00 hospital copayment per rendered service.
5. Adult circumcision, less $20.00 office visit or $125.00 facility copayment.
6. Breast biopsies, unlimited, less $125.00 facility or $250.00 hospital copayment.
7. Allergy vaccines, up to a maximum of twenty (20) per insured, policy year, less 35% coinsurance.
8. Epidural blocks for pain management administered by medically qualified and recognized specialist, one (1) per anatomical region per insured per policy year, less $20.00 copayment.
9. Maxillofacial surgery, diagnostic and therapeutic services for accidental injuries, jaw fractures, neoplasms, injuries to natural teeth, including their replacement within a period of six months following an accident, provided the insured was covered by the policy when the accident occurred, less $250.00 copayment. Pre-authorization required.
10. Assistant Surgeon, when medically necessary: pre-notification required. Less applicable 35% coinsurance.
11. Reconstructive surgery for injuries due to an accident while the insured is covered under the policy and is not covered under any other program (ACAA, FSE, etc.), less $250.00 copayment.
12. Diagnostic tests and treatment associated with Hepatitis C, unlimited, less 35% coinsurance.
13. Diabetes paraphernalia for children and adults: lancets, syringes for insulin administration and glucometer strips up to a maximum of one hundred and fifty (150) of each one per month, less 35% coinsurance.
14. Hyperbaric Oxygenation treatment for people diagnosed with autism spectrum disorder, provided that it is recommended by a certified medical professional or health professional and the treatment is allowed by federal laws and regulations, as provided by Law 63 of July 19, 2019. Less $125.00 facility or $250.00 admission copayment.

Employee Assistance Program (EAP)

The program is offered by [Inspira, Lucy Lopez Roig, APS OptiMind] and includes the following:

1. Counseling, support, guidance and brief psychological therapy for life situations, including labor problems, emotional problems, relationships, and alcohol or drug abuse, covered at 100%, [Up to sixteen (16) sessions per policy year for each insured. Sessions are divided between the employee and dependents; eight (8) sessions for the employee and eight (8) sessions for dependents - Up to eight (8) visits per situation per insured – Unlimited]. Sessions may include the following:
    - crisis intervention
    - initial evaluation
    - marital or family counseling
    - referral to appropriate mental health resources when indicated for specialized treatment or assistance, including long-term therapy or psychiatric treatment.
2. Special crisis intervention services in case of catastrophic or traumatic events at the work-site.
3. Financial advice
4. Legal advice
5. Implementation orientation to administration and personnel

6. Workshops and orientations for employees
7. [Up to 10 occupational evaluations per employee]

Hospice

Hospice Care Program means a coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill insured and his or her insured family members, by providing palliative and supportive medical, nursing and other services through at-home or inpatient care. The hospice must be licensed according to the laws of the Commonwealth of Puerto Rico. It must provide a program of treatment for a person who have been medically diagnosed as having no reasonable prospect of cure for their illness and, as estimated by a physician, are expected to live less than six (6) months as a result of that illness.

Humana will pay benefits for charges for a hospice care program, which is submitted in writing and approved by us. The insured must submit in writing his or her intent to enroll in a hospice care program approved by us. Hospice benefits are subject to the applicable copayment. All the hospice services are subject to $250.00 admission copayment. All services must be received within a twelve (12) month period. Pre-authorization required.

Organ and Tissue Transplant

We will pay benefits of a Covered Organ Transplant as defined below, incurred by an insured for an organ transplant approved in advance by Humana, subject to those terms, conditions and limitations described below and contained in the group policy. These services are subject to any applicable copayment or coinsurance. Please contact the company's Transplant Management Department when in-need of these services.

Covered Organ Transplant means only the services, care, and treatment received for or in connection with the pre-approved transplant of the organs identified hereafter, which are determined by Humana to be medically necessary services and which are not experimental or investigational.

The covered organ transplant includes pre-transplant, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation of the following organs or procedures only:

a) Heart;
b) Lung(s);
c) Heart-lung;
d) Liver;
e) Kidney;
f) Bone Marrow;
g) Intestine;
h) Simultaneous pancreas/kidney;
i) Pancreas following kidney;
j) Any organ not listed above required by state or federal law.

The term bone marrow identified in the foregoing covered organ transplant definition refers to the transplant of human blood precursor cells which are administered to a patient following high dose, ablative or myelosuppresive chemotherapy. a) Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. b) If chemotherapy is an integral part of the treatment involving a covered organ transplant of bone marrow, the term bone marrow includes the harvesting, the transplantation and the

chemotherapy components. c) Storage of cord blood and stem cells will not be covered unless as an integral part of a covered organ transplant of bone marrow approved by Humana.

For a covered organ transplant procedure to be considered totally approved, a written authorization by Humana is required.

a. The insured or his/her physician must notify Humana in advance regarding the need for an evaluation to determine if the organ transplant will be covered. Within five working days of the receipt of this request, Human will contact the insured and his/her physician to clarify transplant benefits available under the insurance, if any.

b. If the product includes benefits of organ transplants, and once the insured has chosen the facility for transplant, Humana proceeds to approve a pre-transplant evaluation.

c. The transplant facility proceeds with the evaluation of the candidate for transplant and must submit to Humana for review seven (7) specific points or articles evaluated.

d. Humana then reviews the clinical results of the facility's evaluation, confirms eligibility, and proceeds to approval on the same day.

e. For solid organ transplants, no medical review is necessary by Humana; bone marrow transplants do require a medical review for final determination.

f. If the transplant is denied, the insured and the physician will receive oral and written explanations of their rights to appeal through the Complaints, Grievances and Appeals system of Humana.

Covered Services:

For approved covered Organ Transplants and all related complications, we will cover only the following expenses:

1. Hospital benefits shown in the schedule of benefits under the Hospital Services section of the group policy will be paid at: (a) 100% of reasonable charges if received at a participating hospital designated by us as an approved transplant facility; and (b) 70% of reasonable charges if received at non-participating hospital.

   Physician benefits shown in this Schedule of Benefits under the Ambulatory Services section of this group policy will be paid at (a) 100% of reasonable charges if received from a participating physician designated by us as an approved transplant provider; and (b) 70% of reasonable charges if received form a non-participating physician.

2. Organ acquisition and donor costs. (a) Except for Bone Marrow transplants, donor costs are not payable under the group policy if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. (b) Coverage for Bone Marrow transplant procedures will include costs associated with donor-patient to the same extent and limitations associated with the insured, except the reasonable costs of searching for the donor may be limited to the immediate family members and the National Bone Marrow Donor Program.

3. Direct non-medical costs* for the insured receiving the covered organ transplant will be paid for: (a) transportation to and from the hospital where the covered organ transplant is performed; and (b) temporary lodging at a prearranged location up to $125.00 per day when requested by the hospital and approved by Humana.

   Transportation costs for the insured to and from the hospital where the covered organ transplant is performed will be paid at: (a) 100% of the reasonable charges if the covered organ transplant is received at a

participating hospital designated by Humana as an approved transplant facility; or, (b) 70% of reasonable charges if the covered organ transplant is received at a non-participating hospital.

Coverage of *non-medical cost will be available only if the insured will travel to the United States for transplant.

4. Direct non-medical costs* for one member of the insured's immediate family (two members if the patient is under age 18 years) will be paid for: (a) transportation to and from the approved facility where the covered organ transplant is performed; and (b) temporary lodging at a prearranged location during the insured's confinement in a hospital, not to exceed $125.00 per day.

   Transportation costs for the insured's immediate family member(s) to and from the hospital where the covered organ transplant is received.

   Coverage of non-medical* will be available only if an immediate family member(s) accompanies the patient to the United States for a transplant.

*All direct non-medical expenses for the insured receiving the covered organ transplant and his/her family member(s) are limited to a combined maximum coverage of $10,000.

Exclusions:

No benefit is payable for or in connection with a covered organ transplant if:

1. We are not contacted for authorization prior to referral for evaluation of the covered organ transplant, unless such authorization is waived by Humana.
2. We do not approve coverage for the covered organ transplant, based on our established criteria.
3. Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received.
4. The expense related to the transplantation of any non-human organ or tissue, unless otherwise stated in the group policy.
5. The expense related to the donation or acquisition of an organ for a recipient who is not covered by Humana.
6. A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow up care, immunosuppressive drugs, and complications of such transplant.
7. The insured for whom a covered organ transplant is requested has not met pre-transplant criteria as established by Humana.

Once the covered organ transplant is approved, we will advise the insured's physician. Benefits are payable only if the pre-transplant services, the covered organ transplant and post-discharge services are approved by Humana.

Services Out of Puerto Rico

Services rendered on the United States of America:

If insured needs a procedure, treatment, test or office visit in the United States as a second opinion, follow up treatment or because the treatment is not available in Puerto Rico, can submit evidence of the incurred expenses, we will reimburse according the established rates for each treatment in Puerto Rico. Apply the copayment or coinsurance of the benefit described in the policy. Pre-authorization required.

These do not include benefits not available in Puerto Rico, available in the United States of America. For these benefits, refer to Section Service Not Available in Puerto Rico, Available in the United States.

Emergency Services Outside Puerto Rico

I. Emergency Services (Including emergency hospitalizations) received in the United States of America:

A. Services received in contracted Humana or ChoiceCare facilities:

1. Whenever possible emergency services should be received in a facility contracted with the Humana or ChoiceCare Networks.
2. Humana P.R. must receive notice of all emergency services within 72 hours of the insured receiving the services.
3. Payments for emergency services and related admissions provided by a contracted provider will be paid according to the Urgent / Emergency Room Services Section under this Schedule of Benefits, less $75.00 copayment.

B. Services received outside of contracted Humana or ChoiceCare facilities:

1. For services provided in emergency rooms of non-participating providers, payment will be the same as if a participating provider, less $75.00 copayment.
2. The physician must receive notice of all emergency services within 72 hours of the insured receiving the services.

   The attending physician may transfer the insured to a contracted facility as soon as medically feasible. Such transfer should in no way compromise or be detrimental to the insured's medical condition or treatment. Humana will assist in the coordination of such transfer.

II. Emergency Services received outside the United States of America or Puerto Rico:

A. The insured will be reimbursed 100% of the contracted fee for similar services by a provider in Puerto Rico or, billed charges, whichever is less, less $75.00 copayment.

1. If the insured requires hospitalization and cannot be transported to a contracted facility in Puerto Rico or the United States, Humana will attempt to negotiate the best possible fee with the non-participating facility for the benefit of the insured.

2. If the insured can be transported without risk to a participating facility in the United States or Puerto Rico, then the admission copayment or coinsurance only will apply from this point forward.

All claims for services rendered outside of Puerto Rico or the United States must be submitted to Humana with all supporting medical and financial records within a period of one (1) year from the date of service or date of discharge (whichever is later) to ensure reimbursement where applicable.

Ambulatory Services for Dependent Studying in College in the United States of America

Dependent studying in college in the United States of America, as included in the definition of direct dependent, (b) through (g), can receive coverage for covered services provided by contracted providers in the United States. To receive coverage the following conditions must be met:

- The dependent studying college degree, in accordance to the definition of dependent indent (b) through (g), must be eligible for coverage, under the Plan and the ambulatory services received in the United States must be covered services under the Humana PPO Policy.
- The insured university student must be a full-time student at an accredited university in the United States. For purposes of this requirement, it will be presumed that the student is full-time if he/she studies twelve (12) credits; six (6) credits in the case of students studying graduate studies. Any exception to this assumption of credit requirements must be certified by the university institution.
- The dependent college student must coordinate and obtain prior authorization from Humana P.R. for the services unless the services meet criteria for urgent or emergency treatment as set forth in the Policy.
- Services provided by a provider in the Humana or ChoiceCare provider network shall be paid according to the benefits under the Policy. Any copays, coinsurance and/or deductibles set forth in the policy applicable to the benefits shall apply.

If the service is rendered by a provider not participating in the Humana or ChoiceCare network, the service will the service will be reimbursed based on contracted fees for similar services in Puerto Rico, less applicable copayments, coinsurances and deductibles. The insured is responsible for the difference between the Humana contracted rate in Puerto Rico and the facility billed charges.

Important:

1. ChoiceCare is a network of providers, including physicians and hospitals, contracted by Humana in the United States. The insured does not need to contact ChoiceCare to access a covered service. The logo on the card will be the identifier to the provider. Since the services require pre-authorization and coordination, Humana will help the insured identify the appropriate provider or facility. A full ChoiceCare directory is available on the web at www.humana.com.
2. For coordination or pre-authorization the member should call Humana's Customer Service Department at 1-800-314-3121.

Services Not Available in Puerto Rico, Available in the United States of America

This benefit is for services not available in Puerto Rico, available in the United States of America, including equipment, treatment and facilities, among others.

A. Humana will cover such services only if the following five conditions are met.

   1. The Insured must be eligible for coverage under the Plan and the services requested must be Included this Schedule of Benefits.

   2. The provider referring must demonstrate that the equipment, treatment or facilities required to provide medically necessary covered services to the insured are unavailable in Puerto Rico**.** A service will not be deemed unavailable in Puerto Rico if the request for services to be provided outside of Puerto Rico involves a modification to the equipment, technique, or surgical approach available in Puerto Rico or is based on the reputation or recognition of any given provider.

   3. The service must be coordinated and pre-authorized with Humana in Puerto Rico at least five (5) working days prior to the date the service will be rendered.

   4. The service must be provided by Humana or ChoiceCare network providers/facilities.

   5. All services under this Section are subject to the applicable copayments and coinsurances for services as described in this Schedule of Benefits.

B. These services or treatments require pre-authorization with Humana, except in emergencies. If the service or treatment is not authorized by and coordinated with Humana in Puerto Rico, the insured will be responsible for the entire payment for such service or treatment. Humana will reimburse the patient based on the applicable Humana fee in Puerto Rico, less applicable copayments or coinsurances as described in this Schedule of benefits only if conditions A1, A2 are met. To receive reimbursement, the insured must provide Humana with all supporting medical and financial information within one (1) year of service or discharge.

Important Notes:

1. ChoiceCare is a network of providers, including physicians and hospitals, contracted by Humana in the United States. The insured does not need to contact ChoiceCare to access a covered service. The logo on the card will be the identifier to the provider. Since the services require pre-authorization and coordination, Humana will help the insured identify the appropriate provider or facility. A full ChoiceCare directory is available on the web at www.humana.com.

2. For coordination or pre-authorization the member should call Humana's Customer Service Department at 1-800-314-3121.

Telemedicine Service
(Virtual Medical Consultation)

Benefit:
Telemedicine service through virtual medical consultation to the insured allows you to receive access to health or minor emergency consultations with a certified primary care physician for the practice of Telemedicine in accordance with Act No. 168 of 2018. Less $20.00 copayment per virtual medical consultation. Through the following website: **www.mdlive.com/humanapr.**
As part of the services of this virtual platform, the insured can also share medical results of their studies.

In cases where the doctor understands that he or she needs medication use according to the insured's clinical picture, the prescription will be coordinated directly to the insured's preferred pharmacy through one of our contracted provider pharmacies.

This Telemedicine service does not replace your doctor, if you have an emergency, it is important that you call the emergency system at 911 or visit the nearest emergency room.

If the doctor determines that the condition by which the insured accesses the virtual consultation cannot be attended through this service, the insured will be immediately referred to an emergency room or personal doctor.

The insured is responsible for verifying their certificate of benefits, description of benefits and / or the medication form to verify if the service is covered.

Medical Exclusions

1. Procedures and/or health services in an experimental or research stage which are not supported by clinical evidence documented in the medical literature of the United States of America, except in connection with a life-threatening condition of the insured for which no effective treatment is available. Humana will pay only for the routine medical expenses associated with the order of such procedure or service which are not reimbursed by the entity conducting the service.
2. Expenses related to illness or injury resulting from war or uprisings.

3. Correspond Services be received, according to the State Workmen's' Compensation Fund Law (*Ley del Fondo de Seguro del Estado*), liability of the insured, private compensation plans at work, car accidents (Automobile Accident Compensation Administration (*Administración de Compensación por Accidentes de Automóviles*, ACAA, for its Spanish acronym).and other services available under state or federal laws. They will also be excluded such services when they are denied by government agencies concerning non-compliance or violation of the requirements or provisions of the above laws, although such failure or violation does not constitute a crime.
4. Expenses caused by military service, war, civil insurrection, international armed conflict, except in those cases where the services received are related to an injury sustained while the insured was active in the military (service connected), in which case Humana will collected such charges from the U.S. Department of Veterans Affairs.
5. Accidents occurring while the insured is participating in races such as: automobile, motorcycle, four-track, boats or other tests of speed, in areas set aside for such activities or any other place.
6. Services provided and/or covered pursuant to state or federal legislation for which the Insured is not legally required to pay.
7. Services received free of charge, rendered by the spouse, parents, siblings, or children of the Insured.
8. Hospitalizations for procedures which can be performed on an ambulatory basis.
9. Hospitalization for diagnostic purposes only; custodial, rest or convalescence services.
10. Services rendered at a time when the policy is not in effect.
11. Electronic prosthesis, including myoelectric arm and cochlear implant, and the removal or insertion of any device, and any other described as non-covered, except the breast prosthesis covered in case of mastectomy.
12. Services considered unreasonable or medically unnecessary for diagnosis or treatment of an illness or injury.
13. Expenses for custodial services, private nurses, personal commodity services such as telephone, television, etc. and all medical services or expenses in convalescence facilities, except for home healthcare services which have been authorized by Humana.
14. Music therapy
15. Cosmetic/esthetic maxillofacial and dental procedures.
16. Esthetic mammoplasty except as applicable in Woman's Rights Cancer Act, and the esthetic mammoplasty in accordance with the Law No. 275 dated on September 27, 2012.
17. Cosmetic/esthetic surgery, except septoplasty when medically justified and with prior authorization.
18. Repair or replacement of instruments or prosthetic devices due to normal wear and tear and impairment.
19. Corrective footwear.
20. Services, treatments, and therapies of alternative medicine by physicians or other certified trained professionals, except naturopathic physician visits.
21. Sports medicine.
22. Eyeglasses and contact lenses for adults, hearing aids.
23. Congenital or genetic deformities and metabolic deformities, except in newborns, recently adopted newborns or newborns recently placed for adoption.
24. All services and/or treatments related to infertility or impotence, except test to detect infertility.
25. Expenses for Physical Examinations to adults required by the employer or health certificates for any type of license and all diagnostic tests or services for these purposes. Except for the annual exam according to Law No. 296 dated on September 1st, 2000, which includes: physical and mental evaluation, oral health, hearing and vision screening, and screenings recommended by the American Academy of Pediatrics.
26. Elective abortions.

27. Acne surgery and acne treatment, including drugs.
28. Growth hormones and all related treatment.
29. Embryo transplantation.
30. Human chorionic gonadotropin (HCG) injections.
31. Vaccinations required for travel.
32. Tuboplasty, vasovasostomy, and any procedure or service for the purpose of fertility.
33. Sickness or injury caused by the insured engaging in an illegal occupation; or committing or attempting to commit a criminal act, except those injuries resulting from an act of domestic violence or medical condition.
34. Enrollment in a health, athletic, or similar club; or a weight loss or similar program.
35. Purchase or rental of supplies of common household use such as: exercise cycles; air purifiers; central or unit air conditioners; water purifiers; allergenic pillows or mattresses; or waterbeds. Except for technical equipment of ventilators for children which are vital for the maintenance of life, including children and those who have started treatment as minors and become age 21, who depend on medical equipment such as respirators or supplemental oxygen, as authorized by the laws of Puerto Rico as outlined in Law Number 62 dated May 4, 2015.
36. Purchase or rental of: motorized transportation equipment; escalators or elevators; saunas or attachment pools; professional medical equipment such as blood pressure kits; or supplies or attachments for any of these items.
37. Expert witness required by a Court that is not included under the benefits or requirements of the mental health law.
38. Services and supplies for treatment of temporomandibular joint disorder or dysfunction (TMJ) and craniomandibular jaw disorders (CMJ) which are recognized as dental procedures. This includes, but is not limited to, the extraction of teeth and the application of orthodontic devices and splints.
39. New diagnostic and therapeutic services/procedures that are done with approved FDA equipment/devices that become available posterior to the effective date of the policy. Unless, the insured suffers from a life-threatening condition for which there is no effective treatment. Humana would then pay for routine medical expenses of the patient which are not covered by the entity carrying out the study.
40. Epidural anesthesia during delivery.
41. Air and maritime ambulance services outside of Puerto Rico, except for dependent studying in the United States
42. Any and all services or treatments not specifically described as covered benefits, except for the services and benefits included in a law that are required to be included in the coverage.

Dental Coverage Exclusions

1. Services or treatments presented for beauty or cosmetic reasons.
2. Services received free of charge; services rendered by spouses, parents, brothers/sisters or children of the insured.

3. Experimental or investigative procedures and/or services, or the drugs related to them.
4. Services rendered before the effective date of the policy.
5. Expenses related to injuries caused by war or disturbances.
6. Illnesses or accidents covered by the State Insurance Fund law -*Ley del Fondo del Seguro del Estado* (FSE) and/or the Automobile Accidents Compensation Administration -*Administración de Compensaciones por Accidentes de Automóviles* (ACAA).
7. Any benefit or service not specified in the dental coverage.
8. Services not used during the policy year do not accumulate for the following year.

Vision Coverage Limitations and Exclusions

1. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
2. Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan
3. Services provided as a result of any worker's compensation law (*Ley del Fondo del Seguro del Estado* -FSE) and/or the Automobile Accidents Compensation Administration (*Administración de Compensaciones por Accidentes de Automóviles* - ACAA).
4. Lenses or vision devices that are not prescribed.
5. Unspecified contact lenses on the vision coverage.
6. Any other frame that is out of the collection.
7. Any treatment or service that is not specified on the vision coverage.

Pharmacy Coverage Limitations and Exclusions

1. Legend drugs which are not deemed medically necessary by us;
2. Any drug prescribed for a sickness or bodily injury not covered under the policy;
3. Any drug, medicine or medication labeled "Caution-limited by federal law to investigational use" or any experimental or investigational drug, medicine or medication, even though a charge is made to you; not covered:
    a. Medications used in research trials which have the sponsorship of manufacturers or government entities.
    b. Medications or services offered during research trials when the sponsor of such tests offers these services and medications at no cost to the participants
4. Allergen extracts(covered under the Medical Coverage);
5. Therapeutic devices or appliances including, but not limited to:

A. Hypodermic needles and syringes (except needles and syringes for use with insulin, and self-administered injectable drugs whose coverage is approved by us);
B. Support garments;
C. Test reagents;
D. Mechanical pumps for delivery of medications; and
E. Other non-medical substances;

6. Dietary supplements; (except for formulas or low protein modified foods necessary for the treatment of phenylketonuria or certain other heritable diseases of amino and organic acids);
7. Nutritional products;
8. Minerals;
9. Herbs and vitamins, except Vitamin D, prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride, OTC Ferrous Sulfate which are covered for Women's Preventive Healthcare;
10. Anorectic or any drug used for the purpose of weight control;
11. Any drug used for cosmetic purposes, including but not limited to:
    A. Tretinoin;
    B. Dermatologicals or hair growth stimulants; or
    C. Pigmenting or de-pigmenting agents, e.g. Solaquin;
12. Any drug or medicine that is:
    a. Lawfully obtainable without a prescription (over the counter drugs), except insulin
13. Progesterone crystals or powder in any compounded dosage form;
14. Abortifacients (drugs used to induce abortions);
15. Infertility services including medications;
16. Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra;
17. Any drug, medicine or medication that is consumed or injected at the place where the prescription is given, or dispensed by the health care practitioner;
18. Prescriptions that are to be taken by or administered to you, in whole or in part, while you are a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
    A. Hospital;
    B. Skilled nursing facility; or
    C. Hospice facility;
    D. Physician office (unless coverage is approved by us)
19. Injectable drugs such as:
    A. Biological sera (covered under the Medical Coverage)
    B. Blood (covered under the Medical Coverage)
    C. Blood plasma (covered under the Medical Coverage)
20. Prescription refills:

A. In excess of the number specified by the health care practitioner; or

B. Dispensed more than one year from the date of the original order;

21. Any portion of a prescription or refill that exceeds a 90-day supply, received from a mail order pharmacy or a retail pharmacy that participates in our program which allows you to receive a 90-day supply of a prescription or refill;
22. Any portion of a prescription or refill that exceeds a 30-day supply, received from a retail pharmacy that does not participate in our program which allows you to receive a 90-day supply of a prescription or refill;
23. Any portion of a specialty drug or self-administered injectable drug received from a retail pharmacy or a specialty pharmacy that exceeds a 30-day supply, unless otherwise determined by us;
24. Any portion of a prescription or refill that:
    A. Exceeds our drug specific dispensing limit, e.g. IMITREX; or
    B. Is dispensed to an insured whose age is outside the drug specific age limits;
    C. Exceeds the duration-specific dispensing limit;
25. Any drug for which a charge is customarily not made;
26. Any drug, medicine or medication received by you:
    A. Before becoming covered under this rider; or
    B. After the date your coverage under this rider has ended;
27. Any costs related to the mailing, sending or delivery of prescription drugs;
28. Any intentional misuse (improper use)of this benefit, including prescriptions purchased for consumption by someone other than you;
29. Any prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
30. Drug delivery implants;
31. More than one prescription or refill for the same drug or therapeutic equivalent medication prescribed by one or more health care practitioners and dispensed by one or more pharmacies until you have used, or should have used, at least 75% of the previous prescription or refill, unless the drug or therapeutic equivalent medication is purchased through a mail order pharmacy, or a retail pharmacy that participates in our program which allows you to receive a 90-day supply of a prescription or refill, in which case you have used, or should have used 66% of the previous prescription. (Based on the dosage schedule prescribed by the health care practitioner);
32. Any copayment or coinsurance you paid for a prescription that has been filled, regardless of whether the prescription is revoked or changed due to adverse reaction or change in dosage or prescription;
33. Bulk Chemicals and Pain Patch not approved by the Food and Drug Administration (FDA)
34. When the FDA has determined that a medication is contraindicated for the condition for which it is prescribed.

These limitations and exclusions apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, service, treatment, supply, or prescription. This does not prevent your health care practitioner or pharmacist from providing or performing the procedure, service, treatment, supply, or prescription; however, the procedure, service, treatment, supply or prescription will not be a covered expense.