



Certificate of Benefits

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

MEDICAL COVERAGE:	MCS Life Insurance Company
PLAN:	PREMIUM
GROUP NUMBER:	79-750096
EFFECTIVE DATE:	JANUARY 1, 2025
POLICY YEAR:	JANUARY 1 TO DECEMBER 31 OF EVERY YEAR
PHARMACY COVERAGE:	MC-Rx
PLAN:	PREMIUM
GROUP NUMBER:	5613
EFFECTIVE DATE:	JANUARY 1, 2025
POLICY YEAR:	JANUARY 1 TO DECEMBER 31 OF EVERY YEAR
DENTAL COVERAGE:	Delta Dental
PLAN:	PREMIUM
GROUP NUMBER:	82425-00001
EFFECTIVE DATE:	JANUARY 1, 2025
POLICY YEAR:	JANUARY 1 TO DECEMBER 31 OF EVERY YEAR



Elevidys Coverage Endorsement Effective March 8, 2024

This Endorsement is effective in March 8, 2024 and forms part of the policy or certificate of benefits to which it is adhered and is subject to terms and conditions of the policy that do not conflict with the terms and conditions of the endorsement. Elevidys drug will cover under the medical coverage as described in this endorsement.

Elevidys is proven and medically necessary for the treatment of Duchenne muscular dystrophy (DMD) in patients who meet all of the following criteria:

- Diagnosis of Duchenne muscular dystrophy by, or in consultation with, a pediatric neuromuscular specialist with expertise in the diagnosis of DMD; **and**
- Submission of medical records (e.g., chart notes, laboratory values) confirming **both** of the following:
 1. A mutation in the DMD gene; **and**
 2. The mutation is not a deletion in exon 8 or exon 9; **and**
- Patient is aged 4 or 5 years of age; **and**
- Submission of medical records (e.g., chart notes) confirming that the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.); **and**
- Patient does not have an elevated anti-AAVrh74 total binding antibody titer $\geq 1:400$; **and**
- Patient will receive a corticosteroid regimen prior to and following receipt of Elevidys in accordance with the United States Food and Drug Administration (FDA) approved Elevidys labeling; **and**
- Elevidys is prescribed by, or in consultation with, a pediatric neuromuscular specialist with expertise in the treatment of DMD; **and**
- Elevidys dosing is in accordance with FDA-approved labeling; **and**
- Patient will not receive exon-skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)] concomitantly or following Elevidys treatment; **and**
- Patient has never received Elevidys treatment in their lifetime; **and**
- Authorization will be issued for no more than one treatment per lifetime and for no longer than 45 days from approval or until 6 years of age, whichever is first.

Pre-authorization determination will be managed within the fifteen (15) – day period of its receipt. In the event the initial request is incomplete, the provider of physician will be notified within a five (5) day period from the date it is received. The initial period could be extended for fifteen (15) additional days, provided the extension period if to handle situations out of MCS Life control or when there is insufficient information to make a determination. In either case, the insured or the provider submitting the request will be notified of the reason of the specific necessary information for the evaluation. If the extension is because the necessary information has not been provided for MCS Life to make a determination, the insured will be given at least a forty-five (45) day period from the date the notice of extension is received to provide the specified additional information. Extensions will be notified during the first fifteen (15) days from the date of receipt of the request.



Elevidys Coverage Endorsement

Effective March 8, 2024

If service is denied, a letter will be sent explaining the reason for the denial of services, including supporting references used, if applicable, as well as information on the right to appeal the denial and corresponding procedure.

MCS Life fax telephone numbers for pre-authorization request are as follows: 787-622-2436 or 787-622-2434, or you can call the dedicated line for Walmart Associates at 787-945-1348 or 1-855-830-9887

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CHAPTER I: MEDICAL BENEFITS

Please, read carefully.

This document is not a Medicare supplement policy or contract. If Walmart has insureds eligible for *Medicare*, please, review the “Guide to Health Insurance for People with Medicare”.

MCS Life Insurance Company hereinafter will be referred to as “MCS Life”.

In the event of a conflict between the Certificate of Benefits and the 2025 Associate Benefit Book (SPD) along with the Summary of Material Modifications of 2023, the SPD will prevail.

WELCOME TO MCS!

Dear insured:

Welcome to the great family of MCS Life Insurance Company. Below you will find a list of the benefits included in your service coverage. In order to provide you the best service possible, we recommend that you read this document carefully.

If you have any questions or concerns related to your benefits, call our Customer Service Center at 787-945-1348 (Metro area) or 1-855-830-9887 (toll free), Monday through Friday from 8:00 A.M. to 8:00 P.M. and Saturdays from 8:00 A.M. to 4:30 P.M. The hearing impaired (TTY) can call 1-866-627-8182. We also invite you to visit our website at www.mcs.com.pr where you can connect to My MCS tool and access our directories and forms mentioned in this certificate.

Our mission and commitment are to facilitate healthy lives through innovative products and services that satisfy and foresee the needs of our members.

Sincerely,

Roberto Pando
President
MCS Life Insurance Company

PART I: DEFINITIONS

Below you will find definitions of the terms used throughout this certificate.

Access	Availability of all health services included in the plan, in such a way that it meets all the medical needs of the insured, as stated in the policies and procedures established by MCS Life.
Accelerated Appeal	A request to review an adverse benefit determination submitted by the insured or his or her doctor when the waiting period for the standard appeal process can seriously jeopardize the insured's life, health or ability to regain maximum function.
Accelerated review	When the insured suffers a health condition and the time required for a first level review complaint could jeopardize the life, health or full recuperation. The accelerated review decision will be made and notified to the insured or his or her authorized representative with the speed required by the insured's medical condition. In no case, it will not exceed more than 48 hours from receipt of the request.
Accident	An unexpected situation that arises from violent, sudden or incidental external causes, beyond the insured's control, that occurs within the effective date of this certificate. Services for accidents covered under the Workers Compensation Act (CFSE, Spanish acronym), that are the responsibility of the insured, automobile accidents (ACAA, Spanish acronym) and other services available through state or federal laws will not be considered.
Adverse Benefit Determination	<ol style="list-style-type: none">1. A determination made by a health benefits administrator or utilization review organization, in which a benefit is denied, reduced, terminated or not paid partially or totally, because when applying the utilization review techniques, based on the provided information, the requested benefit as per the health insurance, does not meet the requirements of medical necessity and appropriateness, place where the services are rendered or level or efficacy of care or if it is determined that it is experimental or investigational in nature;2. The denial, reduction, termination or absence of payment of a benefit, either partially or in full, by the health benefits administrator or a utilization review organization, based on the determination of eligibility of the insured; or3. The determination resulting from a prospective or retrospective review in which the benefit is denied, reduced, terminated or not paid, either partially or in full.
Affordable Care Act (ACA)	Federal Health Care Reform Act signed into law on March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act (PPACA), signed on March 23, 2010 and modified by the Health Care and Education Reconciliation Act on March 30, 2010, as amended. The name Affordable Care Act is used to refer to the final version of the law.

Ambulance	Motor vehicle licensed by government entities to operate as a motor vehicle that offers transportation services for patients.
Appeal	A request to review an adverse benefit determination or the outcome of a complaint investigation.
Associate	Person employed by Walmart Inc. and, that as an employee, enjoys the benefits of the self-insured plan denominated as <i>Walmart Inc. Associates' Health and Welfare Plan</i> , as primary insured.
Authorized Representative	<ul style="list-style-type: none"> • A person to whom the insured has given express written consent to represent him or her when requesting a medical exemption, • A person authorized by law to grant consent on behalf of the insured; • An immediate family member up to second degree consanguinity or second degree affinity, that is, father, mother, children and insured's spouse, or the health care professional who cares for that person, when he or she is unable to consent; • The treating or prescribing health care professional of the insured, with the purpose of requesting a medical exemption on his or her behalf.
Bariatric Surgery	<p>Surgical procedure for morbid obesity, including but not limited to, the following techniques:</p> <ul style="list-style-type: none"> • <i>Gastric Bypass</i> - Bariatric surgery in which the stomach is reduced by fifteen (15) to thirty (30) ml, it is connected directly to the small intestine, and food passes directly to it. It reduces a large segment of the intestine as well as caloric absorption. • <i>Adjustable Gastric Band</i> – Bariatric surgery that consists on placing a band around the upper portion of the stomach that divides it and leaves a small passage to the rest of the stomach. • <i>Sleeve Gastrectomy</i> - Bariatric surgery by vertically removing a portion of the left side of the stomach, especially the gastric fundus, where an appetite-stimulating substance is produced.
Case Management	Group of coordinated activities established by the health benefits administrator for the individual management of the insured's complex, prolonged conditions or any other.
Claim	Statement of dissatisfaction by the insured that can be resolved through orientation, negotiation or short intervention.
Clinical Laboratory	Facilities authorized by the corresponding authorities to offer laboratory services in Puerto Rico.
Clinical peers	A physician or other health care professional who holds an unrestricted license in the United States or Puerto Rico, on an equal or similar specialty as physicians or health care professionals that customarily offer care for a condition, procedure or treatment revised by MCS Life on a claim or appeal.
Clinical Review Criteria	Written procedures for the evaluation, summary of decisions, clinical protocols, and practice guidelines used by the health benefits administrator for determining medical necessity and appropriateness of health care services.

COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a law that requires the employer to provide the associate, the associate's spouse and his/her eligible dependents the opportunity to continue the coverage.
Co-insurance	The amount of money, expressed as a percentage, that the insured is required to pay when certain medical services are received. This amount varies according to the cost of services and fees contracted by MCS Life.
Collateral Visits	Mental health treatment modality with the purpose of collecting information and implementing treatment objectives. The participant, usually is a parent, spouse, de facto partner or sibling. Other individuals may also have the right to collateral visits if he or she shows being significant in the life of the insured.
Complaint	A written or verbal complaint, if it entails an urgent care request submitted by the insured or on his/her behalf, concerning: <ul style="list-style-type: none"> • The availability, delivery or quality of the health care services, including a complaint related to an adverse benefit determination resulting from a utilization review process; • Payment or handling of claims or reimbursements • Issues pertaining to the contractual relationship between an insured and MCS Life.
Concurrent Reviews	Assessment conducted during the stay of an insured in a health care facility or during treatment at the health care professional office or any other place where services are offered to an insured that is admitted or on an outpatient basis.
Convalescent Home	Home where various health services are provided to help people recuperate after a serious illness, surgery or injury. The services can consist of medical, nursing, skilled care or therapy. They can be provided in different settings, including rehabilitation hospitals, outpatient centers, skilled nursing centers and the patient's home.
Co-payment	Fixed amount of money that the insured under this certificate is required to pay to the provider when he or she receives certain services.
Cosmetic Procedures (Cosmetic surgery)	Any procedure or medication solely to improve the appearance of a body part.
Covered Services	Assessments, procedures, and treatments offered by a provider to the insured, subject to the specifications included on the coverage.
Credentialing	Initial process that verifies providers qualifications documents to practice in Puerto Rico, hospital privileges, professional experience and any other relevant criteria periodically established by MCS Life. Related term: Provider
Custodial, Domiciliary or Residential Care	Type of care that does not require continued services by expert staff, physicians, or allied health personnel. Includes care mainly directed to help keep or maintain personal hygiene, nutrition or other means of self-care. Provides socially necessary services through maintenance and requires adherence to a prescribed medication schedule. Custodial care usually is necessary for people with physical illness who cannot take care of themselves, but do not require the services of a licensed practical nurse o registered nurse.
Domestic Partner	To the ends of this certificate, it refers to a couple that:

	<ul style="list-style-type: none"> — Is in a continuous, exclusive and compromised relationship similar to a marriage during at least 12 months and have the intention of maintaining this status indefinitely. — Are not married between themselves nor with anyone else. — Meet the minimum required age for matrimony in their residing state and are mentally competent to participate on a contract. — Are not related in a way that would prevent a legal marriage in their residing state, and — Are not in the relationship for the sole purpose of obtaining the benefits
Deductible	Amount paid by the insured before starting to receive covered services.
Devices (artefacts, apparatus, internal or external prosthesis)	<p>An instrument, device, machine, internal or external implant, or any other similar device, or a related item that includes parts or accessories:</p> <ul style="list-style-type: none"> • Recognized by the U.S. Food and Drug Administration (FDA), whose intended use is for the diagnosis of diseases or other conditions, to cure, mitigate, treat or prevent an illness in a human being; • Whose use is intended to alter the structure or function of the human body; • That does not depend on metabolism to achieve any of its purposes.
Diagnosis	The process of identifying a disease by its signs and symptoms, as determined by a physician or other health care professionals.
Durable Medical Equipment (DME)	Equipment that is necessary for medical reasons and that is strong enough to withstand repeated use without damage. This equipment can be used in the home.
Effective Date	Date in which coverage is in effect for receiving the services described in this certificate.
Elective surgery	Surgical procedure that, while medically necessary and ordered by a physician, does not involve a medical emergency as there is no life-threatening situation, there is no risk for permanent injury to a vital organ or that the patient may suffer permanent disability.
Emergency Services	Health care assistance required to treat an illness or trauma in a medical emergency.
Epidural anesthesia	Administration of local anesthetic into the epidural space to block nerve endings where they exit the spine.
Essential health benefits	The Affordable Care Act guarantees that from 2014, all <i>non-grandfathered</i> health insurances must include comprehensive services coverage, known as essential health benefits. These benefits include articles and services within ten (10) categories defined by law as: emergency services; hospitalization, ambulatory services; maternity and newborn care; mental health and substance abuse, including behavioral health treatment; prescription drugs; rehabilitation and habilitation services and devices; laboratory services; preventive and wellness services and chronic diseases management; and pediatric services, including eye care.
Experimental or Research Services	<p>Medical treatments strictly controlled in humans:</p> <ul style="list-style-type: none"> • To determine if it is safe or effective for managing a health condition • That are not approved by a regulatory entity, for example the Food Drug Administration (FDA), the Department of Health and Human Services

	<p>(DHHS) or the Department of Health of Puerto Rico; or that do not go along with the medical policies established by MCS Life for the indications and specific methods ordered; or</p> <ul style="list-style-type: none"> • Whose scientific evidence does not allow to reach conclusions on the effect of technology on the medical results obtained; or • Whose results do not outweigh the negative effects of the treatment; or • Whose treatment offers no further benefits from other alternative established treatments; or • Whose treatment improvement cannot be obtained outside the investigational phase.
External Appeal	A request to review an adverse benefit determination or an internal appeal before an external independent review organization that meets the requirements established by the Insurance Commissioner of Puerto Rico as set forth in Section 1001 of the Patient Protection and Affordable Care Act, 75 Fed. Reg. 43330-43364 (July 23, 2010).
False or Fraudulent Misrepresentation	Verbal manifestation, conduct or statement made by a person knowing it is false and with the intent to commit fraud.
Full Hospitalization	Admission of an insured to a hospital where his/her stay is over 24 hours until the insured is discharged.
Group Therapy	Psychiatric treatment methodology that focuses on patients receiving treatment as a group. It is led by a licensed professional, has an established treatment plan and certain particular improvement goals.
Habilitation Services	Refers to therapies (physical, speech and occupational) offered to correct defects in the normal development of an insured.
Health and Human Services (HHS)	US Department of Health and Human Services responsible of the administration of health care and wellness programs.
Health Benefits Administrator	Designated entity by the employer Walmart Inc. to manage this Certificate. For the purposes of this Certificate of Benefits, the designated entity is MCS Life Insurance Company.
Health Professionals	Authorized professional that practices in Puerto Rico in the health care and medical care field, such as, physicians, podiatrists, naturopathic doctors, chiropractors, optometrists, clinical psychologists, dentists, pharmacists, nurses, and medical technologists.
Health Risk Assessment (HRA)	<p>The health risk assessment is a questionnaire that offers the insured a current health profile and knowledge of the risks associated with the development of chronic conditions. Through the health profile, MCS has the opportunity of:</p> <ul style="list-style-type: none"> • Educating the insured of how his/her lifestyle could affect their health and wellness • Designing health care promotion and wellness interventions based on identified needs • Following up on the progress of the insured or group to measure the effectiveness of an intervention <p>It is also an essential tool for promoting participation in wellness programs and encouraging participants to take a leading role in their health.</p>
Health care Coverage	Health services included in this certificate.

Home Health Care	Medical services and other types of related services that may include physical therapy, nursing care, counseling and social services offered by a provider in the home of the patient. Includes care and assistance in the home.
Hospice care	Special care provided to people with terminal conditions, with a life expectancy of six (6) months or less. This service includes physical care and counseling. Hospice applies to the period of time the doctor has determined that the insured qualifies and needs this type of care.
Hospital	Accredited institution that offers treatment and medical or surgical diagnosis to hospitalized patients, including general and specialty hospitals.
Illness	When the condition and social, physical, emotional or intellectual functioning of a person are reduced or deteriorated.
Independent Review Organization	Entity that conducts an independent external review of an adverse determination made by the health benefits administrator or the designated utilization review organization.
Injuries	Any harm suffered by the insured caused by accident or trauma, that is not a result of a car or work accident and that requires medical treatment and hospital services.
Insured	Insured person under the coverage of the self-insured plan denominated <i>Walmart Inc. Associates' Health and Welfare Plan</i> sponsored by Walmart employer.
Insurer	In this certificate, insurer refers to <i>Walmart Inc. Associates' Health and Welfare Plan</i>
Intensive Hospitalization	Admission of an insured with critical health conditions and who needs vital support of organic functions besides specialized medical supervision and constant monitoring.
Intensive Outpatient Programs (IOP)	Intensive program that provides treatment and support for certain conditions, such as depression, anxiety, and substance dependence that do not require detoxification.
Internal Appeal	A request to review an adverse benefit determination or the outcome of a complaint investigation submitted to the health benefits administrator.
Maximum Out-Of-Pocket (MOOP)	The maximum amount of money that the insured pays during a policy year before the insurance company pays 100% of covered services.
MCS Life Clinical Affairs	Department that groups pre-authorization, Hospital Review, Education and Wellness, Care Management, and Care Transition units.
Medical Emergency	Condition in which the symptoms presented are severe enough for a person to reasonably come to a conclusion that the absence of immediate medical care would result in: putting at risk the health his/her health or that of an unborn child, a serious impairment to body functions, or serious dysfunction of any body part or organ.
Medical Necessity	Care, service or supply generally accepted by the medical profession as effective, appropriate, and essential to diagnose and treat an illness or injury, and that: <ul style="list-style-type: none"> • Is based on generally accepted or recognized standards of care and that are appropriate for the symptoms, diagnosis and treatment. • Is provided according to the standards of good medical practice.

	<ul style="list-style-type: none"> • Are provided not mainly for the convenience of the insured, physician or facility.
Medically Necessary Services	Services offered by a participating provider to maintain and restore the health of the insured, as per the standards of good medical practice.
Medicare	U.S. government health insurance program for people sixty-five (65) years or older, people of any age with permanent renal problems and some people with disabilities, according to Title XVIII of the Social Security Act. Medicare has four parts: Part A, B, and C and Part D for prescription drugs.
Medicare Beneficiary	Any person sixty-five (65) years old or older, or under sixty-five (65) years with specific disabilities, or permanent renal failure, who requires dialysis or renal transplantation who is eligible for Medicare Parts A, B, C, or D.
Morbid Obesity	Is the excess of body fat, as determined by a Body Mass Index (BMI), greater than or equal to thirty-five (35).
Non-covered or Excluded Services	<p>Services that:</p> <ul style="list-style-type: none"> • Are expressly excluded from coverage. • Are offered by professionals whose expertise lacks the required training or contract to offer such services. • Are considered experimental or research in nature, unless otherwise provided by law. • Are not medically necessary.
Partial Hospitalization (mental health)	Refers to organized services for patients with mental conditions or substance abuse who require hospital care through day or night programs that cover periods of less than 24 hours.
Participating Provider	Health care provider that has entered into a contract with MCS Life to provide services covered under this certificate.
Patient Protection and Affordable Care Act (PPACA)	See Affordable Care Act (ACA).
Physician	Professional authorized to practice medicine in the state where services are rendered. He or she must hold current licenses to be allowed to offer the plan's benefits.
Policy Year	Twelve (12) consecutive month period, beginning on January 1st to December 31st of every year.
PPO or Preferred Provider Organization	Health care access services model which consists of a group of hospitals, physicians and other providers contracted by the health benefits administrator.
Pre-authorization	Previous authorization issued to the insured for obtaining benefits as set forth in this certificate.
Prescription drug	Substance with properties for the treatment or prevention of human being diseases.
Preventive Services	Available exams and services to help the insured in the prevention and detection of diseases, as required by the <i>Affordable Care Act (ACA)</i> .
Prospective Review	Prior assessment conducted by the health benefit administrator before the service or insured treatment is offered, so that such service or treatment is approved, in part or in full, before it is offered.

Provider	Term used for physicians, hospitals and other facilities that have been licensed or certified to provide health care services.
Provider Network	Physician, hospital, skilled nursing facility or any other, related to the offering of health care or ancillary services contracted by the health benefits administrator
Psychiatric Emergency	When a patient has a mental condition that can result in immediate harm to that person, other persons, or property.
Reconstructive Procedure	Procedure that may restore function and/or reshape a body structure.
Rehabilitation Services	Restoration of the abilities of an insured who has suffered an illness or body harm, allowing him/her to recover self-sufficiency and maximum function in a normal fashion or as close to normal as possible.
Residential Care Facilities	Facilities that provide non-hospital specialized care for daily management of disease through structured interventions.
Residential Treatment	Treatment offered at a health care facility that provides therapy at a temporary living environment, for patients with behavior substance abuse disorders who require drug treatment, continuous supervision or relief from environmental stressors.
Rest Home	A residential establishment that provides housing, food and personal care to individuals who need assistance, supervision and are not able to live wholly independently, but that do not need nursing care.
Retrospective Review	Assessment of an already offered service.
Semi-Private Hospital Room	Standard room covered under hospital benefits.
Service Area	Geographical area from where the insured is expected to receive most of the medical and hospital services, within the seventy-eight (78) municipalities in Puerto Rico.
Shared costs	A portion of the cost of services that the insured pays when services are received. Related terms: deductible, co-payment, and co-insurance.
Skilled Nursing Facility	Institution legally authorized and accredited to receive payment for Medicare program services or that meets minimum requirements to be granted such accreditation. Its main purpose is to offer health care offered by skilled nurses, supervised by a licensed physician besides offering room and diet. This type of institution offers health services twenty-four (24) hours a day and treatment and rehabilitation facilities for individuals who are insured, sick or disabled.
Spouse	Person with whom a Walmart Inc. associate is legally married according to the applicable laws.
Surgical Assistance	Licensed physician that actively assists the primary surgeon, during a surgical procedure covered under the policy that due to its complexity justifies the need of assistance.
Telemedicine	The diagnosis and treatment of patients at a distance with the use of telecommunication technology.
Terminal Illness	An incurable or irreversible illness or condition diagnosed by a physician, who according to his/her professional judgment, will result in the patient's death within the next six (6) months.
Transplant	The transfer of a living organ or tissue from one part of the body to another or from one individual to another.

Treatment Plan	A detailed report of the procedures recommended by the physician or other health care professional for the treatment of the medical needs of the insured.
Urgent Care Request	Request for service or treatment in which the established time: <ul style="list-style-type: none"> • Could threaten the life or health of the insured or his or her full recovery; or • In the opinion of a physician with knowledge of the health condition of the insured, could expose him or her to pain that cannot be properly managed without the requested health care service or treatment. <p>Upon determining if the request will be treated as urgent care, the person representing the health benefits administrator will prudently make judgement based on his or her knowledge of health and medicine.</p>
Usual and Customary Charges	The usual costs for a specific medical service based on the geographical area outside of Puerto Rico where the insured receives services.
Utilization Review	Processes established to oversee the health care, procedures or places where such services are offered or to evaluate the medical necessity, their appropriateness, efficacy or efficiency. This could include the review of ambulatory services, prospective review, second opinions, certifications, concurrent reviews, case management, discharge planning or retrospective review.
Utilization Review Organization	Entity contracted by the health benefits administrator to conduct an utilization review when the health benefits administrator is not the one who conducts the review for his/her own insurance plan.
Vision Network	Contracted network to provide vision benefits.

PART II: COVERED BENEFITS

The benefits included herein will only apply when the insured has coverage under this certificate and should comply with the pre-authorization program for procedures and services requested as required. The insured must reimburse for any claims paid by MCS Life as result of charges incurred after an insured has cancelled coverage.

The Services will be covered when they are provided in Puerto Rico, as defined in this certificate, by participating providers contracted by MCS Life. Services pre-authorized by MCS Life Clinical Affairs to be performed in the USA will also be covered, as well as emergency cases, in accordance with the Bill of Rights and Responsibilities of the Patient, Act No. 194 of August 25, 2000, as amended.

This health benefits coverage is *non-grandfathered*, as defined by the *Affordable Care Act (ACA)*. Essential health benefits, as described by ACA, involve a *maximum out of pocket (MOOP)* expenses or disbursements by the insured, whose essential benefits fall into the following ten categories: emergency services; hospitalization; ambulatory services; maternity and newborn care; mental health, and substance abuse, including behavioral health treatment; prescription drugs; rehabilitation services, habilitation and medical equipment; laboratory services; preventive, wellness and chronic disease management services; and pediatric services, including vision care.

The maximum applicable to this certificate is equivalent to that set forth by the U.S. Internal Revenue Services (IRS) and represents the sum of out-of-pocket expenses of the associate, that is, initial deductible, co-payments and/or co-insurance established for medical and prescription drug coverage (combined). When the insured reaches the maximum out-of-pocket, *Walmart Inc. Associates’ Health and Welfare Plan* will cover 100% of essential health benefits. For calendar year 2025, the maximum out-of-pocket expenses established for health benefits by *Walmart Inc. Associates’ Health and Welfare Plan* is \$1,600.00 for individuals and \$3,200.00 for families. The following services as well as shared costs will not be included for MOOP calculation:

- MCS Alivia
- MCS Medilínea MD
- Shared costs paid by a third party

Section I: Essential Health Benefits

Shared costs apply to some of these services, as described in Part VIII of this chapter.

I. Emergency and urgency services

MCS Life will provide and cover, without a waiting period, emergency benefit services, including land ambulance. In such cases, total costs will be paid directly to the provider. For non-emergency land ambulance services, the set forth amount will be paid by reimbursement, as described below in this certificate. Such emergency services will be covered without pre-authorization from MCS Life, regardless if the provider of such services is a participating provider or not.

In the case of non-participating providers in Puerto Rico, services will be covered according to the Bill of Rights and Responsibilities of the Patient, Act No. 194 of August 25, 2000, as amended. MCS Life will compensate the provider offering services and it will have to accept such compensation, for an amount that will not be less than the agreed rate for contracted providers. In addition, under these circumstances, such emergency services will be provided regardless of the conditions of the corresponding health insurance plan. In every medical emergency in which emergency services are accessed through the **9-1-1 system, no pre-authorization will be required** and services will be covered in accordance with Act No. 383 of September 6, 2000.

Benefit	Description	Co-payment/Co-insurance
MCS Life covers emergency room services and the insured pays the applicable co-payment amount.	• Trauma or illness	Illness: \$50 Accident and Trauma: \$0
	• Prescription drugs, materials, and equipment	
	• Laboratories and X-rays	
	• Unlimited respiratory therapy	
	• Self-inflicted conditions (suicide attempt)	
	• Specialized diagnostic tests	

Emergency services in the United States will be covered as any emergency through the contracted network (See Part VII: Service Access Model). The insured must show his or her health plan card in order for the facility to verify eligibility with MCS Life.

Benefit	Description	Co-payment/Co-insurance
MCS Life covers services in an urgency center or facility and the insured pays the applicable co-payment.	• Trauma or illness	\$10
	• Prescription drugs, materials and equipment	
	• Unlimited respiratory therapy	
	• Self-inflicted conditions (suicide attempt)	

2. Hospital Services

Shared costs apply to some of these services, as described in the Co-payments, Co-insurances, and Deductibles Table in Part VIII at the end of this chapter.

Benefit	Description	Co-payment/Co-insurance
Hospital Services: All hospital services covered will be paid according to the fees contracted by MCS Life with network participating hospitals. Corresponding co-payment applies.	• Includes semi-private room. In cases in which the insured requests a private room, the insured will be responsible of paying the difference in cost, provided a medical necessity not exist, as established in Ruling Letter No. N-AV-12-111-99 of December 20, 1999. In addition, hospital and general anesthesia services will be covered due to age, impediment or disability, as required by Act No. 352 of December 22, 1999. Additionally, except for cases in differences in room costs, the contracted provider will not charge for private rooms a different amount to which it is entitled if the insured were in a semi-private room. Admissions and elective surgeries, as well as procedures usually performed in outpatient facilities but that require to be performed in a hospital will require MCS Life Clinical Affairs pre-authorization Division.	\$50
	• Intensive care units, cardiovascular care unit, pediatric intensive care and neonatal intensive care unit.	
	• Universal Newborn Hearing Screening, in accordance with Act No. 311 of December 19, 2003, as amended, and hearing screenings by ENTs (ear, nose and throat specialists) and audiologists	

	<ul style="list-style-type: none"> Screening for critical congenital cardiac defects by pulse oximetry, in accordance with Act No. 192 of December 20, 2014. 	
	<ul style="list-style-type: none"> Telemetry 	
	<ul style="list-style-type: none"> Nursing care and other allied-health care providers 	
	<ul style="list-style-type: none"> Nutrition services offered by the hospital including hyperalimentation 	
	<ul style="list-style-type: none"> Clinical laboratories and radiology tests 	
	<ul style="list-style-type: none"> Diagnostic tests and studies 	
	<ul style="list-style-type: none"> Respiratory and physical therapies. 	
	<ul style="list-style-type: none"> Medical visits 	
	<ul style="list-style-type: none"> Blood, plasma and platelets 	
	<ul style="list-style-type: none"> Medical supplies and medications 	
	<ul style="list-style-type: none"> Chemotherapy, radiotherapy (including cobalt) and medications per medical component if the insured's condition requires such treatments during hospital stay as provided in Act No. 107 of 2012, as amended. MCS Life will cover intravenous, injectable or intrathecal anti-cancer drugs as ordered by a specialist or oncologist. 	
	<ul style="list-style-type: none"> Dialysis and hemodialysis - Walmart is the primary plan during the first 30 months of Medicare eligibility, from then on Medicare will be primary and Walmart secondary, from the first treatment on, when related to the same medical condition. No co-payment applies. 	
	<ul style="list-style-type: none"> Other facilities, services, equipment and supplies usually provided by the hospital and ordered by the physician and that are not expressly excluded from the contract. 	
	<ul style="list-style-type: none"> Hospitalizations due to mental conditions and substance abuse will be covered according with the mental health and substance abuse services, including behavioral health treatment. 	\$50

Other Institutional Services		
Benefit	Description	Co-payment/Co-insurance
Skilled nursing facilities	No co-payment applies. Requires MCS Life Clinical Affairs pre-authorization. Services will be covered if they start within fourteen (14) days	\$0

	following the date in which the insured was discharged from a hospitalization of at least three (3) days and if offered for the same illness or for a health-related condition for which the hospitalization occurred.	
Surgical Assistance in the Hospital	No co-payment applies. Requires MCS Life Clinical Affairs pre-authorization.	\$0
Hospice	<p>Covered without co-payment or co-insurance, for terminally ill insureds with a life expectancy of six months or less. It includes:</p> <ul style="list-style-type: none"> • Social medical services • Nursing care • Durable medical equipment • Medical supplies • Pain medication • Psychologists • Counseling for the insured and family members <p>Note: All these services must be related to the diagnosis for which the insured is admitted to hospice and be offered by authorized personnel and pre-authorized by MCS Life. Treatments and medications for terminal illness and non-preauthorized services are excluded.</p>	0%
Anesthesia in the hospital	Covered service. No co-payment applies.	\$0
In-Hospital Surgeries	Surgeries regularly performed in an ambulatory facility but if needed to be performed in the hospital, MCS Life Clinical Affairs pre-authorization is required. This applies only when the procedure is the reason for the admission. Reconstructive surgery will only be offered when there is a need to restore tissue that has been damaged due to disease or body injury, an accident or to correct a birth defect, including oral defects of the newborn and that are not related to the Automobile Accident Compensation Administration (ACAA, Spanish acronym) or the Worker Accident Compensation Act (CFSE, Spanish acronym) occurring during the effectiveness of the policy. Co-insurance for procedure and co-payment for facility applies.	<p>\$50</p> <p>Procedure: 25%</p>
Hospitalization for mental health or substance abuse and/or alcohol (partial and complete)	Hospitalization co-payment applies. Electroconvulsive therapies require MCS Life Clinical Affairs pre-authorization.	\$50

3. Ambulatory Services

Benefit	Description	Co-payment/Co-insurance
Visits to physicians or health care professionals	Co-payment or co-insurance applies according to medical specialty. This includes: <ul style="list-style-type: none"> • General practitioners • Specialists • Sub-specialists 	\$10 \$10 \$15
Home doctor's visits	Corresponding co-payment applies.	\$15
Optometrist	Co-payment for specialist applies. Covered in accordance with Act No. 148 of August 9, 2002.	\$10
Clinical Psychologist	Co-payment for specialist applies. Covered in accordance with Act No. 148 of August 9, 2002, as amended, and in accordance with Act No. 239 of 2012.	\$10
Audiologist	Co-payment for specialist applies. Covered in accordance with Act No. 127 of September 27, 2007, as amended.	\$10
Chiropractor	For the initial chiropractor visit, the insured pays corresponding visit to a specialist; for subsequent visits, the amount applicable to manipulations applies. Covered in accordance with Bill of Rights and Responsibilities of the Patient, as amended by Act No. 150 of August 8, 2006.	\$10 Manipulations: \$7
Podiatric services	Routine foot care and podiatric surgical procedures are covered. Co-payment for specialist applies per medical visit. For podiatric surgical procedures co-insurance for diagnostic and surgical procedures at the medical office, ambulatory facility or hospitalization applies accordingly, plus co-payment for facility. Podiatric surgical procedures performed in the hospital require MCS Life Clinical Affairs pre-authorization. Covered in accordance with Bill of Rights and Responsibilities of the Patient, as amended by Act No. 148 of August 9, 2002.	Medical visit: \$10 Facility: \$25 Hospital: \$50 Procedure: 25%
Naturopathic Doctors	Co-payment for specialist applies. Covered in accordance with Act No. 210 of December 14, 2007.	\$10

Nutritionists	Co-payment for specialist applies. Unlimited visit coverage per policy year.	\$10
Ambulatory facilities	Use of ambulatory surgery facility is covered and the insured is responsible of co-payment for the use of the facility. Procedures usually performed at the office and require an ambulatory facility are subject to MCS Life Clinical Affairs pre-authorization.	\$25
Pre-admission tests	Co-payment / co-insurance for exams or laboratories applies.	25% General practitioner: \$10 Specialist: \$10 Sub-specialist: \$15
Diagnostic and surgical procedures at the medical office	The insured is responsible of co-insurance for procedures plus co-payment for medical visits.	25% General practitioner: \$10 Specialist: \$10 Sub-specialist: \$15
Diagnostic and surgical procedures at the ambulatory facility	The insured is responsible of co-insurance for procedures plus applicable co-payment for ambulatory facility. Procedures usually performed at the medical office and require an ambulatory surgical center require pre-authorization from MCS Life. For molecular or genetic testing, refer to Part III, Section 8. Laboratories and X-ray services.	25% Facility: \$25
Intra-articular injection	Co-payment for medical visit applies. No pre-authorization required.	General practitioner: \$10 Specialist: \$10 Sub-specialist: \$15
Injectable therapy with sclerosing (veins) agents	Medical office: Co-payment for medical visit applies.	Specialist: \$10 Sub-specialist: \$15
	Ambulatory facility: Co-payment for ambulatory facility applies. Services offered by general surgeon and peripheral sclerotherapy.	\$25
Ambulatory Respiratory Therapy	Co-payment for therapy applies.	\$7
Circumcision	<ul style="list-style-type: none"> Medical office: Co-payment for medical visit applies. 	General practitioner: \$10 Specialist: \$10 Sub-specialist: \$15
	<ul style="list-style-type: none"> Ambulatory facility: Co-payment for facility applies. 	\$25

Vasectomy at the medical office	Co-payment for medical visit applies. Covers one (1) vasectomy for life, per insured. No co-insurance for procedure at medical office applies.	Specialist: \$10 Sub-specialist: \$15
Vasectomy at an ambulatory facility	Covers one (1) vasectomy per life, per insured. Vasectomies at an ambulatory facility require pre-authorization and corresponding co-payment applies.	\$25
Endoscopies at the medical office	Co-payment for medical visit applies. No co-insurance applies for diagnostic and surgical procedures at the medical office.	Specialist: \$10 Sub-specialist: \$15
Endoscopies at an ambulatory facility	Co-payment for ambulatory facility applies. No co-insurance applies for diagnostic and surgical procedures at an ambulatory facility. Requires MCS Life Clinical Affairs pre-authorization.	\$25
Chemotherapy and Radiotherapy (including cobalt) drugs per medical component	In accordance with the provisions of Act No. 107 of 2012, anti-cancer drugs are covered in their various administration routes, intravenous, injectable, or intrathecal, as per medical order of a specialist or oncologist. Co-payment for medical office or ambulatory facility applies.	Specialist: \$10 Sub-specialist: \$15 Facility: \$25
Dialysis and hemodialysis	Walmart is primary during the first 30 months of Medicare eligibility, from then on Medicare becomes primary and Walmart secondary, from first treatment, if related to the same clinical condition. No co-payment applies.	\$0
Lithotripsy	Co-payment for ambulatory facility applies. Requires MCS Life Clinical Affairs pre-authorization.	\$25
Orthognatic Surgery	Co-payment for ambulatory facility or medical visit applies. Requires MCS Life Clinical Affairs pre-authorization.	General practitioner: \$10 Specialist: \$10 Sub-specialist: \$15 Facility: \$25
Services for the treatment of keratoconus	Co-payment for medical visit applies plus a \$250 co-payment per pair of glasses.	General practitioner: \$10 Specialist: \$10 Sub-specialist: \$15 Treatment: \$250
Cervical Cryosurgery	<ul style="list-style-type: none"> Medical office: Co-payment for medical visit applies. Maximum of one (1) procedure per policy year per insured. 	General practitioner: \$10 Specialist: \$10

		Sub-specialist: \$15
	<ul style="list-style-type: none"> Ambulatory facility: Co-payment for ambulatory facility applies. Maximum of one (1) procedure per policy year per insured. Requires MCS Life Clinical Affairs pre-authorization for use of the facility. 	\$25
Thin Prep Pap	Totally covered service.	\$0
Nerve Conduction Velocity Test	Co-insurance for laboratory applies. Two (2) procedures per policy year per insured.	25%
Invasive and Non-Invasive Cardiovascular Tests and Procedures	Co-insurance applies per corresponding test plus co-payment for medical office or ambulatory facility.	25% General practitioner: \$10 Specialist: \$10 Sub-specialist: \$15 Facility: \$25
Post-trauma or medical necessity Septoplasty, Rhinoseptoplasty and Rhinoplasty	Co-payment for ambulatory facility applies. Requires MCS Life Clinical Affairs pre-authorization. Cannot be related to the Automobile Accident Compensation Administration (ACAA, Spanish acronym) or the Workers Accident Compensation Act (CFSE, Spanish acronym) occurring during the effectiveness of this certificate.	\$25
Neurologic Tests and Procedures	Co-insurance for X-rays applies.	25%
Scalenotomy	Co-payment for ambulatory facility applies.	\$25
Hearing Tests	Co-insurance for laboratory applies, up to a maximum of one test (1) per policy year.	25%
Reconstructive Surgery	Co-payment for facility or hospital, accordingly. Requires MCS Life Clinical Affairs pre-authorization. Will only be offered for reconstructive interventions for restoring damaged tissue due to disease, body injury or accident (post-trauma) and for surgeries for correcting birth defects, including oral defects of the newborn. Cannot be related to the Automobile Accident Compensation Administration (ACAA, Spanish acronym) or the Worker Accident Compensation Act (CFSE, Spanish acronym).	Facility: \$25 Hospital: \$50
Cardiac Catheterization	X-ray co-insurance applies, plus co-payment for ambulatory facility.	25% Facility: \$25

4. Maternity and Neonatal Care

Maternity and neonatal care services are available for the insured.

Shared costs apply to some of these services, as described in the Co-payments, Co-insurances, and Deductibles Table in Part VIII at the end of this chapter.

Benefit	Description	Co-payment/Co-insurance
Maternity Services	Corresponding co-payment applies for pre and postnatal care.	\$8
	If the insured enrolls in the “Programa de Madres y Bebés Saludables” during the first three (3) months of pregnancy, no co-payment for prenatal and postnatal services applies. For more details on the program, please see Section 7 – Programs included in your benefits.	\$0
Hospital care coverage for the mother and her newborn(s)	Hospital co-payment applies. Minimum coverage of forty-eight (48) hours for hospital care for the mother and her newborn child per natural birth. If C-section is required, there is minimum coverage of ninety-six (96) hours. Covered in accordance with Act No. 248 of August 15, 1999. Once the mother enrolls in the “Programa de Madres y Bebés Saludables”, there is no hospital admission co-payment at time of birth.	\$50
Other maternity services	Co-payment or co-insurance applies for:	
	• Obstetric services in the hospital and ambulatory.	Hospital: \$50 Facility: \$25
	• Obstetrical sonographies up to three (3) per pregnancy and a maximum of six (6) for high-risk pregnancies, additional ones require MCS Life Clinical Affairs pre-authorization. Co-insurance for X-rays applies. No pre-authorization required for perinatologists.	25%
	• Biophysical profile, limited to one (1) per pregnancy, additional ones require MCS Life Clinical Affairs pre-authorization. Co-insurance for X-rays applies.	25%

	<ul style="list-style-type: none"> • <i>Fetal Non Stress Test</i> up to one (1) per pregnancy, additional ones require MCS Life Clinical Affairs pre-authorization. No pre-authorization required for perinatologists. Co-insurance for X-rays applies. 	25%
	<ul style="list-style-type: none"> • Fetal echocardiography requires MCS Life Clinical Affairs pre-authorization. Co-insurance for X-rays applies. 	25%
	<ul style="list-style-type: none"> • Unlimited amniocentesis (genetic). 	25%
	<ul style="list-style-type: none"> • Unlimited amniocentesis (fetal maturation). Subject to evaluation and MCS Life Clinical Affairs pre-authorization. 	25%
	<p>No co-payment or co-insurance applies:</p> <ul style="list-style-type: none"> • <i>Fetal Monitor Contraction Stress Test</i> up to three (3) per pregnancy, additional ones require MCS Life Clinical Affairs pre-authorization. • Fetal monitoring per pregnancy (belts – production and interpretation) in-hospital, are covered up to three (3) no pre-authorization, additional ones require MCS Life Clinical Affairs pre-authorization. 	\$0
Postpartum follow up visit	Co-payment for medical visit applies. Includes any treatment and medical tests required for both, mother and infant.	\$10
In-Hospital Newborn Care (during stay for childbirth)	<p>No co-payment applies. The following benefits are covered:</p> <ul style="list-style-type: none"> • Health care services for injuries or diseases, including care and treatment for diagnosed birth defects and abnormalities; in-hospital medical care and intensive care unit (NICU); • Use of the Well Baby Nursery; • Universal newborn hearing screening • Screening for critical congenital cardiac defects by pulse oximetry, in accordance with Act No. 192 of November 20, 2014; • Circumcision of the newborn 	\$0
Newborn care (ambulatory services)	<ul style="list-style-type: none"> • Co-payment for medical visit and routine visits for the baby (Well Baby Care) apply. • Health care services for injuries or diseases, including care and treatment for diagnosed birth defects or congenital abnormalities. • Universal newborn hearing screening 	<p>General practitioner: \$10</p> <p>Specialist: \$10</p> <p>Sub-specialist: \$15</p>

Newborn Screening Tests	Preventive tests required by PPACA and set forth by the Department of Health of Puerto Rico and according to Title XIX of the Medicaid Program, Title V of the program for Mother, Children and Adolescents and the American Academy of Pediatrics, as required by Act No. 296 of September 1, 2000, as amended. For information on applicable screenings, refer to Section 8, Preventive, Wellness and Chronic Diseases Management Services.	\$0
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5. Mental Health, Substance Abuse and Behavioral Health Treatment

Mental Health, Drug Abuse and Behavioral Treatment services are offered directly through the provider or through voluntary participation in MCS Solutions program offered twenty-four (24) hours a day, seven (7) days a week in a coverage that integrates mental health care and substance abuse. The purpose of the program is to facilitate immediate access to the necessary services for your situation or condition with a telephone helpline service provided by MCS Life. This coordination facilitates that the insured receives the most appropriate service at the least restrictive level possible, as provided by law.

In addition, the insured has the option to access services directly as needed. In the event of an emergency, the insured may access immediate and direct services at an emergency room.

Services are covered under the Mental Health Act (Act No. 408 of October 2, 2000), as amended, and in accordance with Act No. 239 of September 13, 2012, and in accordance with U.S. *Mental Health Parity Act*. Providers offering psychology services must be certified by the Puerto Rico Board of Psychologist Examiners (Junta Examinadora de Psicólogos de Puerto Rico).

Shared costs apply to some of these services, as described in the Co-payments, Co-insurances, and Deductibles Table in Part VIII at the end of this chapter.

Benefit	Description	Co-payment/Co-insurance
Mental health and substance abuse; ambulatory treatment includes, but not limited to:	• Unlimited visits to psychiatrists and clinical psychologists, with corresponding applicable co-payment	\$10
	• Twenty-three (23) hour stabilization units, after twenty-four (24) hours, it is considered a hospitalization	\$50
	• Hospitalization co-payment applies for intensive outpatient (IOP) treatment. Requires MCS Life Clinical Affairs pre-authorization	\$50
	• Group therapy and collateral visits with corresponding applicable co-payment	\$10

	<ul style="list-style-type: none"> • Co-payment for partial, full or intensive hospitalization applies; partial hospitalization requires MCS Life Clinical Affairs pre-authorization. 	\$50
	<ul style="list-style-type: none"> • Management of intensive cases 	\$50
Substance abuse	The following services are offered under unlimited coverage for dependence or abuse of controlled substances and/or alcohol disorders, in accordance with the Mental Health Act, as amended and in accordance with PPACA:	
	<ul style="list-style-type: none"> • Intensive case management 	\$50
	<ul style="list-style-type: none"> • Psychiatrist 	\$10
	<ul style="list-style-type: none"> • Clinical psychologist 	\$10
	<ul style="list-style-type: none"> • Collateral visits 	\$10
	<ul style="list-style-type: none"> • Group therapy (by clinical psychologists) 	\$10
	<ul style="list-style-type: none"> • Ambulance transfer services from one facility to another 	\$75
Residential Treatment for Dependence or Abuse of Controlled Substances and/or Alcohol	Covered by MCS Solutions or contracted providers in Puerto Rico. No co-payment applies. This benefit includes detoxification due to dependence or abuse of controlled substances in facilities available in Puerto Rico, in accordance with Act No. 408 of 2000, as amended. Requires MCS Life Clinical Affairs pre-authorization.	\$0
Psychological Tests	Co-payment for specialist applies. For people under twenty-one (21) years of age, psychological tests determined by the Department of Health together with the Department of Education subject to the conditions and limitations of the referred agencies or special applicable laws, in accordance with Act No. 296 of September 1, 2000, as amended.	\$10
Employee Assistance Program (EAP)	<p>Eight (8) visits to a psychologist or social worker per insured per policy year, without co-payment. In excess of eight visits, co-payment for Specialists should be paid.</p> <ul style="list-style-type: none"> • Legal consultation • Financial consultation • Crisis management • Marriage counseling 	\$0

6. Rehabilitation, Habilitation and Durable Medical Equipment Services

Shared costs apply to some of these services, as described in the Co-payments, Co-insurances, and Deductibles Table in Part VIII at the end of this chapter.

Benefit	Description	Co-payment/Co-insurance
Ambulatory Rehabilitative Physical Therapy	Corresponding co-payment applies. Covers up to twenty (20) physical therapies per policy year per insured. Additional therapies require MCS Life Clinical Affairs pre-authorization. In accordance with the Welfare, Development and Integration of People with Autism Act (BIDA, Spanish acronym), Act No. 220 approved on September 4, 2012, no limits apply to autism disorders treatments.	\$7
Ambulatory Habilitative Physical Therapy	Corresponding co-payment applies. Covers up to twenty (20) physical therapies per policy year per insured. Additional therapies require MCS Life Clinical Affairs pre-authorization. In accordance with the Welfare, Development and Integration of People with Autism Act (BIDA, Spanish acronym), Act No. 220 approved on September 4, 2012, no limits apply to autism disorders treatments.	\$7
Occupational Therapy (ambulatory)	Co-payment for physical therapy applies. These ambulatory services are only covered for autism disorders, in accordance with the Welfare, Development and Integration of People with Autism Act (BIDA, Spanish acronym), Act No. 220 approved on September 4, 2012.	\$7
Rehabilitative and Non-rehabilitative Speech and Language Therapies (Ambulatory)	Co-payment for physical therapy applies. These ambulatory services are only covered for autism disorders, in accordance with the Welfare, Development and Integration of People with Autism Act (BIDA, Spanish acronym), Act No. 220 approved on September 4, 2012.	\$7
Chiropractor manipulations	<p>Corresponding co-payment applies. Covered up to fifteen (15) manipulations per policy year per insured. Additional therapies require pre-authorization. In accordance with the Welfare, Development and Integration of People with Autism Act (BIDA, Spanish acronym), Act No. 220 approved on September 4, 2012, no limits apply to treatments for autism disorders.</p> <p>Other chiropractor services:</p> <p>Radiology and physical therapy services may be included, provided they are contracted with a participating provider.</p>	\$7
Durable Medical Equipment (DME)	<p>Corresponding co-insurance applies. Requires MCS Life Clinical Affairs pre-authorization. Covered by contracted providers. The most common are:</p> <ul style="list-style-type: none"> • Adjustable beds • Wheelchairs • Oxygen and the necessary equipment for its administration • Ostomy supplies 	25%

	<ul style="list-style-type: none"> • Diabetic shoes, with preauthorization • Insulin pump, including maintenance, without age limit and ordered by a specialist. • Insulin pump supplies. 	
	<p>Associates who enroll in the “Programa Vida” don’t need to pay co-insurance for:</p> <ul style="list-style-type: none"> • Glucometer and blood pressure monitor – Every two (2) years, unlimited age and ordered by any specialist. • Lancets and Strips – up to a maximum of one-hundred (100) for a thirty (30) day supply of each. Unlimited amounts for people younger than twenty-one (21). • Insulin pump supplies. • Syringes – Refer to MC21 Pharmacy Coverage Chapter 2. • Diabetic shoes <p>For insureds not participating in the “Programa Vida”, glucometer, lancets, strips, syringes and blood pressure monitor are covered through pharmacy coverage (see Chapter 2).</p>	0%
Technological Equipment Services	Durable Medical Equipment co-insurance applies. In addition, one daily eight (8) hour shift of skilled nursing services or respiratory therapy specialist is covered. Supplies for managing technological equipment, physical and occupational therapy are included, in accordance with Act No. 125 of September 21, 2007 and Act No. 62 of May 4, 2015.	25%
Respirators, ventilators, and other equipment for the treatment of respiratory paralysis	Corresponding co-insurance applies. Includes tests and equipment for insureds who require the use of a mechanical ventilator.	0%
Orthotic Devices	Corresponding co-insurance applies. Requires MCS Life Clinical Affairs pre-authorization. Includes orthopedic braces and brassieres required post-mastectomy.	25%
Devices	Corresponding co-insurance applies for durable medical equipment. Requires MCS Life Clinical Affairs pre-authorization.	25%
Implants, internal and external prosthesis	Corresponding co-insurance applies. Prosthetic devices limited to one (1) per extremity for the life of the insured. Replacements are excluded. External prosthesis require MCS Life Clinical Affairs pre-authorization.	25%
Implant and Other Surgical Trays	Corresponding co-payment applies. Covered in organ or body parts replacement or for assisting in their functioning. Examples: prosthesis, pacemakers and valves, and others. Replacements are excluded.	\$300

Home Health Care	<p>Covered. No co-payment applies. Combined care will be for up to sixty (60) days in the home per policy year per insured. Requires MCS Life Clinical Affairs pre-authorization.</p> <p>Services will be covered for the following:</p> <ul style="list-style-type: none"> • If within fourteen (14) days following the date in which the insured was discharged from a hospitalization of at least three (3) days and if offered for the same condition or related condition as for the hospitalization. • If provided as continuity of treatment for the same condition-related causes or admission diagnosis that prompted the hospital stay • As an alternative to a hospitalization <p>Services rendered under home health care include:</p> <ul style="list-style-type: none"> • Rehabilitative speech therapy (post-trauma, accident or surgery) • Physical therapy • Occupational therapy • Respiratory therapy • Cardiovascular rehabilitative therapy • Enteral feeding • Nursing care 	\$0
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7. Laboratory and X-rays Services

MCS Life will pay the negotiated and contracted amount in the MCS Life Providers Network for the production and interpretation of Laboratory procedures and X-rays when they are:

- Ordered by a physician
- Necessary for the diagnosis of an illness or injury
- Medically necessary
- Performed by a laboratory or radiologist

Benefit	Description	Co-payment/Co-insurance
Laboratories	Co-insurance applies.	25%
X-rays	Co-insurance applies.	25%
PET CT	Co-insurance for X-rays applies, also known as Pet Scan. Requires MCS Life Clinical Affairs pre-authorization. Covered up to one (1) per anatomical region (head, neck, chest, abdomen, pelvis, genital extremities, thorax, spine and body (chest and abdomen), per policy year.	25%
Molecular or genetic tests	Co-insurance applies for molecular or genetic testing, except for tests required by law as a preventive	25%

	service, only with providers contracted by MCS Life. Requires MCS Life Clinical Affairs pre-authorization. These tests will only be covered upon referral, as per established medical policies.	
Nuclear Medicine	Co-insurance for X-rays applies.	25%
Polysomnography (Sleep study)	Co-insurance for X-rays applies. Unlimited coverage. Requires MCS Life Clinical Affairs pre-authorization.	25%
CT Scan	Co-insurance for X-rays applies. Covered up to one (1) per anatomical region (head, neck, chest, abdomen, pelvis, genital extremities, thorax, spine and body (chest and abdomen), per policy year.	25%
Bone densitometry	Co-insurance for X-rays applies.	25%
Doppler Echocardiography Color Flow	Co-insurance for X-rays applies.	25%
Echocardiogram	Co-insurance for X-rays applies.	25%
Electrocardiogram	Co-insurance for X-rays applies.	25%
Electroencephalogram	Co-insurance for X-rays applies.	25%
Electromyogram	Co-insurance for X-rays applies.	25%
Angiography	Co-insurance for X-rays applies.	25%
Holter	Co-insurance for X-rays applies.	25%
Non-invasive cerebrovascular peripheral testing	Co-insurance for X-rays applies.	25%
Myelography	Co-insurance for X-rays applies.	25%
MRA	Co-insurance for X-rays applies. Covered up to one (1) per anatomical region (head, neck, chest, abdomen, pelvis, genital extremities, thorax, spine and body (chest and abdomen), per policy year.	25%
MRI	Co-insurance for X-rays applies. Covered up to one (1) per anatomical region (head, neck, chest, abdomen, pelvis, genital extremities, thorax, spine and body (chest and abdomen), per policy year.	25%
Sonography	Co-insurance for X-rays applies.	25%
SPECT	Co-insurance for X-rays applies.	25%
Stress test	Co-insurance for X-rays applies.	25%
Stress test with sestamibi, Persantine or thallium	Co-insurance for X-rays applies.	25%
Allergy testing / Challenge testing	Co-insurance for laboratory applies. Unlimited coverage.	25%

8. Preventive, Wellness and Chronic Disease Management Services

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

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

- one (1) evaluation by a physician, as appropriate for the insured's age and gender
- counseling and treatment to identify and reduce identified risk factors

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

Preventive services for under-age children

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

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

Preventive service	Indication
Alcohol Abuse	Screening for adults of eighteen (18) years old and older due to alcohol abuse, and counseling on improper alcohol use reduction to any person involved in a risky or hazardous alcohol use.
Anemia / Iron	Perform risk assessment or screening as appropriate, per recommendations in the current edition of the AAP Pediatric Nutrition: Policy of the American Academy of Pediatrics.
Anxiety in Children and Adolescents: Screening: children and adolescents aged 8 to 18 years	Anxiety evaluation in children and adolescents aged 8 to 18 years.
Autism	Screening for children between eighteen (18) and twenty-four (24) months.
Behavioral / Social / Emotional Screening	The American Academy of Pediatrics (AAP) recommends an annual assessment from newborn to 21 years old.
Bilirubin concentration	Screening for newborns.

Blood pressure	Screening for children between the following ages: (0) to (11) months, (1) to (4) years, (5) to (10) years, (11) to (14) years, (15) to (17) years
Blood screening	Screening for newborns.
Cervical Dysplasia	Screening for sexually active girls.
Depression and Suicide Risk in Children and Adolescents	Screening for major depression disorders (MDD) in adolescents ages twelve (12) to eighteen (21).
Development Screening	Screenings for children under the age of three (3), and observation during the entire childhood.
Dyslipidemia	One-time evaluation for children; between the ages of nine (9) and eleven (11) years, between the ages of seventeen (17) and twenty-one (21), and for minors at high risk for lipid disorders between the following ages: one (1) to four (4) years, five (5) to ten (10) years, eleven (11) to fourteen (14) years and fifteen (15) to seventeen (17) years.
Ocular prophylaxis for gonococcal ophthalmia neonatorum (Gonorrhea)	Topical prophylactic eye medication in all newborns for the prevention of gonococcal ophthalmia neonatorum (Gonorrhea).
Hearing Screening	Hearing loss screening for newborns and children once between the ages of eleven (11) and fourteen (14), once between the ages of fifteen (15) and seventeen (17), and once between the ages of eighteen (18) and twenty-one (21).
Height, Weight, and Body Mass Index Screening	Screening for children between the following ages: zero (0) to eleven (11) months, one (1) to four (4) years, five (5) to (10) years, eleven (11) to fourteen (14) years, fifteen to seventeen (17) years.
Sickle Cell Disease	Screening for newborns.
Enfermedad de células falciformes (Sickle Cell Disease)	Newborn screening.
Hepatitis B Infection	Screening for hepatitis B virus (HBV) infection in newborns through young adults twenty-one (21) years of age who are at increased risk for infection.
Congenital hypothyroidism	Screening for newborns.
Lead screening	For children at risk of lead exposure.
Maternal depression	Screening for mothers of infants at visits of one (1), two (2), four (4) and six (6) months.
Medical history	For all children during development: ages, from zero (0) to twenty-one (21) years old.
Obesity Screening: Minors and Adolescents	Obesity screening for children under six (6) years of age and older and comprehensive counseling, intense behavioral interventions to promote improvement in the child's weight.
Oral Health	Risk assessment for newborn minors up to ten (10) years of age.
Cavity Prevention, Evaluation and Intervention: Under (5) Years of Age	Oral fluoride supplementation to children six (6) months of age and older whose water supply is deficient in fluoride. Application of fluoride varnish to the primary teeth of all infants and minors from the age of eruption of the first teeth.
Phenylketonuria (PKU)	Newborn screening for genetic disorders.
Prevention of Dental Caries in Children Under Five (5) Years of Age: Screening and Interventions	Oral fluoride supplementation starting at six (6) months of age for children whose water supply is deficient in fluoride. If the primary water source is deficient in fluoride, oral fluoride supplementation as recommended by the AAP.
Skin cancer	Counseling for young adults, teens, minors, and parents of minors on how to minimize exposure to ultraviolet (UV) radiation for fair-skinned individuals from six (6) months to twenty-four (24) years of age to reduce their risk of skin cancer.
Sudden cardiac arrest and sudden cardiac death	Risk assessment of sudden heart attack and sudden cardiac death between eleven (11) and twenty-one (21) years of age (to be taken into account the range in which risk assessment may take place) according to AAP policies. (Sudden Death in the Youth: Information for the Primary Care Provider).

Tobacco use: minors and adolescents	Interventions by the doctor, including education or counseling, to prevent the initiation of tobacco use in school-age minors and adolescents.
Tobacco, alcohol, and drug use	Evaluation to identify the use of tobacco, alcohol, and drugs in minors between eleven (11) and twenty-one (21) years of age.
Tuberculina	Tuberculin test for minors at risk of tuberculosis from zero (0) to twenty-one (21) years of age.
Vision screening: children	Eye exam at least once in minors between the ages of three (3) to five (5) years to detect amblyopia or its risk factors.

Preventive services for adults

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

Preventive service	Indication
Abdominal Aortic Aneurysm (AAA) Screening	One (1) ultra-sonogram for the screening of AAA in men ages sixty-five (65) to seventy-five (75) who have smoked at some point.
Evaluation for anxiety disorder	Evaluation for anxiety disorder of adults sixty-four (64) years of age or younger, including pregnant and postpartum individuals.
Prediabetes and Type 2 Diabetes Mellitus screening in asymptomatic adults	Screening and examination for abnormal blood glucose, as part of screening for prediabetes and type II diabetes in asymptomatic adults aged thirty-five (35) to seventy (70) years who are overweight or obese. Clinicians should offer or refer patients with prediabetes to effective preventive interventions.
Colorectal Cancer Screening	Evaluation of colorectal cancer in adults, by fecal occult blood tests, sigmoidoscopy or colonoscopy, beginning at the age of forty-five (45) to seventy-five (75) years of age, in accordance with Law No. 218 of August 30, 2012. The risks and benefits of these screening methods vary. A follow-up colonoscopy after a positive result from a noninvasive screening test. This is a screening test, so policyholders won't have to pay anything out of pocket.
Depression and Suicide Risk Assessment for Adults	Depression screening for adult population, including pregnant or postpartum individuals, and adults sixty-five (65) years of age and older.
Preventing Falls in Older Adults	Vitamin D supplements to prevent falls in adults sixty-five (65) years of age and older who live in the community and are at increased risk for falls.
Advice on healthy diets and exercise to prevent cardiovascular disease	Counseling and recommendation for overweight or obese adults with high risk factors to develop cardiovascular conditions to promote a healthy diet and physical activity for the purpose of preventing such conditions.
Hepatitis B virus (HBV) infection	Screening for adults at high risk for HBV.
Hepatitis C virus (HCV) screening test)	Screening for hepatitis C virus (HCV) infection in adolescents and adults between the ages of eighteen (18) years to seventy-nine (79) years.

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

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

Preventive services for women, including pregnant women

Preventive Service	Indication
Asymptomatic Bacteriuria Screening Test: Pregnant People	Evaluation for the detection of asymptomatic bacteriuria by urine culture in pregnant persons.
BRCA-Related Cancer: Risk Assessment,	Screening and counseling to women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast

Genetic Counseling, and Genetic Testing	cancer susceptibility 1 and 2 (BRCA1/2) gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing.
Use of Preventive Medications to Reduce Breast Cancer Risk	Clinical orientation for patients with a high risk of developing breast cancer, allowing the patient to decide with her physician if drug therapy is appropriate for reducing the risk of developing the disease. The physician may prescribe drugs to reduce the risk of developing breast cancer, such as tamoxifen, raloxifen, or aromatase inhibitors, for women thirty-five (35) years of age or older, who are at increased risk for this disease and at low risk for adverse drug effects.
Mammogram Screening for Breast Cancer	Screening every one (1) or two (2) years for women over forty (40), with or without clinical breast exam. Screening every two (2) years for women ages fifty (50) to seventy-four (74).
Breastfeeding	<p>Comprehensive lactation support services (including consultation, counseling, physician education and peer support services, and breastfeeding equipment and supplies) during the prenatal, perinatal, and postpartum periods to optimize successful initiation and maintenance of breastfeeding.</p> <p>Breastfeeding equipment and supplies include, but are not limited to, double electric breast pumps as a primary option to manual breast pumps (including pump parts and maintenance) and breast milk storage supplies. Breastfeeding equipment may also include equipment and supplies as clinically indicated to support mothers with breastfeeding difficulties and those who need additional services.</p> <p>Breastfeeding equipment is covered by a doctor's order after the third trimester of pregnancy and for the duration of breastfeeding. Additional supplies for the breastfeeding machine are covered, and the equipment is available through contracted providers.</p>
Cervical Cancer Screening	Cervical cancer screening every three (3) years with cervical cytology (Pap test) only in women between twenty-one (21) and twenty-nine (29) years old. For women between thirty (30) and sixty-five (65) years old, is recommended screening with cervical cytology every three (3) years, every five (5) years with high-risk human papillomavirus (hrHPV), or every five (5) years cotesting with hrHPV and cytology test.
Chlamydia Infection Screening in all sexually active women, including pregnant persons	Chlamydia infection screening in all sexually active women twenty-four (24) years of age and younger, and in women twenty-five years or older who are at increased risk for infection.
Contraceptive Methods	<p>All FDA-approved, assigned, or authorized contraceptive methods, sterilization procedures, screening, patient education, counseling, and provision of contraceptives (including in the immediate postpartum period) for all women of reproductive capacity as required are covered with no cost-sharing. Contraceptive care also includes care and follow-up.</p> <p>The following methods will be covered through your medical coverage as an outpatient service, including insertion and removal for applicable devices:</p> <ul style="list-style-type: none"> • Sterilization surgery for men and women • Surgical sterilization of implants for women

	<ul style="list-style-type: none"> • Implantable rod • Copper intrauterine device • Intrauterine device with progesterone • Injection • Diaphragm with spermicide • Sponge with spermicide • Cervical cap with spermicide • Spermicide <p>The following methods will be covered by the drug coverage. Please refer to EHB-2025 Drug Formulary, applicable to this policy:</p> <ul style="list-style-type: none"> • Oral contraceptives (combined pill) • Oral contraceptives (progestin only) • Oral contraceptives extended/continuous use • Patches • Vaginal contraceptive ring • Emergency contraception (ulipristal acetate) • Female condom • Male condom • Spermicide <p>The list of contraceptives includes those currently listed in the FDA's birth control guide and any additional contraceptives approved, granted, or approved by the FDA. Any insertion and removal of contraceptive devices is covered. The CSPP nor applicable federal law established any difference in contraceptive levels. If the formulary includes contraception, no cost-sharing may apply, regardless of the specific tier.</p>
Counseling for Healthy Weight and Weight Gain in Pregnancy: Pregnant People	Effective behavioral interventions are offered to pregnant persons to promote healthy weight gain and prevent gestational overweight in pregnancy.
Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening Women of Reproductive Age	Screening women of childbearing potential for intimate partner violence (IPV), such as domestic violence, and providing or referring women who test positive for intervention services.
Folic Acid Supplements to Prevent Neural Tube Defects: Preventive Medications	Recommendation of the use of daily folic acid supplements containing four tenths to eight tenths (0.4 to 0.8 mg) or four hundred to eight hundred milligrams (400 to 800µg) for women who are planning or can become pregnant. Physician's order is required.
Diabetes in pregnancy	<p>Screening pregnant women for gestational diabetes mellitus (GDM) after 24 weeks of gestation (preferably between 24 and 28 weeks of gestation) to prevent adverse birth outcomes.</p> <p>Screening pregnant women with risk factors for type 2 diabetes or GDM before 24 weeks of gestation—ideally at the first prenatal visit.</p>

Screening for gonorrhea infection	Screening for gonorrhea in all sexually active women twenty-four (24) years of age or younger, and in women twenty-five (25) years of age or older who are at increased risk of infection.
Hepatitis B Virus	Screening for pregnant women, at their first prenatal visit.
Human immunodeficiency virus (HIV) screening: pregnant people	<p>All pregnant people will be tested as follows:</p> <ul style="list-style-type: none"> • First HIV test during the first trimester of pregnancy or at the first prenatal visit • Second test during the third trimester of gestation, between twenty-eight (28) and thirty-four (34) weeks of pregnancy • During delivery if the pregnant woman has never been tested and her HIV status is unknown <p>As set forth in the Department of Health of Puerto Rico Administrative Order No. 307 of August 14, 2013.</p>
Screening for Human Immunodeficiency Virus Infection (HIV)	<p>All adolescent and adult women, ages 15 and older, receive a screening test for HIV at least once during their lifetime. Earlier or additional screening should be based on risk and rescreening annually or more often may be appropriate beginning at age 13 for adolescent and adult women with an increased risk of HIV infection.</p> <p>Risk assessment and prevention education for HIV infection beginning at age 13 and continuing as determined by risk.</p> <p>A screening test for HIV is recommended for all pregnant women upon initiation of prenatal care with rescreening during pregnancy based on risk factors. Rapid HIV testing is recommended for pregnant women who present in active labor with an undocumented HIV status. Screening during pregnancy enables prevention of vertical transmission.</p>
Prevention of obesity in middle-aged women	Guidance to middle-aged women between forty (40) and sixty (60) years of age with a normal or overweight body mass index (BMI) (18.5-29.9 kg/m ²) to maintain weight or limit weight gain to prevent obesity. Counseling may include an individualized discussion about healthy eating and physical activity.
Osteoporosis (postmenopausal women under sixty-five (65) years of age)	Osteoporosis testing with bone measurement testing is recommended to prevent osteoporotic fractures in postmenopausal women under sixty-five (65) years of age who are at increased risk for osteoporosis, as determined by a formal clinical risk assessment tool.
Osteoporosis (women over sixty-five (65) years of age)	Evaluation of osteoporosis with bone measurement tests to prevent osteoporotic fractures in women over sixty-five (65) years of age.
Perinatal Depression Intervention and Counseling	Provide or refer to counseling interventions for pregnant or postpartum women who are at increased risk for perinatal depression.
Prevention of preeclampsia: aspirin for pregnant people at high risk of preeclampsia	Supplemented with a low dose of aspirin (81 mg/d) as a preventive medication after twelve (12) weeks of gestation in people at high risk of preeclampsia.

Hypertensive disorders of pregnancy: asymptomatic pregnant people	Evaluation of hypertensive disorders in pregnant people with blood pressure measurements throughout pregnancy.
Blood group classification – Rh factor (D)	Rh (D) blood type and antibody screening for all pregnant women during the first antenatal visit. Repeat testing for Rh(D) is also recommended for nonsensitized pregnant women who test negative for Rh(D) factor between twenty-four (24) to twenty-eight (28) weeks of pregnancy, unless the biological father is known to be Rh(D)-negative.
Anxiety Evaluation	Screening for anxiety in adolescent and adult women, including pregnant or postpartum women. Optimal assessment intervals are unknown and clinical judgement should be used to determine the frequency of assessment. Given the high prevalence of anxiety disorders, lack of recognition in clinical practice, and multiple problems associated with untreated anxiety, clinicians should consider screening women who have not been screened recently.
Diabetes after pregnancy	<p>Evaluation of type 2 diabetes in women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and who have not been previously diagnosed with type 2 diabetes. Ideally, initial testing should occur within the first year postpartum and can be performed as early as four (4) to six (6) weeks postpartum.</p> <p>Women who were not screened during the first postpartum year or those with a negative baseline should be screened at least every three (3) years for a minimum of ten (10) years after pregnancy. For those with a positive screening test result in the early postpartum period, the test should be repeated at least six (6) months postpartum to confirm the diagnosis of diabetes regardless of the type of initial test (i.e., fasting plasma glucose, hemoglobin A1C, oral test, and glucose tolerance test). Repeat testing is also recommended for women screened for hemoglobin A1C during the first 6 months postpartum, regardless of whether the test results are positive or negative because the hemoglobin A1C test is less accurate during the first 6 months postpartum.</p>
Syphilis Screening: Pregnant Women	Early evaluation of syphilis infection in all pregnant women.
Evaluation of urinary incontinence in women	Screening annually for urinary incontinence. Factors associated with an increased risk of urinary incontinence include increased parity, advanced age, and obesity; however, these factors should not be used to limit detection.
Tobacco use: Pregnant person	Clinical inquiry of pregnant persons about tobacco use, advice on smoking cessation, and provision of behavioral interventions to stop tobacco use in pregnant people.
Well Women Visits also known as <i>Well Women Visits</i>	Annual preventive care (depending on the woman's health status, health needs, and other risk factors) for adult women in order to obtain recommended and appropriate preventive services for their age and development, including preconception care and services needed for prenatal care. These visits include the women's preventive services listed in this policy/certificate. If the physician

	determines that the patient requires additional visits, they will be covered with zero (\$0) copay or zero (0%) coinsurance as appropriate.
Prevención del VIH – (Preexposure prophylaxis o PrEP)	Requires MCS Life Clinical Affairs preauthorization. Doctors may offer pre-exposure prophylaxis (PrEP) with antiretroviral therapy for women at high risk of contracting HIV, referred by their doctor to use these medications and reduce the risk of HIV infection. Visit the link below for clinical considerations; https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis#bootstrap-panel--7 . Zero (\$0) copay or zero (0%) percent coinsurance will apply. The insured must have their annual physical exam, as well as HIV tests that show a negative result. Once completed, the insured is provided with a ninety (90) day dispatch, before the end of these ninety (90) days the insured must repeat the HIV tests that continue to show a negative result, to continue the treatment. In the event that the insured interrupts the treatment, he or she will have up to two (2) attempts per policy year.

Immunizations

Immunizations, counseling, and vaccines administration recommended by the U.S. Preventive Services Task Force (USPSTF) and by the vaccination itinerary of the Puerto Rico Department of Health, are covered for children, adolescents under twenty-one (21) years of age and adults as specified in the Puerto Rico Department of Health vaccination itineraries and the Center for Disease Control (CDC). Including booster shots. Immunizations are covered at zero (\$0) copayment or zero (0%) coinsurance. The insured person will pay the amount that corresponds to the visit to the physician or ambulatory service. The preventive care services to which these conditions apply are defined and described at the following link: <https://www.healthcare.gov/what-are-my-preventive-care-benefits>.

Immunization for children in accordance with the Puerto Rico department of health schedule	
Hepatitis B (Hep B)	As indicated in the Puerto Rico Department of Health Schedule for this policy's current year. The insured can request the current itinerary by phone at the MCS Life Customer Service Call Center at (787) 281-2800..
Diphtheria, Tetanus and Pertussis (Whooping Cough) (DTaP)	
Tetanus and Diphtheria Toxoids (Tdap)	
Rotavirus (RV)	
Inactivated Polio Virus (IPV)	
Haemophilus Influenza, Type B (Hib)	
Pneumococcal (PCV) and (PPV)	
Measles, Mumps and Rubella (MMR)	
Varicella (Var)	
Hepatitis A (Hep A)	
Meningococcal (MCV)**	

Influenza	
Human papillomavirus (HPV)* - vaccine to prevent cervical cancer	
Center for disease control (CDC) vaccination schedule for children, adolescents and adults	
Tetanus, Diphtheria and Pertussis (Td/Tdap)	CDC immunization schedule for the current year of this policy/certificate. The insured may request the current itinerary by telephone at the MCS Life Customer Service Call Center at (787) 281-2800.
Human papillomavirus (HPV)* – vaccine to prevent cervical cancer	
Chickenpox	
Zoster	
Measles, mumps, and rubella (MMR)	
Influenza	
Pneumococcal	
Hepatitis A	
Hepatitis B	
Meningococcal**	
COVID 19***	
Dengue****	
Monkeypox*****	
Respiratory syncytial virus (RSV) (known as the Synagis® vaccine) *****	

- * Immunization against the HPV virus will be covered for males and females nine (9) years of age and older and adolescents with a history of sexual abuse or rape, who have not started or completed the series of three (3) doses, according to Law No. 255 of September 15, 2012.
- ** Immunization for meningitis (MCV4) or the meningococcal vaccine will be covered as required by the OCS's ruling letter (Ruling Letter CN-2011-131-AV).
- *** COVID-19 immunization will be covered for infants and children 6 months to 12 years of age and adolescents 13 to 18 years of age, adolescents over nineteen (19) years of age, and adults, according to the order established by the Puerto Rico Department of Health and the recommendations of the *Advisory Committee on Immunization Practices (ACIP)*, of the *Centers for Disease Control and Prevention (CDC)*. and pursuant to Section 2.050(C) of the CSSPR.
- **** Dengue vaccine will be covered for children ages 9 to 16, who live in dengue-endemic areas and have laboratory confirmation of prior infection. After six months of confirmation of dengue infection, a series of 3 doses will be administered with six-month waiting intervals between each dose as recommended by the *Advisory Committee on Immunization Practices (ACIP)* and the *Centers for Disease Control and Prevention (CDC)*.
- ***** Monkeypox vaccination is recommended for anyone at risk of infection.
- ***** Vaccination is recommended for people during pregnancy and adults over 60 years of age, according to CDC recommendations.

Additional Immunizations

Respiratory Syncytial Virus (RSV)	Requires MCS Life Pharmacy Department pre-authorization. No co-payment applies. Co-payment for medical visit applies. This vaccine is covered at the recommended doses in accordance with Act No. 165 of August 30, 2006.	\$0 General practitioner: \$10 Specialist: \$10 Sub-specialist: \$15
Vaccines for Travelers	Requires pre-authorization. Covered for associates with written authorized special assignments by the Department of Benefits of Walmart Puerto Rico Home Office.	\$0
Pediarix Vaccine	Covered. No co-payment applies for the vaccine. Co-payment for medical visit applies. Covered for children at the recommended doses for age, sex, health condition and conditions set forth by MCS for these services.	\$0 General practitioner: \$10 Specialist: \$10 Sub-specialist: \$15
Prevnar Vaccine	Covered. No co-payment applies for vaccine. Co-payment for medical visit applies. Covered for children at the recommended doses for age, sex, health condition and conditions set forth by MCS for these services.	\$0 General practitioner: \$10 Specialist: \$10 Sub-specialist: \$15

Section 2: Other Covered Services

Shared costs apply to some of these services, as described in Part VIII of this chapter.

Benefit	Description	Co-payment/Co-insurance
Vision Services	<p>This service includes one (1) refraction examination per policy year. Co-payment applies. Covered up to a maximum of one-hundred thirty (\$130.00) dollars per insured per policy year (January to December).</p> <p>These services are covered by MCS Life contracted providers or by reimbursement if services are provided by a non-contracted provider. If the insured incurs in costs for services or supplies prescribed by an optometrist or ophthalmologist, MCS Life will pay such amount up to the maximum established that may be used for the following services:</p> <p>A. Single vision, bifocal, trifocal or lenticular lenses</p> <p>B. Eyeglasses</p> <p>C. Regular or toric contact lenses</p>	\$4

	<p>D. Orthoptic therapies will be covered up to thirty (30) for life.</p> <p>E. Additional options, such as anti-reflective, polycarbonate, ultraviolet rays lenses, and others.</p>	
Mastectomy and Reconstructive Mammoplasty	No co-payment applies for services related to a mastectomy for breast cancer in both men and women, including all stages of reconstruction and surgery for achieving breast symmetry, prosthesis, and complications. Requires MCS Life Clinical Affairs pre-authorization. in accordance with the Women's Health and Cancer Rights Act of 1998.	\$0
	For any other condition: Covered with co-payment for hospitalization. Requires MCS Life Clinical Affairs pre-authorization.	\$50
Lymphedema therapy (breast cancer-related post-mastectomy)	Co-payment for physical therapy applies. Requires MCS Life Clinical Affairs pre-authorization.	\$7
Gynecomastia	No co-payment applies for procedure. Co-payment for ambulatory facility applies. Requires MCS Life Clinical Affairs pre-authorization.	\$25
Temporomandibular joint dysfunction syndrome (TMJ)	Services for mandibular and maxillofacial osteotomy due to atrophy. Hospitalization co-payment applies and requires MCS Life Clinical Affairs pre-authorization.	\$50
Air Ambulance Service in Puerto Rico	Corresponding co-insurance applies. One (1) trip per policy year. Covered according to medical necessity, through contracted providers and in with established protocols for this service.	20%
Annual Physical Examination	One (1) annual physical exam is covered provided it is for preventive purposes and according to age, sex, and health condition of the insured. Physical exams and lab tests for medical certificates are excluded when ordered by the employer or any other non-preventive purpose.	0%
Autism	Treatments for autism disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, will have unlimited coverage, once a medical necessity has been established. Covered services include, but are not limited to, genetics, neurology, immunology, gastroenterology, nutrition, speech and language therapy and non-rehabilitative, psychology, occupational and physical therapy and will include office visits and medically necessary test. Covered in accordance	

	with the Welfare, Development and Integration of People with Autism Act (BIDA, Spanish acronym), Act No. 220 approved on September 4, 2012.	
Hyperbaric Chamber	No co-payment or co-insurance applies. Requires MCS Life Clinical Affairs pre-authorization.	0%
Cancer Patients' and Cancer Survivors Bill of Rights	Covered in accordance with Act No. 275 of September 27, 2012, for patients diagnosed with cancer and cancer survivors.	
Emergency Services in the United States	In the UnitedHealthcare Network: Emergency services in the United States will be covered as any other emergency through the UnitedHealthcare network. Co-payment for emergency services applies. You may access UnitedHealthcare service providers directory at: https://us1.welcometouhc.com or call 1-877-563-9016. Emergency services do not require MCS Life pre-authorization but medical necessity may be verified.	Accident and Trauma: \$0 Illness: \$50
	Outside the UnitedHealthcare Network: Emergency services rendered in the United States by non-participating UnitedHealthcare Network providers will be reimbursed based on the usual and customary services fees of the geographic area were provided, minus the applicable co-payment.	Accident and Trauma: \$0 Illness: \$50
Second Medical Opinion in Puerto Rico	Co-payment applies for medical visits for second medical opinions in Puerto Rico.	General practitioner: \$10 Specialist: \$10 Sub-specialist: \$15
Orthopedic Shoes	Covered only for insureds with a diagnosis of diabetes. Corresponding co-insurance applies. Requires MCS Life Clinical Affairs pre-authorization. For associates enrolled in the "Programa Vida" no co-insurance applies.	25%
Gender Dysphoria	Applies to adolescents and adults twelve (12) years and older who meet MCS Life Clinical Guideline for Gender Reassignment. The following services are included: <ul style="list-style-type: none"> • Behavioral therapy • Psychotherapy • Diagnostic Tests • Specialized Tests (MRI, CT Scan, Pet Scan, Pet CT, MRA, SPECT). Pet Scan and Pet CT require pre-authorization. Surgery for sex 	

	<p>reassignment that may include genital reconstruction surgery and breast and thorax surgery. This benefit is covered if the insured meets the criteria described in MCS Life Clinical Guidelines for Gender Reassignment.</p> <p>Every procedure related to this diagnosis requires pre-authorization.</p> <p>Co-payment or co-insurance applies for services offered in PR. Services unavailable in PR require Clinical Affairs pre-authorization and applicable co-payment or co-insurance according to the services received.</p>	
Gender Reassignment Surgery	<p>Applicable to every insured eighteen (18) years old or older diagnosed with gender dysphoria documented in two (2) referral letters from qualified mental health care professionals. The insured should have received twelve (12) months of continued hormone therapy (unless there exists a medical contraindication or the unwillingness of the insured to take hormone therapy). To learn about the requirements in the letter, please refer to MCS Life Clinical Guidelines for Gender Reassignment.</p> <p>For female-to-male gender reassignment, surgical procedures include:</p> <ul style="list-style-type: none"> • Mastectomy • Hysterectomy • Oophorectomy • Vaginectomy • Vulvectomy • Scrotoplasty • Urethroplasty • Placement of testicular or penile prosthesis • Phalloplasty or metoidioplasty (alternative to phalloplasty) <p>For male-to-female gender reassignment, the surgical procedures include:</p> <ul style="list-style-type: none"> • Penectomy • Vaginoplasty • Clitoroplasty • Labiaplasty • Orchiectomy • Urethroplasty 	

	Every diagnostic-related procedure requires pre-authorization.	
Hearing Aids	Covered with corresponding copayment per ear every 24 months.	\$250
Elevidys	<p>Elevidys is proven and medically necessary for the treatment of Duchenne muscular dystrophy (DMD) in patients who meet all of the following criteria:</p> <ul style="list-style-type: none"> • Diagnosis of Duchenne muscular dystrophy by, or in consultation with, a pediatric neuromuscular specialist with expertise in the diagnosis of DMD; and • Submission of medical records (e.g., chart notes, laboratory values) confirming both of the following: <ul style="list-style-type: none"> 1. A mutation in the DMD gene; and 2. The mutation is not a deletion in exon 8 or exon 9; and • Patient is aged 4 or 5 years of age; and • Submission of medical records (e.g., chart notes) confirming that the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.); and • Patient does not have an elevated anti-AAVrh74 total binding antibody titer \geq 1:400; and • Patient will receive a corticosteroid regimen prior to and following receipt of Elevidys in accordance with the United States Food and Drug Administration (FDA) approved Elevidys labeling; and • Elevidys is prescribed by, or in consultation with, a pediatric neuromuscular specialist with expertise in the treatment of DMD; and • Elevidys dosing is in accordance with FDA-approved labeling; and • Patient will not receive exon-skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)] concomitantly or following Elevidys treatment; and • Patient has never received Elevidys treatment in their lifetime; and • Authorization will be issued for no more than one treatment per lifetime and for no longer than 45 days from approval or until 6 years of age, whichever is first. <p>Pre-authorization determination will be managed within the fifteen (15) – day period of its receipt. In the event the initial request is incomplete, the provider of physician will be notified within a five (5) day period from the date it is received. The initial period could be extended for fifteen (15) additional days, provided the extension period if to handle situations out of MCS Life control or when there is insufficient information to</p>	

	<p>make a determination. In either case, the insured or the provider submitting the request will be notified of the reason of the specific necessary information for the evaluation. If the extension is because the necessary information has not been provided for MCS Life to make a determination, the insured will be given at least a forty-five (45) day period from the date the notice of extension is received to provide the specified additional information. Extensions will be notified during the first fifteen (15) days from the date of receipt of the request.</p> <p>If service is denied, a letter will be sent explaining the reason for the denial of services, including supporting references used, if applicable, as well as information on the right to appeal the denial and corresponding procedure.</p> <p>MCS Life fax telephone numbers for pre-authorization request are as follows: 787-622-2436 or 787-622-2434, or you can call the dedicated line for Walmart Associates at 787-945-1348 or 1-855-830-9887</p>	
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Section 3: Services covered through reimbursement

Shared costs apply for some of these services, as described in **Part VIII** of this chapter.

A. Services eligible through reimbursement:

Benefit	Description	Reimbursement
Non-participating providers in Puerto Rico	The insured will be reimbursed for covered services offered by non-participating physicians or providers based on the lesser amount between the incurred expenses and the fees of a participating provider, minus the corresponding co-payment or co-insurance.	
Land Ambulance Services in Puerto Rico	<p>Maximum amount for reimbursement is seventy-five (\$75) dollars per trip, no trips limit per policy year. This benefit will be covered provided the entity offering services is duly authorized by the Public Service Commission of Puerto Rico or other regulatory agency within the geographic area where service is rendered.</p> <p>The service will only be covered if the insured meets the following requirements:</p> <ul style="list-style-type: none">• The patient suffered an illness or injury for which other types of transportation are not recommended or if a psychiatric emergency in accordance with Act No. 183 of August 6, 2008.• The patient was transported:<ul style="list-style-type: none">• from the place of the emergency to the hospital• between hospitals when the transferring institution or institution authorizing discharge is not appropriate for the covered services• from the hospital to the residence, for patients whose health condition does not allow the use of other means of transportation• between health care institutions <p>In addition, land ambulance service will only be covered if:</p> <ul style="list-style-type: none">• The request for reimbursement for the service includes transportation certificate, pickup location and destination	\$75

	<ul style="list-style-type: none"> Is not a case covered by the Automobile Accident Compensation Administration (ACAA, Spanish acronym) or the Worker Accident Compensation Act (CFSE, Spanish acronym) or any other <i>third-party liability</i>. 	
Respiratory Therapy Equipment	Covered up to one (1) every five (5) years up to a maximum of one-hundred (\$100) dollars per insured per reimbursement.	\$100
	Aero Chamber – Covered up to a maximum of one (1) every two (2) years, up to a maximum of fifty (\$50) dollars per insured per reimbursement.	\$50
Epidural anesthesia during labor	Covered through reimbursement up to a maximum of one-hundred seventy-five (\$175) dollars.	\$175
Social worker	Services will only be reimbursed for autism related treatments in accordance with Act No. 220 of September 4, 2012, known as BIDA Act (Spanish acronym) Act (Act for the Wellness, Integration, and Development of Persons with Autism).	
Vision services for adults and children (in addition to pediatric vision)	<p>If the insured incurs in expenses for services prescribed by an optometrist or ophthalmologist, MCS Life will pay up to a maximum of one-hundred thirty (\$130) dollars for the following benefits:</p> <p>A. Lenses</p> <ul style="list-style-type: none"> Single vision Bifocal Trifocal Lenticular <p>B. Eyeglasses</p> <p>C. Contact lenses, regular or toric</p> <p>D. Orthoptic therapies will be covered through reimbursement according to medical necessity, up to thirty (30) therapies for life.</p> <p>E. Additional options:</p> <ul style="list-style-type: none"> Anti-reflective treatment Polycarbonate lens Anti-scratching treatment Anti-UV treatment Trifocal progressive Bifocal progressive Photosensitive lens (transition lens) 	\$130
Phenylalanine-free amino acid preparations	Reimbursement of the total cost of preparation for patients of all ages with a diagnosis of	0%

	phenylketonuria (PKU), and for other ends, in accordance with Act No.139 of August 8, 2016.	
Cardiovascular rehabilitative therapy	Services are reimbursed according to MCS fees and applicable co-payment. Requires Clinical Affairs pre-authorization. Reimbursement will be covered when offered by a physiatrist with expertise in rehabilitation and exercise physiology. The purpose is to minimize physical and psychological disability that may arise as a result of cardiovascular disease.	\$10

E. Reimbursement Request Process

The insured should complete the reimbursement form after receiving the service and will have twelve (12) months from the date of the service to be submitted for payment. The insured may request a copy of the form at MCS Life Customer Service Centers or by calling our Customer Service Department.

The insured should submit the reimbursement form along with the original receipt and meet the following requirements:

1. Receipt stamped by the provider including: name, address, telephone and specialty.
2. National Provider Identifier (NPI) or one of the following numbers: employer identification number or state license number.
3. Full name of the patient and group and contract information.
4. Date of service (month/day/year).
5. Description of service rendered. If the receipt includes more than one service, each service should be specified.
6. Laboratory receipts must specify all tests done.
7. Service and diagnosis code for each service claimed.
8. Total cost of service and the amount paid by the insured. If the receipt includes more than one service, the cost of each service must be specified.

Section 4: Bariatric Surgery Benefit for the Treatment of Morbid Obesity

Covered services include: gastric bypass surgery, adjustable band surgery, sleeve gastrectomy (open or closed procedures). Other bariatric surgery methods are excluded. The insured is responsible of applicable surgery co-insurance in addition to co-payment for hospital admission.

Coverage is subject to MCS Life Clinical Affairs pre-authorization. Bariatric surgery is limited to one (1) procedure for the life of the insured. To begin the pre-authorization process, the insured should meet the minimum indications described below:

- Body Mass Index (BMI) greater than or equal to thirty-five (35) kg/m² with co-morbidities (type II diabetes with drug treatment, hypertension with drug treatment, established coronary disease, moderate to severe sleep apnea, or pulmonary hypertension secondary to morbid obesity) and documented in the patient's medical history for a period of three (3) years or more; or a BMI greater or equal to forty (40); or over one-hundred (100) pounds over the ideal body weight.

- Diet and lifestyle changes treatment plan of at least six (6) months, under the supervision of a physician or bariatric surgeon prior to surgery. In addition, the physician should indicate the diet plan followed and reasons for failure.
- The physician should specify patient's underlying conditions that worsen with morbid obesity, for example: cardiovascular or cardiopulmonary diseases, severe diabetes, arthritis and sleep apnea, in accordance with Article 3(c) of Act No. 212 of August 9, 2008.
- Assessment by a mental health specialist (psychologist or psychiatrist) certifying that the insured understands and is willing to follow lifestyle changes required for a successful bariatric procedure.

Surgery for the removal of excess skin (known as flaps) will not be covered, except if the physician certifies the need to remove excess skin as it affects a body part function.

Section 5: Programs Included as Part of Your Benefits

Shared costs apply for some of these services, as described in Part VIII of this chapter.

Benefit	Description	Co-payment/Co-insurance
MCS Alivia	<p>Corresponding co-payment applies. Covered up to a maximum of ten (10) visits per policy year per insured, with a maximum of two (2) treatment methods per visit.</p> <p>MCS Alivia is a model of alternative and complementary therapies and treatments integrated into conventional health systems.</p> <p>Some of the integrative medicine services available are:</p> <ul style="list-style-type: none"> • Integrative and complementary health • Traditional Chinese medicine • Medical acupuncture • Therapeutic massage • Homeopathy offered by certified doctors • Bioenergetic medicine (Pranic Healing) <p>To access these benefits and assure the appropriate coordination of all necessary services, the insured must make an appointment. The primary physician will evaluate the insured who will determine the corresponding method.</p>	\$15
MCS Solutions (FHC)	<p>Includes a maximum of up to eight (8) visits per insured per policy year without co-payment. MCS Solutions integrates mental health care and substance abuse treatment. Totally confidential services are offered 24 hours a day, 7 days a week.</p> <p>A program coordinator will provide counseling, health education and referrals in a confidential manner to the insured. In emergency situations, the insured should go directly to the hospital and request the service.</p>	\$0

	For additional information, please call 1-866-627-4327.	
Wellness Programs and Initiatives	<p>These programs address areas that go from physical health to emotional health to meet the expectations of a comprehensive health plan. It includes educational talks, exercise sessions, orientation clinical, among others.</p> <p>For additional information on available programs, the insured can contact our dedicated line for Walmart associates at 787-945-1348 or 1-855-830-9887, Monday to Friday from 8:00 A.M. to 8:00 P.M., Saturdays from 8:00 A.M. to 4:30 P.M. The hearing impaired (TTY) can call 1-866-627-8182.</p>	\$0
"Programa de Madres y Bebés Saludables"	<p>A useful educational program offering orientation on health care for the mother-to-be and her baby. Its purpose is to offer orientation and education to the pregnant women on appropriate prenatal care, management of pregnancy, delivery, and how to start a successful breastfeeding. By participating in this program, the insured, except for dependent daughters, will be able to take part in the one-to-one workshop Preparation for Labor and Breastfeeding, and receive a "Guide for Pregnancy and Labor". Registration should occur during the first three (3) months of pregnancy in order to take advantage of the zero (\$0) co-payment in prenatal and postnatal visits (otherwise, an eight (\$8) dollar co-payment applies). Once enrolled in the program, she can benefit from zero (\$0) co-payment for visits to the obstetrician and for hospital admission for delivery.</p> <p>How does the Program work?</p> <p>Upon confirmation of the pregnancy, the insured can enroll by calling the dedicated line for Walmart associates at 787-945-1348 or 1-855-830-9887 or visit www.mcs.com.pr.</p>	\$0
MCS Medilínea MD	<p>Corresponding co-payment applies for MCS Medilínea MD. Access to virtual visits with primary physicians, including family medicine, general practitioners, internists, and pediatrician through MCS Medilínea MD digital platform. Children under eighteen (18) years of age must be accompanied by an adult during consultation.</p> <p>Some conditions appropriate for consultation through this service are:</p> <ul style="list-style-type: none"> • allergies • constipation • cough • diarrhea • ear problems • fever • flu 	\$0

	<ul style="list-style-type: none"> • headache • insect bites • nausea • conjunctivitis • skin rash • sore throat • urinary tract problems/UTI • vomiting <p>Parents or tutors of children under thirty-six (36) months are required to complete a form different from the medical history disclosure prior to making an appointment or consultation with a physician provider of MCS Medilínea MD. Children younger than 36 months with fever should be referred by his or her pediatrician to an urgency center or emergency room.</p> <p>In acute cases in which the physician deems necessary the use of medications for treating the patient, the delivery of the prescription will be coordinated directly with the insureds preferred pharmacy.</p> <p>If the physician determines that the condition for which the patient has made the consultation cannot be managed through the platform, the insured will be referred to an emergency room, an urgency center or his or her primary physician. The patient is responsible of verifying his or her documentation on Description of Benefits and/or pharmacy coverage through MC-Rx to determine drug coverage. The patient should cover applicable co-payment for visit each time platform services are accessed.</p>	
MCS Care Clubs	<p>Voluntary program part of basic coverage at no additional cost. Consists of two (2) visits with no co-payment to a preferred MCS Care Club:</p> <ul style="list-style-type: none"> • First visit: <ul style="list-style-type: none"> a. The insured should complete a Health Risk Assessment (HRA) as well as an initial evaluation. The purpose of the HRA is to identify potential conditions and continue developing wellness programs for the general population. b. The physician will recommend preventive services available at the Care Club, based on the results of the HRA. Services will be recommended according to age and gender as established by the United States Preventive Services Task Force. • Second visit: <ul style="list-style-type: none"> a. The physician will discuss with the insured the results of tests performed and personalized 	\$0

	<p>profile report. If necessary, additional recommendations or referral to other specialists, as applicable, will be offered.</p> <p>If the insured needs additional tests due to a condition or clinical indication, referrals to the necessary services will be made. This program is available to all insured aged eighteen (18) or older.</p>	
“Programa Vida”	<p>Covered for Walmart Associates only with a confirmed diagnosis of Diabetes and/or Hypertension. The “<i>Programa Vida</i>” offers its participants educational and clinical interventions on hypertension and diabetes. Through the program, participants will have a quarterly clinical visit for evaluation and follow-up at the MCS Care Clubs.</p> <ul style="list-style-type: none"> • Participants will have a personalized intervention plan prepared by clinical staff plus service coordination assistance. • Quarterly interventions at MCS Excellence Centers (Centros de Excelencia MCS). • The protocol includes, among others, laboratories, X-rays with no co-payment or co-insurance. <p>Services provided that are not included in this protocol require co-payment and co-insurance.</p>	\$0
Transcita	<p>Covered up to a maximum of two (2) trips (<i>one way</i>) per associate per policy year (only for Associates). Must be coordinated through Transcita, 1-866-769-2482 Monday to Friday 5:00 A.M. – 10:00 P.M. and Saturdays 5:00 A.M. – 8:00 P.M.</p>	\$0

PART III: COVERAGE EXCLUSIONS

Section I: Coverage Exclusions

The following services are not covered:

1. Services rendered while the insurance is not in effect.
2. Services corresponding to the Workers Accident Compensation Act (CFSE, Spanish acronym), the Automobile Accident Compensation Administration (ACAA, Spanish acronym), and other services available in compliance with state or federal laws. Such services are also excluded when these are denied by government agencies due to non-compliance or violation of law with requirements or provisions of the above mentioned laws, or of any others, even if such non-compliance or violations do not constitute crime.
3. Services covered under any other insurance or other third party liability. MCS Life has the right of subrogation to recuperate medical claims paid when the primary responsibility relies on another insurance or entity.
4. Services for treatments resulting from the commission or attempt to commit a crime or any other criminal act as a result of non-compliance with the laws of the Commonwealth of Puerto Rico or any other country. In addition, such services resulting from war, declared or not, acts of terrorism or incidental act or participation in a riot or civil disturbance, except if the injury is as a result of a domestic act of violence or a medical condition. Additionally, in cases in which the services rendered are for service-connected injuries, MCS Life will submit a claim to the Veterans Administration.
5. Services received at no charge or defrayed through donations; or that the person receives or has a right to receive free of charge or under any other government plan.
6. Personal commodity expenses and services, such as: private room (except if the service is required due to a medical necessity), telephone, TV, custodial care services, rest home, convalescence home (except skill nursing facilities) or home care.
7. Services rendered by health care professionals that are not certified physicians or paramedics, except those specified on the benefits coverage.
8. Services not listed in Part II of this certificate, or not required by any federal or local law requiring coverage of such service.
9. Expenses for physical exams to obtain medical certificates or any other purpose other than prevention, except as otherwise provided, in accordance with Act No. 296 of September 1, 2000, as amended.
10. Services that are not medically necessary, are considered experimental or investigational, as defined by the *Food & Drug Administration (FDA)*, *Department of Human and Health Services (DHHS)*, the Department of Health, or that are not in accordance with medical policies established by authorized health entities for the specified indications and methods ordered.
11. Drugs or experimental treatments labeled "Precaution: Limited by federal law to investigational use". Expenses or services for new medical procedures that are not considered experimental or investigational, except if required by a state or federal law. Notwithstanding that provided in above numbers 10 and 11, if an insured suffers a life-threatening illness for which there is no effective treatment approved by state and federal agencies, and is eligible to participate in an authorized treatment study, as per the study protocol, MCS Life will cover routine medical expenses of the patient. Expenses will be covered if the insured's participation in the study offers a potential benefit and the study referring physician understands the participation of the insured is appropriate, or when MCS Life is provided evidence. The expenses or study-related tests, or expenses that reasonably have to be paid by the entity conducting the study will not be considered routine medical expenses.

12. Expenses for surgeries, procedures, treatments or care to correct physical appearance defects, except for reconstructive interventions to repair damaged tissue due to illness or physical injury caused by an accident, or surgery to correct a congenital anomaly, including oral defects in newborns. Surgeries for the removal of excessive skin (commonly known as flaps) will not be covered, except if the physician certifies the need to remove excessive skin because it affects a body part function, in accordance with Act No. 212 of August 9, 2008.
13. Cosmetic treatments.
14. Hospital, medical and surgical services, and complications associated to cosmetic treatments, regardless of medical justification for the procedure, except as provided in Act No. 212 of August 9, 2008.
15. Charges resulting from an illness or body injury during the performance of the insured's job duties.
16. Charges for drugs administered at medical office visits.
17. Charges for thermography services offered or ordered by chiropractors and other specialists.
18. Charges for infertility treatments or related to conception methods, except laboratory test for diagnostic purposes.
19. Charges for orthoptic therapy services (vision therapies), as well as necessary devices as part of the therapies after exhausting the maximum established in vision coverage.
20. Charges for orthopedic insoles.
21. Charges for prosthesis replacement.
22. Charges for support stockings, canes and crutches.
23. Charges for rendering elective abortions, including all the related services.
24. Charges for psychometric tests without clinical justification. Autism treatments or conditions, as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and in accordance with Act No. 220 of September 4, 2012, known as BIDA (Spanish acronym) will be covered without limitations.
25. Any procedure or treatment with the purpose of reestablishing the ability to procreate – such as vasovasostomy and tuboplasty – or procedures not under the condition of infertility, with the purpose of inducing pregnancy, such as, *in vitro* fertilization.
26. Ambulatory occupational and speech therapy, social worker, except for treatments for the conditions of autism, as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and in accordance with Act No. 220 of September 4, 2012, known as BIDA (Spanish acronym). Occupational and speech therapies are covered under home health care services.
27. Expenses for vaccines and related services required by Walmart to obtain or maintain employment.
28. Expenses for Rhogam vaccine (see Chapter 2: Pharmacy Coverage).
29. Home health care services do not include residential or custodial care, services provided for personal convenience or comfort, for example, housework, childcare and food delivery services, regardless if recommended by a nutritionist or doctor.
30. Dialysis and hemodialysis services, services at hospitals or renal care facilities, medical-surgical services and related complications; after exhausting the maximum first thirty (30) months for Medicare eligibility.
31. Fetal monitoring at the medical office (belts).
32. *Lasik* procedures and surgeries for correction of refractive defects.
33. Cochlear implant procedures.
34. Special Wellness Program.
35. Rehabilitative visual therapy services.
36. Organ transplantation services.
37. Intravenous or inhalation analgesia administered by a physician or dentist, except for anesthesia, in accordance with Act No. 352 of December 22, 1999.
38. Surgical anesthesia for ambulatory surgery.
39. Durable medical equipment not described in this certificate, including custom made medical equipment. Excluded also are services and equipment for Optune® treatment.

40. Every service not pre-authorized and that requires MCS Life Clinical Affairs pre-authorization, as described in the benefits of this certificate.
41. Expenses for contraceptive methods, except for sterilization or vasectomy (see Chapter 2: Pharmacy Coverage).
42. Complementary medicine services not offered by MCS Alivia contracted providers.
43. Expenses for sport medicine services.
44. Expenses for oral chemotherapy services (see Chapter II: Pharmacy Benefit, Part X: Limitations).
45. Expenses for maternity services to dependent daughters.
46. Expenses for NICU services for children of dependent daughters.
47. Water ambulance.
48. Growth hormones.
49. Allergy vaccines.
50. Consultations to specialists or subspecialists through MCS Medilínea MD services, except for family medicine physicians, internists, and pediatricians.
51. Telemedicine consultations outside the network or platform contracted for MCS Medilínea MD service.
52. Coverage for United States residents.
53. Paid expenses accrued by an assistance program or a third party for maximum out-of-pocket expenses (MOOP).
54. Non-emergency services in the United States.
55. Services outside of the United States.
56. The following services are excluded from basic coverage: Pharmacy, Dental, Orthodontics and Life Insurance.
57. Services under major medical expenses are excluded from basic coverage, as described in Part III, Section 6 of this Chapter.
58. Walmart reserves the right to select new medications that are available on the market to include in its medication formulary. Any expense for new medications will not be covered until such medication is evaluated by the MCS Life Pharmacy and Therapeutics Committee following its applicable policies and procedures. The Pharmacy and Therapeutics Committee evaluates new prescription drugs approved by the U.S. Food & Drug Administration (FDA) within a period of no more than ninety (90) days, counted from the date of approval issued by the FDA. In that term, MCS Life will make a recommendation regarding whether or not to include said new medication in the formulary following Walmart's determination. Even new drugs that are within excluded therapeutic classifications (categories) will be considered excluded. Except as required by state or federal law.
59. Expenses or services for new treatments or medications with a minimum of 12 months on the market, medications approved by the FDA through the Accelerated Approval Program, Fast Track Designation, Breakthrough Therapy designation, and/or FDA-approved drugs that lack evidence of clinical effectiveness, except for drugs whose coverage is required by applicable state or federal law. Therefore, those FDA-approved medications that fall within the categories set forth above are not covered.
60. New medications within a therapeutic class that is excluded will also not be covered. Treatments for rare diseases and/or complex administration, or therapies that require specialized administration and evaluation, will not be covered.
61. Gene Therapy, with exception of Elevidys: Any new technology, treatment, medication or devices that alters the body's genes, genetic correction or expression of, and medications categorized as Cell and Gene Therapy. For example, brexucabtagene autoleucel (Tecartus), Ciltacabtagene autoleucel (Carvykti), casimersen (Amondys45); except when required by state or federal law.

Section 2: Vision Exclusions

1. Any illness or body injury resulting from or during the performance of the insured's job duties.
2. Expenses for sunglasses or tinted glasses.
3. Expenses incurred for medical or surgical eye treatments other than those specified.
4. Expenses for cosmetic use.
5. Expenses incurred for Pediatric Aphakic Contact Lenses or other type of contact lenses other than regular or toric.
6. Expenses incurred after exhausting the benefit or service, as described in the vision coverage.
7. Deductibles or co-insurances that correspond to the insured.
8. Devices needed as part of the orthoptic therapies.

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

1. Surgery for the removal of excess skin (known as flaps) will not be covered except if certified by a physician as necessary because it affects a body part function.
2. Other techniques or methods of bariatric surgery other than gastric bypass, adjustable band surgery or sleeve gastrectomy are excluded from the benefit.
3. Bariatric surgery benefit is limited to the geographical area of Puerto Rico; bariatric surgeries performed outside Puerto Rico are not covered.
4. Bariatric surgery is limited to one (1) for life, regardless of the surgical technique used.
5. Bariatric surgery or bariatric surgery-related reconstructive procedures without MCS Life pre-authorization are excluded from the benefit.

PART IV: PRE-AUTHORIZATION OF SERVICES, STUDIES, AND PROCEDURES

Pre-authorization requests will be initiated by a physician or provider. The request should be signed and faxed along with a medical order to MCS Life Clinical Affairs Division. MCS Life is not responsible of the payment of services received or rendered without pre-authorization, except for emergency cases, in accordance with Act No.194 of August 25, 2000, as amended.

MCS Life fax numbers for pre-authorization requests are: 787-622-2436 or 787-622-2434, or you can call the dedicated line for Walmart Associates at 787-945-1348 or 1-855-830-9887.

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

Procedure for a regular pre-authorization

Pre-authorization determination will be managed within the fifteen (15)-day period of its receipt. In the event the initial request is incomplete, the provider or physician will be notified within a 5-day period from the date of receipt. The initial period of time could be extended to fifteen (15) additional days, provided the purpose of the extension is to handle situations beyond the control of MCS Life or when there is insufficient information for the determination. In either case, the insured or provider submitting the request will be notified of the specific reason for the extension or the specific information needed for the evaluation. If the extension is due to insufficient information for MCS Life to make a determination, the insured will have a period of time of at least forty-five (45) days from the date of receipt of the notification for extension to provide the additional

specified information. Extensions will be notified during the first fifteen (15) days from the date of receipt of the request.

Procedure for an accelerated pre-authorization

The provider may request an accelerated or urgent pre-authorization. MCS Life will treat such request as urgent, provided the situation threatens the life, health, or full recuperation of the insured or because the insured will suffer such unmanageable pain if the requested service or treatment is not received. In case the request and required documentation for an urgent or accelerated process is incomplete, MCS Life will notify of the lack of documentation in twenty-four (24) hours from the time of receipt. Once the completed information is received, MCS Life will notify of the determination no later than twenty-four (24) hours from the date in which the completed information is received.

In cases of requests of a concurrent review for urgent care, in which the insured requests an extension of treatment, MCS will make a determination with respect to the request and will notify the insured in a twenty-four (24)-hour period before the expiration of the original deadline.

If the submission is complete, but the clinical information submitted is insufficient for a determination, MCS Life will notify of the deficiency in or before twenty-four (24) hours of receipt of the request. The insured has up to fourteen (14) days to submit additional clinical information. In case the information is not received during the set period of time, it will be denied due to lack of information.

When the requested service meets all the established criteria, the provider will be authorized and notified of the authorization number. In addition, an approval letter will be sent to both the provider requesting prior authorization and the insured. Pre-authorization will be effective for thirty (30) calendar days.

If service is denied, a letter will be sent explaining the reason for the denial of services, including supporting references used, if applicable, as well as information on the right to appeal the denial and corresponding procedure.

Emergency cases do not require pre-authorization.

PART V: COORDINATION OF BENEFITS (COB)

Coordination of Benefits (COB) is the method employed to determine payment for claims when an insured has more than one insurance plan.

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

With the coordination of benefits, the insured will receive up to one-hundred percent (100%) reimbursement or medical expenses incurred. The insured is required to identify all insurance plans covering his or her family members. This information is necessary to determine if *Walmart Inc. Associates' Health and Welfare Plan* is the "primary" or "secondary" payer of benefits.

NOTICE TO INSURED

If the insured or his or her dependents are covered under more than one plan, claims should be submitted to each plan and inform providers of all such coverages.

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

Plan	<p>For the purposes of the COB, a plan is a type of coverage which allows coordination of benefits.</p> <ol style="list-style-type: none">1. Primary plan – will pay established services without taking into account the existence of another plan.2. Secondary plan – will pay any covered service that has not been paid by the primary plan, taking into consideration that services will be paid according to the provisions and limitations of each policy.
This plan	<p>For the purposes of the COB, “this plan” includes the part of the benefits agreement that covers health care to which the COB provisions apply and that can be reduced according to the benefits covered by another plan.</p>
Allowable expense	<p>Any part of the health care expense, including co-insurances, co-payments and any applicable deductibles, covered, in whole or in part, by any of the plans under which the insured is covered for whom the COB claim is submitted. When a plan provides benefits in the form of services, the reasonable value of each service is considered an allowable expense and a paid benefit.</p> <p>Expenses not covered under any plan covering the associate are not an allowable expense. In addition, any expense that a provider – by law or contract relation – is not allowed to charge a covered person, is not an allowable expense.</p> <p>Below are examples of non-allowable expenses:</p> <ol style="list-style-type: none">1. The difference in costs between a semi-private and private hospital room, unless one of the plans provides coverage for private hospital room or the hospital stay is medically necessary (as per the generally accepted terms within the practice of medicine).2. When the highest reimbursement amount is exceeded, if the insured is covered by two or more plans calculating the payment of benefits based on regular and customary charges or other method of reimbursement.3. Any amount that exceeds the highest negotiated fees when an insured is covered by two or more plans that provide benefits based on negotiated fees.4. If an insured is covered under a plan that calculates its benefits based on regular and customary fees and under another plan providing benefits based on negotiated fees, the payment agreement of the primary plan will be the allowable expense for all plans. However, if the provider has contracted the secondary plan to provide benefits for a specified negotiated charge or an amount of payment different to that arranged with the primary plan, and if allowed by the contract, such negotiated charge or payment will be the allowable expense used by the secondary plan to determine benefits.5. The amount of any reduced benefit because the insured does not meet the provisions of the primary plan. Some examples include second opinions for surgeries, pre-authorization for admissions and when contracted providers are not used.

Custodial parent	Parent whose legal custody of a child is granted by a court order or in absence of court order, with whom the child lives more than half of the calendar year, excluding temporary visits.
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2. Determination of Payment Order, as per NAIC rules:

1. **Dependent or non-dependent rule:** The plan covering a person as primary insured will be the primary plan and the secondary plan is the one covering as dependent.
2. **Dependents of non-separated parents (Birthday Rule).** The plan of the parent whose birthday comes first during the year (month and day) will be the primary plan and the other plan will be secondary. If both parent's birthday is on the same day, the plan that has provided coverage for the longest time will be the primary.
 - a. If the secondary plan does not abide by the birthday rule, the gender rule will prevail; the father's plan will be primary and that of the mother secondary. This rule will prevail over the birthday rule.
3. **Dependents of separated or divorced parents:** Unless for a court order determining otherwise — in which case, the court determination will prevail over the coordination rule — the primary plan will be that of the one who holds custody. The secondary plan will be that of the parent who does not hold custody over the children. When there is another insurance covering the dependent, the order of benefits will be as follows:
 - a. First, the plan of that who holds custody of the dependent;
 - b. Then, the plan of the spouse of that who holds custody of the dependent;
 - c. Finally, the plan of that who does not hold custody of the dependent.
4. **Active, retired or laid-off insureds:**
 - a. If the children of a retired or laid-off insured are also dependents of an active insured, the plan covering the active insured will be the primary plan and the plan of the retired or laid-off will be the secondary plan.
 - b. When determining coordination for a retired insured who is dependent in a plan of an active insured, the plan covering as a retired is the primary plan. In this case, the dependent/non-dependent rule will prevail.
 - c. If an insured is not subject to the situations described above, the plan that has covered the insured for the longest time will be the primary plan and the plan covering for the shortest time will be the secondary plan (seniority rule).
 - d. The plan without COB clause, will be the primary with respect to the one with a clause.
5. **Coordination with other federal health programs:** There are five (5) government health plans that are coordinated with private health plan: *Medicaid, Indian Health Service (IHS), Tricare, a program for dependents of armed forces members (CHAMPUS), Veterans Administration (VA), and the Federal Employees Health Benefit Act (FEHBA).*
 - a. In accordance with the laws and regulations, the aforementioned government health plans, will be secondary to a private plan.
 - b. When services are provided at a VA facility, it becomes secondary before a private plan, unless the condition being treated is service connected, in which case, VA will be the primary.

6. **Coordination with the government health plan:** The health insurance plan of the government of Puerto Rico will always be a secondary payer before any other plan, without exception. The employer plan will always be the primary payer.
7. **Coordination with Medicare:**
- a. Medicare because of age – If an insured has Medicare because of age (older than sixty-five (65) years old), the employer plan of the insured and/or spouse will be the primary if the employer group to which he or she belongs has a payroll of twenty (20) employees or more.
 - b. Medicare because of disability – If an insured has Medicare because of disability (younger than sixty-five (65) years old), the employer plan of the insured, his or her spouse, and /or any family member will be primary if the employer group to which he or she belongs has a payroll of one hundred (100) associates or more.
 - c. Medicare because of renal disease – If an insured has Medicare because of a renal condition, Medicare establishes a period of coordination of thirty (30) months in which the employer plan is considered primary. When Medicare grants renal or ESRD (End-Stage Renal Disease) status, the following are not taken into account: the age of the insured, the number of employees of the employer, or belonging to a group of active or retired employees. While Medicare establishes a period of coordination of thirty (30) months, MCS Life will apply a period of coverage for dialysis services, as set forth in the Certificate of Benefits. Once Medicare becomes the primary payer, Walmart (MCS) becomes the secondary payer. This scenario only applies under the Coordination with Medicare for Renal Condition (ESRD) described in this section.
 - d. Medicare is primary when the insured:
 - is applicable to Medicare (except for renal disease) along with an employer plan for retirees;
 - has government health plan
 - has other direct-payment health or COBRA (non-renal patient).

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

When this plan is primary, it will determine payment of benefits first, before considering the benefits of any other plan. When this plan is secondary, it determines its benefits after that of the primary, and may reduce the benefits it pays in order that all the plans benefits do not exceed one-hundred percent (100%) of the total allowable expenses.

3. Rules for determining the order of payment of benefits:

When an insured has health insurance coverage under two (2) or more plans, the rules for determining the order of payment of benefits will be as follows:

- A. The primary plan pays or provides benefits according to the terms of coverage without taking into consideration the benefits covered under any other plan.
- B. A plan without COB provisions consistent with this Section, will always be the primary plan, provided the certificate of coverage or policy specifies which will be the primary plan. This provision does not apply with respect to coverage obtained in virtue of a group membership not designed as supplementary to a part of a basic package of benefits and provides that this supplementary coverage applies when in excess of any other part of the plan provided with the owner of the contract.

- C. A plan can take into account the benefits paid or provided by another plan when calculating payment of its benefits solely when it is secondary to that other plan.

4. Effect on the benefits of this plan:

When this plan is secondary, it can reduce the benefits, in such a way that the total of the benefits paid, or provided by all the plans during a plan year, do not exceed the total allowable expenses. When determining the amount to be paid for a claim, the secondary plan will calculate the benefits that it would have paid in absence of the other coverage, and will apply that calculated amount to any allowable expense under its plan that has not been paid by the primary plan. The secondary plan may reduce the payment for that amount in such a way that when combining the amount paid by the primary plan, the total benefits paid or provided by all plans for that claim, does not exceed the total allowable expenses for that claim. In addition, the secondary plan should credit to its plan deductible any amount that it would have accredited its deductible in absence of another health care coverage.

5. Right to receive, use, or disclose necessary information:

Certain information about coverage is necessary in order to apply these rules of COB and to determine the payable benefits under this plan and other plans. MCS Life can obtain the information and share it with organizations or individuals with the purpose of applying these rules and to determine payable benefits under this and other plans covering the claimant of the benefits. MCS Life does not need to notify or get consent from anyone to obtain and share the necessary information.

6. Ease of payment:

A payment done by another plan could include an amount that should have been paid by MCS Life. If this were the case, MCS Life can pay such amount to the organization making the payment. This amount will be treated as a benefit paid by MCS Life, and as such, MCS Life will not have to pay that amount again. The term “payment made” means the reasonable cash value of the benefits provided in the form of services.

7. Right of recovery:

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

MCS Life will, at all times, comply with the federal applicable rule, as set forth in 45 C.F.R. sec. 146.152 (Guaranteed Renewability of Coverage for Employers in the Group Market).

PART VI: COMPLAINT SYSTEM

The insured has the right to submit a complaint in relation to an adverse determination and a request for review of a complaint related to an adverse determination in accordance with Act No. 194 of August 25, 2000, Bill of Rights and Responsibilities of the Patient, Act No. 161 of November 1, 2010 to amend Art. 2 and 7 of Act No. 194 of 2000, and in accordance with the Patient Protection and Affordable Care Act 75 Fed. Reg. 43330-43364 (July 23, 2010).

In case the insured has a claim or doubt regarding benefits coverage, he or she may submit a claim by calling our Customer Service Department or visiting one of our Service Centers located throughout the Island.

There is also a complaint and appeals process which warrants the insureds the right to submit, of efficiently investigating a complaint, and to a timely decision. Our purpose is the satisfaction of our insureds with the service being offered and to achieve respect of the rights and responsibilities of those involved, ensuring confidentiality between the parties.

The insured or his or her authorized representative, with written consent, can submit a complaint or complaint. In addition, the following persons or entities can file a claim or complaint on behalf of the insured:

- The health care provider with written consent
- Persons authorized by court or in accordance with state laws on behalf of the insured,
- A representative appointed by the state on behalf of the deceased insured
- Personnel of a government agency, such as the Office of the Insurance Commissioner, Office of the Health Ombudsman, Senate and House of Representatives, Office of the Citizen's Ombudsman and the Governor's Office.

MCS Life will confirm that the person submitting the complaint is the authorized representative appointed by the insured, by means of a phone call to the insured or any written documentation provided. If MCS Life cannot confirm the representation, a letter will be sent to the insured letting him or her know that the case will not be processed until such information is received.

Procedure

Availability of assistance for submitting complaints and its process:

Taking into consideration the special needs of the insured who may have hearing, vision and/or reading limitations, MCS Life provides the following services free of charge:

- TTY/TDD phone line: 1-866-627-8182
- Sign language and/or interpretation or translation services for foreign languages
- Audio tapes
- Braille

MCS Life ensure all services, either clinical or non-clinical, are available to all member and that these are provided under a cultural competence approach.

MCS Life does not discriminate because of race, color, nationality, age, disability or gender. It also warrants ascertained, fair, and equal resolution of complaints regarding prohibited behavior or action in accordance with Section 1557 of the Affordable Care Act.

Submission of complaints

MCS Life will work on any situation or question submitted by the insureds or their authorized representative in each call or during visits to our Service Centers. In case of complaints received through a phone call, MCS Life has a call back system to let the insured know the status of the request. If the insured is not satisfied with the alternatives offered by the MCS Service Representative, the insured will receive orientation on the formal procedure to evaluate the claim through the complaint process. The insured has the right to submit a complaint unrelated to the adverse determination without going through the complaint process.

Situations that can be resolved through the call back system, considering they require short interventions or actions for their solution are:

- Eligibility issues: Questions regarding the insured's eligibility in the plan, including validation of electronic files.
- Questions about the status of a request, such as: Pre-authorization, registry of special conditions, and others.
- General orientation about the plan.
- Assistance with appointment coordination and seeking participating providers.

Submission of complaints unrelated to adverse determinations

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

- Service Centers
- Calling the dedicated telephone line for Walmart associates at 787-945-1348 or 1-855-830-9887. Users of TTY/TDD can call 1-866-627-8182.
- By regular mail along with a description of the claim and the contract number to the following address:

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

- MCS Life will notify the insured of the right to submit written comments, documentation, records, and other material related to a complaint. In addition, MCS Life will notify the insured of having the right to receive assistance when submitting a complaint by authorized personnel or a government officer, such as:
 - Office of the Health Ombudsman: The insured can visit the office of the Health Ombudsman throughout the Island or headquarters located at 1215 Ponce de León Ave., Stop 18, San Juan, Puerto Rico, by calling [787 977-1100 or toll free at 1-800-981-0031] or visiting the website at [www.ops.pr.gov] in accordance with that provided in the Bill of Rights and Responsibilities of the Patient and Act No. 161 of November 1, 2010.
 - Office of the Insurance Commissioner: The insured can call 787-304-8686, by fax at 787-273-6082 or visiting the offices located at Gam Tower, Tabonuco St., Suite 400, San Patricio, Guaynabo, Puerto Rico, and visiting www.ocs.gobierno.pr.

Investigation, resolution, and notification of a complaint unrelated to an adverse determination

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

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

MCS Life will provide the insured within three (3) work days of receipt of the complaint the name, address, and phone number of the persons designated to conduct the review. The insured has the right to submit written

comments, documentation, records, and other material related to the complaint. The designated persons will be different from those who handled the issue object of the complaint.

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

- Titles and credentials of the people participating in the complaint review process (the Reviewers);
- A statement regarding the interpretation conducted.
- The determination of the reviewers, in clear terms, and the contractual base or medical justification for the insured to respond to the opinion of MCS Life.
- Reference to the evidence or documentation supporting the grounds of the determination.
- Notice of the right that assists the insured to contact the Office of the Commissioner or the Office of the Health Ombudsman to request assistance, the phone number and address of both offices.

Confidentiality

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

Submission of complaints related to an adverse determination

First level review of an adverse determination

The insured can submit complaint on or before one-hundred eighty (180) days from the date of receipt of an adverse determination of benefits resolution issued by MCS Life. A complaint pertaining to an adverse determination may be submitted in writing or verbally, if it entails a request for accelerated care by:

- Visiting MCS Life Service Centers.
- Calling the dedicated line for Walmart associates at 787-945-1348 or 1-855-830-9887. TTY/TDD insured can call 1-866-627-8182.
- Regular mail accompanied by an explanation and contract number to the following address:

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

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

- Office of the Health Ombudsman: The insured can visit the offices of the Health Ombudsman located throughout the Island or the headquarters located at 1215 Ponce de León Ave., Stop 18, San Juan, Puerto Rico. Also, by calling 787 977-1100 or 1-800-981-0031] or visiting the website at [www.ops.pr.gov in accordance with that provided in the Bill of Rights and Responsibilities of the Patient and Act No. 161 of December 1, 2010.
- Office of the Insurance Commissioner: The insured can call 787-304-8686 or by fax at 787-273-6082 or visit the office located at Gam Tower Building, Tabonuco St., Suite 400, San Patricio, Guaynabo, Puerto Rico, or visit www.ocs.gobierno.pr.

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

MCS Life will evaluate and resolve an appeal promptly according to the medical condition of the insured, taking into consideration medical necessity and according to the type or claim:

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

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

MCS Life will designate one or several peer clinicians of the same or similar specialty to the health professionals that would normally manage the case for which the adverse determination was made, and that have not been previously involved in making decisions or level of review. When the initial denial has been based on lack of medical necessity, the complaint will be evaluated by a health professional with the appropriate clinical expertise to treat the condition or illness of the insured. If more than one peer clinician is designated for the review, MCS Life will make sure that they have adequate expertise.

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

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

The insured will be able to examine, before and during the investigation and resolution process, the complaint record, for example: medical records, new evidence to consider, identification of medical experts and

professionals consulted, as well as any other document related to the complaint, and to request copy of this documentation free of charge, subject to the exceptions and limitations imposed under the applicable laws pertaining to confidential or privileged information.

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

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

The notification will include:

- Titles and credentials of those participating in the first level review process (the reviewers);
- Statement of the interpretation made;
- Clear determination along with the contractual or medical justification in order for the insured to reply to the statements of MCS Life;
- Supporting evidence or documentation on which the determination was based.

In case MCS Life issues an adverse determination, after having conducted the complaint review, as defined in this certificate and per applicable laws and regulations, the notice for such determination will include:

- State specific reasons for the adverse determination.
- Make reference to specific provisions on the coverage in which the determination is based.
- Include a statement on the right of the insured to receive free of charge and upon request, reasonable access and copies of all documentation, registries, and other pertinent information.
- If the document, record or other information is pertinent to the claim will be based on the definition set for in ERISA (2560.503). Pertinent means that: (a) they were used in the determination of benefits; (b) they were submitted, considered or generated regarding the adverse determination, even if the determination of benefit did not depend on such documentation, records or other information; (c) they show that when making the determination, the health benefits' administrator consistently followed the same procedures and administrative assurances as with other insureds in similar circumstances; or (d) they constitute health insurance policy statements or guidelines regarding to the denied health care service or treatment and the diagnosis of the insured, regardless if they were taken into consideration or not when making the initial adverse determination.
- The right to request free copies of the rule, guide, internal protocol or other similar criteria on which the adverse determination was based, if applicable, and the instructions for its request.
- The right to request free of charge an explanation of the scientific or clinical rationale when making the adverse determination based on medical necessity or the experimental or investigative nature of the treatment, if applicable, and the instructions for its request.
- A description of the procedures to obtain an independent external review.
- A notification of the right of the insured to contact the Office of the Insurance Commissioner or the Office of the Health Ombudsman to request help at any time, with phone numbers and addresses of both offices.
- A statement of the right of the insured to file a civil action under ERISA Section 502(a) after an adverse benefits determination under review.
- The right to seek other voluntary options of dispute resolution between the insured and the plan, such as mediation. One of the ways to identify available options is by contacting the U.S. Department of Work and Human Resources or the Office of the Insurance Commissioner of Puerto Rico.
- A statement indicating the right of the insured to file an action in a competent court.

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

Continuity of services

In the event of concurrent reviews determinations, if MCS Life has previously certified the ongoing treatment for a specific period of time or for a certain amount of treatments, MCS Life will notify the insured of the adverse determination. Notification will be sent prior to the reduction or termination, in such a way that the insured can submit an internal complaint and get a determination before the benefit is reduced or terminated.

The health care or treatment services object of the adverse determination will continue until MCS Life notifies the insured of the determination taken concerning the internal complaint.

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

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

External reviews

If the insured is not satisfied with the adverse determination, the insured may request a review before an external independent organization that meets the requirements of the Insurance Commissioner of Puerto Rico and with that provided in PPACA Section 1001. Independent review organizations are certified by an accreditation organization that warrants that the reviewers are duly qualified and are independent of the plan. Among the reasons to request a review are: denial of service for being experimental or investigational in nature, the decision of an MCS Life internal review, or if MCS Life does not provide a determination within the time limits set forth for internal reviews.

The insured, his or her authorized representative or physician should submit such request to MCS Life, or directly before an independent review organization, through the means listed in the written resolution issued by MCS Life in one-hundred twenty (120) of having received notification of the adverse determination.

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

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

If the insured has provided all required information for the external review process, MCS Life will proceed to refer the request to one of the three contracted independent review organizations mentioned below: *Advance Medical Review*, *Alicare Medical Management*, and *BHM Health Care Solutions*. The independent review organization to conduct a review is randomly selected among contracted and qualified independent review organizations.

If, on the other hand, MCS Life determines that the request for an external revision does not meet the required information criteria, it will notify the insured or his or her authorized representative of the inappropriateness of such request based on the following:

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

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

The insured or his or her authorized representative may submit an accelerated review for an adverse determination if:

- The insured suffers a health condition that the time required for an accelerated internal review could threaten his or her life, health or full recovery.
- The insured has submitted an accelerated internal review for which an adverse determination was made.
- The insured suffers a health condition that the time required for an ordinary external review could threaten his or her life, health or full recovery.
- The final adverse determination is related to the admission to a health care facility, the availability of service or the continued stay at a facility where the insured received emergency services and still has not been discharged.

MCS Life will immediately observe the decision of the Independent Review Organization.

The insured will pay a face value of twenty-five (\$25.00) dollars per review. The cost cannot exceed seventy-five (\$75.00) dollars per policy year for the same insured. The amount paid by the insured will be reimbursed if the opinion is favorable for the insured.

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

- Has submitted an internal complaint resource and
- has not received written notice of the determination from MCS Life within thirty (30) calendar days of receipt of the appeal resource without the parties have not agreed on the extension of the term to issue the determination.

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

The premise that the insured exhausted the internal appeal processes will not apply, as long as the violations do not affect the insured, whenever the plan can show that the violation was for a good cause, or that it was beyond the plan's control and that the violation occurred in the context of an ongoing exchange of information in good faith between the insured and MCS Life. This exception does not apply if the violation is part of a pattern of violations from MCS Life. The insured may request a written explanation of why it is understood that such violation exhausts all internal complaint processes. A response is expected in ten (10) days.

PART VII: SERVICE ACCESS MODEL

Physician

The health plan is designed to provide free selection of physicians, facilities and specialists.

Under this model, the insured does not need a referral from a primary care physician to access services from other specialists or subspecialists within the applicable network.

To ensure health insurance benefits are received, the insured should visit a service provider within the MCS Life PPO network.

Laboratories

PPO Laboratory Network: Corresponding co-payment or co-insurance applies. The insured should refer to the Providers Directory to learn about the PPO Laboratory Network.

Contracted Network in the United States

UnitedHealthcare: Contracted network providers to offer services in the United States. For details on providers in this network, please visit www.unitedhealthcareonline.com or call the Help Center at 1-800-226-5116.

PART VIII: CO-PAYMENT, CO-INSURANCES AND DEDUCTIBLES TABLE

PREMIUM	
Deductibles and maximum-out-of-pocket (MOOP)	
Annual deductible for medical benefits	
Individual	N/A
Family	N/A
Maximum-out-of-pocket (MOOP) expenses for medical benefits	
Individual	\$1,600
Family	\$3,200
Essential health benefits	
Emergency and urgency services	
Accident and Trauma	\$0
Illness	\$50
Urgency centers	\$10
Hospitalization	
Partial hospitalization	\$50
Hospitalization (including mental health)	\$50
Skilled Nursing Facility	\$0
Surgery Assistance	\$0
Ambulatory Services	
General practitioner	\$10
Specialist (including psychiatrists, psychologists, podiatrists, first visit to chiropractors, audiologists, optometrists, and nutritionists)	\$10
Sub-specialist	\$15
Home doctors' visits	\$15
Ambulatory facility	\$25
Diagnostic and surgical procedures at the medical office	25%
Diagnostic and surgical procedures at an ambulatory facility	25%
Endoscopies	0%
Cervical cryosurgery	0%
Dialysis and hemodialysis	0%
Rehabilitation, habilitation, and durable medical equipment	
Physical therapy (including respiratory therapy and chiropractor manipulations)	\$7
Ambulatory respiratory therapy	\$7
Chiropractor manipulations	\$7
Home Health Care	0%
Durable Medical Equipment	25%
Internal and external prosthesis	25%
Orthoptic devices	25%

Implant trays and other surgical trays	\$300
Mental health	
Group therapy	\$10
Collateral visits	\$10
Psychological tests (for associates who meet Act No. 296 de 2000 requirements)	\$10
Psychiatrists	\$10
Laboratories and X-ray services	
PPO Network for Laboratories	25%
X-rays	25%
Specialized Tests (CT Scan, PET Scan, PET CT, MRI, MRA, and SPECT)	25%
Preventive, wellness, and chronic disease management services	
Preventive services	0%
Prenatal and Postnatal Care Visits	\$8
If the insured enrolls in the "Programa de Madres y Bebés Saludables" within the first three months of pregnancy	\$0
Genetic Amniocentesis	25%
Amniocentesis (fetal maturation)	25%
Preventive Immunizations (vaccines)	0%
Immunization (vaccine) for respiratory syncytial virus (Synagis)	0%
Other services covered	
Air ambulance in Puerto Rico	20%
Bariatric Surgery	Surgery: 0% Hospital co-payment applies: \$50
Programs included as part of benefits	
MCS Alivia	\$15
MCS Medilínea MD	\$0
Vision Coverage	
Refraction tests (adults and children)	\$4
\$130 Coverage per policy year per insured	

ANTI-FRAUD NOTIFICATION

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

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

Certificate of Benefits prepared by:



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

www.mcs.com.pr



**ENDORSEMENT TO THE CERTIFICATE OF BENEFITS
HEALTH PLAN OF WALMART PUERTO RICO, INC.
PREMIUM 79-750096**

PREMIUM PHARMACY BENEFIT SUMMARY

This document notifies changes in the pharmacy benefit for associates and eligible dependents of **Walmart Puerto Rico's** medical plan, effective **January 1, 2024.**

PART XI: EXCLUSIONS

The following exclusions will be part of this section:

24. **Walmart** reserves the right to select those new drugs that are available in the marketplace to be included in the drug formulary of your pharmacy benefit. Any new drug expense will not be covered until such drug is evaluated by **MC-Rx's** Pharmacy and Therapeutics Committee following its applicable policies and procedures. The Pharmacy and Therapeutics Committee evaluates new prescription drugs approved by the U.S. Food & Drug Administration (FDA) quarterly. In this term, **MC-Rx** will recommend whether or not to include the drug on the formulary following the recommendations of the Pharmacy and Therapeutics Committee.
25. New drugs within an excluded therapeutic class will not be covered. Treatments for rare diseases and/or complex administration, or therapies requiring specialized administration and evaluation will not be covered, except as required by state or federal law.
26. Gene therapy: Any new technology, treatment, drug or device that alters the body's genes, genetic correction or expression of, and drugs categorized as Cell and Gene Therapy. For example, brexucabtagene autoleucel (Tecartus), Ciltacabtagene autoleucel (Carvykti), casimersen (Amondys45); except when required by state or federal law.

PHARMACY BENEFIT



Pharmacy Benefit Summary Walmart Puerto Rico

PART I: Introduction

This document is a summary of the pharmacy benefit that **Walmart Puerto Rico** offers to its associates and their dependents that are eligible to the health plan. It contains the most important information about your rights and responsibilities, the dispensing of drugs, copayments, how to access the updated pharmacy directory, and available programs, among others. This pharmacy benefit is directly contracted by **Walmart Puerto Rico** with **MC-Rx**.

MC-Rx is a Pharmacy Benefit Manager (PBM) that adheres to all regulations and privacy laws. Our goal is to provide you with the highest quality products and services, while protecting the confidentiality, integrity and security of your information. You can access our privacy policy through www.mc-rx.com.

MC-Rx provides services according to the high standards established by the Utilization Review Accreditation Commission (URAC), an accreditation organization founded in 1990 which sets quality standards for all health industry. By maintaining our accreditation status, we keep pace with the health system changes and provide a mark of distinction to demonstrate our commitment to quality and the responsibility of offering an excellence service.

For more information about your pharmacy benefit, you may call **MC-Rx Member Call Center** toll free **1-855-252-2292 / 711 (TTY)**. We offer service 24/7. Whenever you contact us, you should have your insured identification number on hand. This information appears on the id-card issued by MCS. You can also register in the Member Portal at www.mc-rx.com or in the **MC-Rx** Member APP on your cell phone (Apple or Android) to obtain information about medications, copayments, an updated list of participating pharmacies, and more.

This pharmacy benefit covers the dispensing of generic and brand drugs that have the federal legend on the label "**Caution: Federal Law prohibits dispensing without prescription**". It is governed by the Federal Food and Drug Administration (FDA) guidelines that include dosage, equivalence of drugs, therapeutic classification, among others. It is important that you have knowledge of the available drug options (generic or brand) and their payment implications.

PART II: Definitions

Your pharmacy benefit covers a wide selection of drugs. **MC-Rx** Pharmacy and Therapeutics Committee has the responsibility of assessing drugs for which you have coverage. This committee is composed of physicians and pharmacists who meet periodically to evaluate new therapies and determine the needs to recommend strategies for cost containment. Committee's members take into consideration clinical literature to evaluate the safety and cost-effectiveness of drugs.

The following are some terms that you should know:

- **Biosimilar drugs:** These are biological drugs equivalent in quality, efficacy and safety to the original drug. This benefit covers the dispensing of a biosimilar drug as first alternative in those categories of specialized drugs that have it available in the market.
- **Generic drugs:** Drugs approved by the U.S. Food and Drug Administration (FDA) that have the same active ingredients as the brand name drugs. They are safe, effective and usually cost less than brand rugs. This benefit covers the dispensing of generic drugs as first option.
- **Brand drugs:** These are drugs marketed and sold under the original name of the pharmaceutical company that manufactures them. Your pharmacy benefit covers a wide variety of brand drugs that do not have a generic alternative available in the market.
- **Specialty or biotechnological drugs:** These drugs are used to treat chronic and high risk conditions that require special handling or administration due to their composition. Some of the conditions that they treat are: rheumatoid arthritis, Crohn's disease, Gaucher's disease, multiple sclerosis, pulmonary hypertension, hepatitis C, cancer, osteoporosis, and psoriasis, among others.
- **Drugs for acute conditions:** These are drugs prescribed for an illness that develops quickly, is intense or severe, lasts a relatively short period of time but needs urgent care, (e.g. antibiotics, anti-catarhal, antifungal, antiviral, antiemetic, antihistamines, among others).
- **Maintenance drugs:** These are drugs prescribed to treat chronic conditions and need to be used for extended periods of time or lifetime, (e.g. fffproducts for diabetes (including insulin), drugs for thyroid, diuretics, antihypertensives, anticoagulants, anticonvulsants, antiarthritics, antiasthmatics, drugs for cholesterol, Parkinson, and glaucoma, among others).
- **Preventive drugs:** These are certain drugs included in the Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA) that are used to prevent certain health conditions for adults and children. These drugs are 100% covered and require a written prescription from a physician to be dispensed:

Product	Description
Aspirin 81 mg	For patients from 50 to 59 years. Limited to one tablet daily. Include OTC products only.
Statins	For cardiovascular diseases prevention,
Vitamin D	For the prevention of falls in people over 65 years.
Folic Acid 400 mcg, 800 mcg	Include OTC products only.

Product	Description
Sodium Fluoride	Oral administration for patients of 6 years old or younger.
Contraceptives	Include OTC and prescription products. Some covered contraceptives are: oral contraceptives, IUD, diaphragm, female condom, male condom, foam or gel spermicides, copper intrauterine contraceptive, Mirena® ring, Nuvaring® ring, and Ortho Evra® patch, among others.
Tamoxifen / Raloxifene	For the prevention of breast cancer.
Smoking Cessation	Covered for 90 consecutive days up to twice a year. Include OTC and prescription products.
Prenatal vitamins	Include OTC and prescription products.
Colon preparation	For patients of 50 years and over when prescribed by a gastroenterologist. Covered Colyte and its generics and Suprep.
Truvada	Drug used as pre-exposure prophylaxis (PrEP) for HIV in combination with other prevention methods. The prescription must include patient's diagnosis.

- **Over the counter (OTC) drugs:** These are drugs that do not have the federal legend "Caution: Federal Law prohibits dispatch without prescription", and can be sold to a person without a physician's prescription. The Federal Food and Drug Administration (FDA) approved these medications at the same dose as when they were legend drugs. These drugs have proven to be safe and effective. This pharmacy benefit covers certain OTC drugs that require a physician prescription indicating "OTC." These drugs are:

Category	Drugs
Proton Pump Inhibitors (PPIs)	Prilosec® (tab), Prevacid® 24 hrs. (cap.), Nexium® 24 hrs., Zegerid® and their generics
Non-Sedative Antihistamines	Allegra®, Allegra-D®, Claritin®, Claritin-D®, Aller Clear®, Allergy Relf®, Zyrtec®, Zyrtec D®, Xyzal® and their generics
Nasal steroids	Rhinocort®, Nasacort®, Flonase®, Flonase Sensimist® and their generics
Ocular allergies	Alaway®, Claritin® Eye Drops, Zaditor® and their generics

PART III: Cost Containment Strategies

Some cost containment strategies apply to certain drugs. These strategies are actions implemented to assure that some drug therapies are used only when medically necessary, to control drugs, and prevent fraud, waste, and abuse of drugs. The main cost containment strategies are:

- **Quantity Limit:** Drugs have a limit on the amount to be dispensed. This amount is established according to FDA and manufacturer's recommendations of the maximum amount that does not cause adverse effects and is effective to treat a condition, (e.g. migraine drugs and opioids).
- **Age Limit:** Drugs dispensing is limited to certain age groups, (e.g. codeine, acne, and ADHD products).
- **Medical Specialist Limit:** Drugs dispensing is limited to certain medical specialties according to medical literature, (e.g. oncology products).
- **Prior authorization:** The drug's claim requires to be evaluated since it requires authorization before being dispensed to the patient. The preauthorization is managed by the pharmacy directly with **MC-Rx**, (e.g. specialty drugs, drugs that cost exceeds \$750, and compound drugs that exceed \$75).
- **Step Therapy:** This program encourages the use of clinically proven and cost effective drugs (first step) prior to using newer drugs (second step) that often have shorter history of clinical effectiveness and higher cost. This program only applies to new patients or to those who have not taken their drugs in a previous period of 6 months. The Step Therapy applies for the following diabetes drugs:

First Step Drugs	Second Step Drugs
Biguanides o Sulfonylureas (e.g. metformin, glipizide)	Glitazonas (e.g. <i>Actos</i> , <i>Avandia</i> , pioglitazona)
Biguanides, Sulfonylureas o Glitazonas (e.g. metformin, glipizide, pioglitazona)	DPP-4 (e.g. <i>Januvia</i> , <i>Janumet</i> , <i>Tradjenta</i>)
DPP-4 or SGLT-2 (e.g. <i>Jardiance</i> , <i>Tradjenta</i>)	DPP-4 & SGLT-2 (e.g. <i>Trijardy</i> , <i>Qtern</i>)
Biguanides, Sulfonylureas o Glitazonas (e.g. metformin, glipizide, pioglitazona)	GLP-1 (e.g. <i>Trulicity</i> , <i>Victoza</i>)
Biguanides, Sulfonylureas o Glitazonas (e.g. metformin, glipizide, pioglitazona)	SGLT-2 Inhibitors (e.g. <i>Farxiga</i> , <i>Jardiance</i> , <i>Invokana</i>)
Metformin IR / SR (e.g. metformin)	Metformin Osmotic / Liberación Modificada (e.g. <i>Fortamet</i> , <i>Glumetza</i>)
Alpha glucosidase Inhibitors (e.g. acarbose, miglitol)	Alpha glucosidase Inhibitors (e.g. <i>Glyset</i>)
GLP1 o Insulina de larga duración (e.g. <i>Trulicity</i> , <i>Victoza</i> , <i>Lantus</i>)	GLP-1 o Insulina de larga duración (e.g. <i>Xultophy</i> , <i>Soliqua</i>)

PART IV: Copays and Coinsurances

The following copays or coinsurances apply to **Premium Coverage**:

Drug	Copay/Coinsurance
Generic	\$0
If the member chooses a brand drug instead of an available generic, applies generic drug's copay plus the difference between the cost of the brand and generic drug.	

Brand	25%
Rhogam Vaccine	20%
Vaccines included in PR Department of Health Vaccines' Program	\$0
Maintenance (90 days) thru Flex 90® or Mail Order	
Generic	\$0
Brand and new	\$20
Specialty	30%, maximum \$250
Biosimilar	\$150
Drugs required by federal laws <i>Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA), Health Care and Education Reconciliation Act 2010, Public Law No. 111-152 (HCERA)</i>	\$0
Out of the Counter (OTC)	\$0

A Maximum Out of Pocket (MOOP) apply to this pharmacy benefit. Once the member reaches the amount established in the disbursement of copays and coinsurance, no copays will apply for the rest of the benefit year (January 1st to December 31).

PART V: Drugs Dispensing

This pharmacy benefit covers generic drugs as first choice and brand drugs labeled: **“Caution: Federal law prohibits dispensing without prescription.”**

- **Drugs for acute conditions:** Up to 15 days, no refills are covered.
- **Maintenance drugs:** Up to 30 or 90 days' supply, refills are covered.
 - 30 days' supply: The quantity of drug provided under an original prescription will be limited to one supply up to 5 refills.
 - 90 days' supply: The quantity of drug provided under an original prescription will be limited to one supply and one refill.

Prenatal vitamins are covered as maintenance drugs, limited to 30 days' supply, up to 5 refills.

Benzodiazepine drugs are covered as maintenance drugs, limited to 30 day's supply, up to 5 refills without medical specialist restriction, (e.g. alprazolam, lorazepam, clonazepam).

90 days' supply drugs and one refill dispensing are limited to diabetes products, including insulin, thyroid drugs, nitroglycerin, diuretics, digital preparations, antihypertensives, anticoagulants, anticonvulsants, antiarthritics, vasodilators, antiasthmatics, cholesterol, Parkinson and glaucoma.

Diabetes supplies (lancets, strips, syringes, and alcohol wipes) are covered as maintenance for a 90 days' supply and one refill. Associates participating in Programa Vida will obtain the lancets and strips through MCS.

Drugs shall not be dispensed until a 75% of current supply is consumed or if the original prescription has more than one year, except controlled drugs which prescription is limited by law for 6 months.

PART VI: Pharmacy Network

Drugs covered under this pharmacy benefit are obtained through a network that has 700 participating pharmacies in Puerto Rico, including Vieques and Culebra. This network includes pharmacy chains (except CVS) and community pharmacies.

Maintenance drugs for a 90 days' supply can also be obtained by mail through Walmart Mail Services.

Drugs for chronic conditions that require specialized management should be obtained through the specialty pharmacy network. These pharmacies have highly qualified personnel in the management of drugs to treat chronic diseases, which ensure a continuous, quality, cost-effective and adequate treatment according to patient's condition. In addition, they deliver the drugs to the place chosen by you or your physician. Also, some specialty drugs can be obtained in both Walmart and Sam's pharmacies.

MC-Rx has a broad pharmacy network in the United States of more than 69,000 participating pharmacies. This network includes the main pharmacy chains throughout the nation.

To obtain your drugs, you just have to present your prescription along with your medical plan id-card. **MC-Rx's** information appears on the back of your MCS id-card. If the services are rendered by a participating pharmacy, it will not charge any amount to the member resulting in excess of the established copay or coinsurance. If you visit non participating pharmacies of the network, you will not be able to request reimbursement for the drugs paid.

For more information about our pharmacy networks, you may contact **MC-Rx Member Call Center** toll free **1-855-252-2292 / 711 (TTY)** or access our Member Portal at www.mc-rx.com or Member APP on your cell phone (Apple or Android).

PART VII: Mandatory Flex 90® Program

The Flex 90® Program allows the dispensing of 90 days' supply for some drugs included in certain categories of your pharmacy benefit

How does the mandatory Flex 90® Program work?

The dispensing of the 90 days' maintenance drug begins after you have taken 3 previous 30 days' supply of a drug in the same dose.

Steps to follow:

1. Ask your physician for a prescription of your maintenance drug for a 90 days' supply. The prescription must include one of these instructions: 90 days, one refill or 30 days, up to 5 refills.
2. Choose a participating pharmacy from the pharmacy network.
3. Present your medical insurance card at the pharmacy.
4. When you pick up the supply, you pay a maximum of \$20 for brand or new drugs or \$0 for generics.

What advantages does the Flex 90® Program have?

- You save money in copays for brand and new drugs.
- Have available adequate amount of drugs for the adherence to your medical treatment.
- Less travels to the pharmacy.

Maintenance Drugs that are not part of the Flex 90® Program

- Drugs that require continuous level monitoring for dose adjustments.
- Injectable drugs (except insulins), drops, inhalers, and creams.
- Drugs that have limit on the amount to be dispensed due to safety reasons or FDA indications,
- Specialty drugs.

PART VIII: Mail Order Program

The Mail Order Program allows you to receive 90 days' supply for some medications included in certain categories of your pharmacy benefit by mail in the comfort of your home or anywhere else you choose.

How to use the Mail Order Program

You should register in the Mail Order Program to start enjoying its benefits.

- Tell your doctor about the service and ask for a prescription of your maintenance drug for 90 days' supply. The prescription must have the instruction of 90 days' supply and one refill.
- If you have a new written prescription, complete the order form and send it by mail along with the payment information to:

Walmart Home Delivery
1025 W Trinity Mills Rd

- You can obtain the mail order request form through www.walmart.com/homedelivery.
- If you need help with your refills, you may call 1-800-273-3455. You can also ask your doctor to send your prescription electronically directly to Walmart Pharmacy Mail Services by email at wmsrx@wal-mart.com or by fax 1-800-406-8976. Provide your doctor with pharmacy's E-Prescribing information: NABP (4500369) or NPI (1215956222).

PART IX: Coordination of Benefits (COB)

The Coordination of Benefits (COB) is the process that allows members who have more than one pharmacy plan to use them to process the same prescription at the time of receiving services at the pharmacy.

The Coordination of Benefit (COB) transaction is on line with the prescription processor, so in many cases the insured can reduce or eliminate the copayment or coinsurance, as applicable, according to the benefit design. Let the pharmacy know if you or any of your dependents have another pharmacy plan so they can benefit from the Coordination of Benefits (COB).

PART X: Limitations

1. Generic drugs will be dispensed as first choice, except when they are not available in the market.
2. Glucometer and sphygmomanometer are 100% covered with a medical order if the associate is enrolled under Programa Vida. If the associate is not enrolled in this program, a 20% coinsurance applies.
3. Lancets, strips and syringes are limited up to a maximum of 100 for 30 days and a maximum of 300 for 90 days. These quantity limits do not apply for members under 21 years.
4. Weight loss drugs will be covered only by preauthorization according to clinical protocol.
5. Immunosuppressive drugs are covered with preauthorization, as long as they are not related to transplants.
6. Zoladex® Implant is covered with preauthorization.
7. Fluoride products for dental use, for patients older than 6 year.
8. Only oral chemotherapies, including Temodar and Xeloda, are covered under the pharmacy benefit. Injectable or infused treatments are covered under medical plan.

PART XI: Exclusions

1. Drugs without federal legend **"Caution: Federal Law prohibits dispensing without prescription."**, except insulins and OTC drugs mentioned on Part II.
2. New prescriptions or refills which written date exceeds one year or the rules established by the Controlled Substances Act.

3. Medical supplies, therapeutic equipment, and devices including hypodermic needles, syringes, hospital solutions, and other items that are not drugs, even if a prescription is needed to obtain them; except alcohol wipes, lancets, strips, and syringes for insulin that are covered as maintenance.
4. FDA approved contraceptives that do not have a written prescription or are not approved by FDA.
5. The following drugs are excluded from the pharmacy benefit regardless of containing federal legend "Caution: Federal Law prohibits dispensing without prescription":
 - a. Drugs for beauty/cosmetic purposes, for wrinkles or any product for the same purpose, even if prescribed by a physician.
 - b. Drugs for skin conditions such as pediculicides and escabicides, except Permethrin 5%.
 - c. Drugs for dandruff treatment including shampoo, lotions and soaps.
 - d. Drugs for alopecia treatment (hair loss).
6. Drugs for pain treatment (Nubain® y Stadol®)
7. Dietary products
8. Medications to treat infertility, fertility, impotence or implants
9. Products used as vitamins and nutritional supplements for oral use, except those covered under federal laws related to preventive services.
10. Oral vitamins, except prenatal and injectable
11. Medications used as alternative medicine treatment
12. Growth hormone
13. Nutrients
14. Agents for diagnostic purposes, except blood and urine glucose tests
15. Drugs used for organ and tissue transplants
16. Anabolic steroids
17. Agents for pigmentation or depigmentation
18. Biological serum, blood, plasma and related substances
19. Administration charges of any injectable drug
20. Prescriptions in cases of work accidents, automobile and those that, according to United States or Puerto Rico laws, the person has the right to receive them without charge.
21. Drugs considered experimental or investigative for the treatment of certain conditions, for which FDA has not authorized its use.
22. Drugs to be administered while the member is in a medical office or hospitalized in a nursing home, sanatorium, extended care facility or any similar institution that is authorized to provide drugs or pharmaceutical products.
23. The member will be no entitled to reimbursement if obtain services in pharmacies that are not part of the participating pharmacy network.

PART XII: Complaints and Grievances

If you have a complaint about the services received, you must complete the Complaint Form available in the section of Member Service in our website www.mc-rx.com. Your complaint will be evaluated by **MC-Rx Customer Affairs Department**.

You can also call **MC-Rx Member Call Center** toll free **1-855-252-2292 / 711 (TTY)**. We offer service 24/7. Whenever you contact us you must have your member's identification number on hand. This information appears on MCS id-card.

PART XIII: Appeals Process for Prescription Drugs

MC-Rx will send a letter by mail to the member and the physician who prescribed the drug when an adverse determination (clinical denial) is issued. This letter will inform you the reason for the denial and the steps to appeal the decision. The member, the physician or an authorized representative can file an appeal request if they disagree with the adverse determination (clinical denial) of a drug.

Types of appeals

There are two types of appeals that the insured, their doctor or authorized representative can file:

- Standard appeal – Determination notice will be issued within 30 calendar days of receiving the appeal request.
- Expedited appeal (death risk) – Determination notice will be issued within 72 hours of receiving the appeal request.

Steps to present an appeal:

1. Submit an appeal letter.
2. Include a written justification, signed by the physician and any written comment, document, file or information related to the case that support the appeal within 180 calendar days from the date of the adverse determination notice (clinical denial) was issued.
3. Fax all documents at **1-866-827-8024** or send by mail to:

MC-Rx
Customer Services Department (Appeals)
Call Box 4908
Caguas, Puerto Rico 00726

For more information you may contact **MC-Rx Member Call Center** toll free **1-855-252-2292 / 711 (TTY)**.



Walmart Puerto Rico Dental Plan Summary of Benefits

PREMIUM COVERAGE

Part I: Introduction

This document is a summary of the dental plan that **Walmart Puerto Rico** provides its associates and eligible dependents. It contains important information about your rights and responsibilities, co-insurance, and dental providers, as well as information about your coverage benefits, as approved by **Walmart Puerto Rico**. This dental plan benefit is contracted by **Walmart Puerto Rico** directly with **Delta Dental of Puerto Rico, Inc.**

Delta Dental was founded in 1954 by a group of dentists who recognized the need to increase access to oral health care by creating a number of dental service organizations in the United States.

For 40 years, Delta Dental has offered dental benefits coverage in Puerto Rico as the only insurer exclusively providing dental benefits. Our vast Provider Network includes dentists of every specialty.

For additional information about your dental coverage, please call our Call Center toll-free at **1-855-359-6409, Monday to Friday, from 8:00 a.m. to 5:00 p.m.** Make sure you have your Enrollee ID Number at hand every time you call. This number is on the card issued by Delta Dental of Puerto Rico, Inc.

You may also visit our webpage at www.deltadentalpr.com and register in the Enrollee Portal to obtain information about participating providers, eligibility, benefits, coverage details, and coinsurance. You may also request duplicates of cards or certificates of coverage and get answers to any questions you may have online.

Part II: Covered Benefits

Your dental coverage includes basic dental, basic restorative and major restorative.

Basic Dental Services

- ▮ **Diagnostic** - Procedures that help your dentist evaluate an existing condition to determine the dental treatment required, including oral evaluations.
- ▮ **Preventive** - Procedures that help prevent dental disease, including prophylaxis (dental cleaning), topical application of fluoride solutions, space maintainers, and sealants.
- ▮ **X-rays** - Full-mouth and bitewing x-rays.

Basic Restorative Services

- **Basic Restoration** - Procedures for restoring teeth with amalgam or resin composite in the treatment of cavities.
- **Oral Surgery** - Tooth extraction and other surgical procedures, including pre- and post-operative care.
- **Endodontics** - Procedures for removing the pulp (nerve) from a tooth, replacing it with filling material at the root canal, and sealing it.
- **Palliative** - Emergency services for treating dental pain.

Part III: Coinsurances

The percentages of costs listed on the table are subject to exclusions and limitations specifically described in the contract. The Coinsurance Program is used to determine the payment for services, which is explained further on.

The following coinsurance amounts apply to **Premium Coverage**:

Basic Allowances		Coverage
Maximum per policy year per covered person (excluding orthodontics).		\$750
Maximum COVID fee per service * Note: The insured is responsible for paying the difference in the cost of the service.		Not covered
Diagnostic and Preventive Services		
Service	Frequency	Coinsurance
* Routine checkups	Two per policy year	0%
* Emergency examination	Limited to one per 12-month period	
* Detailed and extensive oral evaluation	Limited to one per 12-month period	
* Bitewing, periapical, and occlusal x-rays	One pair, two per policy year. Will be limited in combination with bitewing and periapical x-rays to no more than six x-rays in a twelve-month period	
* Full-mouth or panoramic x-ray	One per 3-year period	
* Dental prophylaxis (cleaning)	Two per policy year	
* Topical application of fluoride to minors under 19 years of age	Two per policy year	

* Topical application of fluoride for adults with special conditions only	Two per policy year	
*Flouride varnish to minors under 5 years of age	Two per policy year	
*Oral evaluation for newborn up to 3 years of age	One per 12-month period	
* Pulp vitality test	One per 6-month period, only for diagnosing emergency conditions	
* Fissure sealants for children	Applies to children under 14, in permanent posterior (back) teeth	
* Unilateral and bilateral spacers in deciduous (primary) teeth	Limited to children under 14 only, to maintain space of posterior deciduous teeth Not covered for anterior (front) teeth	20%
Regular Restorative Services		
Service	Frequency	Coinsurance
* Amalgam (silver) restorations in molars and premolars	Limited to every 24 months per tooth per surface	30%
* Resin (white) restorations, on all teeth	Limited to every 24 months per tooth surface	
* Endodontics: root canal treatment on anterior and premolar teeth	Limited to one per tooth for per lifetime	
* Direct and indirect pulp capping	Limited to one per tooth in a 24-month period	
* Pulpotomy	Limited to one per tooth in a 24-month period	
* Root canal retreatment on anterior and premolar teeth	Limited to one per tooth for per lifetime	
* Stainless steel crowns on deciduous (primary) teeth	Limited to one per tooth, one per 5-year period	
* Temporary crown	On permanent teeth, limited to one per tooth per lifetime	
* Repair of full or partial dentures	Limited to one per arch in a 6-month period	

*Re-cement or re-bond inlay or crown	Limited to one per tooth per lifetime	
* Extractions and oral surgery, including pre- and post-operative care and general anesthesia	Limited to one per tooth per lifetime	
* Extractions of erupted teeth and residual roots	Limited to one per tooth per lifetime	
* Surgical exposure of impacted tooth	Limited to one per tooth per lifetime	
* Exostosis (removal of bony growth)	Limited to once per quadrant per lifetime	
Frenotomy (correction of tongue-tie)	Limited to one per arch per lifetime	
* Palliative treatment to relieve pain	Based on clinical determination	

Part IV: Participating Provider Network

Participating dentists are licensed providers in Puerto Rico who have been contracted by Delta Dental of Puerto Rico, Inc. to implement policies related to services, fees, and other Delta Dental obligations with its enrollees.

To obtain information about participating dentists, you may call Delta Dental customer service at **1-855-359-6409** or visit our webpage, **www.deltadentalpr.com**, and go to “Find a Dentist”.

Part V: Predetermination of Benefits

Predetermination is not a condition for receiving benefits under the Plan.

If the total cost of a treatment plan for you, your spouse/domestic partner, or your covered dependents in the Delta Dental plan exceed \$300, a predetermination is recommended for the approval of charges and services to ensure that both you and your dentist know which benefits and amounts the Plan will cover before beginning the treatment. Delta Dental will promptly return a predetermination voucher to both you and the dentist, which will include a verification of eligibility and the definition and extent of the benefits in a period of twelve months to complete the services.

The predetermination voucher will also specify the financial responsibility of the applicable copay that will be paid by you and the amount Delta Dental will pay, provided that: (1) the covered person to be treated is eligible on the date each procedure begins; (2) the procedures are completed within 60 days after the date of the predetermination notice; (3) the claim is submitted no later than six months after the date of service; and (4) the benefits continue to be within the applicable maximum benefit allowances and frequency limitations of the covered procedures. If you are eligible and have not used up your benefits, Delta Dental may extend the period of predetermination of benefits at your request or the dentist's; this, provided that the period complies with continued eligibility, the applicable maximum allowances have not been used up and there is a continued inapplicability of the frequency limitations for the procedure.

Where to find additional information
Delta Dental of Puerto Rico, Inc. Call Center Monday to Friday, 8:00 a.m. to 5:00 p.m. 1-855-359-6409

Part VI: Delta Dental PPO and Delta Dental Premier Panel of Dentists

You and your covered dependents in the plan can visit any dentist.

Your copays and coinsurance will depend on whether you receive services from:

- ☐ A dentist in the Delta Dental PPO network;
- ☐ A dentist in the Delta Dental Premier network; or
- ☐ A non-participating dentist.

Delta Dental PPO Participating Dentists

The payment for services provided by participating dentists in the Delta Dental PPO network is calculated by Delta Dental based on the contracted fees indicated on the schedule of fees of your Delta Dental PPO program. These dentists have agreed to accept such fees as total payment for services covered under the contract.

Delta Dental calculates its portion in the Delta Dental PPO schedule of covered fees (Delta Dental Payment) using the Copay Program previously described and sends it to the participating dentist. Delta Dental will notify you of any charges that are not payable and for which you are responsible. These generally include: coinsurance, deductibles, and charges exceeding maximum limits, or charges for services not covered under the contract (payment by the enrollee).

Delta Dental Premier Participating Dentists

The payment for services provided by participating dentists in the Delta Dental Premier network who do not have a contract with the Delta Dental PPO program is also based on the Delta Dental PPO program schedule of fees or the fee charged, whichever is lower.

Delta Dental Premier dentists have agreed to accept the fee contracted with Delta Dental as payment for services covered under the contract. Delta Dental of Puerto Rico, Inc. calculates its portion of the amount in the Delta Dental PPO schedule of fees using the Coinsurance Program previously described and sends it to the Premier participating dentist (Delta Dental Payment). You will be responsible of any difference between the fee contracted with Delta Dental and the Delta Dental PPO schedule of covered fees, as well as any coinsurance, deductible, charges exceeding the maximum allowance, or service charges not covered

under the contract.

Non-participating Dentists

The payment for services provided by a non-participating dentist including dentists outside of Puerto Rico is also calculated based on the Delta Dental PPO schedule of fixed fees, using the Coinsurance Program previously described; however, in this case, Delta Dental will issue the payment to you. You will be responsible of the full payment of the non-participating dentist's private fee which may include amounts additional to the portion of the contracted fee specified in the Delta Dental PPO schedule of fees and for services not covered under the contract.

Part VII: How to submit a claim

All Delta Dental of Puerto Rico, Inc. participating dentists submit claims directly to the plan. Your dentist can complete a claim in the manner approved by the American Dental Association (ADA) and send it to:

DELTA DENTAL OF PUERTO RICO, INC.

14 Street 2 Suite 200
Guaynabo, Puerto Rico 00968-1735

In the event that a predetermination is needed, the dentist will submit the claim form for the planned dental treatment in advance directly to Delta Dental. If a predetermination is not necessary, the provider will deliver the service and then submit the claim to the Plan.

The predetermination procedure is the process through which your dentist submits a proposed treatment plan to Delta Dental, accompanied by x-rays and a report explaining the treatment to be provided. This treatment plan is evaluated by a dental consultant who will proceed with its approval or denial, in accordance with the design of the contracted coverage and provided the services continue to be within the applicable benefit maximum allowances and frequency limitations; additionally, the treatment plan is evaluated to determine if it is necessary and to ensure that it complies with generally accepted dental standards of practice.

If the predetermination process is favorably completed, a document will be issued to the dentist for execution, specifying that such document is not a guarantee of payment for services; payment will ultimately depend on other factors, including: (1) the continuation of the patient's eligibility for treatment; (2) the applicable maximum benefit allowances have not been used up; and (3) the continued inapplicability of the frequency limitations for the procedures caused by claims in transit that have not yet been received by Delta Dental. When the course of the predetermined covered treatment is completed, the dentist will resubmit the claim for processing.

If you see a non-participating dentist, you will have to assume the complete cost and later submit a claim for reimbursement, accompanied by the payment receipt. The maximum time to request the reimbursement is twelve (12) months after the date of service. You may request a claim form at the Office of the Plan Administrator or by calling the Delta Dental of Puerto Rico, Inc. Call Center at **1-855-359-6409**

Part VIII: Maximum Payment Allowance

The maximum benefit payment will be limited to the amounts described in the **COVERAGE DESIGN Section, Diagnostic and Preventive Services, of the Description of Benefits and Dental Plan Summary.**

Part IX: Non-Covered Services and Procedures (Exclusions)

Dental benefits and services provided in the Delta Dental PPO table will exclude the following:

1. Services for injuries or conditions covered by the State Insurance Fund (Corporación del Fondo del Seguro de Estado, CFSE) and the Automobile Accident Compensation Administration (Administración de Compensaciones por Accidentes de Automóviles, ACAA).
2. Dental services determined by Delta Dental to correct congenital malformations and cosmetic dentistry procedures, including, but not limited to, cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis, laminates, veneers posterior to the first molar, and teeth whitening.
3. All services or procedures initiated before the date the patient becomes eligible for the plan.
4. All services or procedures initiated after the date in which the patient is no longer eligible for the plan.
5. General anesthesia, except when administered jointly with oral surgery by a dentist licensed to do so.
6. Prescription medications, pre-medication or painkillers.
7. Oral hygiene and dietary instructions.
8. Plaque control programs and specialized techniques.
9. Myofunctional therapy.
10. Treatment for temporomandibular joint (jaw) disturbances and all related symptoms, including, but not limited to, splints, interocclusal guards, and any other related device or treatment.
11. Experimental procedures.
12. All hospital costs and any additional fees charged by the dentist for hospital treatments.
13. Extraoral grafts (grafting of tissues from outside the mouth to or into oral tissues).
14. Procedures, appliances or restorations needed to increase vertical dimension and restore or maintain occlusion. Such procedures include, but are not limited to, stabilization, periodontal splinting, restoration of tooth structure lost to attrition, and restoration of misaligned teeth.
15. Maxillofacial prosthesis
16. Benefits will not be paid for treatment provided by any practitioner who is not a dentist or under the direct supervision of a dentist according to the laws governing the practice of dentistry.
17. Charges for services or supplies that the patient is not legally obligated to pay or for which charges would not have been made if there were no dental coverage.
18. Periodontics, crowns, prosthodontics and orthodontics services are not a covered benefit under the contract, unless otherwise specified in Your Plan Design of the Summary of Dental Description and Benefits.

19. Delta Dental will not make any payments for repair or replacement of damaged, lost, or stolen space maintainers, or for the replacement of missing, lost, or stolen dental prosthetic appliances.
20. Implant services, including surgical procedures and implant supported prosthetic.
21. Endodontic retreatment in molars.
22. Re-treatment of endodontics in molars.
23. Temporary prosthetic services.
24. Procedure tray preparation and asepsis.
25. Claims submitted after 12 months from the date of service.
26. Cosmetic dentistry and related procedures for aesthetic purposes, including, but not limited to, laminates and teeth whitening, in addition to resin composite restorations performed for the purpose of improving tooth appearance.

Part X: Limitations

Services provided by Delta Dental are subject to the following limitations:

1. The initial exam is limited to one per provider, no more than twice per year. Prophylaxis and oral periodic oral examinations shall be provided but limited to two per policy year.
2. Prophylaxis is limited to eligible children under 12 years of age. Prophylaxis in children over 12 will be considered adult prophylaxis.
3. Emergency examinations are limited to one in a 12-month period.
4. Extensive and detailed examinations will be limited to one specialist visit, for the treatment of a specific condition, in a 12-month period. Limited to the following specialties: endodontic, periodontal, orthodontic, and oral and maxillofacial surgery.
5. Fluoride applications are limited to dependents under 19 years of age and adults with special conditions, up to a maximum of two per policy year.
6. Additional bitewing and periapical x-rays are limited to no more than six in combination, in a 12-month period.
7. Full-mouth x-rays are a contracted benefit that can be performed once in a 3-year period, unless it is for the diagnosis and treatment of a specific disease or injury.
8. The pulp vitality test will be covered once per 6-month period per tooth for diagnosing an emergency condition.
9. Fissure sealants will be limited to minors under 14 in permanent teeth (bicuspid and molars), one per lifetime.

10. Space maintainers are limited to minors under 14 and only to maintain space in posterior deciduous teeth. They are not covered for anterior teeth.
11. Amalgam and resin restorations are limited to one surface in a 24-month period.
12. Sedatives are limited per tooth per 24-month period.
13. Coverage will be provided for stainless steel crown on the same tooth, after a period of five years from the date on which the crown was supplied for the last time.
14. Prefabricated and cast posts, including cores and any restoration that may be necessary, are limited to one per 5-year period.
15. Optional treatment - In all cases in which you select a service or benefit that is more expensive than the one usually provided, Delta Dental shall pay the applicable percentage of the usual fee for the service or benefit. You will be responsible of the balance of the dentist's fees. This clause will apply to the following cases:
 - a. Crown restorations - If an amalgam or resin restoration would properly restore the tooth, Delta Dental will award the appropriate amount for this procedure towards the cost of a crown restoration.
 - b. Relining and rebasing are benefits allowed in any 3-year period for any patient.

Part XI: Coordination of Benefits

There are specific conditions applicable to payment determination if you, your spouse/domestic partner or dependent child have separate dental benefits available under other programs. The participation of each insurance company in the total cost incurred will be reviewed. The payment will be made according to the rule adopted by the majority of insurance companies the birthday rule. In no case shall Delta Dental pay an amount in excess of the total contractual obligation it would have paid if it were the only insurance company involved. If the other insurance company determines its benefits first, Delta Dental will pay any difference between the amount paid by the other insurer and the charge for the covered service up to the amount of Delta Dental's benefit for a given procedure.

This excludes covered persons who have double coverage with the plan. Covered persons who have Delta Dental coverage with Walmart and are also covered through their spouse will not have to coordinate payments, since these will be issued automatically and directly to the provider. Such payment or coordination will be based on the coinsurance and services applicable to each coverage.

Certificate of Benefits prepared by:



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

www.mcs.com.pr



MCS Life Insurance Company

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

Endorsement of integration of biosimilar medicines as first line therapy MCS Life Insurance Company 01/2023

This endorsement is part of the policy or certificate of benefits to which you adhere and is subject to the terms and conditions of the policy that do not conflict with the terms and conditions of the endorsement. Biosimilar drugs will be covered under the medical component, as described in this endorsement.

A biosimilar drug is a biologic* drug that has no clinically significant differences from an FDA-approved reference drug – the original biologic. This means that the same safety and efficacy are expected with a biosimilar throughout a treatment as with the reference product. FDA approval includes full review of data and information including analytical studies demonstrating that the biologic is highly similar to the reference product. It may also include studies in animals, such as toxicity assessment and clinical studies. This with the purpose of demonstrating the safety, purity, and potency of the proposed biosimilar product in one or more of the indications for which the reference product is authorized.

Unlike a bioequivalent medication, a pharmacy cannot substitute one medication for another at the time of dispensing the same. The doctor shall provide a prescription with the name of the biosimilar medicine so that the pharmacy can process it. Both biosimilar medicines and biological medicines require the pre-authorization process due to their high cost and usage specifications.

Since the therapy is not substitutable, the step therapy *edit* is placed on all medicines with a medical component that have a biosimilar on the market.

Step therapy, by definition, is when MCS requires the use of certain biologic drugs to treat some medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, MCS may deny Drug B unless you try Drug A first. If Drug A does not work for you, MCS will cover Drug B.

Drug A (Biosimilar)	Drug B (biologic reference)
Inflectra	Remicade
Mvasi	Avastatin
Kanjinti	Herceptin
Truxima	Rituxan

**Medicines can be made from sugars, proteins, living cells, tissues, or a combination of these. They are made from natural, living sources such as animal and plant cells, and microorganisms such as bacteria and yeast.*

Note: For more details about your benefit coverage, refer to the parent policy and its corresponding endorsements.