Member**Handbook**

Commercial**Accounts**

CALVO'S Select Care HEALTH PLANS

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Welcome to Calvo's SelectCare!

We would like to welcome you and your family as members of the Calvo's SelectCare Health Plans. This Handbook is designed to provide general information about the Calvo's SelectCare Plans that are offered to you through your employer.

We encourage you to read this Handbook and its enclosures to better understand your plan, its benefits, and the participating medical providers that you may access.

Enclosed with this Handbook is a Schedule of Benefits, a Participating Provider Directory, a Drug Formulary & Specialty Drug List and Member ID Cards.

The Schedule of Benefits is a listing of your plan's coverage benefits, co-payments, co-insurances, and deductibles. Medical services and conditions not listed on your Schedule of Benefits are NOT covered.

The Participating Provider Directory is a listing of Participating Providers to which you have access. The Drug Formulary & Specialty Drug List is a listing of preferred drugs covered by the plan; Specialty Drugs are medications used to treat complex and rare conditions. The information contained in this publication may change from time to time. We, therefore, encourage you to call our office for a current listing should the need arise.

This Handbook and any enclosures are for informational purposes only. For a full detailed description of your specific plan, its benefits, exclusions, terms, limitations and procedures, please refer to the Group Contract/Policy issued to your employer.

Please feel free to contact our Calvo's SelectCare Office on Guam should you have any questions. For your convenience, we have provided contact information and our office locations on the back cover of this booklet.

Member's Rights and Responsibilities

As a member of the Calvo's SelectCare Plans you have the following rights:

Information

- Know the names and qualifications of health care professionals involved in your medical treatment.
- Get updated information about the services covered and any limitations or exclusions.
- Know how your plan decides what services are covered.
- Get information about copayments and fees that you must pay.
- Get updated information about providers that participate in the plan.
- Get information on how to file a complaint or appeal with the plan.
- Know how the plan pays for services to in-network and out-of-network health care professionals.
- Receive information from health care professionals about your medications, how to take them, and possible side effects.
- Receive information from health care professionals about any proposed treatment or procedure, as you may need in order to consent to or refuse a course of treatment. Except during an emergency, this information should include a description of the proposed procedure or treatment, the potential risks and benefits involved, any alternate course of treatment (even if not covered) or non-treatment and the risks involved in each, and the name of the health care professional who will carry out the procedure or treatment.
- Be informed by participating health care professionals about continuing health care requirements after you are discharged from inpatient or outpatient facilities.
- Be informed if a health care professional plans to use an experimental treatment or procedure in your care. You have the right to refuse to participate in research projects.
- Receive an explanation about non-covered services.
- Receive a prompt reply when you ask the plan questions or request information.
- Receive a copy of the plan's Member Rights and Responsibilities Statement.

Access to care

- Obtain primary and preventive care from the primary care physician you chose from the plan's network.
- Change your primary care physician to another available primary care physician who participates in the plan.
- Get necessary care from participating network specialists, hospitals and other health care professionals.
- Get referrals to participating network specialists who are experienced in treating your chronic illness.
- Be advised by your health care professionals on how to schedule appointments and get health care during and after office hours. This includes continuity of care.
- Be told how to get in touch with your primary care physician or a back-up physician 24 hours a day, every day.
- Call 911 (or any available emergency response service) or go to the nearest emergency facility when you have a medical condition with acute symptoms that are severe enough that a prudent layperson, who has average knowledge of health and medicine, could reasonably expect the lack of immediate medical attention to result in serious danger to the person's health.
- Receive urgently needed medically necessary care.

The freedom to make decisions

- Use these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, genetic information, or source of payment for your care.
- Have any person who has legal responsibility to make medical care decisions for you make use of these rights on your behalf.
- Refuse treatment or leave a medical facility, even against the advice of doctors (providing you accept responsibility and the consequences of the decision).
- Complete an Advance Directive, Living Will or other directive and give it to your health care professionals.
- Know that you or your health care professional cannot be punished for filing a complaint or appeal.

As member of the Calvo's SelectCare HMO or PPO Plans you have the following responsibilities:

Member responsibilities

- To provide complete and accurate information to the best of your ability about your health, medications (including over-the-counter products and dietary supplements), and any allergies and sensitivities.
- Agree to follow the treatment plan prescribed by your provider and to participate in your care.
- Inform the provider about any living will, medical power of attorney, or other directive that could affect your care.
- Accept personal financial responsibility for any charges not covered by insurance, if applicable.
- Treat all health care providers, staff, and others respectfully.
- Know that you or your health care professional cannot be punished for filing a complaint or appeal.

Health Care Terms & Definitions

This section defines some terms used frequently in this Handbook to describe your coverage.

Agreement is the group contract between your employer and Calvo's SelectCare.

Benefits are the medically necessary services covered by your health plan and paid in part or in full by Calvo's SelectCare.

Centers of Excellence are the selected outstanding off-island hospitals, which have agreed to provide services at reduced rates to Calvo's SelectCare members.

Contract Year or Plan Year is normally a twelve-month period of your insurance coverage.

COBRA is an acronym for the Consolidated Budget Reconciliation Act of 1986 and as amended by HIPAA in 1996.

Co-Insurance is the percentage of covered services that must be shared by a covered person as specifically set forth in the Schedule of Benefits. Co-insurance is expressed as a percentage rather than as a dollar amount.

Co-Payment is the amount of covered medical expenses that must be shared by a covered person at the time of service as specifically set forth in the Schedule of Benefits. Co-payments are expressed as dollar amounts rather than percentages.

Coordination of Benefits is a provision in the plan that allows for the coordination of payments for covered medical services when a member is covered under more than one plan. Benefits paid by all plans will be limited to 100% of the covered charges for covered medical services. More information is contained in the "General Information" section of this Handbook.

Coverage Maximum is the maximum amount that the plan will pay for all covered expenses. This includes any defined Benefit Maximum as indicated on your plan's Schedule of Benefits.

Covered Dependent shall be defined as a Dependent eligible to receive benefits under the terms of this Plan.

Deductible is the amount of covered medical expenses that a member must first incur and pay before the plan pays for any covered medical expenses as set forth in the Schedule of Benefits.

Doctor / Physician is a properly licensed doctor of medicine (M.D.), osteopath (D.O.), podiatrist (D.P.M.), dentist (D.D.S. or D.M.D.), psychiatrist, psychologist (Ph.D.), or chiropractor (D.C.).

Drug Formulary & Specialty Drug List is a list of preferred drugs covered by the plan. The Drug Formulary & Specialty Drug List is a separate publication included with this Handbook.

Eligible Charge shall be defined as the portion of charges made to a Covered Person for Covered Services rendered which are payable to the Provider under this Agreement. For a Participating Provider, the Eligible Charges shall be the reimbursement amounts agreed to between Calvo's SelectCare and the Participating Provider.

For a Non-Participating Provider, the Eligible Charges for covered medical services is the Usual, Customary and Reasonable (UCR) charge which shall be limited to the lesser of (a) the actual charge made by the provider, or (b) in the United States, the Medicare Participating Provider fees in the geographic area where the Service was rendered; or (c) in Asia, the fees most recently contracted by the Company at the St. Luke's Medical Center in Manila, Philippines, or (d) elsewhere, the Medicare National Standard Fee.

For a Non-Participating Provider, the Eligible Charges for covered dental services shall be the lesser of (a) the actual charges made by the provider or (b) the usual customary and reasonable charge, as determined by the Company, for the dental Service in the geographic region in which that Service was rendered.

Emergency in general, shall be defined as an accidental injury or an acute or serious medical condition of sudden or unexpected onset requiring immediate medical attention because any delay in treatment, in the opinion of the Physician, would seriously impair future treatment or result in permanent disability, a serious worsening of the condition, or irreparable harm to the Covered Person's health or endanger his or her life. Examples of Emergencies include, but are not limited to heart attack, severe hemorrhaging, loss of consciousness, convulsions and loss of respiration.

H.I.P.A.A. shall be defined as the Health Insurance Portability and Accountability Act of 1996, as amended including amendments by PPACA, all provisions codified at 42 U.S.C. §300gg, and the regulations promulgated thereunder.

Member or Covered Person is an individual or dependent that has or is enrolled in the plan according to the eligibility criteria set forth by the agreement between their employer and Calvo's SelectCare.

Medically Necessary shall mean services or supplies which, under the provisions of this Agreement, are determined to be:

- appropriate and necessary for the symptoms, diagnosis or treatment of the injury or illness or dental condition;
- provided for the diagnosis or direct care and treatment of the injury or illness or dental condition;
- within standards of good medical or dental practice within the organized medical or dental community;
- not primarily for the convenience of the Covered Person or of any Provider providing Covered Services to the Covered Person;
- an appropriate supply or level of service needed to provide safe and adequate care;
- within the scope of the medical or dental specialty, education and training of the Provider;
- provided in a setting consistent with the required level of care; or
- Preventative Services as provided in the Plan.

Non-Participating Providers shall be defined as Providers who are NOT contracted by Calvo's SelectCare to provide medical or dental services to Covered Persons.

Open Enrollment Period is the annual period when you may join, cancel or adjust your coverage with Calvo's SelectCare. The date may vary and is set by your employer and Calvo's SelectCare.

Out-of-Pocket Maximum shall be defined as the total maximum of any Eligible Charges paid, or payable as defined by a payment schedule or arrangement by a Covered Person to a Participating Provider to satisfy any applicable Deductible, Co-Payment, and/or Co-Insurance specified in this Agreement before the Plan will begin to pay Covered Services at one hundred percent (100%) for the remainder of the Plan Year, subject to the maximum amounts provided in the Plan as set forth in the Schedule of Benefits.

Participating Providers are doctors, dentists, labs, pharmacies, hospitals, clinics and other allied medical providers, which have a contract with Calvo's SelectCare to provide covered services to covered members at negotiated rates.

PPACA shall be defined as the Patient Protection and Affordable Care Act.

Pre-certification is a process by which a medical provider obtains prior approval or authorization from the plan for off-island care, to perform certain treatment plans or provide covered services such as diagnostic testing, home health care, physical therapy, the procurement of durable medical equipment, Brand Name drugs not listed on the Drug Formulary or Specialty Drug List. More information is contained in the "General Information" section of this Handbook.

Premium shall be defined as the dollar amount paid to Calvo's SelectCare for the provision of this Plan to Covered Persons, including any contributions required from the Covered Persons.

Premium Period is the length of time covered by the periodic premium payments.

Q.M.C.S.O. is an acronym for a Qualified Medical Child Support Order. For more information, please refer to the "Summary of Federally Mandated Programs" section of this Handbook.

Referral is a formal recommendation by your doctor or physician for you to receive services from a specialist, consultant, or off-island facility.

Service Area is the geographic region in which your plan was purchased which may include either Guam, or The Commonwealth of the Northern Marianas.

Specialty Drugs are a high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of the patient's drug therapy. Most Specialty Drugs are used to treat chronic diseases. Specialty Drugs are identified on the Drug Formulary & Specialty Drug List provided. Please refer to "Specialty Drugs" section under "Outpatient Medical Benefits" for details of the Specialty Drug benefit under your plan.

U.C.R. is the "Usual, Customary and Reasonable" charge for services or supplies. Please refer to "Eligible Charge" above.

USPSTF is the acronym for United States Preventive Services Task Force.

W.H.C.R.A. is an acronym for the Women's Health and Cancer Rights Act of 1998. For more information, please refer to the "Summary of Federally Mandated Programs" section of this Handbook.

Becoming a Member

Eligibility Information

In order to enroll in a Calvo's SelectCare health plan, you and your dependents must first meet the eligibility requirements defined in the Agreement between Calvo's SelectCare and your employer.

You must complete an Enrollment Application and submit it with any other required documentation during an Open Enrollment period or within 30 days from the date you first become eligible for enrollment under the plan.

Subscriber Eligibility Requirements

- You must maintain legal residency in the Service Area. Calvo's SelectCare members must not be absent from the Service Area for more than 90 consecutive days.
- You must be working at least 30 hours or more per week.

Dependent Eligibility Requirements

Aside from meeting the eligibility requirements set forth by your employer, family members are eligible for coverage as dependents provided they are:

- Your legal spouse.
- Your domestic partner (subject to Employer approval):
  - A domestic partner must be at least 18 years of age and must have lived with you for two consecutive years. A notarized affidavit is required.
  - A domestic partner may only be added during your employer's Open Enrollment Period or within 30 days from the date you first become eligible to enroll in the plan.
  - Children of a domestic partner, who are not your own children, are not eligible for coverage.
- Married or unmarried dependent children under the age of 26 years.
- Off-island Dependent children or children who reside outside the Service area who are between the ages of 19 thru 25 years may be eligible provided your dependent child is a full-time student physically attending an educational institution of higher learning.
  - A student verification letter from the registrar's office verifying the status of a full-time student must be submitted every beginning of the Fall and Spring semester or quarter. Failure to regularly submit the student verification letter will result in the automatic termination of coverage for such dependent. Consequently, you would have to wait to enroll your dependent until your employer's next Open Enrollment Period.
  - Coverage for off-island full-time students will terminate upon reaching the age of 26 years.
- For natural children with a different last name from your own, you must provide the following:
  - A copy of the birth certificate which verifies you as a parent, or
  - A notarized government Paternity Form which verifies you as a natural parent.
- For other dependents such as stepchildren, legally adopted children, and children you have been awarded legal guardianship, you must provide the following:
  - Birth Certificate.
  - Parents' marriage certificate (when required).
  - Legal Guardianship must be for "Full Guardianship" and not limited or shared. A copy of the guardian's latest income tax filing or an affidavit stating that the dependent will be included in the guardian's next tax filing.
  - Court documentation signed by a judge ordering adoption or legal guardianship.
  - Legal guardianship terminates at the age of 18 and dependents under this relationship will no longer be eligible for coverage under the plan.
  - Unborn children awarded for legal guardianship are not eligible for coverage.
- Your disabled dependent child who is beyond the limiting age may continue to be eligible provided they are incapable of self-sustaining employment due to mental retardation or physical disability.
  - Proof of total disability from a licensed medical physician is required upon enrollment.
  - Proof of dependence, such as a copy of the subscriber's tax filing may be required.
- Q.M.C.S.O. or a copy of the qualified medical child support order must be provided. Children permanently residing outside the service area are only eligible to enroll in the plan if they qualify under the Q.M.C.S.O.

Enrollment Period

You may elect to enroll on any of these occasions:

- Initial Employment. You may enroll within 30 days from the date you first become eligible to enroll in the plan.
- Annual Open Enrollment Period designated by your employer.
- Special Enrollment Periods: Full-time employees and their eligible dependent(s) may enroll outside of open enrollment as a result of a Qualifying Event as defined by H.I.P.A.A. Under H.I.P.A.A. a Qualifying Event is an event that causes you to lose coverage in another health plan due to:
  - Termination of spouse's coverage or death of your spouse.
  - Divorce, Annulment or Legal Separation from your spouse.
  - Medicare or Medicaid eligibility ends.

A Special Enrollment opportunity also occurs if you acquire a new dependent through:

- Birth or Adoption.
- Marriage.

Enrollment Applications or Change of Status (COS) Forms and any required documents must be submitted within 30 days following a Qualifying Event. If you have lost coverage in another health plan due to a Qualifying Event, you are also required to submit a H.I.P.A.A. Certificate of Creditable Coverage from your previous plan. Your previous plan is required to issue a H.I.P.A.A. Certificate to you in a timely manner.

Your coverage will begin on the first day of the first Premium Period following receipt of your Enrollment Application by Calvo's SelectCare.

For more information, please refer to the "Summary of Federally Mandated Programs" section of this Handbook.

Adding Dependents and Changes to your Coverage

You are able to enroll your new dependent(s), if you get married, adopt a child or have a newborn baby as long as they meet the eligibility requirements. Coverage begins on the first day of a Premium Period, however, coverage for newborn dependents begins at birth, and coverage for adopted dependents begins on the actual date of custody of the dependent.

If you do not enroll your dependents within the 30 day period from when they first become eligible, you would have wait to enroll them during your employer's next Open Enrollment Period.

To add dependents, you, as the subscriber must notify Calvo's SelectCare in the following manner:

- Complete a "Change of Status" Form (COS),
- Submit all Required Documentation as outlined above,
- Make your request within 30 days of your dependent first becoming eligible.

Updating Your Information

Your Enrollment Application contains pertinent information. This information is very important because it identifies you and your dependent(s) as eligible members. Please inform our Customer Service Department immediately of any error on your Member ID Card or any changes in name, address, phone numbers or email address.

Obtaining Care

You and your enrolled dependents may receive care and services from any of the participating medical, dental or pharmacy providers appearing in the most updated Participating Provider Directory.

Once properly enrolled, Calvo's SelectCare will issue Member ID Cards for you and your eligible dependent(s) under the plan. We recommend that you carry your Member ID Card with you and present it to your health care provider to verify your coverage.

Participating Providers

For your convenience, Calvo's SelectCare has contracted with medical providers in Guam, The CNMI, Hawaii, the Continental United States and the Philippines to provide you with convenient access to quality medical care.

Please refer to your Schedule of Benefits and the Participating Provider Directory to determine which off-island providers apply to your plan. Because Participating Providers may change from time to time, we encourage you to call any Calvo's SelectCare Office for a more current listing should the need arise.

When visiting your doctor, arrive promptly for appointments and remember to call in advance if you must cancel. The plan does not pay for any fees or charges for any missed appointments.

Non-Participating Providers

Expect to pay more for services that you obtain through Non-Participating Providers. Refer to "Your Payment Responsibilities" section of this Handbook for a more detailed explanation.

Pharmacy

Calvo's SelectCare has contracted with a national Prescription Benefit Manager (P.B.M.). The local participating pharmacy providers work with our P.B.M. to dispense prescribed drugs and help manage the prescription drug benefits and Drug Formulary offered under your plan. The Drug Formulary is subject to change throughout the year.

For more information regarding the drug benefit under your plan, refer to your "Schedule of Benefit" section of this Handbook

Emergencies

Calvo's SelectCare covers emergency medical services provided by either Participating Providers or Non-Participating Providers. Although the Co-Payment/Co-Insurance amount indicated on the Schedule of Benefits is the same for Participating and Non-Participating Providers, the actual amount you may be responsible for may differ. Please see "Important Information on Non-Participating Providers" for more details.

Emergencies incurred at non participating providers will be covered as if the emergency services were provided through a participating provider and the cost-sharing component of the charged fee may not exceed the cost-sharing component of the fee or payment if the care was obtained in-network. However, out-of-network providers may "balance bill" the patient for the difference between the provider's charges and what has been paid by the plan and the patient in the form of a co-payment or coinsurance.

You must notify us within 48 hours of the initial service at an Emergency Room.

EXAMPLE:

Emergency Bill from Non-Participating Provider: $20,000
Eligible charges based on similar situated Participating Provider: $10,000
Plan pays as follows:

- $10,000 (Eligible charges as stated above)
- Minus applicable deductible (i.e. $2,000)
- Minus coinsurance: 20% or $1,600
- **Total plan payment: $6,400**

Your responsibility: $13,600, which includes the deductible, coinsurance, and the excess over the eligible charges as illustrated. ***The above numbers are hypothetical and for illustration purposes only.***

Non-Emergency Services – when offered by the plan

During a medical emergency, please seek proper care. However, before seeking emergency care, you need to be reasonably assured that you have an emergency condition. If you receive emergency care for an injury or illness which does not qualify as a true medical emergency, your treatment MAY NOT BE COVERED. Please check your Schedule of Benefits to determine the level of Non-Emergency coverage you have under your plan.

Your Payment Responsibilities

Premium
The periodic premium due for you and your dependents is normally handled by your employer through their payroll system. Please check with your employer for details on the employer premium contributions they may pay on your behalf.

Under certain circumstances, as when you are on "Leave Without Pay", you are responsible for making the periodic premium payments directly to Calvo's SelectCare. These payments must include both your employer's share and your share, if any. You must make payments to us within 15 days from the start of your leave period otherwise, you will be terminated and will not be allowed to enroll back into the plan until the next Open Enrollment Period.

Deductible
For charges within your deductible (or if a Co-Insurance percentage applies), a Participating Provider should only charge you the amount they have negotiated with Calvo's SelectCare, and they should refund you any amount in excess of the negotiated amount. Excess Charges above the negotiated amount will not accumulate towards meeting the deductible and/or the out of pocket maximum.

Aside from any applicable deductibles, a provider may occasionally prefer that you pay charges in full for care at the time you receive it. Calvo's SelectCare will reimburse you for such expense less any applicable co-payment, co-insurance, and excess provider charges.

You must submit Deductible and Reimbursement items within 90 days from the date of service otherwise these expenses will NOT be covered or applied towards meeting your Deductible. If you have paid any amount as part of a Deductible or any amount which will require a reimbursement, please submit a completed Deductible/Reimbursement Claim Form and all required information and documentation within 90 days. Please refer to the section of this Handbook regarding "Completing Your Deductible / Reimbursement Claim Form" for the listings of required information and documentation.

Important Information on Non-Participating Providers
Your plan has a deductible for services rendered by Participating Providers, and a separate deductible for services rendered by Non-Participating Providers. You will have to meet the applicable deductible specifically for Non-Participating Providers before the plan pays for any eligible charges. You are responsible for obtaining and providing to us any and all necessary information to process a claim for all services received at non-participating providers within 90 days from date of service.

The coverage provided by the Plan for Non-participating Providers is normally much less than the coverage provided for Participating Providers. This is because the Eligible Charges are based on the amount that Medicare reimburses its participating providers in the geographical area where the services are rendered, and are not based on the actual charges. Actual charges from a Non-Participating Provider are normally significantly higher than Medicare rates and the plan will not pay for these differences.

EXAMPLE:
Bill from Non-participating Provider: $30,000
Eligible charges based on Medicare's participating provider: $15,000
Plan pays as follows:
- $15,000 (Eligible charges as stated above)
- Minus applicable deductible or $4,000
- Net allowable $11,000
- Minus co-insurance 50% or $5,500
- **Total Plan Payment: $5,500**

Your total responsibility: $24,500 that includes the deductible, co-insurance, and the excess **over the eligible charges** as illustrated. ***The above numbers are hypothetical and for illustration purposes only.***

Co-Payments & Co-Insurances
After any applicable deductible is met, a Participating Provider should only collect the applicable co-payment or co-insurance from you and will bill Calvo's SelectCare for the remaining amount. Please refer to your Schedule of Benefits for the co-payment and co-insurance amounts for each specific benefit.

Non-covered and Non-approved Services
You are responsible for payments if you choose to receive services:

- Which are not listed on the attached Schedule of Benefits; or
- If they are specifically excluded on the Schedule of Benefits, this Handbook or the policy; or
- Services which were not approved through the plan's Pre-certification process when prior authorization is required.

Out-of-Pocket Maximum
A limit is placed on the maximum amount of co-payments and co-insurance that you are required to pay during a contract or plan year. If you are enrolled as an individual, you must meet the individual out-of-pocket maximum. If you are enrolled as a family, the entire family must meet the out-of-pocket maximum. Once the out-of-pocket maximum is met, the plan will pay 100% for covered services.

Refer to your plan's Schedule of Benefits for the annual out-of-pocket maximums required under your specific plan.

The out-of-pocket maximums do not apply to Non-Participating Providers.

Coverage Maximum
Refer to your plan's Schedule of Benefits for the maximum amount that Calvo's SelectCare will pay for all covered expenses within any given plan or contract year. Certain Benefits have maximum limits as to what Calvo's SelectCare will pay for the plan year; you are responsible for amounts in excess of such limits.

Hospital Inpatient Medical Benefits

This section includes an explanation of key benefits received while hospitalized. Co-payments and Co-insurance percentages are listed on your plan's Schedule of Benefits enclosed with this Handbook.

Hospitalization and Inpatient Benefits
Medically necessary hospital services are covered, including: semi-private room and board, intensive care, isolation, operating and recovery rooms, labor and delivery rooms, laboratory, diagnostic and therapeutic services, radiology, nuclear medicine, medications and pharmacy, inhalation therapy, acute dialysis, EKG, EEG, EMG, anesthesia supplies, professional charges by the hospital pathologist or radiologist, coordinated discharge planning and other miscellaneous charges for medically necessary care and treatment.

Blood & Blood Derivatives
Blood and blood derivatives are NOT covered. Only the cost of administration of blood, blood and blood derivatives are covered.

Breast Reconstructive Surgery
Breast reconstructive surgery is covered in accordance with the 1998 Women's Health and Cancer Rights Act (W.H.C.R.A.). For more information regarding W.H.C.R.A., please refer to the "Summary of Federally Mandated Programs" section of this Handbook.

Hospital Inpatient Medical Benefits (continued)

Chronic Orthopedic Conditions
Medical and surgical treatment for chronic orthopedic deformities or conditions is covered. As indicated on your Schedule of Benefits, there is an annual limit on the amount your plan will pay towards this benefit; any amounts in excess of this annual limit will be your responsibility.

Physician Care
The plan covers medically necessary services provided by physicians, surgeons, assistant surgeons, anesthesiologists, and any other specialty required to provide the appropriate level of medical care while you are hospitalized.

Inpatient Rehabilitation Care
Calvo's SelectCare covers concentrated and coordinated short-term inpatient rehabilitation programs by health care professionals to improve a patient's ability to function independently.

Maternity Care
Complete inpatient hospital benefits as previously described, including delivery by cesarean section, miscarriage, and any complications of pregnancy or childbirth are covered.

Newborn Care
Post-natal hospital services for newborns are covered if a Change of Status Form (COS) adding the newborn is submitted to Calvo's SelectCare within 30 days from the date of birth. Circumcisions provided within 30 days from the date of birth are also covered.

Oral Surgery
Oral surgical procedures are covered when approved by Calvo's SelectCare in connection with the stabilization and emergency treatment within 48 hours of an acute accidental injury to sound natural teeth, jaw bone, or surrounding tissues, and correction of physiological conditions of a non-dental origin, including cleft lip and cleft palate, which have resulted in severe functional impairment.

Skilled Nursing Care
Inpatient skilled nursing care is covered when medically necessary and provided by a Participating Provider facility.

Airfare Benefit
Not all plans cover the Airfare Benefit; please refer to your Schedule of Benefits to determine if coverage applies. The Airfare Benefit applies when you have a catastrophic illness which requires a Qualified Medical Treatment or Procedures that are not available in your Service Area, and if you have been enrolled in the plan for at least 4 months.

The plan will only pay charges under this benefit if the proposed service is performed at a Center of Excellence AND meets one of the following Qualifying Conditions/Procedures: Open-heart surgery, Oncology Surgery, Aneurysmectomy, Pneumonectomy, Intra Cranial Surgery, Acute Leukemia, Gamma Knife Surgery or if the level of care is NICU Level III.

When approved in advance by Calvo's SelectCare, the Airfare Benefit covers only the economy round-trip airfare for you, a medical attendant and a companion, if required.

The airlines that service Guam may offer medical referral rates. If you qualify for the Airfare Benefit, Calvo's SelectCare will only pay or reimburse members for the actual cost of the fare or the lowest medical economy fare, whichever is lower. All airline penalties are excluded.

A list of Centers of Excellence can be found in your Participating Provider Directory.

The plan does not pay any Airfare Benefit purely for diagnostic procedures or to confirm or rule out the diagnosis of another Physician.

Outpatient Medical Benefits

The following benefits are available on an outpatient basis when provided through a Participating Provider or approved through the plan's Pre-certification process.
Refer to your enclosed Schedule of Benefits for the Co-payments or Co-insurance applicable to the specific benefits below.

Ambulance
Ground ambulance transportation is covered when medically necessary. Emergency ambulance services are covered under the Emergency Benefit. Non-emergency ambulance services are not covered. Air Ambulance transportation is not covered.

Chemotherapy Benefit
The plan covers medically necessary services, including physician fees, chemotherapy medication and chemotherapy administration.

Diagnostic X-Rays & Lab Tests
Outpatient diagnostic laboratory and therapeutic radiological services in support of basic health care services to be used in the screening or detection of disease and determined to be medically necessary are covered.

Diagnostic Testing
MRI, CT scans and other diagnostic procedures must be approved through the plan's Pre-certification process.

Durable Medical Equipment (DME)
Durable medical equipment coverage is limited to the lesser amount between the purchase or rental of crutches, walkers, standard wheelchairs, standard hospital beds, suction machines, and portable oxygen tank, refills and accessories when prescribed by a physician. Members are responsible for any required deposits. Disposable supplies are not covered.

Eye Care
Medical and surgical treatments of the eye are covered when medically necessary. Annual refraction exams to determine the health of your eyes and the possible need for vision correction, and corrective lenses are NOT covered unless specifically indicated on your plan's Schedule of Benefits.

Family Planning
Contraceptive coverage:

- Depo-Provera: The medication and injection are covered.
- Vasectomy & Tubal Ligations are covered

Health Improvement / Wellness
Calvo's SelectCare may offer coverage for health improvement programs designed to help members manage their lifestyle and health risks.

Home Health Care
Home health care services are covered provided:

- It is medically necessary, and
- Services are provided by a Participating Provider, and
- It is approved by the plan through the plan's Pre-certification process.

Home health care supplies (over-the-counter medications and medical supplies) are not covered.

Immunizations (Routine)
Charges incurred in connection with immunizations in accordance with the guidelines recommended by the United States Preventive Services Task Force.

Maternity Care
Pre-natal care, delivery and post-natal care up to six weeks as rendered by a Participating Provider are covered to include the non-spouse dependant. Procedures intended solely for sex determination of an unborn child are not covered.

Outpatient Medical Benefits (continued)

Mental/Behavioral Health
Outpatient mental and behavioral health and substance abuse services are covered. The visits may be for mental health or substance abuse or any combination as needed.

Outpatient Surgery
The services of a short stay, day care or other similar outpatient surgery facility are covered when provided as a substitute for inpatient care and performed at a Participating Provider's outpatient surgery department or ambulatory surgical center.

Preventive Services
Coverage for preventive services is provided by the Plan in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations and is limited to those services with a recommendation grade of A or B only. For additional information on the guidelines, you may access the USPSTF website at: www.uspreventiveservicestaskforce.org/recommendations.

Preventive Services in accordance with the above guidelines are covered without having to meet your required deductibles and without paying Co-Payments when the service is obtained through our Participating Providers.

Physical examinations required for obtaining or continuing any employment, insurance, schooling or licensing are excluded from this benefit.

Prescription Drugs
The enclosed Drug Formulary & Specialty Drug List are the preferred drugs covered by the plan. The Formulary indicates which are "Generic" Drugs and which are "Brand" Name Drugs. Brand name drugs not listed on the Drug Formulary and not on the Specialty Drug List are "Non-Formulary" Drugs. "Mail Order" is a process where you are able to receive up to a 90 day supply of your maintenance prescription drugs through the mail. Different Co-Payments apply for each type of drug; please check your Schedule of Benefits for the applicable Co-Payments. Not all plans provide coverage for Non-Formulary drugs.

Except for Mail Order, a prescription unit is a 30-day supply or 100-unit supply, whichever is less; or one commercially prepared unit (e.g. one vial of insulin, one inhaler, one vial of ophthalmic medication or one tube of ointment).

Drugs available over-the-counter or for which there is an over-the-counter substitute available are not covered even if prescribed by a physician.

Insulin, syringes and blood glucose test strips are covered. Urine glucose test strips and lancets are not covered.

Specialty Drugs
Specialty Drugs are high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of the patient's drug therapy. Most Specialty Drugs are used to treat chronic diseases. Specialty Drugs are identified on the Drug Formulary & Specialty Drug List accompanying this Member Handbook.

Specialty Drugs require prior approval from the plan. In some cases, we may need to make special arrangements with a supplier.

Please check your Schedule of Benefits for the Co-Insurance or Co-Payments associated with Specialty Drugs.

Radiation Therapy
Therapy that uses high-energy radiation to shrink tumors and kill cancer cells. X-rays, gamma rays, and charged particles are types of radiation used for cancer treatment.

The radiation may be delivered by a machine outside the body (external-beam radiation therapy), or it may come from radioactive material placed in the body near cancer cells (internal radiation therapy, also called brachytherapy).

Prosthetics & Implants
Prosthetics are artificial device extensions that replace a missing body part designed to replace all or part of a permanently inoperative or malfunctioning body part. Examples of internal prosthetics are joint replacements and pacemakers. Examples of external prosthetics are limbs and terminal devices.

Implants are devices placed under the human skin which may be subdermal or transdermal.

Prosthetic devices and Implants require prior approval from the plan.

Outpatient Rehabilitation Services
Rehabilitation services are covered on a short-term basis only. Services required after 90 consecutive days of a rehabilitation period are not covered. Inpatient rehabilitation services are covered under the Hospital Benefit.

Specialist Care
Care provided by a Participating Provider who is a specialist or consultant is covered.

Well-Baby Care
Preventive health services are covered up to age 2 in accordance with the guidelines established by the U.S Department of Health and Human Services.

General Information

Pre-certification Process
Pre-certification is a process by which a medical provider obtains prior approval or authorization from the plan to perform certain treatment plans or provide covered services such as diagnostic testing, home health care, physical therapy, the procurement of durable medical equipment, Non-Formulary Drugs or Specialty Drugs.

Pre-certification is also the process of collecting information prior to certain inpatient admissions. The process permits advance eligibility verification, determination of coverage and communication with the physician and/or member. Pre-certification becomes more important when a member is traveling off-island by coordinating and streamlining the process to prevent any inconvenient delay of care to such member. In some instances, Pre-certification is used to inform physicians, members and other health care providers about cost-effective programs and alternative therapies and treatments.

Certain health care services require Pre-certification to ensure coverage for those benefits. When a member is to obtain such services through a local Participating Provider, this provider should pre-certify those services prior to treatment.

If your plan provides coverage for Non-Participating Providers and you elect to receive services from such a provider, it is your responsibility to contact Calvo's SelectCare to assure those services which require Pre-certification are approved.

Pre-certification approvals are only valid for 30 days from date of approval, if services are not completed within the 30 days, then the approved Pre-certification will be null and void.

Off-Island Care
Please refer to the "Off-Island Care" section in this Handbook.

Explanation of Benefits (EOB)
After a medical service is rendered to you, whether by a physician, clinic, lab, or hospital, a claim is submitted to Calvo's SelectCare for payment. An EOB will be mailed to you only if:

- You owe money beyond your normal co-payment, co-insurance or deductible,
- Additional information is required from you or your provider regarding the treatment from an accident,

- The treatment or service is excluded under your plan, or
- The limitations on specific benefits have been exhausted.

The amount stated on the EOB under "Employee's Responsibility" is the dollar-amount that you owe. The EOB will also state in boldface, "THIS IS NOT A BILL". You can expect to be billed that amount by your provider, or you might have already paid this portion of the bill at the time of treatment. It's good practice to compare their bill with the EOB to make sure that the amounts due agree.

Coordination of Benefits

You must tell us if you or a covered family member has coverage under another health plan. This is called "dual coverage". When you have dual coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other health plans, determine which coverage is primary according to the U.S. National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the full benefits for which you are covered. When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

Medicare

Medicare is a U.S. health insurance program for:

- People 65 years of age or older.
- Some people with disabilities under age 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in U.S. Medicare covered employment, you should be able to qualify for premium-free Part A insurance. Otherwise, if you are age 65 or older, you may be able to buy it.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your monthly retirement check.
- Part C ("Medicare+Choice" now known as "Medicare Advantage"). The 1997 Balanced Budget Act expanded the types of private health care plans that may offer Medicare benefits to include medical savings accounts, managed care plans, and private fee-for-service plans. The new Medicare Part C programs are in addition to the fee-for-service options available under Medicare Parts A and B. The availability of Part C on Guam and the C.N.M.I. is limited.
- Part D (Prescription Drug Coverage). Medicare offers a prescription drug benefit. You can enroll in Part D only if you are enrolled in Part A or Part B. Those who wish to enroll in a Medicare Part D program must choose from a large list of approved drug plans. It is recommended that you contact the Guam Medicare Assistance Program under the Department of Public Health and Social Services at 735-7388 or Medicare directly at 1-800-633-4227 for information and enrollment assistance.

When Medicare benefits are your primary coverage, they will take the place of Calvo's SelectCare benefits. Benefits allowed by Calvo's SelectCare will be reduced by an amount equal to the amount paid by Medicare.

You must enroll in any Medicare program if it is available to you at no cost. Your Calvo's SelectCare plan benefits will be reduced by the amount that Medicare would have paid, even if you are not enrolled. If you have questions regarding the plan's coordination with Medicare benefits, contact our Customer Service Department.

Third-Party Liability

If you or any covered dependent are injured by the actions of another person (a third party), and receive compensation for your medical services, you will be required to reimburse Calvo's SelectCare for the medical services we paid to treat your injury up to the amount of such compensation.

In such cases, you will be asked to complete the appropriate forms to assist in the recovery of expenses from the third party and their insurer. Calvo's SelectCare members are asked not to settle any claim or release any person from liability without the written consent of Calvo's SelectCare. Should you compromise your claim without recognizing Calvo's SelectCare's claim for reimbursement, Calvo's SelectCare has the right to initiate legal action against you to recover its claim.

Workers Compensation

If you are receiving benefits as a result of Workers' Compensation, Calvo's SelectCare will not duplicate those benefits.

Stop Health Care Fraud

Fraud increases the cost of health care for everyone. Here are some things you could do to prevent fraud:

- Be wary of giving your Calvo's SelectCare member number over the telephone or to people you do not know, except to your doctor or other provider.
- Avoid using health care providers who say that an item or service is usually not covered, but they know how to bill us to get it paid.
- Carefully review any Explanation of Benefits (EOB) that you receive from us after we process your claim.
- Do not ask a doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call your Calvo's SelectCare office and explain the situation.
- Does not maintain as a family member on your plan:
  - Your former spouse after a divorce decree or annulment is final,
  - Your child over age 26 unless he/she is disabled and incapable of self support.

Grievance & Appeals Procedures

Calvo's SelectCare believes that member complaints can be one of the best sources of information for the plan. A member who has a complaint or criticism can be our best customer over time if the complaint is handled quickly and fairly. We believe that effective and efficient complaint handling is aimed at member retention; it is important to establish a process whereby our members can address their complaints or grievances directly with the health plan in order to come to a fair and equitable resolution.

Calvo's SelectCare will make every attempt to resolve any concerns that you may have. When Calvo's SelectCare denies payment of a claim or disapproves a Pre-certification/authorization of a service and if you do not agree with the decision, you need to let us know within 60 days of the denial. We urge you to call our Customer Service department to see if we can resolve the concern over the phone.

If we are unable to resolve your concerns or if our solution is unacceptable to you, you have the right to submit a formal appeal through the Grievance & Appeals Procedure described below and in the group contract between your employer and Calvo's SelectCare.

Our Grievance & Appeals process may involve 3 stages of reviews and appeals, (1) The Internal Review Process, (2) The External Review Process, and (3) Binding Arbitration. The time frames indicated below are for non-critical grievance reviews. Calvo's SelectCare will make every effort to expedite any review process where a delay may reasonably appear to seriously jeopardize a member's life or health or jeopardize a member's ability to regain maximum function.

To initiate the Internal Review process, a Grievance Form or letter should be completed by you and submitted to our Grievance Coordinator. It should include the following information:

- Subscriber's ID number.
- Subscriber's name.

- Patient's name.
- The nature of the grievance arising.
- The factual circumstances giving rise to the grievance.
- A summary of the actions already taken.
- A statement about the desired remedy sought for the situation.
- Any other information that may be helpful for the review.

You may be assisted or represented by a person of your choosing, including a family member, employer representative or attorney provided you complete and sign an authorization form.

The Grievance Coordinator will gather all the material provided in the request for review, along with other needed information from other departments and the medical provider to conduct a thorough review of the grievance.

During the Internal Review process, the Coordinator will consult with our Utilization Manager and Medical Director for all cases relating to Medical Necessity and will consult with the Plan Administrators for all cases related to coverage and benefits. You will be notified of our decision in writing within 10-15 working days from receiving the complaint.

If you disagree with our decision, you have the right to an External Review Process and have our decision reviewed by independent health care professionals who have no association with us if our decision involved:

- Making a Judgement as to the Medical Necessity,
- Appropriateness, Health Care Setting,
- Level of Care, or Effectiveness of the Health Care Service or Treatment you requested.

You must submit a request for **External Review** within 4 months after receipt of our denial to the Office of the Insurance Commissioner (Insurance and Banking Division, Dept. of Rev & Tax Bldg. in Barrigada - phone: (671) 635-1846).

A decision will be made within 45 days of receiving your request. If you have a medical condition that would seriously jeopardize your life or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request for an **Expedited External Review** of our denial. If our denial to provide or pay for health care services or course of treatment is based on the determination that the service is Experimental or Investigation, you also may be entitled to file for a request for External Review of our denial. For details, please review your Benefit Plan Document, contact us or the Office of the Insurance Commissioner.

After-hours care

Sometimes you may have a medical problem that is not an emergency and your doctor's office is closed. At those times, you can use one of Calvo's Urgent Care Services (After Hours Services).

Here are some examples of Urgent Care or After Hours Services:

- Sore throat
- Back pain
- Headache
- Cold
- Minor injury
- Flu
- Ear ache
- Cuts & minor wounds
- Frequent urination

Call your primary care doctor for help in getting these urgent, after-hours services. Please refer to the Provider Directory for more information on Urgent Care Facilities

Advance Directives

Advance Directives are written instructions that tell your doctor what kind of care you would like to have if you were in a serious medical situation that would make you unable to make medical decisions. They do not take away your right to decide about your current healthcare needs.

Advance Directives include the following:

- **Living Will** allows you to specify or limit the kinds of life-prolonging procedures you wish to receive if you become unable to make medical decisions.
- **Life Prolonging Declaration** allows you to specify your wish to receive life-prolonging procedures that would extend your life if you become terminally ill and unable to make medical decisions.
- **Health Care Surrogate Designation** allows you to name someone else to make health care decisions for you should you become unable to make health care decisions. The other person can be a husband, wife or friend.
- **Appointment of Durable Power of Attorney for Healthcare** allows you to name an agent or proxy (substitute person) to make your health care decisions if the time comes that you are unable to do so.

The Guam legislature has provided statutes governing the content and use of a living will declaration. Refer to Guam Health and Safety Code, Title 10, Div. 4, Chapter §9110 to §9117 for specific information.

If your doctor has a copy of your Advance Directive, he/she will be able to honor your choices. If he or she cannot then they will let you know why they will not.
To download an Advance Directive form go to: www.lifecaredirectives.com
If you have questions about Advance Directives call Calvo's SelectCare at (671) 477-9808.

End of Life Care

End-of-life care is the term used to describe the support and medical care given during the time surrounding death. Such care does not happen only in the moments before breathing ceases and the heart stops beating. Older people often live with one or more chronic illnesses and need a lot of care for days, weeks, and even months before death.

In the final stages of many terminal illnesses, care priorities tend to shift. Instead of ongoing curative measures, the focus often changes to palliative care for the relief of pain, symptoms, and emotional stress. Ensuring a loved one's final months, weeks or days are as good as they can be requires more than just a series of care choices.

Examples of end of life care include:

- Practical care and assistance with routine activities when a loved one can no longer talk, sit, walk, or eat. These tasks can be supported by personal care assistants, a hospice team, or physician-ordered nursing services.
- Hospice is typically an option for patients whose life expectancy is six months or less, and involves palliative care (pain and symptom relieve). Hospice care can be provided onsite some hospitals, nursing homes, and other health care facilities, although in most cases hospice is provided in the patient's own home.
- Comfort and dignity – when the patient's cognitive and memory functions are depleted help to ease discomfort and provide meaningful connections to family and loved ones.
- Respite Care –to give you and your family a break from the intensity of end-of-life caregiving. It may be simply a case of having a hospice volunteer sit with a patient for a few hours so you can meet friends for coffee or watch a movie, or it could involve the patient having a brief inpatient stay in a hospice facility.
- Grief support with bereavement specialists or spiritual advisors to help you and your family prepare for the coming loss.

Web site resources

- **End of Life Care**
  National Institute on Aging, End of Life: Helping with Comfort and Care
  https://www.nia.nih.gov/health/publication/end-life-helping-comfort-and-care introduction

- **Advance Care Planning and Advance Directives**
  National Institute on Aging, Advance Care Planning
  https://www.nia.nih.gov/health/publication/advance-care-planning
  www.lifecaredirectives.com

Medical Exclusions & Limitations

The following medical services and conditions are Not Covered. You are responsible for all related charges.

Specific Medical Exclusions

- Charges made for treatment, services, or supplies not included in the Eligible Expenses under the "Comprehensive Medical Expense Benefit" and "Special Provisions" sections;
- Charges for disability incurred due to Injury or Sickness resulting from or sustained as a result of being engaged in an illegal occupation, commission of or attempted commission of an assault or felonious act, participation in a riot, insurrection, or resulting from being under the influence of alcohol or a chemical or controlled substance;
- Charges incurred in connection with the care or treatment of any injury sustained or sickness contracted as a result of war or any act of war, declared or undeclared;
- Charges incurred in connection with the eye refractions or the purchase or fitting of eyeglasses. This exclusion does not apply if coverage is provided by an accompanying SelectCare Vision Plan or unless specifically covered under your plan. Vision correction procedures including but not limited to the use of surgery lasers, radiofrequency of implants. or hearing aids; charges for radial keratotomy;
- Charges for hearing aids or hearing aid evaluations except as mandated by law.
- Charges for Hyperbaric Oxygen (HBO) treatment unless specifically covered by your plan
- Charges incurred from any intentionally self-inflicted injury, including injury or illness due to attempted suicide, unless such intentionally self-inflicted injury is a result of a medical condition (such as depression).
- Charges incurred for services which are furnished, paid for, or otherwise provided for by reason of past or present services of any Covered Person in the armed forces of a government or while on active duty in a police or military unit;
- Charges for services or supplies which are not medically necessary for treatment of the Injury or Sickness or are not recommended and approved by the Attending Physician unless otherwise noted as covered under your Plan Policy;
- Charges incurred for services or supplies which constitute personal comfort or beautification items and are chosen by the Covered Person;
- Surgical correction (e.g. gastroplasty, gastric by-pass, stapling), or complications resulting from surgical correction unless medically necessary, or non-medical treatment of obesity, (e.g. dietary or exercise counseling for weight control, etc.);
- Charges for expenses incurred for a condition for which a Covered Person is eligible for covered benefits under National Health Insurance, Social Security, Workers' Compensation or other similar law;
- Charges that would have not been made if no coverage existed or charges that a Covered Person is not required to pay;
- Charges incurred prior to the date an individual becomes a Covered Person or charges incurred after the date he ceases to be a Covered Person;
- Charges made by a Physician for the Covered Person's failure to appear as scheduled for an appointment.
- Charges for or related to sex change surgery or any treatment related to gender identity or sexual dysfunction; charges for birth control devices or drugs, fertility drugs, artificial insemination, in-vitro fertilization and services or a surrogate mother; non-life threatening abortion, sterilization or reversal of sterilization, or cosmetic surgery except as outlined under "Special Provisions" under your Plan Policy;
- Charges for services provided by the Covered Person's spouse, child, brother, sister, or parents, whether by blood or by law;
- Any part of any expense, charge, or fee that exceeds the "Usual, Customary, and Reasonable" expense;
- Charges for services, drugs, or procedures that are not fully approved by the U.S. Food and Drug Administration, or not approved by the public health authority of the jurisdiction or other health regulatory body;
- Charges for air conditioners, dehumidifiers and humidifiers, air purifiers, heating pads, hot water bottles, home enema equipment, and similar equipment and supplies; charges for electrical power, water and disposal systems, baths and pools or their installation;
- Charges for services related to obtaining or implanting a non-human, artificial, or mechanical organ, except for cardiac pacemakers;
- Charges incurred for dental services except for surgical procedures as a result of accidental injury to natural teeth or jaw; such services do not include capping, bridges or retainers as benefits. Charges incurred for dental care including any treatment in connection with mouth conditions due to abscess, periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar process, or gingival tissue or any dental care or treatment ordinary performed by a dentist.

  This exclusion does not apply:

  - To oral surgery due to accidental injury to your natural teeth or jaw. Treatment of accidental injuries is limited to treatment that will alleviate acute symptoms and does not include any definitive restorative treatment such as crowns and bridgework, dentures, amalgam or acrylic restoration.
  - If coverage is provided by an accompanying SelectCare Dental Plan.
- Charges, including but not limited to oral care and supplies, for temporomandibular (jaw) joint disorders and related TMJ diseases;.
- Charges for expenses in connection with Chronic Brain Syndrome, or custodial care charges resulting from senile deterioration, unless otherwise noted as covered under your Plan Policy;
- Charges for biofeedback and other forms of self-care or self-help training;
- Any charges incurred as a result of pregnancy with respect to anyone other than the Subscriber or the Subscriber's Spouse/Domestic Partner covered under your Plan Policy;
- Charges for any drug, medicine, implant, injection, or devices listed under Section VI "Exclusions and Limitations on Out-Patient Drugs";
- Charges for treatment or services for which payment or reimbursement is received by or for a Covered Person as a result of a legal action or settlement subject to the provisions under "Third Party Liability and Subrogation";
- Charges for TV, Radio, VCR's or similar machines or equipment for entertainment, additional beds or cots or other comfort items, including charges for hospital admission kits:
- Charges for nasal reconstruction except to correct a deformity resection as a result of:
  - An accidental injury which occurred within 90 days of the date of surgery
  - The removal or treatment of cancer of the nose.
- Charges for Orthopedic shoes or devices;
- Charges for duplicate or spare items such as leg, back or neck braces, artificial legs, arms, eyes or teeth, hearing aids;
- Charges for rest cures or custodial care, domiciliary or convalescent care;
- Charges for treatment or services for experimental medical, surgical and health care procedures and services related thereto. Procedures and services not covered by Medicare are considered experimental.
- Charges for organ transplant in which the Covered Person is the donor.
- Charges for physical examinations and all services related thereto when required for obtaining or continuing employment, insurance, schooling or governmental licensing or sporting activities;
- Charges for airfare and living expenses, including but not limited to air ambulance service;
- Charges for elective cosmetic surgery and treatment; including treatment for acne related services unless otherwise covered under your Plan Policy;
- Charges for non-medical expenses, including but not limited to state and local taxes, finance and interest charges;
- Charges for interrupted pregnancy (non-medically necessary); non-life threatening abortions unless medically necessary;

Medical Exclusions & Limitations (continued)

- Charges for Over-the-Counter drugs or drugs for which a prescription from a licensed physician is not required under federal law;
- Charges for annual physical examinations and related services outside of Guam, The Commonwealth of the Northern Mariana Islands, Hawaii, Asia and Micronesia unless otherwise covered under your Plan Policy;
- Charges for allergy testing and treatment unless otherwise covered under your Plan Policy;
- Charges for corrective appliances, artificial aid and unless otherwise covered under your Plan Policy;
- Charges for the care and services related to or replacement of joints and use of orthopedic and prosthetic devices, intra-ocular lenses, and artificial joints and limbs; or any services related to chronic orthopedic conditions unless otherwise covered under your Plan Policy.
- Charges in excess of the Maximum Benefits and other specific maximum limits of coverage as noted under your Plan Policy;
- Charges due to the failure of refusal of the Covered Person to discharge himself even if the discharge has been duly authorized by the Attending Physician. The Company will only pay the Eligible Expenses up to the time and day of the Attending Physician's authorized discharge.
- Charges for benefits and services not specified as covered are considered exclusions under your Plan Policy;
- Treatments for injuries sustained while participating in hazardous sporting activities, such as, but not limited to fighting sports, off-road vehicle activities and sky diving;
- Charges related to the treatment and services of Dialysis in excess of any applicable amounts indicated under your Plan Policy;
- Treatment for services and supplies related to sexual dysfunction (i.e. Viagra);
- Treatment for services and supplies related to sleeping disorders.
- Treatment of end-stage renal disease/hemodialysis unless otherwise covered under your Plan Policy.

Dental Benefits

Calvo's SelectCare covers all the dental services and conditions listed here. Not all plans offer Dental Benefits. Dental benefits are offered at the discretion of your employer.

To participate in the Calvo's SelectCare dental plan, you must be a member of a Calvo's SelectCare medical plan, you must specifically enroll for dental coverage and you must carry both medical and dental coverage throughout your plan year.

In general, Calvo's SelectCare pays for a large portion and often the full amount of your covered dental expenses, and you pay the remaining amount, if any. If a dental service is not listed here, it is considered an exclusion, and you are responsible for all related charges.

You may select any dentist from among those in our list of Participating Providers.

If you have any questions about your dental coverage, do not hesitate to call us.

Diagnostic Services

Diagnostic dental services including caries (tooth decay) susceptibility tests; clinical exams once every six months; study models; routine bite wing X-rays; and full mouth X-rays once every three years are covered.

Preventive Services

Routine teeth cleaning (prophylaxis) once every 6 months, fluoride treatment once a year for children age 19 and under, sealants for permanent molars of children age 15 and under, space maintainers including adjustments within six months of installation for children age 15 and under, treatment plans and instruction on methods of properly cleaning teeth are covered.

Emergency Care

Emergency treatment (during office hours) for acute infection, pain and bleeding or for accidental injury to the teeth and adjacent soft tissues is covered.

Restorative Care

General restorative services such as routine fillings (silver amalgam and composite resin), additional tooth surface next to filling, and pulp treatment are covered.

Oral Surgery

Simple and complicated extractions, impacted teeth and other necessary oral surgeries are covered unless otherwise excluded.

Endodontics

Root canals, pulpotomy and other endodontic surgery and care are covered.

Periodontics

Consultation, evaluation and treatment of soft tissue and bones supporting the teeth; periodontal cleaning (prophylaxis) once every six months; suprogingival and subgingival gross scaling, subginginval curettage, root planning and periodontal surgery are covered.

Major Replacement Services

Fixed prosthetics such as porcelain and metal crowns, gold inlays and onlays, bridges, crown replacements once every 5 years, and space maintainers are covered.

Removable prosthetics such as full and partial dentures once every five years; repairs, relining or reconstruction of dentures; and removable bridges are covered.

Sedation

Anesthesia when required by your dentist is covered.

Plan Maximum

Your dental benefit is limited to an annual plan maximum. Please refer to your dental plan's Schedule of Benefits for the annual maximum benefit.

Service Charges

If you fail to keep a dental appointment and do not cancel 24 hours in advance, your dentist may assess a service charge. When copies of your dental records are made, there may also be a service charge from your dentist. These charges are your responsibility.

Dental Exclusions & Limitations

Any dental service, which is NOT specified as covered, is excluded. Calvo's SelectCare Dental Plan does NOT cover the following dental services and conditions and no benefits will be paid for:

Work in progress on the effective date of coverage. Work in progress is defined as:

- A prosthetic or other appliance, or modification of one, where an impression was made before the patient was covered, or
- A crown, bridge, or cast restoration for which the tooth was prepared before the patient was covered, or
- Root canal therapy, if the pulp chamber was opened before the patient was covered.
- Services not specifically listed in the agreement, services not prescribed, performed or supervised by a dentist; services which are not medically or dentally necessary or customarily performed; services that are not indicated because they have a limited or poor prognosis; or services for which there is a less expensive, professionally acceptable alternative.
- Any service unless required and rendered in accordance with accepted standards or dental practice.
- A crown, cast restoration, denture or fixed bridge or addition of teeth to one, if work involves a replacement or modification of a crown, cast restoration, denture or bridge installed less than 5 years ago, or one that replaces a tooth that was missing before the date the enrollee became eligible for services under the plan (including previously extracted or missing teeth).
- Replacement of existing dentures, crowns or fixed bridgework if the existing dentures, crowns or fixed bridgework can be made serviceable.
- Precision attachments or stress breakers.
- Replacement of lost or stolen appliance, or replacement of any appliance damaged while not in the mouth.
- Any service for which the enrollee received benefits under any other coverage offered by the company.
- Spare or duplicate prosthetic devices.
- Services included, related to or required for:
  - Implants;
  - Cosmetic purposes;
  - Services or appliances to change the vertical dimension or to restore or maintain the occlusion, including but not limited to equilibrium, full mouth rehabilitation and restoration for malalignment of teeth;
  - Temporomandibular joint (TMJ) or craniomandibular disorders, myofunctional therapy or the correction or harmful habits;
  - Experimental procedures; and
  - Intentionally self inflicted injury unless resulting from a medical condition (including physical or mental conditions) or from domestic violence.
- Any over the counter drugs or medicine.
- Fluoride varnish.
- Charges for finance charge, broken appointments, completion of insurance forms or reports, providing records, oral hygiene instruction, pit and fissure sealants and dietary instruction, or lack of cooperation on the part of the patient.
- Charges in excess of the amount allowed by the plan for a covered service.
- Any treatment, material, or supplies which are for orthodontic treatment, including extractions for orthodontics.
- Services for which no charge would have been made had the agreement not been in effect.
- All treatments not specifically stated as being covered.
- Surgical grafting procedures.
- General anesthetic, conscious sedation, and other forms of relative analgesia, except as otherwise specifically provided herein.
- Services paid for by Workers' Compensation.
- Charges incurred while confined as an inpatient in hospital unless such charges would have been covered had treatment been rendered in dental office.
- Treatment and/or removal of oral tumors.
- All surgical procedures except for surgical extractions of teeth and periodontal surgeries performed by a dentist.
- Panoramic x-ray or full mouth x-ray if provided less than 3 years from the covered person's last panoramic x-ray or full mouth x-ray.

Summary of Federally Mandated Programs

Calvo's SelectCare is pleased to provide this summary as a means of keeping you better informed as decision-makers and consumers of health care. We are committed to meeting all the requirements and certifications outlined in these federally mandated programs.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA gives workers who lose their health benefits the right to choose to continue group health benefits provided by the plan of a previous employer under certain circumstances.

COBRA is available when an employer employs 20 or more employees. Continuation of coverage under COBRA does not apply for employer groups with less than 20 employees. An employee has up to 60 days after the separation date from the employer to convert his or her enrollment to a non group policy.

Continued medical benefits under COBRA must be comparable to those benefits currently offered to active employees. The premium under COBRA must also be fully paid by the employee, including any employer share.

A qualifying event is defined as an event that results in a loss of coverage, which entitles qualified beneficiaries to COBRA benefits. The following are qualifying events and the corresponding maximum length of COBRA coverage:

- Termination of employment (18 months)
- Retirement (18 months)
- Reduction in Hours (18 months)
- Divorce/Legal Separation (36 months)
- Death of employee (36 months)
- Loss of dependent child status (36 months)
- Disability under the Social Security Act (29 months)

Family and Medical Leave Act of 1993

This act entitles eligible employees to 12 work weeks of unpaid leave during a 12 month period for any of the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- The care of a child, spouse, or parent who has a serious health condition;
- The employee's own serious health condition that prevents performance of his or her job.

Summary of Federally Mandated Programs (continued)

Employers are required to allow any employee who is out on family and medical leave to be enrolled in the group health plan.

Health Insurance Portability and Accountability Act (H.I.P.A.A.) of 1996

The Health Insurance Portability and Accountability Act (H.I.P.A.A.) offers new protections for employees that improve portability and continuity of health insurance coverage.

H.I.P.A.A. protects employees and their families by:

- Limiting exclusions for pre-existing medical conditions to 12 months or 18 months for late enrollees;
- Provides credit for prior health coverage;
- Provides new rights that allow individuals to enroll for health coverage when they lose other health coverage or add a new dependent;
- Allows for only a 6 month look back period regarding illnesses;
- No pre-existing condition for newborns, adopted children and pregnancy;
- Prohibits discrimination in enrollment and in premiums charged to employees based on health status and related factors.

Certificates of Creditable Coverage must be automatically provided by the plan when an individual loses coverage under the plan. Certificates of Creditable Coverage must be provided, if requested, before losing coverage or within 24 months of losing coverage.

Special Enrollment Rights are provided for individuals who lose their coverage in certain situations and for individuals who become a new dependent through marriage, birth, adoption or placement for adoption.

Newborns' & Mothers' Health Protection Act of 1996

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) puts the decisions affecting length of hospital stays following childbirth in the hands of mothers and the attending providers.

The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict mothers' or newborns' benefits for a hospital length of stay that is in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who is a person such as the mother's physician or nurse midwife) may, in consultation with the mother, discharge earlier.

The Newborns' Act and the new regulations, also prohibit incentives in any way (positively or negatively) that could encourage less than the minimum protections under this act as described above.

Patient Protection and Affordable Care Act (PPACA)

The enactment of the Patient Protection and Affordable Care Act (PPACA) was enacted into law on March 23, 2010 and amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), and are both collectively referred to as the Affordable Care Act (ACA). ACA launches an overhaul of the health care system wherein changes to the American Health Care system will take effect in stages up trough 2018 and beyond. Several changes which are in effect as of September 23, 2010 are as follows:

- Coverage for children until age 26. Parents will be allowed to keep their children on their health plans until age 26, unless the child is eligible for coverage through a job.
- Lifetime Limits. All existing health plans will be prevented from imposing lifetime limits on coverage in group and individual health plans.
- Preventive Health Services. Group and individual health plans must provide first dollar coverage for preventive coverage.
- No coverage rescissions. Health Insurance companies may no longer cancel insurance policies unless there is proof of fraud.

Women's Health and Cancer Rights Act Of 1998 (W.H.C.R.A.)

The Women's Health and Cancer Rights Act contains protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. In certain cases, plans offering coverage for a mastectomy must also cover reconstructive surgery in connection with a mastectomy.

Under the Act, reconstructive benefits must include coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and physical complications at all stages of mastectomy, including lymphedemas.

Please be advised that benefits under this act may be subject to annual deductibles and co-insurance consistent with those established for other benefits under the plan.

Mental Health Parity Act of 2008

The Mental Health Parity Act of 2008 took effect on January 1, 2010. It requires employers with more than 50 employees that offer a health insurance plan with mental health coverage to provide the mental health benefits at the same level as medical and surgical benefits, including deductibles, Co-Payments, out-of-pocket expenses, inpatient stays, and outpatient visits. The law ends limits on mental health coverage if a company's plan does not have similar limits for physical ailments.

Notice of Privacy Practices

Protected Health Information (PHI)

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

This Notice describes the privacy policies of Calvo's SelectCare (CSC) Tokio Marine Pacific Insurance Limited ("TMPI") and health benefit plans underwritten by TMPI (the "Plans"), and how that information may be used or disclosed in administering the Plans. It is intended to describe the policies that protect medical information relating to your past, present and future medical conditions, health care treatment and payment for that treatment ("PHI"). This notice applies to any information created or received by the Plans on or after the September 23, 2013 that would allow someone to identify you and learn something about your health. It does not apply to information that contains nothing that could reasonably be used to identify you. It applies to you if you are insured by TMPI on or after September 23, 2013.

The terms "we" or "us" as used throughout this Notice refer to Calvo's SelectCare Health Plans, TMPI or the Plan. The terms "you" and "your" refer to each individual participant in the Plans.

Our Legal Duties:

- We are required by law to maintain the privacy of your PHI.
- We are required to provide you this Notice of Privacy Practices.
- We are required to abide by the terms of this Notice until we officially adopt a new notice.

How we may use or disclose your PHI:

We may use your PHI, or disclose your PHI to others, for a number of different reasons. This notice describes the categories of reasons for using or disclosing your information. For each category, we have provided a brief explanation, and in many cases have provided examples. The examples given do not include all of the specific ways we may use or disclose your PHI. However, any time we use or disclose your information in administration of the Plans, it will be for one of the categories listed below.

Treatment: We may use or disclose PHI for treatment purposes. For example, we may use or disclose your PHI to coordinate or manage your health care with your doctors, nurses, technicians, or other personnel involved in taking care of you.

Payment: We may use and disclose PHI for purposes related to payment for health care services. For example, we may use your PHI to anyone who helps pay for your care, to settle claims, to reimburse health care Plans for services provided to you or disclose it to another health plan to coordinate benefits.

Health Care Operations: We may use and disclose PHI for plan operations. For example, we may use or disclose your PHI for quality assessment and improvement activities, case management and care coordination, to comply with law and regulation, accreditation purposes, patients' claims, grievances or lawsuits, health care contracting relating to our operations, legal or auditing activities, business management and general administration, underwriting, obtaining re-insurance and other activities to operate the Plans.

To Business Associates: We may hire third parties that may need your PHI to perform certain services on behalf of TMPI or the Plans. These third parties are "Business Associates" of TMPI or the Plans. Business Associates must protect any PHI they receive from, or create and maintain on behalf of, TMPI or the Plans.

Plan Sponsor: We may disclose certain health and payment information about you to the sponsor of your Plan (the "Plan Sponsor") to obtain premium bids for the Plan or to modify, amend or terminate the Plan. We may release other health information about you to the Plan Sponsor for purposes of Plan administration, if certain provisions have been added to the Plan to protect the privacy of your health information, and the Plan Sponsor agrees to comply with the provisions. Note, however, that your Plan is prohibited from, and will not, use or disclose protected health information that is genetic information of an individual for underwriting purposes.

Family and Friends: We may disclose your PHI to a member of your family or to someone else who is involved in your medical care or payment for care. We may notify family or friends if you are in the hospital, and tell them your general condition. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object and you notify us that you object. We may also disclose PHI to your personal representatives who have authority to act on your behalf (for example, to parents of minors or to someone with a power of attorney).

Treatment Options: We may use your PHI to provide you with additional information. This may include giving you information about treatment options or other health-related services that are available for you based on your medical condition.

Public Health Oversight: We may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; licensure or disciplinary actions (for example, to investigate complaints against health care Plans); inspections; and other activities necessary for appropriate oversight of government programs (for example, to investigate Medicaid fraud). This also includes such activities as preventing or controlling disease, and notifying persons of recalls, exposures to disease.

Plan Government Programs Providing Public Benefits: We may disclose your health information relating to eligibility for or enrollment in the Plans to another agency administering a government program providing medical or public benefits, as long as sharing the health information or maintaining the health information in a single or combined data system is required or otherwise authorized by law.

To Report Abuse: We may disclose your PHI when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

Legal Requirement to Disclose Information: We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the health care system. For instance, we may be required to disclose your PHI, and the information of others, to a state department of health.

Law Enforcement: We may disclose your PHI for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your PHI to a federal agency investigating our compliance with federal privacy regulations.

For Lawsuits and Disputes: We may disclose PHI in response to an order of a court or administrative agency, but only to the extent expressly authorized in the order. We may also disclose PHI in response to a subpoena, a lawsuit discovery request, or other lawful process, but only if we have received adequate assurances that the information to be disclosed will be protected.

Specialized Purposes: We may disclose your PHI for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security and intelligence purposes. We may disclose the PHI of members of the armed forces as authorized by military command authorities. We also may disclose PHI about an inmate to a correctional institution or to law enforcement officials to provide the inmate with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution. We may also disclose your PHI to your employer or as otherwise authorized or required by law for purposes of workers' compensation and work site safety laws (OSHA, for instance). We may disclose PHI to organizations engaged in emergency and disaster relief efforts.

In our effort to better serve your complete insurance needs, we may use the information we collect about you to better understand your relationship with us when assessing your needs, providing you services, and determining what products you may want to know more about.

To Avert a Serious Threat: We may disclose your PHI if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

Research: We may disclose your PHI in connection with medical research projects if allowed under federal and state laws and rules. The Plans may also disclose PHI for use in a limited data set for purposes of research, public health or health care operations, but only if a data use agreement has been signed.

Your Rights:

Authorization: We will ask for your written authorization if we plan to use or disclose your PHI for reasons not covered in this notice, including but not limited to uses and disclosures relating to psychotherapy notes, marketing activities, and any sale of your PHI. If you authorize us to use or disclose your PHI, you have the right to revoke the authorization at any time. If you want to revoke an authorization, send a written notice to the Privacy Official listed at the end of this notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have already given out your information or taken other action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other laws may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization.

Request Restrictions: You have the right to request that we restrict how we use or disclose your PHI for treatment, payment, or health care operations. You must make this request in writing. We will consider your request, but we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law. We may end the restriction if we tell you.

An important note regarding your right to request restrictions at your health care providers

You have a right to restrict your provider from disclosing protected health information to insurers or health plans because you paid for provider services or items out of pocket and in full. If you choose to use a medical expense reimbursement/flexible spending account (FSA) or a health savings account (HSA) to pay for the health care items or services that you wish to have restricted, you may not restrict disclosure to the FSA or HSA necessary

to substantiate or effectuate that payment or reimbursement. That means you will still be required to provide the necessary substantiation of the expenses in order to receive payment.

Confidential Communication: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you may ask that we contact you only at home or only by mail. If you want us to communicate with you in a special way, you will need to give us details about how to contact you, including a valid alternative address. You also will need to give us information as to how payment will be handled. We may ask you to explain how disclosure of all or part of your health information could put you in danger. We will honor reasonable requests. However, if we are unable to contact you using the requested ways or locations, we may contact you using any information we have.

Access to and Copies of PHI: With certain exceptions (i.e., psychotherapy notes, information collected for certain legal proceedings, and health information restricted by law), you have a right to access the PHI held by TMPI or the Plans in their enrollment, payment, claims adjudication, and case or medical management records systems that are used by the Plans in making decisions about you (the "Designated Record Set"). To the extent PHI is maintained electronically, you have a right to request an electronic copy of those records. We may charge a reasonable, cost-based fee for copying, mailing, and transmitting the records, and the cost of any specific media you request, to the extent allowed by state and federal law.

To ask to inspect your records, or to receive a copy, send a written request to the Privacy Official listed at the end of this notice. Your request should specifically list the information you want copied. We will respond to your request within a reasonable time, but generally no later than 30 days. If your Health Plan cannot respond to your request within 30 days, an additional 30 days is allowed if that Health Plan provides you with a written statement of the reason(s) for the delay and the date by which access will be provided. We may deny you access to certain information, such as if we believe it may endanger you or someone else, in which case we will also explain how you may appeal the decision.

Amend PHI: You have the right to ask us to amend PHI contained in the Designated Record Set held by TMPI or the Plans if you believe that PHI is not correct, or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We will respond to your request in writing within 30 days. Any amendment we agree with will be made by an addendum. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

Accounting of Disclosures: You have a right to receive an accounting of certain disclosures of your information to others. The list will include dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must request this list in writing, and indicate the time period you want the list to cover. We cannot include disclosures made prior to the most recent 6 year period (the longest period that records of disclosures are maintained). Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or health care operations; disclosures incident to a permitted use or disclosure; disclosures as part of a limited data set; disclosures to your family members, other relatives, or friends who are involved in your care or who otherwise need to be notified of your location, general condition, or death; disclosures for national security purposes; certain disclosures to correctional or law enforcement personnel; disclosures that you have authorized; and disclosures made directly to you or your representatives.

Right to Notification of Breach of Unsecured PHI: We will comply with the requirements of HIPAA and its implementing regulations to provide notification to affected individuals, HHS, and the media (when required) if TMPI, a Plan or a business associate discovers a breach of unsecured PHI.

Rights More Stringent Than HIPAA: In certain instances, protections afforded under applicable state or territorial law may be more stringent than those provided by HIPAA and are therefore not preempted. We will comply with applicable state or territorial law to the extent it is more stringent than HIPAA with regard to requested disclosures of records (i.e., if we receive a subpoena for your PHI, and the state or territory in which you live requires your written consent or a court order to disclose the type of records requested).

Paper Copy of this Privacy Notice: You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the office of the Privacy Official listed at the end of this notice.

Future Changes to this Notice: We reserve the right to change this Notice and the privacy practices of TMPI or the Plans covered by this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future.

If this Notice is maintained by TMPI or the Plans on a website, material changes will be prominently posted on that website, and information regarding the updated Notice will be made available in TMPI's or your Plan's next annual mailing. If the Notice is not maintained on a website, copies of the revised Notice will be made available to you within 60 days of a material change.

Complaints: You have a right to complain if you think your privacy has been violated. We encourage you to contact our Privacy Official. You may also file a complaint with the Secretary of the Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Office of the Privacy Official: If you have any questions regarding this Notice or if you wish to exercise any of your rights described in this Notice, you may contact the Privacy Official at:

Calvo's Insurance Underwriters, Inc.,
Attn: Frank Campillo
P.O. Box FJ
Hagatña, Guam 96932

Off-Island Care

The following was developed to assist members with the off-island referral process. Please contact our office for any additional assistance you may require.

Referral Procedures and Required Documents

- Visit the Calvo's SelectCare office to see a Customer Service Representative at least four (4) weeks prior to departure. It is advisable not to purchase airline tickets without a confirmed off-island doctor's appointment. You will be asked to complete our Off-Island Appointment Request Form. Among other things, this form is used to convey your preferred off-island facility, appointment dates and the required level of care and provides us with additional information to better serve your off-island needs. Your Representative will be able to provide you with the necessary information for you to make the best possible choices regarding your off-island medical care.

Required Documents

- Off-island medical referral from your local doctor.
- Medical Records related to your illness. You will likely need to bring these records with you to present to your off-island provider.
  - Copies of diagnostics tests such as Ultrasound, X-Ray, MRI, CT Scan, Biopsy Reports, Pathology Slides, Angiogram CD, and any other pertinent records.
  - Most Recent Blood Tests/Laboratory/Pathology and other diagnostic procedure results.

- If you were recently discharged from a hospital, please bring the Discharge Summary, Laboratory Results, and any Operative Reports.

- Completed Calvo's SelectCare form authorizing us to receive health information from your off-island provider.
- Calvo's SelectCare Member ID Card and a picture ID.
- Please allow us time to review your request, generate the necessary paperwork, and confirm acceptance by a physician and/or facility. Most delays in processing are due to appointment unavailability, changes in schedule, and/or incomplete records. All appointments are subject to provider and facility availability and there may be a waiting period until your scheduled appointment.
- A hospital Social Worker may provide assistance for Hospital-to-Hospital transfers, so please communicate with them as they have standard procedures and protocols for Hospital-to-Hospital transfers.
- When a referral packet is ready, we will call you for pick-up. Anticipate and allot 30 minutes of your time to review the off-island referral packet and sign any necessary documents.

Additional Information and Suggestions

- Passport: It is recommended that you always have a valid passport with more than 6 months prior to its expiration. This document is necessary to travel and seek care with our providers outside the United States, especially in cases where a medical transfer or evacuation is necessary.
- **Advanced Health Care Directive – aka Living Will:** You should set up a personal directive, advance directive, or advance decision, or living will. This is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity.
- For travel and lodging arrangements, you should register and coordinate with the Guam Medical Referral Office on Guam (671-475-9350) or their satellite offices in the Philippines, Hawaii and California as they may be able to assist you with lodging and travel arrangements.
- Completed Fitness for Travel Forms may be required by the airline and must be obtained from your referring physician prior to 10 days of departure and forwarded to the airline for their review.
- Please verify with the attending physician if oxygen is needed during the trip and during any layovers. If required, please coordinate with the Guam Medical Referral Office to make arrangements.
- Wear comfortable clothing and footwear when undergoing physicals.
- Your Calvo's SelectCare plan only pays for covered medical services, aside from applicable deductibles, Co-Insurance, or Co-Payments, you should also be prepared to pay for any items not related to your care, such as phone calls and comfort items. Payments must be made at the time of service or at the time of discharge from the hospital. We suggest bringing extra money or credit cards in anticipation of such expenses.
- Please obtain receipts for any payment you may make for your covered medical care and submit them to our office no later than 120 days from the date of service.
- Be sure to bring back all medical records and reports related to your off-island care and present to your local provider to help in the continuity of your care.
- If care is sought in the Philippines, you may need to coordinate with our Calvo's SelectCare Office located at one the following locations:

  Calvo's SelectCare at St. Luke's Medical Center: Quezon City
  Rm. 716 7th Floor, North Tower
  Cathedral Heights Building Complex
  St. Luke's Medical Center Compound
  #279 E. Rodriguez Sr. Avenue,
  Quezon City, Philippines
  Phone: +(632) 413-1312

  Calvo's SelectCare at St. Luke's Medical Center: Global City
  Rm. 1008 10th Floor
  Medical Arts Building
  32nd St. Bonifacio Global City
  Taguig City, 1112 Philippines
  Phone: +(632) 555-0443/0448

  Calvo's SelectCare at The Medical City: Pasig City
  Business Center, 9th Floor
  The Medical City, Ortigas Center
  Pasig City, Philippines
  Phone: +(632) 650-0589

- Bringing along a companion is a good idea. He or she may be very helpful.

  Whenever you want someone else to communicate with Calvo's SelectCare to coordinate your referral (e.g. spouse, companion, Guam Medical Referral Office, etc.), you must sign our form authorizing us to release Protected Health Information (PHI) to anyone acting on your behalf. Verbal authorizations are not accepted.
- Please refer to our directory of Participating Providers to avoid the extra expenses that you may incur if you obtain care from Non-participating Providers. When you go to a Non-participating Provider without the Plan's prior approval, you may end up financially responsible for significant sums. A more detailed explanation is found in the "Your Payment Responsibilities" section of this Handbook.
- Coverage for certain procedures requires the Plan's prior approval. Contact our office for clarifications.
- If you lose your coverage for any reason at any time during your off-island care, you will be required to reimburse Calvo's SelectCare or any providers for charges incurred beyond the insurance coverage period.
- **Coverage for dependent child or children residing in the Continental USA:** We will extend coverage to an eligible dependent child or children residing in the Continental USA through the PHCS/ Multiplan PPO network. We recommend that you or your dependent child identify and select a medical provider by accessing the PHCS/ Multiplan website: https://www.multiplan.com. Once a provider is identified, it is advisable that you inform us, so we can issue a coverage letter to your child and the provider. This will improve the manner in which your dependent child or children access care. It is also recommended that you check with the provider regarding his or her participation with the PHCS/ Multiplan network, as their participation status may change.

Please notify us immediately for any of the following:

- Hospital Admission
  - Outpatient Surgery
  - Emergency Room Visit
  - High Level Diagnostic Testing such as MRIs or CT Scans

Completing your

Deductible/Reimbursement Claim Form

Reminder:

Deductible/Reimbursement Claims along with all receipts must be submitted within **120 days from the date of service,** otherwise these expenses will not be covered.

If you are seeking reimbursement on a claim you have paid, it is important that you provide us with the following in order for us to process your claim or reimbursement in a timely manner:

- **A properly completed Deductible/Reimbursement Claim Form; and**
- **ALL the required information below:**

Medical or Dental Services

- **Medical & Dental:** Name of Doctor
- **Medical:** Diagnosis Code (ICD)
- **Medical & Dental:** Procedure Code (CPT & Modifier)
- **Medical & Dental:** Itemized Bill of Charges
- **Medical:** Clinic Notes from Doctor
- **Dental:** Tooth # or Surface or Quadrant
- **Medical & Dental:** Proof of Payment
- **Medical:** If injury from an accident - Cause and Place of Accident
- **Medical Certificate from Philippine or foreign Non-participating Providers**

Hospital Services

- UB04 Claim Form
- Itemized Bill of Charges
- Complete Medical Report
- Patient's Account Number
- Proof of Payment

Laboratory

- Name of Laboratory
- Diagnosis Code (ICD)
- Procedure Code (CPT)
- Description of Procedure
- Itemized Bill of Charges
- Proof of Payment

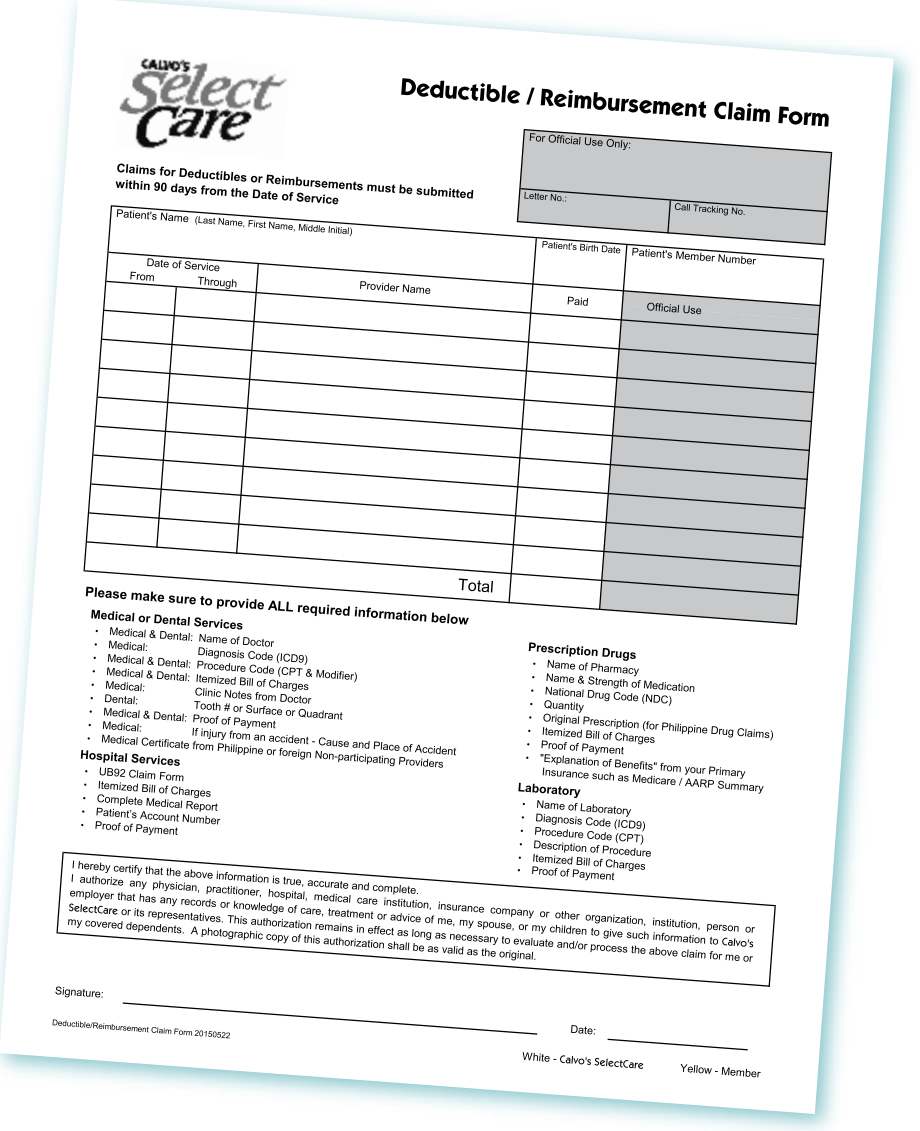
Prescription Drugs

- Name of Pharmacy
- Name & Strength of Medication
- National Drug Code (NDC)
- Quantity
- Original Prescription (for Philippine Claims)
- Itemized Bill of Charges
- Proof of Payment

Please Note:

All reimbursements will be processed based on the contracted fees with our Participating Providers. You may need to seek reimbursement from a provider for any excess charges over such contracted fees.

We will not be able to accept any bill or required document in a foreign language unless it is translated to English.



CALVO'S Select Care

Deductible / Reimbursement Claim Form

For Official Use Only:

Letter No.: | Call Tracking No.

Claims for Deductibles or Reimbursements must be submitted within 90 days from the Date of Service

Patient's Name (Last Name, First Name, Middle Initial) | Patient's Birth Date | Patient's Member Number

Date of Service From	Through	Provider Name	Paid	Official Use
		Total		

Please make sure to provide ALL required information below

Medical or Dental Services

- Medical & Dental: Name of Doctor
- Medical: Diagnosis Code (ICD9)
- Medical & Dental: Procedure Code (CPT & Modifier)
- Medical & Dental: Itemized Bill of Charges
- Medical: Clinic Notes from Doctor
- Dental: Tooth # or Surface or Quadrant
- Medical & Dental: Proof of Payment
- Medical: If injury from an accident - Cause and Place of Accident
- Medical Certificate from Philippine or foreign Non-participating Providers

Hospital Services

- UB92 Claim Form
- Itemized Bill of Charges
- Complete Medical Report
- Patient's Account Number
- Proof of Payment

Prescription Drugs

- Name of Pharmacy
- Name & Strength of Medication
- National Drug Code (NDC)
- Quantity
- Original Prescription (for Philippine Drug Claims)
- Itemized Bill of Charges
- Proof of Payment
- "Explanation of Benefits" from your Primary Insurance such as Medicare / AARP Summary

Laboratory

- Name of Laboratory
- Diagnosis Code (ICD9)
- Procedure Code (CPT)
- Description of Procedure
- Itemized Bill of Charges
- Proof of Payment

I hereby certify that the above information is true, accurate and complete. I authorize any physician, practitioner, hospital, medical care institution, insurance company or other organization, institution, person or employer that has any records or knowledge of care, treatment or advice of me, my spouse, or my children to give such information to Calvo's SelectCare or its representatives. This authorization remains in effect as long as necessary to evaluate and/or process the above claim for me or my covered dependents. A photographic copy of this authorization shall be as valid as the original.

Signature: _____ Date: _____

Deductible/Reimbursement Claim Form 20150522

White - Calvo's SelectCare Yellow - Member

List of Procedures & CPT Codes requiring Pre-Certification:

Procedures which are not specifically listed will be evaluated based on Medical Necessity and the member's plan benefits. Medicare CCI rules apply. This is a brief summary and list may change throughout the year.

	Procedures	CPT Range
1	All outpatient surgical procedures requiring use of surgical facilities (except for female sterilization)	
2	Any and all Diagnostic & Surgical Procedures in excess of $300.00	
3	Arthroscopy (knee)	29870
4	Cardiac Catheterization	93501, 93510-11, 93514, 93524, 93526-93533, 93536, 93539-45
5	Carpal Tunnel Release, Monofilament Testing	
6	Chemotherapy and Radiation Therapy	
7	Diagnostic Colonoscopy / Proctosigmoidoscopy	45380, 45355, 45382-83, 45379, 45384-85, 44388-44392, 44394
8	CT Scans	
9	Dexa Scans	76075-76076
10	Diagnostic Laparoscopy (pelvic)	49320
11	Durable Medical Equipment: Std. hospital bed, Std. wheelchairs, walkers, crutches, oxygen, suction machine	
12	EMG / NCT (upper extremities)/ Autonomic Testing	95860-95864, 95872
13	Home Health Referrals	
14	Laparoscopic Vaginal Hysterectomy	47562-47564
15	Mammograms (with the exception of those for routine screening according to the guidelines of the American Cancer Society)	
16	MIBI Scan, Thallium Stress Test, Exercise Stress Test	
17	MRI's	
18	Nuclear Medicine Studies	
19	Ophthalmology Diagnostic Procedures	92225-92287, 92018-92140
20	Pain Management Studies & Treatment	
21	Percutaneous Coronary Angioplasty	92982, 92984, 92986, 92986, 92987, 92990
22	Percutaneous Diskectomy	62287
23	Physical Therapy requiring more than five (5) out-patient visits	
24	Wellness Center Referrals	
25	Sleep Apnea Studies	95810
26	Ultrasounds (Except the first OB ultrasound)	
27	Upper GI Endoscopy	43234-35, 43239, 43241, 43243, 43233-51, 43255, 43258-59
28	Dx procedures performed or ordered by the same provider on any one patient two or more times	
29	Specialty Medications	See Drug Formulary

Guam

115 Chalan Santo Papa
P.O. Box FJ Hagåtña, Guam 96932
Monday-Friday 8:30am to 5:00pm
Saturday 8:30am to 1:30pm
Phone: (671) 477-9808
Fax: (671) 477-4141

Saipan

Oleai Center Bldg., San Jose
P.O. Box 500035, Saipan, MP 96950-0035
Monday-Friday 8:30am to 5:00pm
Saturday 8:30am to 1:30pm
Phone: (670) 234-5690/9
Fax: (670) 234-5696

Palau

JR Professional Bldg., Suite 2
P.O. Box 10248, Koror, Palau 96940
Monday-Friday 8:00am to 5:00pm
Phone: (680) 488-7222
Fax: (680) 488-7333

Philippines

5th Floor, First Life Center
174 Salcedo Street, Legaspi Village
Makati City, Philippines
Monday-Friday 8:00am to 5:00pm
Phone: (632) 759-2871/813-1989
Fax: (632) 759-3126

St. Luke's Medical Center: Global City

Rm. 1008 10th Floor
Medical Arts Building
32nd St. Bonifacio Global City
Taguig City, 1112 Philippines
Monday-Friday 8:00am to 4:30pm
Phone: (632) 555-0443/0448
Fax: (632) 555-0438

St. Luke's Medical Center: Quezon City

Rm. 716 7th Floor, North Tower
Cathedral Heights Building Complex
St. Luke's Medical Center Compound
#279 E. Rodriguez Sr. Avenue,
Quezon City, Philippines
Monday-Friday 8:00am to 4:30pm
Phone: (632) 413-1312
Fax: (632) 413-5721

The Medical City: Pasig City

Business Center, 9th Floor
The Medical City, Ortigas Center
Pasig City, Philippines
Monday-Friday 8:00am to 4:30pm
Phone: (632) 650-0589

Web

www.calvos.net

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