Certificate of Benefits

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

MEDICAL COVERAGE:	**MCS Life Insurance Company**
PLAN:	ELITE
GROUP NUMBER:	79-750096
EFFECTIVE DATE:	JANUARY 1, 2024
POLICY YEAR:	JANUARY 1 TO DECEMBER 31 OF EVERY YEAR
PHARMACY COVERAGE:	**MC-Rx**
PLAN:	ELITE
GROUP NUMBER:	5613
EFFECTIVE DATE:	JANUARY 1, 2024
POLICY YEAR:	JANUARY 1 TO DECEMBER 31 OF EVERY YEAR
DENTAL COVERAGE:	**Delta Dental**
PLAN:	ELITE
GROUP NUMBER:	82425-00001
EFFECTIVE DATE:	JANUARY 1, 2024
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 ≥ 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.

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 1: MEDICAL BENEFITS

Please read carefully.

This document is not a Medicare supplement policy or contract. If Walmart has insureds that are eligible for Medicare, 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 2022 Associate Benefit Book (SPD) along with the Summary of Material Modifications of 2023, the SPD will prevail.

WELCOME TO MCS!

Dear insured:

We welcome you to the great MCS Life Insurance Company family. 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 or 1-855-830-9887 (toll free), Monday through Friday from 8:00 AM to 8:00 PM, and Saturdays from 8:00 AM to 4:30 PM. The hearing impaired (TTY) can call 1-866-627-8182. You can also visit our web page 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 the 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	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; or 3. The determination resulting from a prospective or retrospective review in which the benefit is denied, reduced, terminated or not paid, either partially or in full.
Affordable Care Act (ACA)	Federal Health 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 into law 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 Walmart Inc. Associates' Health and Welfare Plan, as primary insured.
Authorized Representative	• 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	Surgical procedure for morbid obesity, including but not limited to, the following techniques: • Gastric Bypass - 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. • Adjustable Gastric Band – 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. • Sleeve Gastrectomy - Bariatric surgery by vertically removing a portion of the left side of the stomach, especially the gastric fundus, where the 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: • 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 provider's qualification 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:

	— 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)**	An instrument, device, machine, internal or external implant, or any other similar device, or a related item that includes parts or accessories: • 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 need to be performed immediately because there is no imminent risk to the life of the insured, 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.
E*ssential health benefits*	The Affordable Care Act guarantees that from 2014, all *non-grandfathered* 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	Medical treatments strictly controlled in humans: • 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 (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 • Whose scientific evidence does not allow to reach conclusions on the effect of technology on the medical results obtained; or • Whose results do not overweigh 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)	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: • 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

	It is also an essential tool for promoting participation in wellness programs and encouraging participants to take a leading role in their health.
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 *Walmart Inc. Associates' Health and Welfare Plan* sponsored by Walmart employer.
Insurer	In this certificate, insurer refers to *Walmart Inc. Associates' Health and Welfare Plan*
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:

	• 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. • 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	Services that: • 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 coved 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 *Affordable Care Act* (ACA).
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 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: • 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. 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.
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 apply only when a person is insured under this certificate and must comply with the pre-authorization program for those procedures and services as required. The insured must reimburse MCS Life for any claims paid by MCS Life as result of charges incurred after an insured has cancelled coverage.

The Services will be covered 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 benefit coverage is a non-grandfathered plan, as defined by the Affordable Care Act (ACA). The essential health benefits described by ACA, carry a maximum out-of-pocket (MOOP) expenses or disbursement

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; rehabilitative and habilitative services and medical equipment; laboratory services, preventive and wellness services and chronic disease management; pediatric services, including vision care.

The maximum that applies to this certificate will be equivalent to the maximum established by the U.S. Internal Revenue Service (IRS) and it represents the sum of out-of-pocket expenses of the associate, in other words, the initial deductible, co-payments and/or co-insurance established for medical and prescription drugs coverage (combined). When the insured reaches the maximum out-of-pocket expenses, Walmart Inc. Associates' Health and Welfare Plan will cover one-hundred percent (100%) of the essential health benefits. For calendar year 2023, the maximum out-of-pocket expenses for health benefits established by the Walmart Inc. Associates' Health and Welfare Plan is $1,600 for individual coverage and $3,200 dollars for family coverage. The following services and their 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.

1. Emergency and Urgent 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 corresponding co-payment.	• 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 attempts)	
	• Specialized diagnostic tests	

Emergency services in the United States will be covered as any other 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 offered at an urgency center or facility and the insured pays the corresponding co-payment.	• Trauma or illness	$10
	• Prescription drugs, materials and equipment	
	• Unlimited respiratory therapy	
	• Self-inflicted conditions (suicide attempts)	

2. Hospital Services

Shared costs apply to some of these services, as described in the Co-payment, Co-insurance and Deductible 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. If the insured requests a private room, the insured will be responsible of paying the difference in cost between a semi-private and a private room, provided a medical necessity does 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. Also, except in the case of differences in room cost, 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 and procedures usually performed in outpatient facilities but that require to be performed in a hospital, will require MCS Life Clinical Affairs pre-authorization.	$50

	• Intensive care units, cardiovascular care unit, pediatric intensive care unit 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.	
	• Screening for critical congenital cardiac defects by pulse oximetry, in accordance with Act No. 192 of December 20, 2014.	
	• Telemetry	
	• Nursing care and other allied-health care providers	
	• Nutrition services offered by the hospital, including hyperalimentation	
	• Clinical laboratories and radiology tests	
	• Diagnostic tests and studies	
	• Respiratory and physical therapies	
	• Medical visits	
	• Blood, plasma and platelets	
	• Medical supplies and medications.	
	• 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.	
	• Dialysis and hemodialysis – Walmart is the primary plan during the first thirty (30) months of Medicare eligibility, from then on, Medicare becomes the primary plan and Walmart the secondary, from the first treatment on, when related to the same medical condition. No co-payment applies.	
	• Other facilities, services, equipment and supplies usually provided by the hospital and ordered by the physician and that are not expressly excluded from the contract with the hospital.	

	• Hospitalizations because of 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 of the date in which the insured was discharged after a hospitalization of at least three (3) days and if offered for the same condition or for any health-related condition for which the hospitalization occurred.	$0
Surgical Assistance in the hospital	No co-payment applies. Requires MCS Life Clinical Affairs pre-authorization.	$0
Hospice Care	Covered without co-payment or co-insurance, for terminally ill insured with a life expectancy of six (6) months or less. Includes: • Social medical services • Nursing care • Durable medical equipment • Medical supplies • Pain medication • Psychologists • Counseling for the insured and family members 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.	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 admission. Reconstructive surgery will only be offered as a reconstructive intervention to restore damaged	$50 Procedure: 20%

	tissue because of illness or body injury, an accident or to correct a birth defect, including oral defects of the newborn, and not 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. Co-payment for procedure and co-insurance for facility applies.	
Hospitalization for Mental Health or Substances Abuse and/or Alcohol (Partial or Full)	Co-payment for hospitalization applies. Electroconvulsive therapies require pre-authorization from MCS Life Clinical Affairs.	$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. These include: • General practitioners • Specialists • Subspecialists	 $10 $10 $15
Home Doctor's Visits	Corresponding co-payment applies.	$15
Optometrist	Co-payment for specialists applies. Covered in accordance with Act No. 148 of August 9, 2002.	$10
Clinical Psychologists	Co-payment for specialists applies. Covered in accordance with Act No. 148 of August 9, 2002, as amended and in accordance with Act No. 239 of 2012.	$10
Audiologists	Co-payment for specialists applies. Covered in accordance with Act No. 127 of September 27, 2007, as amended.	$10
Chiropractor	For the initial visit to a chiropractor, the insured will pay the corresponding amount for the visit to a specialist. For subsequent visits, the corresponding amount for manipulations applies. Services are covered in accordance with the Bill of Rights and Responsibilities of the Patient Act No. 150 of August 8, 2006.	$10 Manipulations: $7
Podiatric Services	Routine foot care and podiatric surgical procedures are covered. Co-payment for	Medical visit: $10 Facility: $25

	visits to a podiatrist applies. Corresponding co-insurance for diagnostic and podiatric surgical procedures in the doctor's office, ambulatory facility or hospitalization applies, plus co-payment for facility. Podiatric surgical procedures in the hospital require MCS Clinical Affairs pre-authorization. Covered in accordance with the Bill of Rights and Responsibilities of the Patient, Act No. 148 of August 9, 2002, as amended.	Hospital: $50 Procedure: 20%
Naturopathic Doctor	Co-payment for specialists applies. Covered in accordance with Act No. 210 of December 14, 2007.	$10
Nutritionist	Co-payment for specialists applies. Unlimited visits covered per policy year.	$10
Ambulatory Facilities	The use of ambulatory surgery facilities is covered; the insured is responsible of co-payment for the use of the facility. Procedures usually performed at the medical office but need to be performed at an ambulatory facility require MCS Life Clinical Affairs pre-authorization.	$25
Pre-admission tests	Co-payment/co-insurance for the corresponding examinations or laboratories applies.	20% General Practitioner: $10 Specialist: $10 Subspecialist: $15
Diagnostic and Surgical Procedures at the Medical Office	The insured will be responsible of co-insurance for procedures plus co-payment for medical visits.	20% General Practitioner: $10 Specialist: $10 Subspecialist: $15
Diagnostic and Surgical Procedures at the Ambulatory Facility	The insured will be responsible of co-insurance for procedures plus applicable co-payment for ambulatory facility. Procedures usually performed at the medical office but need to be performed at an ambulatory facility require MCS Life Clinical Affairs pre-authorization. For molecular or genetic testing, refer to Part III, subsection 8. Laboratory and X-ray services.	20% Facility: $25
Intra-articular Injection	Co-payment for medical visit applies.	General Practitioner: $10 Specialist: $10

		Subspecialist: $15
Sclerosant Injection Therapy	Medical office: Co-payment for medical visit applies.	Specialist: $10 Subspecialist: $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	• Medical office: Co-payment for medical visit applies.	General Practitioner: $10 Specialist: $10 Subspecialist: $15
	• Ambulatory Facility: Co-payment for facility applies.	$25
Vasectomy at the Medical Office	Co-payment for medical visit applies. MCS Life will cover one (1) vasectomy for life, per insured. No co-insurance applies for procedure done in medical office.	Specialist: $10 Subspecialist: $15
Vasectomy at an Ambulatory Facility	Covered. One (1) vasectomy for life, per insured. Vasectomies at an ambulatory facility require pre-authorization and corresponding co-payment applies.	$25
Endoscopy at the Medical Office	Co-payment for medical visit applies. No co-insurance applies for diagnostic and surgical procedures performed in medical office.	Specialist: $10 Subspecialist: $15
Endoscopy at an Ambulatory Facility	Co-payment for ambulatory facility applies. No co-insurance applies for diagnostic and surgical procedures performed in ambulatory facility. Requires MCS Life Clinical Affairs pre-authorization.	$25
Chemotherapy and Radiotherapy (including Cobalt) Medications 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 Subspecialist: $15 Facility: $25

Dialysis and Hemodialysis	Walmart is the primary plan during the first thirty (30) months of Medicare eligibility, from then on Medicare becomes the primary plan and Walmart the secondary, from the 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
Orthognathic Surgery	Co-payment for ambulatory facility or medical visit applies. Requires MCS Life Clinical Affairs pre-authorization.	General Practitioner: $10 Specialist: $10 Subspecialist: $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 Subspecialist: $15 Treatment: $250
Cervical Cryosurgery	• Medical office: Co-payment for medical visit applies. Maximum of one (1) procedure per policy year per insured.	General Practitioner: $10 Specialist: $10 Subspecialist: $15
	• 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	Full coverage.	$0
Nerve Conduction Velocity Test	Co-insurance for laboratory applies. Two (2) procedures per policy year per insured	20%
Invasive and Non-invasive Cardiovascular Tests and Procedures	Co-insurance per corresponding test applies, plus co-payment for medical office or ambulatory facility visit.	20% General Practitioner: $10 Specialist: $10 Subspecialist: $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	$25

	(CFSE, Spanish acronym) occurring during the effectiveness of this certificate.	
Neurological Tests and Procedures	Co-insurance for X-rays applies.	20%
Scalenotomy	Co-payment for ambulatory facility applies.	$25
Hearing Tests	Co-insurance for laboratory applies. One (1) test per policy year.	20%
Cochlear Implant	No co-payment applies. Requires MCS Life Clinical Affairs pre-authorization.	$0
Reconstructive Surgery	Corresponding co-payment for facility or hospital applies. Requires MCS Life Clinical Affairs pre-authorization. Only offered for reconstructive interventions to restore damaged tissue because of illness, body injury, or accident (post-trauma) or to correct a birth defect, including oral defects of the newborn. and not related to the Automobile Accident Compensation Administration (ACAA, Spanish acronym) or the Workers Accident Compensation Act (CFSE, Spanish acronym).	Facility: $25 Hospital: $50
Cardiac Catheterization	Co-payment for X-rays applies plus co-payment for ambulatory facility.	20% 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-payment, Co-insurance and Deductible 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 will apply for pre and postnatal care services. For more details on this program, please see Section 7 – Programs included in your benefits.	$0

Inpatient care coverage for the mother and her newborn(s)	Hospital co-payment applies. At least forty-eight (48) hour coverage for hospital care will be provided for the mother and her newborn(s) per vaginal birth, and ninety-six (96) hours for a cesarean section. 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.	
	• Hospital and ambulatory obstetric services.	Hospital: $50 Facility: $25
	• Obstetric sonography, up to three (3) per pregnancy and up to 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 perinatologist.	20%
	• Biophysical profile, limited to one (1) per pregnancy, additional ones require MCS Life Clinical Affairs pre-authorization. Co-insurance for X-rays applies.	20%
	• Fetal non stress test, up to one (1) per pregnancy, additional ones require MCS Life Clinical Affairs pre-authorization. No pre-authorization required for perinatologist. Co-insurance for X-rays applies.	20%
	• Fetal echocardiogram requires MCS Life Clinical Affairs pre-authorization. Co-insurance for X-rays applies.	20%
	• Unlimited amniocentesis (genetic).	20%
	• Unlimited amniocentesis (fetal maturation). Subject to evaluation and MCS Life Clinical Affairs pre-authorization.	20%
	No co-payment or co-insurance applies. • Fetal monitor contraction stress test, up to three (3) per pregnancy, additional ones require MCS Life Clinical Affairs pre-authorization. • Up to three (3) fetal monitoring for pregnancy (belts – production and interpretation) in hospital will be covered	$0

	without pre-authorization, additional ones require MCS Life Clinical Affairs pre-authorization.	
Postpartum follow up visit	Co-payment for medical visit applies. Follow-up visit will include any treatment and medical tests required for both, mother and infant.	$10
In-Hospital Newborn Care (during stay for childbirth)	No co-payment applies. The following benefits are covered: • Health care services for injuries or diseases, including care and treatment for birth defects and abnormalities as diagnosed by a physician. Medical care in the hospital and neonatal intensive care units (NICU); • Use of the Well Baby Nursery; • Universal newborn hearing screening in the hospital; • Screening for critical congenital cardiac defects by pulse oximetry, in accordance with Act No. 192 of December 20, 2014; • Circumcision of the newborn;	$0
Neonatal Care (ambulatory services)	• Co-payment for medical visit and routine visits for the baby (Well Baby Care) apply. • Health care services for injuries or illnesses, including care and treatment for birth defects and congenital abnormalities as diagnosed by a physician; • Universal newborn hearing screening;	General Practitioner: $10 Specialist: $10 Subspecialist: $15
Newborn Screening Tests	Preventive tests required by PPACA and set forth by the Department of Health of Puerto Rico and according to Title XIX of the Medicaid Program, Title V of the Mother, Children and Adolescents Program and the American Academy of Pediatrics, as required under Act No. 296 of September 1, 2000, as amended. For information on applicable screenings, refer to subsection 8, Preventive, Wellness and Chronic Diseases Management Services.	$0

5. Mental Health, Substance Abuse and Behavioral Health Treatment

Mental health, substance abuse and behavioral treatment services are offered directly through the provider or through your voluntary participation in the MCS Solutions program, twenty-four (24) hours a day, seven (7) days a week through a coverage that integrates mental health and substance abuse care. The purpose of the program is to facilitate immediate access to the necessary services for your situation or condition with a

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 determined 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 2012, and in accordance with the Mental Health Parity Act. Professionals who provide 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-payment, Co-insurance and Deductible 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 is not limited to:	• Unlimited visits to psychiatrists and clinical psychologists, with the corresponding 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 co-payment.	$10
	• Co-payment for partial, full or intensive hospitalization applies; partial hospitalization requires MCS Life Clinical Affairs pre-authorization.	$50
	• 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:	
	• Intensive case management	$50
	• Psychiatrist	$10
	• Clinical psychologists	$10
	• Collateral visits	$10
	• Group therapy (by clinical psychologists)	$10

	• Ambulance transfers 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 from controlled substance dependence or abuse at 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 specialists applies. For people under twenty-one (21) years of age, psychological tests covered are those determined by the Department of Health in collaboration with the Department of Education, subject to the conditions and limitations set forth by the referred agencies and/or special applicable laws, in accordance with Act No. 296 of September 1, 2000, as amended.	$10
Employee Assistance Program (EAP)	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. • 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-payment, Co-insurance and Deductible 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. Ambulatory services will only be covered for the treatment of 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. Ambulatory services will only be covered for the treatment of 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	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. Other chiropractor services: Radiology and physical therapy services may be included, provided they are contracted with a participating provider.	$7
Durable Medical Equipment (DME)	Corresponding co-insurance applies. Requires MCS Life Clinical Affairs pre-authorization. Covered by contracted providers. The most common are: • Adjustable beds • Wheelchairs • Oxygen and the necessary equipment for its administration • Ostomy supplies • Diabetic shoes, with preauthorization • Insulin pump, including maintenance, without age limit and ordered by a specialist. • Insulin pump supplies.	20%
	Associates who enroll in the "Programa Vida" don't need to pay co-insurance for: • 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	0%

	For insureds not participating in the "Programa Vida", glucometer, lancets, strips, syringes and blood pressure monitor are covered through pharmacy coverage (see Chapter 2).	
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.	20%
Respirators, Ventilators and other Equipment for Respiratory Paralysis Treatment	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.	20%
Devices	Corresponding co-insurance for durable medical equipment applies. Requires MCS Life Clinical Affairs pre-authorization.	20%
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 requires MCS Life Clinical Affairs pre-authorization.	20%
Implant and Other Surgical Trays	Corresponding co-payment applies. Covered for organ and body parts replacement, or to aid in their function. Examples: prosthesis, pacemakers and valves, among others. Replacements are excluded.	$300
Home Health Care	Covered. No co-payment applies. Covered up to sixty (60) combined days in the home per policy year per insured. Requires MCS Life Clinical Affairs pre-authorization. Services will be covered for the following: • 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 hospitalization. Services rendered under home health care include: • Rehabilitative speech therapy (post-trauma, accident or surgery)	$0

	• Physical therapy • Occupational therapy • Respiratory therapy • Cardiovascular rehabilitative therapy • Enteral feeding • Nursing care	

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.	20%
X-rays	Co-insurance applies.	20%
PET CT	Co-insurance for X-rays applies. Also known as Pet Scan. Requires MCS Life Clinical Affairs pre-authorization.	20%
Molecular and/or Genetic Tests	Co-insurance applies for molecular or genetic testing, except for tests required by law as a preventive 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.	20%
Nuclear Medicine	Co-insurance for X-rays applies.	20%
Polysomnography (Sleep study)	Co-insurance for X-rays applies. Unlimited coverage. Requires MCS Life Clinical Affairs pre-authorization.	20%
CT Scan	Co-insurance for X-rays applies.	20%
Bone Densitometry	Co-insurance for X-rays applies.	20%
Doppler Echocardiography Color Flow	Co-insurance for X-rays applies.	20%
Echocardiogram	Co-insurance for X-rays applies.	20%
Electrocardiogram	Co-insurance for X-rays applies.	20%
Electroencephalogram	Co-insurance for X-rays applies.	20%
Electromyogram	Co-insurance for X-rays applies.	20%

Angiography	Co-insurance for X-rays applies.	20%
Holter	Co-insurance for X-rays applies.	20%
Non-Invasive Cerebrovascular Peripheral Tests	Co-insurance for X-rays applies.	20%
Myelography	Co-insurance for X-rays applies.	20%
MRA	Co-insurance for X-rays applies.	20%
MRI	Co-insurance for X-rays applies.	20%
Sonography	Co-insurance for X-rays applies.	20%
SPECT	Co-insurance for X-rays applies.	20%
Stress Test	Co-insurance for X-rays applies.	20%
Stress Test with Septa Mibi, Persantine or Thallium	Co-insurance for X-rays applies.	20%
Allergy Testing/Challenge testing	Co-insurance for laboratory applies. Unlimited coverage.	20%

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	Screening for anxiety 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.
Hematocrit or hemoglobin screening	Screening for all children.
Sickle Cell Disease	Screening for newborns.
Hepatitis B Virus Infection	Screening for hepatitis B virus (HBV) infection in newborns through young adults (21 years of age) at highest risk of infection.
Congenital hypothyroidism	Screening for newborns.
Lead screening	For children at risk of lead exposure.
Maternal depression	Screening for mothers of infants at 1, 2, 4, and 6-month visits.
Medical History	For all children during development: Ages from zero (0) to twenty-one (21) years.
Obesity screening: children and adolescents	Obesity screening for children ages six (6) years and older, comprehensive counseling, and intense behavioral interventions to promote improved weight in the child.
Oral Health	Risk evaluation for children from newborns up to ten (10) years of age.
Prevention of dental caries, screening and interventions: children younger than 5 years	Oral fluoride supplementation to children (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 children from the age of eruption of the first teeth.
Phenylketonuria (PKU)	Screening of newborns for genetic disorders.
Prevention of dental caries in children younger than 5 years: Screening and Interventions	Oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. Also, the American Academy of Pediatrics (AAP) recommends if primary water source is deficient in fluoride, consider oral fluoride supplementation
Skin Cancer	Counseling for young adults, adolescents, children and parents of children about minimizing exposure to ultraviolet radiation (UV), for people with fair skin from six (6) months of age to twenty-four (24) years to reduce skin cancer risk.
Sudden cardiac arrest and sudden cardiac death	The American Academy of Pediatrics (AAP) recommend assessing risk for sudden cardiac arrest and sudden cardiac death has been added to occur from 11 to 21 years (to account for the range in which the risk assessment can take place) to be consistent with AAP policy ("Sudden Death in the Young: Information for the Primary Care Provider"). Perform a risk assessment, as appropriate
Tobacco use: children and adolescents	The physician-led interventions that include education or counseling aimed to prevent initiation of tobacco use among school-aged children and adolescents.

Use of Tobacco, Alcohol and Drugs	Evaluation to identify tobacco, alcohol and drug use in children between eleven (11) and twenty-one (21) years old.
Tuberculin	Tuberculin test for children at risk of tuberculosis from zero (0) to twenty-one (21) years of age.
Vision screening: children	At least one vision screening for children between three (3) to five (5) years old 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.
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. Physicians should offer or refer patients with prediabetes for effective preventive interventions.
Colorectal Cancer Screening	Colorectal Cancer screening through fecal occult blood tests, sigmoidoscopy or colonoscopy, beginning from forty-five (45) to seventy-five (75) years old, in accordance with Law No. 218 of August 30, 2012. The risks and benefits of these screening methods vary. Also, a follow-up colonoscopy after a positive result from a non-invasive test. This test is a screening test and so patients will not have any out-of-pocket costs.
Depression Screening	Evaluation for depression in adults, including pregnant or post-partum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, an effective treatment and appropriate follow-up.
Falls prevention in older adults: Vitamin D	Vitamin D supplementation to prevent falls in community dwelling adults age 65 years and older who are at increased risk for falls.
Healthy diets and exercises counseling to prevent cardiovascular disease	Counseling and recommendation for overweight or obese adults with high risk factors for developing cardiovascular conditions to promote healthy diet and physical activity in order to prevent such conditions.
Hepatitis B Virus (HBV) Infection	Evaluation for adults at high risk of contracting HBV.
Screening Test for Hepatitis C Virus (HCV)	Screening for hepatitis C virus (HCV) infection in adolescents and adults aged eighteen (18) years to seventy-nine (79) years.
Hypertension screening in adults 18 years or older without known hypertension	Hypertension screening for insureds age eighteen (18) years or older. Measurements must be obtained outside the clinical scenario for diagnosis confirmation before commencing the treatment.

HIV Prevention – (Pre-exposure prohylaxis, PrEP)	Requires MCS Life Clinical Affairs preauthorization. Physicians may offer anti-retroviral therapy with pre-exposure prophylaxis (PrEP) for people at high risk of HIV. For insureds at high risk of HIV referred by their physicians to using these drugs, zero-dollar ($0) copayment or zero percent (0%) coinsurance applies. The insured should undergo an annual physical exam as well as HIV testing showing negative results. Once completed, the insured will be dispensed a ninety (90) day supply. Before those ninety (90) days have elapsed, the insured should repeat his or her HIV testing showing continuous negative results in order to continue treatment. In case the insured interrupts treatment, he or she will have two (2) more attempts per policy year.
Cholesterol Screening	Cholesterol screening 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: nonpregnant adolescents and adults	Human immunodeficiency virus (HIV) screening for adolescents and adults between fifteen (15) and sixty-five (65) years old. Younger adolescents and elderly people with higher risks must also go through screening tests. Human Immunodeficiency Virus (HIV) testing as part of the routine screenings of any medical examination performed at least once every five (5) years, based on the clinical criteria for adolescent and adult people between thirteen (13) and sixty-five (65) years old at low risk, and once a year for all people at high risk. For pregnant women, the applicable requirements are described in the "Preventive Services for Women, including pregnant women" section, further in this policy/this certificate.
Lung Cancer Screening	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.
Obesity screening 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 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.

Statin use for prevention of cardiovascular disease in Adults: preventive medication	Use of statin for prevention of CVD for adults aged 40 to 75 years who have one (1) or more CVD risk factors (i.e. dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk of a cardiovascular event of 10% or greater.
Syphilis infection in non-pregnant adolescents and Adults	Screening for syphilis infection in asymptomatic persons, nonpregnant adolescents and adults who are at increased risk for infection
Tobacco Use and Medication: nonpregnant adults	Screening for all adults and interventions for stopping tobacco use. For those who use products to quit tobacco use, this plan covers *U.S. Food and Drug Administration* (FDA)-approved drugs used to stop smoking for an attempt of ninety (90) consecutive days and up to two (2) attempts per year.
Tuberculosis screening: adults	Tuberculin test for adults at risk of latent tuberculosis infection (LTBI).
Unhealthy alcohol consumption: adults	Screening for unhealthy alcohol consumption is recommended in primary care scenarios in adults eighteen (18) years of age or older, including pregnant women, as well as providing brief behavioral counseling interventions to people involved in risky or dangerous alcohol consumption behavior in order to reduce unhealthy alcohol consumption.
Harmful drug use	A question-based evaluation on the unhealthy use of drugs is recommended in adults eighteen (18) years of age or older. Implementation of the evaluation should be performed when services can be offered or derived for an accurate diagnosis, effective treatment, and proper care. (Evaluation refers to questions on the unhealthy use of drugs, not biologic sample testing.)

Preventive services for women, including pregnant women

Preventive Service	Indication
Asymptomatic Bacteriuria Screening: pregnant persons	Screening for asymptomatic bacteriuria using urine culture in pregnant persons.
BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing	Screening and counseling to women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing.
Use of Preventive Medications to Reduce Breast Cancer Risk	Clinical orientation for patients with a high risk of developing breast cancer, allowing the patient to decide with her physician if drug therapy is appropriate for reducing the risk of developing the disease. The physician may prescribe drugs to reduce the risk of developing breast cancer, such as tamoxifen, raloxifen, or aromatase inhibitors, for women thirty-five (35) years of age or older, who are at increased risk for this disease and at low risk for adverse drug effects.

Mammogram Screening for Breast Cancer	Screening every one (1) or two (2) years for women over forty (40), with or without clinical breast exam. Screening every two (2) years for women ages fifty (50) to seventy-four (74).
Breastfeeding	Comprehensive lactation support services (including consultation, counseling, physician education and peer support services, and breastfeeding equipment and supplies) during the prenatal, perinatal, and postpartum periods to optimize successful initiation and maintenance of breastfeeding. Breastfeeding equipment and supplies include, but are not limited to, doble electric breast pumps as a primary option to manual breast pumps (including pump parts and maintenance) and breast milk storage supplies. Breastfeeding equipment may also include equipment and supplies as clinically indicated to support mothers with breastfeeding difficulties and those who need additional services. Breastfeeding equipment is covered by a doctor's order after the third trimester of pregnancy and for the duration of breastfeeding. Additional supplies for the breastfeeding machine are covered, and the equipment is available through contracted providers.
Cervical Cancer Screening	Cervical cancer screening every three (3) years with cervical cytology (Pap test) only in women between twenty-one (21) and twenty-nine (29) years old. For women between thirty (30) and sixty-five (65) years old, is recommended screening with cervical cytology every three (3) years, every five (5) years with high risk human papillomavirus (hrHPV), or every five (5) years cotesting with hrHPV and cytology test.
Chlamydia Infection Screening in all sexually active women, including pregnant persons	Chlamydia infection screening in all sexually active women twenty-four (24) years of age and younger, and in women twenty-five years or older who are at increased risk for infection.
Contraceptive Methods	Guidance, counseling, and supply of all contraceptive methods approved, granted, or cleared by the *U.S. Food and Drug Administration* FDA, as required by law, including those after childbirth and follow-up care. For these medications zero ($ 0) dollars copayment or zero (0%) percent coinsurance will apply. The following methods are covered through the pharmacy coverage. The Value Drug Formulary applicable on this policy/this certificate, include the following: • Sterilization surgery for men and women • Surgical sterilization of implants for women • Implantable rod • Copper intrauterine device • Intrauterine device with progesterone • Injection • Diaphragm with spermicide • Sponge with spermicide • Cervical cap with spermicide • Spermicide

	The following methods will be covered by the drug coverage. Please refer to EHB-2024 Drug Formulary, applicable to this policy: • Oral contraceptives (combined pill) • Oral contraceptives (progestin only) • Oral contraceptives extended/continuous use • Patches • Vaginal contraceptive ring • Emergency contraception (ulipristal acetate) • Female condom • Male condom • Spermicide The list of contraceptives includes those currently listed in the *U.S. Food and Drug Administration* (FDA) birth control guidance and any additional contraceptives approved, granted or cleared by the FDA.
Counseling for healthy weight and weight gain in pregnancy: Pregnant women	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 of women in reproductive age	Screening for women in reproductive age to detect partner violence (IPV), such as domestic violence, and to provide or refer women with positive test result to intervention services.
Folic Acid Supplements	Recommendation of the use of daily folic acid supplements containing four tenths to eight tenths (0.4 to 0.8 mg) or four hundred to eight hundred milligrams (400 to 800µg) for women who are planning or can become pregnant. Physician's order is required.
Diabetes in pregnancy	Screening pregnant women for gestational diabetes mellitus (GDM) after 24 weeks of gestation (preferably between 24 and 28 weeks of gestation) to prevent adverse birth outcomes. Screening pregnant women with risk factors for type 2 diabetes or GDM before 24 weeks of gestation—ideally at the first prenatal visit
Screening for gonorrhea infection	Screening for gonorrhea in all sexually active women twenty-four (24) years of age or younger and in women twenty-five (25) years of age or older who are at increased risk of infection.
Hepatitis B Virus	Screening for pregnant women at their first prenatal visit.
Screening for Human Immunodeficiency Virus (HIV): pregnant persons	Covered for all sexually active women. Testing will be performed in all pregnant women as follows: • First HIV test during the first trimester of gestation or during the first prenatal visit • Second test during the third trimester of gestation, between twenty-eight (28) and thirty-fourth (34) weeks of pregnancy

	• During delivery, if the pregnant woman has never been tested and her HIV status is unknown As set forth in the Department of Health of Puerto Rico Administrative Order No. 307 of August 14, 2013.
Screening for Human Immunodeficiency Virus Infection (HIV)	All adolescent and adult women, ages 15 and older, receive a screening test for HIV at least once during their lifetime. Earlier or additional screening should be based on risk and rescreening annually or more often may be appropriate beginning at age 13 for adolescent and adult women with an increased risk of HIV infection. Risk assessment and prevention education for HIV infection beginning at age 13 and continuing as determined by risk. A screening test for HIV is recommended for all pregnant women upon initiation of prenatal care with rescreening during pregnancy based on risk factors. Rapid HIV testing is recommended for pregnant women who present in active labor with an undocumented HIV status. Screening during pregnancy enables prevention of vertical transmission.
Obesity prevention in midlife women	Counseling midlife women aged 40 to 60 years with normal or overweight body mass index (BMI) (18.5-29.9 kg/m2) to maintain weight or limit weight gain to prevent obesity. Counseling may include individualized discussion of healthy eating and physical activity.
Osteoporosis (post-menopausal women younger than sixty-five (65) years of age)	Osteoporosis testing with bone mass measuring is recommended for the prevention of osteoporotic fractures in post-menopausal women younger than sixty-five (65) years at higher risk of osteoporosis, as determined by a formal risk detection tool.
Osteoporosis (women older than sixty-five (65) years of age)	Osteoporosis screening with bone mass measuring to prevent osteoporotic fractures in women sixty-five (65) years and older.
Intervention and counseling for perinatal depression	Providing or referring pregnant or postpartum persons who are at increased risk of perinatal depression to counseling interventions.
Preeclampsia prevention: aspirin in pregnant persons at high risk for preeclampsia	Low dose aspirin (81 mg/d) supply as preventive medication after the twelfth (12) week of gestation in persons who are at high risk for preeclampsia.
Preeclampsia Screening	For pregnant women with blood pressure measurement during pregnancy.
Blood Group Classification – Rh(D) Factor	Rh (D) blood type and antibody detection in all pregnant women at first prenatal visit. Repeated testing of Rh (D) antibody is recommended on pregnant women with negative non-sensitive Rh (D) tests between weeks twenty-fourth (24) and twenty-eighth (28) of pregnancy, unless the biological father is known to be Rh (D) negative.
Anxiety Evaluation	Evaluation for anxiety detection in adolescent and adult women, including during pregnancy and post-partum. Optimal screening intervals are unknown and clinical judgment should prevail to determine the frequency of evaluation. Due to the prevalence of anxiety disorders, the lack of recognition in clinical practice, and multiple problems associated with

	treatment of untreated anxiety, physicians should consider screening women who have not been recently examined.
Diabetes after pregnancy	Screening for type 2 diabetes in women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes. Initial testing should ideally occur within the first year postpartum and can be conducted as early as 4–6 weeks postpartum. Women who were not screened in the first year postpartum or those with a negative initial postpartum screening test result should be screened at least every 3 years for a minimum of 10 years after pregnancy. For those with a positive screening test result in the early postpartum period, testing should be repeated at least 6 months postpartum to confirm the diagnosis of diabetes regardless of the type of initial test (eg, fasting plasma glucose, hemoglobin A1C, oral glucose tolerance test). Repeat testing is also indicated for women screened with hemoglobin A1C in the first 6 months postpartum regardless of whether the test results are positive or negative because the hemoglobin A1C test is less accurate during the first 6 months postpartum.
Syphilis screening: pregnant women	Early screening for syphilis infection in all pregnant women.
Urinary incontinence screening in women	Annual urinary incontinence screening. Factors associated with a higher risk of urinary incontinence include increased births, older age, and obesity; however, these factors should not be taken into consideration for limiting screening.
Tobacco Use: pregnant persons	Clinical inquiry to pregnant persons on the use of tobacco, counseling on smoking cessation, and offering behavioral intervention to quit the use of tobacco in pregnant persons.
Preventive Visits for Women also known as "well women visits"	Annual preventive care (depending on the status of women's health, health needs and other risk factors) for adult women in order to obtain recommended and appropriate preventive services according to their age and development, including preconception care and services needed for prenatal care. These visits include the preventive services for women mentioned in this policy/this certificate. In the event the physician determines that the patient requires additional visits for other preventive services, these will be covered with zero ($0) copayment or zero (0%) coinsurance, accordingly.
HIV Prevention – (Pre-exposure prohylaxis, PrEP)	Requires MCS Life Clinical Affairs preauthorization. Physicians may offer anti-retroviral pre-exposure prophylaxis (PrEP) for women at high risk of HIV referred by their physicians to using these drugs. Zero dollar ($0) copayment or zero percent (0%) coinsurance applies. The insured should undergo an annual physical exam as well as HIV testing showing negative results. Once completed, the insured will be dispensed a ninety (90) day supply. Before those ninety (90) days have elapsed, the insured should repeat her HIV testing showing continuous negative results

	in order to continue treatment. In case the insured interrupts treatment, 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 According to the Puerto Rico Department of Health Schedule	
Hepatitis (Hep B)	As indicated in the Puerto Rico Department of Health Schedule for this policy/this certificate 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 Influenzae, Type B (Hib)	
Pneumococcal (PCV) and (PPV)	
Measles, Mumps and Rubella (MMR)	
Varicella (Var)	
Hepatitis A (Hep A)	
Meningococcal (MCV) and (MPS)**	
Influenza	
Human Papillomavirus (HPV) * - vaccine for the prevention of cervical cancer	

Centers for Disease Control (CDC) Vaccination Schedule for Children, Adolescents and Adults	
Tetanus, Diphtheria, and Pertussis (Whooping Cough) (Td/Tdap)	Centers for Disease Control (CDC) vaccination schedule for this policy/this certificate current year. The insured can request the current itinerary by phone at the MCS Life Customer Service Call Center at (787) 281-2800.
Human Papillomavirus (HPV) *	
Chicken Pox	

Shingles	
Measles, Mumps and Rubella (MMR)	
Influenza	
Pneumococcal	
Hepatitis A	
Hepatitis B	
Meningococcal **	
COVID-19***	
Dengue****	

* The immunization against the HPV virus will be covered for males and females aged nine (9) years and above and adolescents with a medical history of abuse or rape, who have not started or completed the three (3)-dose series, according to Act No. 255 of September 15 of 2012.

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

*** COVID-19 immunizations will be covered for adolescents over sixteen (16) 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), the Centers for Disease Control and Prevention (CDC) and in compliance with Section 2.050 (C) of the CSSPR.

**** The dengue vaccine will be covered for children 9 to 16 years of age, who live in dengue endemic areas and have laboratory confirmation of a previous infection. Six months after confirmation of dengue infection, a 3-dose series will be administered, with six-month waiting intervals between each dose, according to the recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC).

Additional Immunizations

Respiratory Syncytial Virus (RSV)	Requires MCS Life Pharmacy Department pre-authorization. No co-payment applies for the vaccine. Co-payment for medical visit applies. This vaccine is covered at the recommended dose, in accordance with Act No. 165 of August 30, 2006.	0% General Practitioner: $10 Specialist: $10 Subspecialist: $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	$0

	recommended doses for age, sex, health condition and conditions set forth by MCS for these services.	General Practitioner: $10 Specialist: $10 Subspecialist: $15
Prevnar 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 Subspecialist: $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	This service includes one (1) refraction examination per policy year. Co-payment applies. Covered up to one-hundred thirty ($130.00) dollars per insured per policy year (January to December). The 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 can be used for the following services: A. Single vision, bifocal, trifocal or lenticular lenses. B. Eyeglasses (frames) C. Regular or toric contact lenses. D. Orthoptic therapy will be covered up to thirty (30) for life. E. Additional options, such as anti-reflective, polycarbonate, ultraviolet ray lenses, among others.	$15
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 because of atrophy. Hospitalization co-payment applies and requires MCS Life Clinical Affairs pre-authorization.	$50
Air Ambulance Services in Puerto Rico	Corresponding co-insurance applies. One (1) trip per policy year. Covered according to medical necessity, through contracted providers and according to the established protocol 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 non-rehabilitative therapies, psychology, occupational and physical therapy, and will include medical visits and medically necessary tests. 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 the UnitedHealthcare providers' directory at:	Accident and trauma: $0 Illness: $50

	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.	
	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 where rendered, minus the applicable co-payment.	Accident and trauma: $0 Illness: $50
Dependents Children Studying in the United States	**In the UnitedHealthcare network:** Basic coverage co-payments and co-insurances in Puerto Rico apply to college students without pre-authorization. Neonatal care is not included. Organ transplant and cancer treatment require pre-authorization. Basic coverage services will be provided through the UHC Network. **Outside the UnitedHealthcare Network:** Emergency services rendered in the United States by non-participating UnitedHealthcare Network providers will be reimbursed according to the usual and customary services fees of the geographic area where rendered.	
Treatments not Available in Puerto Rico Coordinated through Clinical Affairs	MCS will cover medical, laboratory and X-rays, diagnostic tests and specialized studies and hospitalizations not available in Puerto Rico with pre-authorization. Treatments not available in Puerto Rico require MCS Life Individual Case Management Program medical referral and pre-authorization. **In the UnitedHealthcare Network:** Covered with a twenty percent (20%) co-insurance within the UnitedHealthcare Network. You may access the UnitedHealthcare providers' directory at: https://us1.welcometouhc.com or call 1-877-563-9016. **Outside the UnitedHealthcare Network:** Covered by reimbursement with a twenty percent (20%) co-insurance. Services not available in Puerto Rico coordinated through Clinical Affairs	20%

	will be reimbursed based on usual and customary service fees of the geographic area where rendered, minus the twenty percent (20%) co-insurance.	
Second Medical Opinion in Puerto Rico	Co-payment applies for medical visits for second medical opinions in Puerto Rico.	General Practitioner: $10 Specialist: $10 Subspecialist: $15
	Second medical opinion in the United States, refer to Section 6: Major Medical Expenses	
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.	20%
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: • Behavioral therapy • Psychotherapy • Diagnostic tests • Specialized test (MRI, CT Scan, Pet Scan, Pet CT, MRA, SPECT). PET Scan and PET CT require pre-authorization. Surgery for sex 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 Guide for Gender Reassignment Every procedure related to this diagnosis requires pre-authorization. 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.	
Gender Reassignment Surgery	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. For female-to-male gender reassignment, surgical procedures include: • Mastectomy • Hysterectomy • Oophorectomy • Vaginectomy • Vulvectomy • Scrotoplasty • Urethroplasty • Placement of testicular or penile prosthesis • Phalloplasty or metoidioplasty (alternative to a phalloplasty) For male-to-female gender reassignment, the surgical procedures include: • 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

Shared costs apply to 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 applicable co-payment or co-insurance.	
Services offered in the United States, except for emergencies, or those not coordinated by MCS Life Clinical Affairs	Will be reimbursed according to MCS contracted fees in Puerto Rico, minus the applicable co-payment or co-insurance.	

Land Ambulance Services in Puerto Rico	Maximum amount for reimbursement is seventy-five ($75) dollars per trip, up to four (4) trips 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 the service is rendered.
	The service will only be covered if the insured meets the following requirements:
	• The patient suffered an illness or injury for which other types of transportation are not recommended or is a psychiatric emergency, in accordance with Act No. 183 of August 6, 2008.
	• The patient was transported:
	  ◦ 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 home, for patients whose health condition does not allow the use of other means of transportation
	  ◦ between health care institutions
		$75

	In addition, land ambulance service will only be covered if: • The request for reimbursement of the service includes transportation certificate, pickup location and destination • Is not a case covered by the Automobile Accident Compensation Administration (ACAA, Spanish acronym), Workers Accident Compensation Act (CFSE, Spanish acronym) or any other third-party liability.	
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.	$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 Wellbeing, Integration, and Development of Persons with Autism).	
Vision Services for Adults and Children (in addition to pediatric vision)	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: A. Lenses • Single vision • Bifocal • Trifocal • Lenticular B. Eyeglasses (frames) C. Regular or toric contact lenses D. Orthoptic therapies will be covered through reimbursement, according to medical necessity, up to thirty (30) therapies for life. E. Additional options: • Anti-reflective treatment • Polycarbonate lens • A anti-scratching treatment • Anti-UV treatment • Trifocal Progressive	$130

	• Bifocal Progressive • Photosensitive lens (transition lens)	
Emergency Services outside the United States	Reimbursement based on the usual, customary, and reasonable costs (UCR) of the geographic area or according to fees negotiated by MCS Life with the provider through the United State network, minus the corresponding co-payment or co-insurance.	
Phenylalanine-free Amino Acid Preparations	Reimbursement of the total cost of preparation for patients of all ages with a diagnosis of phenylketonuria (PKU), and for other ends, in accordance with Act No. Ley 139 of August 8, 2016.	0%
Cardiovascular Rehabilitative Therapy	Services are reimbursed according to MCS fees and applicable co-payment. Requires MCS Life Clinical Affairs pre-authorization. Reimbursement will be covered when provided by a physiatrist with knowledge in rehabilitation and exercise physiology. The purpose is to minimize physical and psychological disability as a result of a cardiovascular disease.	$10

B. 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, both in basic coverage and in major medical expenses. The insured may request a copy of the form at MCS Life Customer Service Center or by calling the 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 must be specified.
6. Laboratory receipts must specify all the 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: Bone, Skin, Cornea, Organs and Bone Marrow Transplant Services

Bone, Skin and Cornea Transplants Services

Services will be covered and require MCS Life Clinical Affairs pre-authorization; not available through reimbursement. No co-payment applies for reasonable and customary charges if provided by participating providers and at institutions or hospitals with which services have been previously coordinated. Service coverage for bone, skin and cornea transplant includes pre and post procedure care, including immunosuppressant drugs, as per doctor's order. Immunosuppressant drugs will be one-hundred percent (100%) covered and require MCS Clinical Affairs pre-authorization.

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

Organ and Bone Marrow Transplant

Will be covered with Clinical Affairs pre-authorization and is not available through reimbursement. No co-payment applies for reasonable and customary charges by participating providers in Puerto Rico (as first option) or in the United States, including institutions, hospitals, or with a provider, as coordinated with MCS Life Clinical Affairs.

To begin the procedure, the medical provider should contact MCS Life Clinical Affairs to notify about the transplant procedure. Then, MCS Life Clinical Affairs Division, together with the provider, completes the necessary documentation required for the procedure.

Organ Transplants:

Services covered include heart, heart-lung, lung (unilateral or bilateral), liver, pancreas, pancreas-kidney, kidney, and small intestine. Expenses for organ transplant procurement, preservation and transportation are covered, without maximum limit.

- Covered recipient expenses are limited to those directly related to the transplant procedure, including, assessment, preoperative and postoperative care and immunosuppressant drugs. Immunosuppressant drugs will be one-hundred percent (100%) covered and require MCS Clinical Affairs pre-authorization.
- Expenses incurred by the transplant donor include procurement, surgery, storage and transportation directly related with the organs to be used in the procedure. They will be covered without maximum limits.
- A maximum amount of up to ten-thousand ($10,000) dollars per transplant will be covered for transportation expenses to and from the facility where the surgery will take place, for the insured and a companion. If the insured is under nineteen (19) years of age, transportation for two (2) companions will be covered, provided they are the parents or the persons holding the legal custody of the insured.
- Expenses for meals and lodging are covered up to one-hundred ($100) dollars per day per person and up to a two-hundred ($200) dollars per day for two persons. The maximum established limit for meals and lodging is up to six-thousand ($6,000) dollars per transplant.

Bone Marrow Transplant:

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

- Covered recipient expenses will be limited to those directly related to the transplant procedure, including, assessment, preoperative and postoperative care and immunosuppressant drugs. Immunosuppressant drugs will be one-hundred percent (100%) covered and require MCS Clinical Affairs pre-authorization.
- Bone marrow donation and storage. Donor's procurement, conservation, and transportation expenses directly related to the organs to be used in the procedure will be covered without maximum limit.
- Chemotherapy or radiation therapy before the transplant procedure.
- Up to ten-thousand ($10,000) dollars per transplant will be covered for transportation expenses to and from the facility where the surgery will take place, for the insured and one (1) companion. If the insured is under nineteen (19) years of age, transportation for two (2) companions will be covered, provided they are the parents or the persons holding the legal custody of the insured.
- The maximum benefit limit of covered expenses for meals and lodging is one-hundred ($100) dollars per day per person, up to a maximum of two-hundred ($200) dollars for two persons. The maximum limit for meals and lodging is six-thousand ($6,000) dollars per transplant.

Section 5: Bariatric Surgery Benefit for Treatment of Morbid Obesity

Covered services include gastric bypass surgery, adjustable band surgery or sleeve gastrectomy (open or closed procedures through laparoscopy). Other methods of bariatric surgery are excluded. 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 requirements described below:

- Body Mass Index (BMI) greater than or equal to thirty-five (35) kg/m^2 with co-morbidities (Type 2 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 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 6: Major Medical Expenses

Definitions:

Initial Deductible Amount	The stipulated deductible applies to all insured and is the amount of charges eligible to be paid every policy year prior to MCS Life reimbursement. If the initial family deductible has been covered, the remaining members do not have to cover the additional deductible for that year. a. Individual – three-hundred ($300) dollars b. Couple - six-hundred ($600) dollars c. Family - six-hundred ($600) dollars
Co-insurance Amount	Stipulated amount based on the percentage of eligible charges that apply to every insured per policy year, payable by MCS Life after initial deductible has been covered. Charges applied to any amount of co-insurance cannot be applied to another expense. a. Twenty percent (20%) of the medical expenses covered up to a maximum of three-thousand ($3,000.00) dollars per insured per year (January-December) after payment of initial deductible amount. b. Twenty percent (20%) of the medical expenses covered up to a maximum of six-thousand ($6,000.00) dollars per family per year (January-December) after payment of initial deductible amount. **Note:** Deductible per person and deductible per couple or relative will apply to all services received in the United States, to pre-authorized services or received due to an emergency. If the insured does not have pre-authorization, reimbursement will be made according to the fees of the participating providers network contracted by MCS Life in Puerto Rico, provided the initial applicable deductible amount has been accrued.
Annual Maximum Limit	No annual maximum applies.

Benefits Covered through Major Medical Expenses

Benefit	Description	Co-payment/Co-insurance
Non-rehabilitative Speech Therapy	Covered by major medical expenses through reimbursement with twenty percent (20%) co-insurance after completing the initial deductible. Maximum of forty (40) therapies per policy year.	20%
Occupational therapy	Covered as ambulatory service by major medical expenses through reimbursement with twenty percent (20%) co-insurance after completing the initial	20%

	deductible. Maximum of forty (40) therapies per policy year.	
Rehabilitative Visual Therapy	Covered as ambulatory service by major medical expenses through reimbursement with twenty percent (20%) co-insurance after completing the initial deductible.	20%
Vasovasostomy	Covered by major medical expenses through reimbursement with twenty percent (20%) co-insurance after completing the initial deductible. Reimbursement will be made based on reasonable and customary charges.	20%
Tuboplasty	Covered by major medical expenses through reimbursement with twenty percent (20%) co-insurance after completing the initial deductible. Reimbursement will be made according to the reasonable and customary charges.	20%
Allergy Vaccines	Covered by major medical expenses through reimbursement with twenty percent (20%) co-insurance after completing the initial deductible.	20%
Services not available in Puerto Rico with of Clinical Affairs Pre-authorization	Covered through reimbursement by major medical expenses with twenty percent (20%) co-insurance, no initial deductible for major medical expenses applies. Eligible charges for non-emergency services or services not available in Puerto Rico, coordinated through MCS Life Clinical Affairs, will be based on MCS Life fees applicable to Puerto Rico, minus twenty percent (20%) co-insurance applicable to major medical expenses. Charges that exceed MCS Life fees will be considered ineligible charges and will be the insured responsibility.	20%
Second Medical Opinion in the United States	• Covered through reimbursement by major medical expenses with twenty percent (20%) co-insurance. • Pre-authorized services provided through the UHC Network. No deductible for major medical expenses applies. • Pre-authorized services provided outside the UHC Network, deductible for major medical expenses applies. Reimbursement will be based on reasonable and customary fees applicable to the geographic area where services were rendered.	20%

	• Major medical deductible applies to non-pre-authorized services. Reimbursement will be based on MCS Life fees in Puerto Rico.	
Emergency Services outside the United States	Emergency services provided outside the United States will be reimbursed with twenty percent (20%) co-insurance, based on reasonable charges of the geographic area where the service is rendered after completing initial deductible.	20%
Dependent Children Studying in the United States	**Outside of the UnitedHealthcare Network:** Twenty percent (20%) co-insurance applies for services provided outside the UnitedHealthcare Network, after completing major medical expenses deductible. Reimbursement will be based on MCS Life fees in Puerto Rico.	20%
Emergency Ambulance Service in the United States	Land: Covered through reimbursement by major medical expenses with twenty percent (20%) co-insurance; no initial deductible for major medical expenses applies. This service is subject to assessment after the service has been offered and will be reimbursed based on reasonable and customary fees of the geographic area where the service is rendered.	20%
	Air: Covered through reimbursement by major medical expenses with twenty percent (20%) co-insurance; no initial deductible for major medical expenses applies. This service is subject to assessment after the service has been provided and will be reimbursed based on reasonable and customary fees of the geographic area where service is rendered. Limited to one (1) trip per policy year.	20%

Major Medical Expenses Exclusions

Charges incurred will not be paid if:

- They are excluded under **Basic Coverage Exclusions and Limitations.**
- They are as a result of illness or body injury from or during the performance of the insured's job duties.
- For visual refraction and for eyeglasses adjustment.
- For personal comfort items.
- For temporomandibular joint dysfunction syndrome treatment.
- Are payable or exceed any limitation under another **medical expense benefit**.
- Are excluded from payment in another medical expense benefit.

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

Benefit	Description	Co-payment/Co-insurance
MCS Alivia	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. MCS Alivia is a model of alternative and complementary therapies and treatments integrated into conventional health systems. Some of the integrative medicine services available are: • Integrative and complementary health • Traditional Chinese medicine • Medical acupuncture • Therapeutic massage • Homeopathy offered by certified doctors • Bioenergetic medicine (Pranic Healing) 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.	$15
MCS Solutions (FHC)	Includes a maximum of eight (8) visits per insured per 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. 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. For additional information, please call 1-866-627-4327.	$0
Wellness Programs and Initiatives	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 clinics, among others. 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 AM to 8:00 PM and Saturdays from 8:00 AM to 4:30 PM. The hearing impaired (TTY) can call 1-866-627-8182.	$0

"Programa de Madres y Bebés Saludables"	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. **How does the Program work?** 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 MCS webpage: www.mcs.com.pr.	$0
MCS Medilínea MD	Corresponding co-payment applies for MCS Medilínea MD. Access to virtual visits with primary physician, including family medicine, general practitioner, internist and pediatrician, through MCS Medilínea MD digital platform. Children under eighteen (18) years of age must be accompanied by an adult during consultation. Some conditions appropriate for consultation through this service are: • allergies • constipation • cough • diarrhea • ear problems • fever • cold • headache • insect bites • nausea • conjunctivitis • skin rash • sore throat • urinary tract problems/UTI • vomiting 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	$25

	months with fever should be referred by his or her pediatrician to an urgency center or emergency room. In acute cases in which the physician deems necessary the use of medications for treating the patient, the delivery of the prescription will be coordinated directly with the insureds preferred pharmacy. If the physician determines that the condition for which the patient 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.	
MCS Care Clubs	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. • First visit: 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: a. The physician will discuss with the insured the results of tests performed and personalized profile report. If necessary, additional recommendations or referral to other specialists, as applicable, will be offered. If the insured needs additional tests because of 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.	$0
"Programa Vida"	Covered for Walmart Associates only. The "Programa Vida" 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.	$0

	• Participants will have a personalized intervention plan prepared by the 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. • Co-payment and co-insurance apply for services not included in this protocol.	
Transcita	Covered for a maximum of two (2) trips (one way) per associate per policy year (only for Associates). Must be coordinated through Transcita at 1-866-769-2482, Monday through Friday, 5:00 AM to 10:00 PM and Saturdays from 5:00 AM to 8:00 PM.	$0

PART III: COVERAGE EXCLUSIONS

Section 1: 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), 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 because of non-compliance or violation of law requirements or provisions of the above laws mentioned, or of any others, even if such non-compliance or violations do not constitute crime.
3. Services covered under any other insurance or *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 military active 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 because of 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, dentists or paramedics, except as set forth in the benefits coverage.
8. Services not listed in Part II of this certificate or that are not required by 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 because of illness or physical injury, an accident, or surgery to correct a birth defect, including oral defects in newborns. Surgery for the removal of excess skin (known as flaps) will not be covered except if certified by a physician as being necessary because it affects a body part function, in accordance with Act No. 212 of August 9, 2008.
13. Cosmetic treatments.
14. Hospital services, medical-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 any 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 artificial 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 drug with the purpose of reestablishing the ability to procreate, except vasovasostomy and tuboplasty procedures covered in this Certificate, or procedures not under the condition of infertility, with the purpose of inducing pregnancy, such as, *in vitro* fertilization.
26. Ambulatory occupational and speech therapies and social worker, except for treatment of autism disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders, in accordance with Act No. 220 of September 4, 2012 (BIDA Act). Occupational and speech therapies are covered under home 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 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, in the hospital or renal care facilities, medical-surgical services and associated complications; after exhausting the maximum first thirty (30) months for Medicare eligibility.
31. Fetal monitoring in medical office (belts).
32. Lasik procedures and surgeries for correction of refractive defects.
33. Intravenous analgesia services or analgesia administered through inhalation by the doctor or dentist, except anesthesia, in accordance with Act No. 352 of December 22, 1999.
34. Surgical assistance services for ambulatory surgeries.
35. Durable medical equipment not described in this certificate, including custom made medical equipment. Also excluded are services and equipment for Optune® treatment.
36. Services not pre-authorized and that requires MCS Life Clinical Affairs pre-authorization, as described in the benefits section of this certificate.
37. Expenses for contraceptive methods other than sterilization or vasectomy (see Chapter 2: Pharmacy Coverage).
38. Complementary medicine services not offered by providers contracted by the MCS Alivia program.
39. Expenses for sports medicine services.
40. Expenses for oral chemotherapy (see Chapter II: Pharmacy Benefit, Part X: Limitations).
41. Expenses for maternity services to dependent daughter(s).
42. Expenses incurred in the NICU for babies of dependent daughter(s).
43. Water ambulance.
44. Growth hormones.
45. Consultation to specialists or subspecialist through MCS Medilínea MD services, except for family medicine doctor, internist and pediatrician.
46. Telemedicine consultations outside the network or platform contracted through MCS Medilínea MD.
47. Coverage for United States residents.
48. Paid expenses accrued by an assistance program or a third party for maximum out-of-pocket expenses (MOOP).
49. Non-emergency services in the United States or that are available Puerto Rico, except for dependent students previously notified to the Insurer. Services unavailable in Puerto Rico require MCS Life Clinical Affairs coordination.
50. Elective services and medical visits outside the United States.
51. The following services are excluded from basic coverage: Pharmacy, dental, orthodontics and life insurance.
52. Services under major medical expenses are excluded from basic coverage, as described in Part III, Section 6 of this Chapter.
53. 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.
54. 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.

55. 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.
56. Gene Therapy: 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 o tinted glasses.
3. Expensed incurred for medical or surgical treatments for the eyes, other than those specified.
4. Expenses for cosmetic use.
5. Expenses incurred for Pediatric Aphakic Contact Lenses or any other type of regular or toric contact lenses.
6. Expenses incurred after exhausting the benefit or service, as described in your vision coverage.
7. Deductibles or co-insurances that correspond to the insured.
8. Devices needed as part of the orthoptic therapies.

Section 3: Bone, Skin, Cornea, Organs and Bone Marrow Transplant Services Exclusions

The following services are excluded:

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

Section 4: 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 or sleeve gastrectomy are excluded from the benefit.
3. Bariatric surgery benefit is limited to the geographical area of Puerto Rico; bariatric surgeries performed outside Puerto Rico are excluded from coverage.

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 should be initiated by a physician or provider. The request should be signed and faxed along with medical order to MCS Life Clinical Affairs. 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 telephone numbers for pre-authorization requests 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.

It is suggested that pre-authorization requests for services, studies, or procedures planned in ambulatory surgery facilities or 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 five (5) day period from the date it is received. The initial period could be extended for fifteen (15) additional days, provided the extension 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 or 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.

Accelerated Pre-authorization Procedure

Your provider may request an accelerated or urgent pre-authorization. MCS Life will treat the request as urgent care, 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 expedited 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 case 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 notify the insured in twenty-four (24) hours 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 from the receipt of the request. The insured has up to fourteen (14) days to submit additional clinical information. If the additional information is not received within the set period of time, it will be denied because of lack of information.

When the requested service meets all 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: BENEFITS COORDINATION (COB)

The 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 plan, either group or individual or if Medicare eligible, insurance companies are allowed to apply rules set forth by the National Association of Insurance Commissioners (NAIC) as well as that of the Centers for Medicare and Medicaid Services (CMS), to determine the order of payment for 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.

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

NOTICE TO INSURED

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

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

Plan	For the purposes of the COB, a plan is a type of coverage that allows the coordination of benefits. 1. Primary Plan – will pay established services without taking into consideration the existence of another plan. 2. Secondary Plan – will pay any covered service that has not been paid by the primary plan, taking into consideration that the services are paid according to the provisions and limitations of each policy.
This Plan	For the purposes of the COB, "this plan" includes the part of the benefits agreement that covers health care to which the COB provisions are applicable and that may be reduced according to the benefits covered by the other plan.
Allowable Expense	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.

	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. Below are examples of non-allowable expenses: 1. The difference between a semi-private hospital room and a private room, provided one of the plans provides coverage for private room or the patient's stay is medically necessary (as per the terms generally accepted in medical practice). 2. When highest reimbursement amount is exceeded, if the insured is covered by two (2) or more plans that calculate their payments for benefits based on the usual and customary fees or another reimbursement method. 3. Any amount exceeding the highest negotiated fee, if an insured is covered under two (2) 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.

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 (month and day) will be the primary plan, the other plan is the 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 Employees:**
   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 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), the employer plan of the insured and/or his or her spouse will be primary if the employer group to which he or she belongs to has a payroll of twenty (20) employees or more.
   b. Medicare because of disability – If an insured has Medicare for disability (younger than sixty-five (65) years old), the employer plan of the insured, his or her spouse and/or any family member will be primary if the employer group to which he or she belongs has a payroll of one hundred (100) associates or more.
   c. Medicare because of renal disease – If the insured has Medicare because of a renal condition, Medicare establishes a period of coordination of thirty (30) months in which it considers the employer plan as primary. When Medicare grants renal or ESRD (End-Stage Renal Disease) status, it does not take into account the age of the insured, the number of employees of the employer nor if the person is in the group of active or retired employees. While Medicare establishes a thirty (30) month period of coordination, MCS Life will apply a period of coverage for dialysis, as set forth in this 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 coverage; is a beneficiary under COBRA (non-renal patient).

If the aforementioned rules do not determine the order of the benefits, 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 determines the payment of its benefits first, before considering the benefits of other plan. When this plan is secondary, it determines its benefits after those of the other plan and may reduce the benefits it pays in order that all the plan's 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 to determine the order of payment of the benefits will be as follows:

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

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

5. Right to Receive, Use, and Disclose Necessary Information:
Certain information is needed about health care coverage and services in order to apply these COB rules and to determine the payable benefits under this plan and other plans. MCS Life can obtain the necessary information and share it with other organizations or individuals in order to apply these rules and to determine the payable benefits under this plan and other plans covering the claimant of the benefits. MCS Life does not need to inform or obtain consent from any person to obtain and share the necessary information.

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

7. Right of Recovery
If the amount of the payments made by MCS Life is greater than the amount that should have been paid under COB, the excess amount may be recovered from one or more people to whom the payment was made or for whom the payments were made 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 request for review of a complaint related with 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 Article 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 formal 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 personal representative, with written consent may submit a claim or complaint. In addition, the following persons or entities may submit a claim or complaint on behalf of the insured:

- The health care provider with written consent;
- Persons authorized by court or in accordance with state laws to act on behalf of the insured;
- A representative appointed by the state on behalf of a 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 or visual deficiencies, and/or reading limitations, MCS Life provides 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 try to solve any situation or question submitted by insureds or their authorized representative in each call or during visits to one of the Service Centers. In the case of complaints received through a phone call, MCS Life has a call back system available to let the insured know the status of his or her 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 an 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 may be submitted in writing or verbally by:

- 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:

Complaint 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 Not Related 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 in or before thirty (30) calendar days from the receipt of the complaint. The notification will include:

- The titles and credentials of the persons 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:

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

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

MCS Life will notify the insured of 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 of 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 expedited way available.

- First level review of an adverse determination with prospective review - MCS Life will work on the review and should respond to allegations in a term not greater than fifteen (15) calendar days from having received the request. MCS Life will provide the insured within three (3) work days of having received the complaint the name, address, and phone number of the persons designated to conduct the review of the complaint. The insured has the right to submit written comments, documentation, records, and other materials related to the complaint. The insured may request free access to all documentation and records, and to get copies of these as well as pertinent information of the complaint.
- First level review of an adverse determination related to a retrospective review- MCS Life will work on the review 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 along 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 notification 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:

- The specific reasons for the adverse determination;
- Reference to the specific provisions of coverage in which the determination was based;
- A statement mentioning the right of the insured to receive, without charge and upon request, reasonable access to all documentation, including copies, records and other pertinent information.
- If the document, record or other information is pertinent to the claim, it 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 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 submit 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 determination of benefits 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 may initiate the external review process of the claim or exert any of the available remedies under ERISA §502(a) or under the laws of Puerto Rico.

Continuity of Services

In case of concurrent review determinations, if MCS Life has previously certified the 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 the 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 personal representative or physician should submit such request to MCS Life, or directly before an independent review organization through the means mentioned in the written resolution issued by MCS Life in one-hundred twenty (120) days 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 an 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 plan;
- 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 the required information for the external review process, MCS Life will proceed to refer the request to one of the following three contracted independent review organizations: *Advance Medical Review, Alicare 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 external review 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 the required documentation; or
- if the insured is not eligible for an external review, MCS Life will notify in writing of the reasons for the ineligibility 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 organization should submit its determination within forty-five (45) days after having received the request and within seventy-two (72) hours for the accelerated external review.

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 has been 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 an admission to a health care facility, the availability of a service or 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 from the time of receipt of the complaint resource and the parties have not agreed on the extension of the term to issue the determination.

If MCS Life does not comply with the process required for handling the appeal (i.e., notice of the determination within the established time limits), it will be considered denied under the premise that the insured exhausted the internal appeals 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 the violation exhausts the internal complaint process. 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 referral from a primary care physician to access services from other specialist or subspecialist within the applicable network.

To make sure health insurance benefits are received, the insured should visit a service provider from the MCS Life PPO Network.

Laboratories

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

Contracted Network in the United States

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

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

ELITE	
Deductibles and Maximum Out-of-Pocket (MOOP)	
Annual Deductibles for Medical Benefits	
Individual	N/A
Family	N/A
Maximum Out-of-Pocket (MOOP) Expenses for Medical Benefits	
Individual	$1,600
Family	$3,200
Maximum Out-of-Pocket (MOOP) for Major Medical Expenses	
Individual	$3,000
Family	$6,000
Annual Initial Deductible for Major Medical Expenses	
Individual	$300
Couples	$600
Family	$600
Essential Health Benefits	
Emergency and Urgency Services	
Accident and Trauma	$0
Illness	$50
Urgent Care Centers	$10
Hospitalization	
Partial Hospitalizations	$50
Hospitalization (including mental health)	$50
Skilled Nursing Facility	$0
Surgery Assistance	$0
Ambulatory Services	
General Practitioner	$10
Specialist (including psychiatrists, psychologists, podiatrists, chiropractors (first visit), audiologists, optometrists and nutritionists)	$10
Subspecialist	$15
Home doctors' visits	$15
Ambulatory facility	$25
Diagnostic and Surgical Procedures at the Medical Office	20%
Diagnostic and Surgical Procedures at an Ambulatory facility	20%
Endoscopies	0%
Cervical Cryosurgery	0%
Dialysis and Hemodialysis	0%

Rehabilitation, Habilitation and Durable Medical Equipment Services	
Physical Therapy (including respiratory therapy and chiropractor's manipulations)	$7
Ambulatory Respiratory Therapy	$7
Chiropractor Manipulations	$7
Home Health Care	0%
Durable Medical Equipment (DME)	20%
Internal and External Prosthesis	20%
Orthotic Devices	20%
Implants 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
Psychiatrist	$10
Laboratory and X-rays Services	
Laboratory PPO Network	20%
X-rays	20%
Specialized Test (CT Scan, PET Scan, PET CT, MRI, MRA, SPECT)	20%
Preventive, Wellness and Chronic Disease Management Services	
Preventive Services	0%
Prenatal and Postnatal Care Visits If insured enrolls in the "Programa de Madres y Bebés Saludables" during the first three months of pregnancy.	$8 $0
Genetic Amniocentesis	20%
Amniocentesis (Fetal maturation)	20%
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% Co-payment for hospital applies: $50

Programs Included as Part of Your Benefits	
MCS Alivia	$15
MCS Medilínea MD	$25
Vision Coverage	
Refraction Test (Adults and Children)	$15
One-hundred thirty ($130) dollars 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.
ELITE 79-750096

ELITE 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 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 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-catarrhal, 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. products 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.
Sodium Fluoride	Oral administration for patients of 6 years old or younger.

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

PART IV: Copays and Coinsurances

The following copays or coinsurances apply to **Elite 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	20%

Rhogam Vaccine	20%
Vaccines included in PR Department of Health Vaccines' Program	$0
Maintenance (90 days) thru Flex 90® or Mail Order Generic Brand and new	 $0 $20
Specialty	30%, maximum $250
Biosimilar	$150
Drugs required by federal laws: ***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)***	$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, clorazepate).

    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
Carrollton, TX 750006

- 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 years.
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 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 the **MC-Rx Member Call Center** toll free **1-855-252-2292 / 711 (TTY)**.

Delta Dental of Puerto Rico, Inc.
14 Calle 2 Suite 200
Guaynabo, PR 00968-1735
Tel. (939) 205-3300
Fax. (787) 749-2600

ENDORSEMENT NO. 1

GROUP NO.: 82425 & 82426 WALMART, INC.

It is hereby understood and agreed that effective on January 1st, 2024, the following benefit code under the above reference group, change as follows:

- Covid Fee code (D-1999) – Not covered.

Certified correct, today September 5, 2023.

DELTA DENTAL OF P.R. INC. 2002 CORPORATE SEAL SAN JUAN, PR

Marianne Ortiz
President & CEO

endorsgen/mrc

This Endorsement forms part of the original Policy, which above number is indicated, to which must be permanently attached.

DELTA DENTAL®

Walmart Puerto Rico Dental Plan Summary of Benefits

ELITE 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 39 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 and restorative, major restorative and orthodontic services.

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 Restorations** - Procedures for restoring teeth with amalgam or resin composites 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.
- **Periodontics** - Procedures for treating diseases of the gums and bone supporting the teeth.
- **Palliative** - Emergency services for treating dental pain.

Major Restorative Services

- **Crowns** - Procedures for constructing crowns when teeth have fractures or non-restorative damage, or after an implant.
- **Prosthodontics** - Procedures for constructing fixed bridges, removable bridges, and partial or full dentures; repair of fixed ridges and relining and rebasing of dentures.

Orthodontics Services

- Procedures required for correcting improper alignment of teeth, i.e., procedures performed by a licensed dentist involving the use of an active orthodontic device and a post-treatment retainer for treating misaligned teeth or jaws that significantly interfere with normal function.

Part III: Coinsurance

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 **Elite Coverage**:

Basic Allowances		**Coverage**
Maximum per policy year per covered person (excluding orthodontics).		**$2.000**
Maximum COVID fee per service *__Note__: The insured is responsible for paying the difference in the cost of the service.		**$15**
Diagnostic and Preventive Services		
Service	**Frequency**	**Coinsurance**

* Routine checkups * Emergency examination	Two per policy year Limited to one per 12-month period	**0**%
* 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	**0**%
* 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 three years of age	One per 12-month period	
* Pulp vitality test	One per 6-month period, only for diagnosing emergency conditions	
* Fissure sealant 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 years only, to maintain space of posterior (back) 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 twenty-four months per tooth per surface	**20%**
* Resin (white) restorations, on all teeth	Limited to every 24 months per tooth surface	
* Endodontics: root canal treatment on all 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 all 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	
* Crown repair	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	
* Extractions and oral surgery, including pre- and post-operative care and general anesthesia	Limited to one per tooth per lifetime	
* Extraction 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	

Splint (occlusal guard)	One per 3-year period	
* Outpatient surgical service in hospital	One per 6-month period (Based on clinical determination)	**100%**

Periodontics Includes all the procedures needed for the treatment of diseases of the gums and bone supporting the teeth, including periodontal surgery.		
Service	**Frequency**	**Coinsurance**
* Gingivectomy and gingivoplasty	Limited to one per quadrant per 24-month period	**40%**
* Root planning per quadrant	Limited to four different quadrants 24-month period	
* Periodontal surgery and debridement per quadrant	Limited to four different quadrants per 36-month period	
* Periodontal maintenance	Limited to 2 treatments per year, followed by periodontal surgical treatment	
Special Restorative Services		
Service	**Frequency**	**Coinsurance**
Crowns – Porcelain crowns, porcelain-fused-to-metal crowns or resin-processed-to metal crowns	Covered persons 12 years-old and older are eligible. Coverage will be provided for one crown after a period of five years from the date on which the crown was supplied for the last time.	
* Fixed bridges * Removable bridges * Partial and full dentures * Maryland bridge (fixed bridge)	These services are limited to once per 5-year period.	
Service		**Coverage**
Orthodontic Services: □ Orthodontic appliances (braces) □ Interceptive and corrective treatment □ Retainers □ Habit-breaking appliance		**$1.000** Maximum per covered person per lifetime

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 findadditional 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 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 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: Orthodontics Coverage Limitations

Delta Dental will be responsible of making monthly payments or other periodic payments for an orthodontic treatment plan after the effective date of coverage.

The amount to be paid, as specified in the COVERAGE DESIGN section of the Description of Benefits and Dental Plan Summary, will fully apply to this payment and to subsequent payments. Delta Dental is not responsible of paying more than the selected coinsurance percentage based on the balance of the treatment cost, subject to the orthodontic benefit maximum allowance stipulated herein. For cases of orthodontic treatments that are active when the plan becomes effective, Delta Dental will take into consideration the payment made by the previous plan and will deduct such amount from the maximum per covered person per lifetime.

Delta Dental's obligation to issue monthly payments or other periodic payments for orthodontics will end:

1. When you reach your orthodontic benefit maximum allowance.
2. On the payment due date after loss of eligibility.
3. Upon termination of treatment for any reason before its completion.
4. On the date of termination or expiration of this contract.

Delta Dental will not issue payment for repair or replacement of a damaged, lost, missing, or stolen orthodontic appliance.

The dentist may opt for terminating treatment due to lack of interest or cooperation on the part of the covered person through written notice to Delta Dental and the covered person.

When the services in progress are interrupted and completed later by another dentist, Delta Dental will review the claim in order to calculate payment of the services provided by each dentist.

All payments will be made monthly or with a determined frequency in accordance with customary billing practices for orthodontic treatments, i.e., a down payment and monthly payments for the duration of active treatment.

Delta Dental will issue payment to the dentist or the enrollee, as per the monthly copay percentage. No payment

will be issued for treatments that are in an extension period.

Part IX: 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.**

Limitations on the maximum amounts to be paid during a policy year for other selected benefits shall not apply to orthodontic services, which are subject to a maximum allowance per lifetime as described under the COVERAGE DESIGN Section of the Description of Benefits and Dental Plan Summary.

Part X: 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, with the exception of orthodontics benefit. If the patient began receiving orthodontic services before their plan eligibility date, payments will continue to be received as applicable.

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. 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.

19. Implants and related services (surgery, prosthesis, etc.), except for implant crowns.

20. Orthodontic treatments that are not provided by a licensed dentist according to the laws governing the practice of dentistry.

21. Orthodontic treatments applied by the covered person without the direct involvement of a dentist will not be covered.

22. Orthodontic treatment extensions.

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 XI: 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 twice in a 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. Detailed and extensive oral evaluations 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 (bicuspids and molars), one per lifetime.

10. Space maintainers are limited to children under 14 only, to maintain space in posterior (back) deciduous teeth. They are not covered for anterior (front) 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. Outpatient surgical services are covered every 6 months only when the condition or circumstances do not allow the covered person to receive treatment at a dental office.

14. Splints are limited to one per 3-year period. The construction of occlusal guards (splints) will be covered once per 3-year period.

15. Porcelain crowns, porcelain-fused-to-metal crowns or resin-processed-to metal crowns are covered for dependents over 12 years of age.

16. Temporary crowns will be covered for permanent teeth, limited to one per tooth per lifetime.

17. Coverage will be provided for one regular crown, implant crown, or 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.

18. Prefabricated and cast posts, including cores and any restoration that may be necessary, are limited to one per 5-year period.

19. Root planning per quadrant is limited to four different quadrants per 24-month period.

20. Periodontal surgery per quadrant is limited to four different quadrants per 36-month period.

21. Periodontal maintenance is limited to 2 treatments per year, followed by periodontal surgical treatment.

22. 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. Prosthodontics - If a partial denture made of acrylic and metal is the standard procedure indicated, Delta Dental will award the usual amount for said procedure towards a more complicated precision appliance that may be selected by the covered person or the dentist.

    c. Implants - Delta Dental will award the cost of a standard partial or complete denture towards the cost of implants or appliances constructed in relation to them. Delta Dental will not provide for the surgical removal of implants and will not pay for the replacement of appliances within the subsequent five years.

    d. Complete dentures - This benefit will not be greater than that of a complete upper and complete lower denture for the period the policy is in effect. This also applies to any subsequent renewal by a patient in any 5-year period.

    e. Partial dentures, fixed bridges or removable bridges are excluded from the benefits under this contract for any covered person more than once in a 5-year period, except when the loss of additional teeth requires the construction of a new appliance.

    f. Relining and rebasing are benefits allowed in any 3-year period for any patient.

    g. The 5-year period will be counted from the date in which the prosthetic appliance was supplied for the last time under the policy, after any subsequent renewal of said policy or of any other Delta dental contract.

Part XII: 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.

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.**