Triple-S Salud, Inc.
San Juan, Puerto Rico

Independent Licensee of the Blue Cross and Blue Shield Association

GROUP HEALTH PLAN RIDER
TRIPLE-S OPTIMO PLUS

The President of the Board of Directors and the President of the Corporation sign this rider on behalf of Triple-S Salud, Inc.

Jesús R. Sánchez Colón, D.M.D.
President, Board of Directors

Socorro Rivas, CPA
President and CEO

This rider is part of the policy to which it is attached and is issued in consideration of the payment in advance of the corresponding premiums. It will be subject to the terms and conditions of the policy that are not in conflict with the terms and conditions of the rider.

This rider amends the following sections of the Triple-S Salud group policy Model PG-OP 07/2008:

Clause 17 of the Definitions Section has been modified to read as follows:

17. DIRECT DEPENDENTS: The following are considered direct dependents:

a. The spouse, person with whom one is married, having complied with the ceremonies and formalities required by law, of the insured employee, included in the Family Contract as long as the policy is in effect and the insured lives permanently with that spouse under the same roof.

b. Natural or adopted children of the insured employee until they reach twenty-six (26) years old. Not eligible under this plan are the children's spouses (son or daughter in-law) of the insured employee, grandchildren of the insured employee, or the in-laws children of the insured employee.

c. Minors placed in the insured employee's house during the adoption process, until they turn twenty-six (26) years old. The employee must include the adoption papers with the corresponding documentation requested by Triple-S Salud.

d. Will be eligible as a direct dependent a minor not emancipated that is a grandchild or blood relative of the insured employee, if the permanent custody of the child was adjudicated to the insured employee by a competent court of law with jurisdiction through a firm and final decision, as long as the insured employee has permanent custody and until the minor attains age twenty-six (26). Will also be eligible as a direct dependent a grandchild or blood relative of the insured employee, if such person is declared handicapped by court of law with jurisdiction through a firm and final decision and the custody of such person was adjudicated to the insured employee. In both cases, the insured employee that will want to subscribe a grandchild or blood relative as a direct dependent under this clause, must evidence his/her custodial rights presenting a Final Decree from Court adjudicating the custody.

e. Foster Children of the insured employee (as defined under Law No. 121 of August 31, 2000) as long as they are totally dependent on the insured employee for their well- being and until they attain age twenty-six (26). The foster child status must be evidenced with the documentation requested by Triple-S Salud.

Clause 2 and 3 of the Changes Section has been modified to read as follows:

2. Divorced of the insured employee: If the insured employee divorces while this policy is still valid, a request for change to terminate insurance together with the Divorce Decree issued by the court must be submitted within thirty (30) days following the date of the divorce. The change will be effective on the first day of the month after the date Divorce Decree was issued by the court and notified, or if the divorce was declared valid by other means, the ruling was issued by a court in another jurisdiction.

3. A child, under the definition of direct dependent of this policy, ceases to be eligible as direct dependent of the insured employee:

   a. The child attains age twenty-six (26). The birth date will be taken as date of the request for change to end insurance coverage. The change will be effective on the first day of the month following the birth date.

Covered Services Section has been modified to include:

Preventive Services required by the federal laws, Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA) and Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152 (HCERA), and as established by the United States Preventive Services Task Force are covered under this policy.

The vaccine benefit under the Outpatient Medical-Surgical and Diagnostic Services Section has been modified to read as follows:

- Rotavirus vaccine will be covered up to 8 months of age, Pneumococcal Conjugated vaccine (PCV - Prevnar 13 y Prevnar) up to 5 years of age and Hemophilus Influenza B up to 6 years of age. DTaP and DPT/Hib vaccines will be covered up to 7 years of age, Polio up to 18 years of age, Tdap up to 19 years of age and HPV (Human Papiloma Virus) up to 27 years of age. Zoster vaccine will be covered up to 60 years of age. DT, Hepatitis A, MMR, Varicella, Meningococcal Conjugated (MCV), Meningococcal Polysaccharide (Menomune), Pneumococcal Polysaccharide (PPV), Influenza and Hepatitis B (pediatric/adult) vaccines are covered without age limitations. $0.00 copayment.

- Pentacel vaccine will be covered up to 4 years of age. Kinrix vaccine up to 6 years of age, Pediarix (DTaP, IPV, HepB) up to 7 years of age, Hepatitis B (dialysis or immunosuppressed) up to 17 years of age and Td up to 18 years of age. Tetanus Toxoid vaccine will be covered without age limitations. $5.00 copayment.

- Inmunoprophylaxis for respiratory syncytial virus (palivizumab) will be covered up to 2 years of age, subject to precertification. 20% coinsurance.

The Summary of Copayments and Coinsurances Section has been modified:

	Copayment	Coinsurance
Vaccines: Rotavirus, PCV, Hemophilus Influenza B, DTaP, DPT/Hib, Polio, Tdap, HPV, Zoster, DT, Hepatitis A, MMR, Varicela, MCV, Menomune, PPV, Influenza and Hepatitis B (pediatric/adult)	$0.00	_____
Vaccines: Pentacel, Kinrix, Pediarix (DTap, IPV, HepB), Td, Tetanus Toxoid and Hepatitis B (dialysis or immunosuppressed)	$5.00	_____
Preventive Services (required by the Federal Law)	$0.00	_____

The Bill of Patient's Rights and Responsibilities was modified to include the following paragraph, under the *Right to confidentiality of information and medical record* Section:

Will receive a quarterly utilization report that includes, among other things the name of the plan member, type and description of the service received, the date and the provider that rendered the service, as well as the amountpaid by the service. The main plan member may access the utilization report that details the services paid in his benefits and the benefit of his dependents, by registering in Triple-S Salud website www.ssspr.com.

The Section of Benefits Adverse Determinations Appeals has been modified to read as follows:

Right to Appeal in cases of Adverse Determinations

An adverse determination of Triple-S Salud subject to Triple-S appeals procedure is a determination that includes a denial, reduction or termination of your coverage or a failure to make a payment for a particular benefit when the adverse determination has been based on:

- A determination on eligibility to the plan
- A determination on a service not covered by the plan
- A determination of a covered service based on an exclusion for a preexisting condition ; this may be based on exclusion based on how the injury or illness occurred, or an exclusion from the provider in the provider network or other limitations on covered services

The foregoing determinations concerning claims of pre and post-service benefits.
It is also considered an adverse determination, the plan's decision to cancel your contract retroactive to the effective date or another date prior to the notice of cancellation, provided that the reason for the determination is not for non-payment of premiums.

If you disagree with an adverse determination made by Triple-S Salud regarding a reimbursement application, a request for precertification, the cancellation of your plan, or any denial of benefits as described in this policy, you may appeal Triple-S Salud's determination under the following procedure:

Appeals for Adverse Determination

If you understand that the determination made by Triple-S Salud on the aspects mentioned above is adverse to you, you must submit an appeal in accordance with the procedure described below.

An appeal is a written request to Triple-S Salud to review the determination notified to you on the subject requested to Triple-S Salud. The appeal must be initiated by you or your authorized representative (refer to the requirements of a representative described further in this document.)

You or your authorized representative must submit your appeal, in writing, within 180 days following the date you received the notification on adverse determination. For your appeal to be considered, it must include the following, if applicable:

- Name and contract number of the plan member that received the services being appealed
- Date of service
- Number of services and description of the services received
- Original receipt for any amount paid by the appellant
- Invoices from the provider
- Name and address of the provider
- Evidence of the precertification granted and/or the medical need certification, if any of these was required to receive the service
- Forms CMS-1500 or UB-92 Forms, duly completed by the provider
- A written statement explaining why you believe Triple-S Salud was mistaken in its decision on your reimbursement, precertification or benefit claim.

You must also submit any other written evidence or information regarding your appeal. You must send your appeal request to Triple-S Salud, Customer Service Division, PO BOX 363628, San Juan, PR 00936-3628.

If your case is considered urgent, Triple-S Salud will notify its decision within a period that does not exceed 72 hours, counting from the date the completed application for appeal was received. Incomplete applications will not be considered until they meet the requirements thereof. Urgent appeals means those appeal requests that correspond to services that pose a serious risk or damage to the life of the plan member or the ability of a vital organ of the body to function at its maximum capacity.

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

If you do not agree with Triple-S Salud's decision on your appeal, you have the right to request a second review within 60 days from the date Triple-S Salud notified its decision on your first appeal. With this second request for review, you must include a copy of all the documents related to your first appeal, a statement explaining why you believe Triple-S Salud's decision on your first appeal was incorrect and additional evidence to support your allegations. Your second appeal will be

evaluated by persons that did not intervene in the decision on the first appeal and are not subordinates of the persons who made the decision on your first appeal. Triple-S Salud's previous decision will not be considered. You have the right to request Triple-S Salud to disclose the names and positions of the officers or consultants that evaluated your second appeal, as well as an explanation of the criteria on which they based their decision.

In case of urgent appeals, Triple-S Salud must respond to your request within 72 hours. In cases of precertification appeals, Triple-S Salud must respond to your second appeal within 15 days from the date it received your appeal. In other cases, Triple-S Salud must respond within 30 days from the date it received your appeal. If you are not satisfied with this second decision, you are entitled to submit this before a competent court under Section 502 (a) of the Employee Retirement Income Security Act (ERISA) or initiate a process with the Office of the Insurance Commissioner of Puerto Rico to request an investigation of the case. It is required that you make use of all the internal claims procedures herein described before go to court with your claim or before the Office of the Insurance Commissioner of Puerto Rico.

Right to Appoint a Representative

You have the right to appoint a representative to act on your behalf in submitting any request for appeal to Triple-S Salud. The designation of a representative must meet the following criteria:

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

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