GROUP
ADMINISTRATIVE
Guide

CALVO'S Select Care HEALTH PLANS

GROUP
ADMINISTRATIVE
Guide

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Welcome

We thank you for selecting Calvo's SelectCare; your business is important to us. This Group Administrative Guide is designed to assist you in the administration of your health plan. This guide contains instructions on how to decide if your employees are eligible for coverage and when they are able to enroll.

This guide also lists what documentation is required for different circumstances. The billing section will help you understand our billing procedures and timelines.

Updates or revisions to this guide will be provided to you should any changes occur. We also welcome any comments or suggestions you may have that will assist us in better serving your needs. Please call your account representative or our Group Administration Department if you have any questions or encounter a situation not covered in this guide.

How to Contact Us:

GUAM

115 Chalan Santo Papa Hagatna, Guam
Telephone: (671) 477-9808 **Fax:** (671) 477-4141
Mailing Address: P.O. Box FJ Hagatna, Guam 96932
Hours of Operation: Monday through Friday: 8:30 a.m. to 5:00 p.m.
Saturday: 8:30 a.m. to 1:30 p.m.

SAIPAN

Oleai Center Building San Jose, Saipan
Telephone: (670) 234-5690/9 **Fax:** (670) 234-5693
Mailing Address: P.O. Box 500035 Saipan, MP 96950-0035
Hours of Operation: Monday through Friday: 8:30 a.m. to 5:00 p.m.
Saturday: 8:30 a.m. to 1:30 p.m.

PALAU

JR Professional Bldg., Suite 2
Telephone: (680) 488-7222 **Fax:** (680) 488-7333
Mailing Address: P.O. Box 10248 Koror, Palau 96940
Hours of Operation: Monday through Friday: 8:30 a.m. to 5:00 p.m.
Saturday: 8:30 a.m. to 1:30 p.m.

Eligibility Requirements for Employees

- An employee is eligible for enrollment only if he or she resides in the Service Area; this is the jurisdiction where the policy is issued; which is normally either Guam, the CNMI or Palau.

- An employee must be permanent full-time status with a normal workweek of at least thirty (30) hours.

- Taxes must be withheld from an employee's payroll.

- An employee must be 16 years of age or older.

- Employees generally not eligible for coverage include:
  - Part-time employees or employees who work less than thirty (30) hours per week
  - Temporary employees
  - Seasonal employees
  - Board of Directors, Partners and Officers unless they are full-time employees of the group
  - Independent Contractors
  - Unpaid workers
  - Members of household staff or personal employees
  - Employees not having satisfied the group imposed probation or introductory period
  - Employees on long term disability
  - Employees not scheduled to return to work

Enrollment

- Employees normally become eligible after completing a probation or introductory period. Employers are not allowed to waive a portion of an employee's probation period without the approval from the Plan.

- Employees and their dependents may ONLY enroll during an Open Enrollment period or immediately after first becoming eligible to enroll under the plan.

- An "Open Enrollment" period is the 30-day period prior to a group's annual renewal date in which employees and dependents are eligible to enroll for coverage or make changes to their coverage under a health plan.

- During an Open Enrollment Period or when an employee first becomes eligible, a new enrollee must complete an Enrollment Application for coverage. The application should be completed thoroughly and contain all necessary information on the employee and any dependents enrolling for coverage. The employee MUST sign and date the application. In addition, you as the employer must sign the application.

- Coverage will be effective on the first day of the month following the date the employee has met the probation period, and provided the enrollment application was received within 30 days from that date. For example, if a newly eligible employee was to enroll for coverage on January 15th, coverage will not be effective until February 1st.

- **An employee or dependent who does not submit an application during the Open Enrollment Period, or, within 30 days from the date they are first eligible will be considered a Late Enrollee. Late Enrollees are not allowed in the plan and will not be afforded coverage unless any of the following "Qualifying Events" apply.**

Qualifying Events:

- An employee gains a new dependent as a result of marriage, birth, adoption, or placement for adoption, provided that they enroll such dependent within 30 days of the marriage, birth, adoption, or placement for adoption. Coverage will be effective on the 1st day of becoming a dependent.

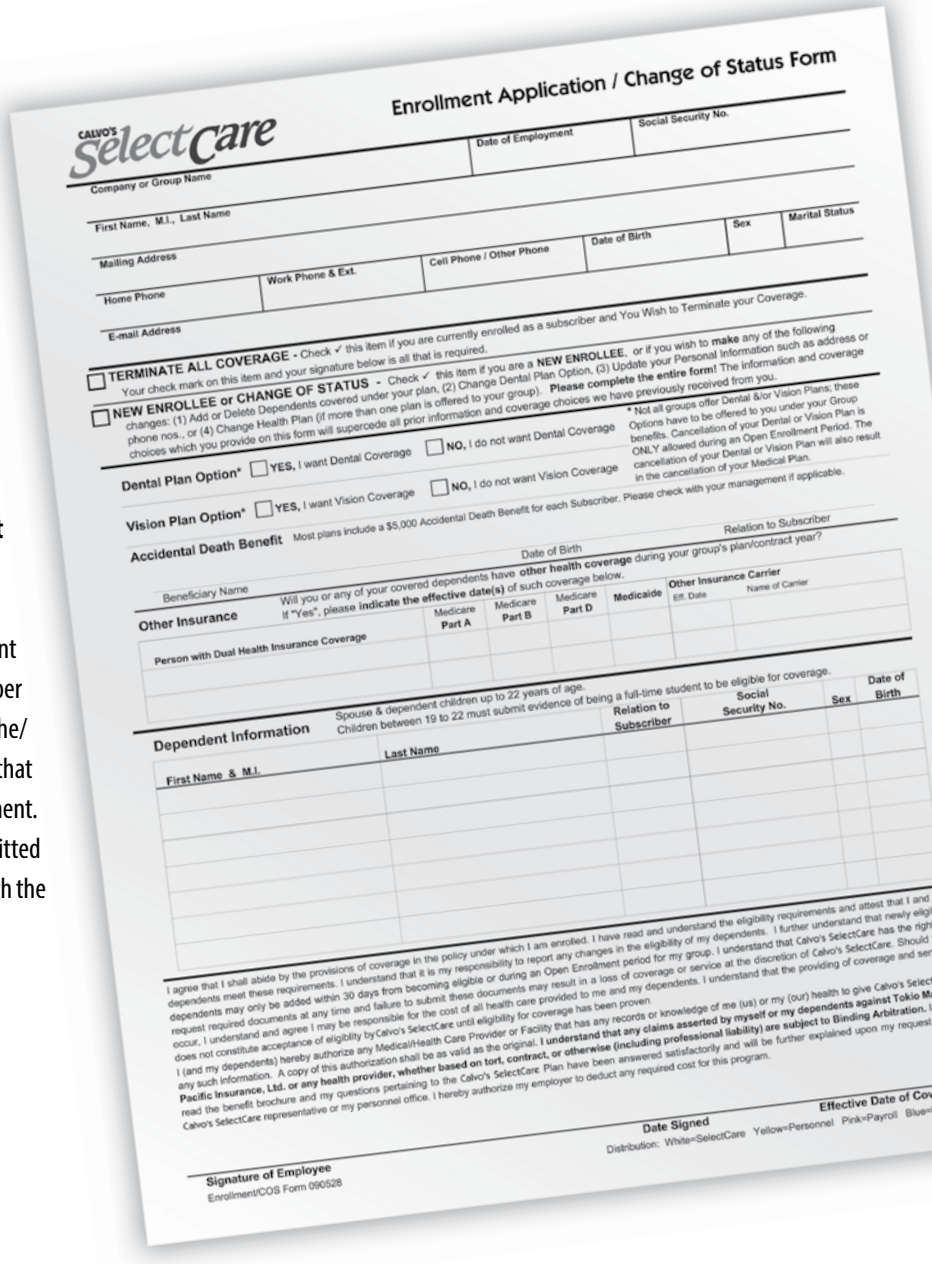
- An employee declined coverage when first becoming eligible under this plan or during an Open Enrollment period because they had other health insurance at that time and now, that coverage is lost. A completed Health Statement and a HIPAA Certificate are required in addition to the Enrollment Application. The treatment of any pre-existing conditions may be excluded from coverage until your plan's next anniversary date.

  A more detailed explanation regarding health statements, HIPAA certificates and pre-existing conditions can be found under the "For Companies with less than 20 Employees" section of this Guide.

- **Enrollment documents must be received within 30 days of the "Qualifying Event" or loss of coverage.**

- **All other Late Enrollees will not be eligible to enroll until the next Open Enrollment Period.**

- **Military Service** - If an employee or their dependent cancels coverage to serve in the military, the member would be granted reinstatement into the same plan he/she was enrolled at the time of cancellation provided that he/she is eligible for coverage at the time of re-enrollment. An application requesting re-enrollment must be submitted within 30 days from the date their particular service with the military ends.



CALVO'S SelectCare

Enrollment Application / Change of Status Form

Company or Group Name | Date of Employment | Social Security No.

First Name, M.I., Last Name

Mailing Address

Home Phone | Work Phone & Ext. | Cell Phone / Other Phone | Date of Birth | Sex | Marital Status

E-mail Address

☐ **TERMINATE ALL COVERAGE** - Check ✓ this item if you are currently enrolled as a subscriber and You Wish to Terminate your Coverage.
Your check mark on this item and your signature below is all that is required.

☐ **NEW ENROLLEE or CHANGE OF STATUS** - Check ✓ this item if you are a **NEW ENROLLEE**, or if you wish to **make** any of the following changes: (1) Add or Delete Dependents covered under your plan, (2) Change Dental Plan Option, (3) Update your Personal Information such as address or phone nos., or (4) Change Health Plan (if more than one plan is offered to your group). **Please complete the entire form!** The information and coverage choices which you provide on this form will supercede all prior information and coverage choices we have previously received from you.

Dental Plan Option* ☐ **YES,** I want Dental Coverage ☐ **NO,** I do not want Dental Coverage

Vision Plan Option* ☐ **YES,** I want Vision Coverage ☐ **NO,** I do not want Vision Coverage

* Not all groups offer Dental &/or Vision Plans; these Options have to be offered to you under your Group benefits. Cancellation of your Dental or Vision Plan is ONLY allowed during an Open Enrollment Period. The cancellation of your Dental or Vision Plan will also result in the cancellation of your Medical Plan.

Accidental Death Benefit Most plans include a $5,000 Accidental Death Benefit for each Subscriber. Please check with your management if applicable.

Beneficiary Name | Date of Birth | Relation to Subscriber

Other Insurance Will you or any of your covered dependents have **other health coverage** during your group's plan/contract year?
If "Yes", please **indicate the effective date(s)** of such coverage below.

Person with Dual Health Insurance Coverage	Medicare Part A	Medicare Part B	Medicare Part D	Medicaide	Other Insurance Carrier Eff. Date	Name of Carrier

Dependent Information Spouse & dependent children up to 22 years of age.
Children between 19 to 22 must submit evidence of being a full-time student to be eligible for coverage.

First Name & M.I.	Last Name	Relation to Subscriber	Social Security No.	Sex	Date of Birth

I agree that I shall abide by the provisions of coverage in the policy under which I am enrolled. I have read and understand the eligibility requirements and attest that I and dependents meet these requirements. I understand that it is my responsibility to report any changes in the eligibility of my dependents. I further understand that newly eligi dependents may only be added within 30 days from becoming eligible or during an Open Enrollment period for my group. I understand that Calvo's SelectCare has the righ request required documents at any time and failure to submit these documents may result in a loss of coverage or service at the discretion of Calvo's SelectCare. Should occur, I understand and agree I may be responsible for the cost of all health care provided to me and my dependents. I understand that the providing of coverage and ser does not constitute acceptance of eligibility by Calvo's SelectCare until eligibility for coverage has been proven.
I (and my dependents) hereby authorize any Medical/Health Care Provider or Facility that has any records or knowledge of me (us) or my (our) health to give Calvo's Select any such information. A copy of this authorization shall be as valid as the original. **I understand that any claims asserted by myself or my dependents against Tokio M Pacific Insurance, Ltd. or any health provider, whether based on tort, contract, or otherwise (including professional liability) are subject to Binding Arbitration.** I read the benefit brochure and my questions pertaining to the Calvo's SelectCare Plan have been answered satisfactorily and will be further explained upon my request Calvo's SelectCare representative or my personnel office. I hereby authorize my employer to deduct any required cost for this program.

Signature of Employee | **Date Signed** | **Effective Date of Cov**

Distribution: White=SelectCare Yellow=Personnel Pink=Payroll Blue=

Enrollment/COS Form 090528

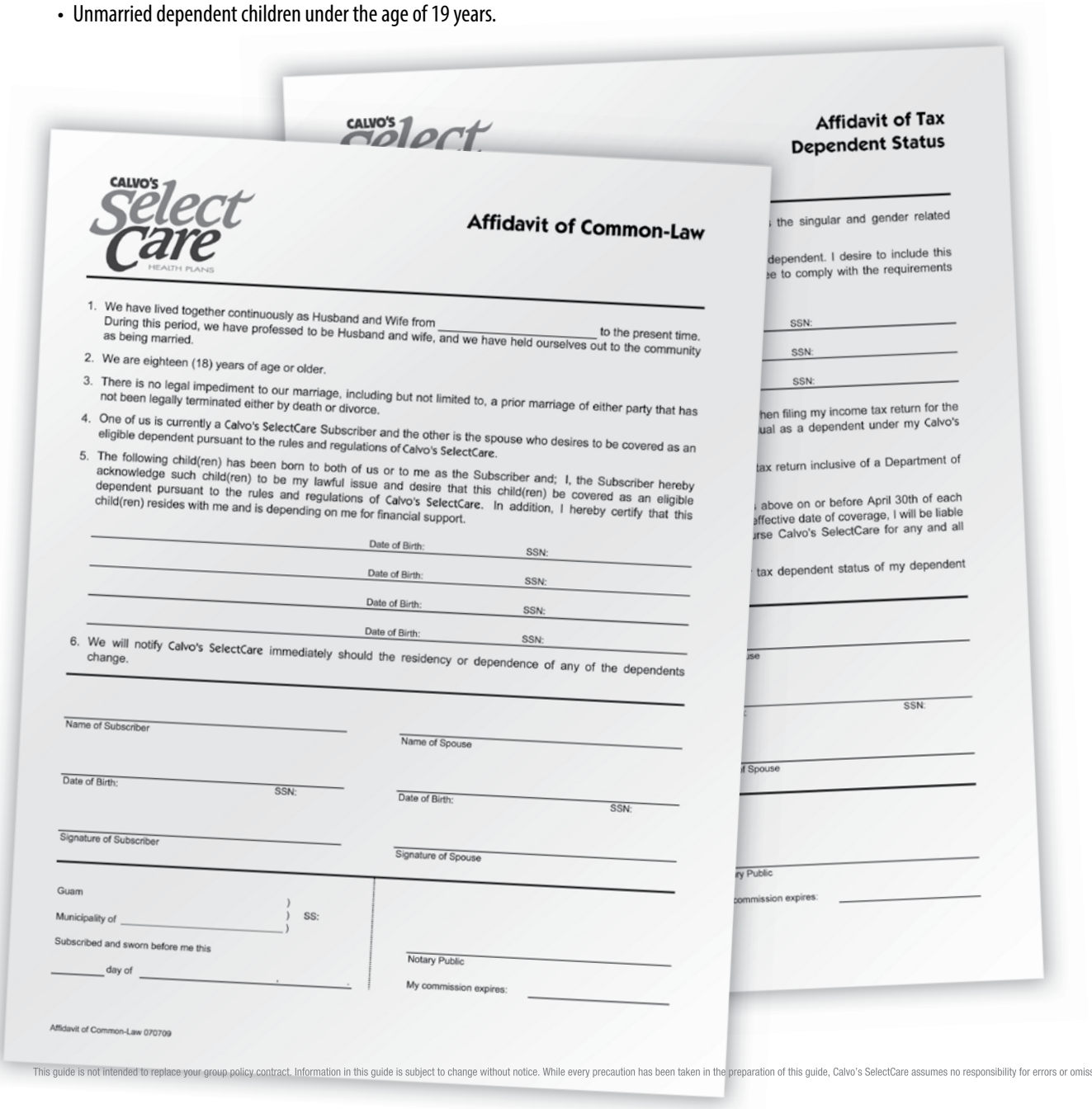
Eligibility and Documentation Requirements for Dependents

Eligible dependents must reside in the service area unless attending school. Eligible dependents of the employee are any of the following:

- Employee's legal spouse.

- Employee's common-law spouse (subject to your Group's employment and benefit policies).
  - A common-law spouse must be at least 18 years of age and must have lived with the employee for two consecutive years. A notarized Affidavit of Common Law is required.
  - A common-law spouse may ONLY be added within 30 days from the date the employee first becomes eligible to enroll in the plan or during your Open Enrollment Period.
  - Children of a common-law spouse, who are not the employee's natural children, are not eligible for coverage unless Full Legal Guardianship is granted to the employee or adopted by the employee. "Full Legal Guardianship" means 100% Guardianship and may not be limited or shared.

- Unmarried dependent children under the age of 19 years.



CALVO'S Select Care HEALTH PLANS

Affidavit of Common-Law

1. We have lived together continuously as Husband and Wife from _____ to the present time. During this period, we have professed to be Husband and wife, and we have held ourselves out to the community as being married.
2. We are eighteen (18) years of age or older.
3. There is no legal impediment to our marriage, including but not limited to, a prior marriage of either party that has not been legally terminated either by death or divorce.
4. One of us is currently a Calvo's SelectCare Subscriber and the other is the spouse who desires to be covered as an eligible dependent pursuant to the rules and regulations of Calvo's SelectCare.
5. The following child(ren) has been born to both of us or to me as the Subscriber and; I, the Subscriber hereby acknowledge such child(ren) to be my lawful issue and desire that this child(ren) be covered as an eligible dependent pursuant to the rules and regulations of Calvo's SelectCare. In addition, I hereby certify that this child(ren) resides with me and is depending on me for financial support.

Date of Birth: SSN:
Date of Birth: SSN:
Date of Birth: SSN:
Date of Birth: SSN:

6. We will notify Calvo's SelectCare immediately should the residency or dependence of any of the dependents change.

Name of Subscriber | Name of Spouse
Date of Birth: SSN: | Date of Birth: SSN:
Signature of Subscriber | Signature of Spouse

Guam)
Municipality of _____) SS:
)
Subscribed and sworn before me this
_____ day of _____

Notary Public
My commission expires: _____

Affidavit of Common-Law 070709

CALVO'S Select

Affidavit of Tax Dependent Status

the singular and gender related
dependent. I desire to include this
e to comply with the requirements
SSN:
SSN:
SSN:
hen filing my income tax return for the
ual as a dependent under my Calvo's
tax return inclusive of a Department of
above on or before April 30th of each
effective date of coverage, I will be liable
rse Calvo's SelectCare for any and all
tax dependent status of my dependent
se
SSN:
f Spouse
ry Public
commission expires:

- Dependent children who are beyond the age of 19 thru 22 years may be eligible provided the 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 Fall and Spring semester or quarter. Failure to regularly submit the student verification letter will result in the termination of coverage for such dependent. Consequently, the employee would have to wait until the next Open Enrollment Period to enroll the dependent.
    - Coverage for full-time students will terminate upon reaching the age of 23 years.

- For natural children with a different last name from the employee, the following must be provided:
    - A copy of the birth certificate which verifies the employee as a parent, or
    - A notarized government Paternity Form which verifies the employee as a natural parent.

- Other dependents such as stepchildren, legally adopted children, and children who have been awarded legal guardianship, the following must be provided:
    - Birth Certificate.
    - Parents' marriage certificate (when required).
    - Court documentation signed by a judge ordering Adoption or Full Legal Guardianship. A copy of the guardian's latest income tax filing or a notarized Affidavit of Tax Dependent Status stating that the dependent will be included in the guardian's next tax filing.
    - A 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 employee's tax filing may be required.

- Q.M.C.S.O. or Qualified Medical Child Support Order is a court order that provides health benefit coverage for the child of a non-custodial parent under that parent's group health plan. A copy of the QMCSO must be provided. Children permanently residing outside the service area are only eligible to enroll in the plan if they qualify under the QMCSO.

Dependents NOT eligible for coverage include:

- Ex-Spouse, even if required by legal decree;
- Parents and other adult relatives;
- Unborn children;
- Children who are 23 years of age or older or who are married.

Minimum Participation Requirements

In addition to our medical plans, you may elect to offer your employees a dental plan and/or a vision benefit. Please be aware of the specific minimum participation requirements below. The minimum percentages are computed against either (a) "Eligible Employees" as defined above or (b) Employees enrolled under our medical plan. Calvo's SelectCare reserves the right to revise premiums or cancel coverage should a group fail to maintain any minimum participation requirement during a contract/plan year.

Employees are not permitted to enroll in a dental or vision plan without being enrolled in a medical plan.

Once enrolled in any plan, Employees are committed to participate in that plan for the entire contract/plan year.

For Companies with less than 20 employees:

Health Statements and HIPAA Certificates: Employees enrolling are required to complete and sign a Health Statement in addition to the Enrollment Application. The Health Statement should accurately detail any and all medical conditions. Upon review of a Health Statement, we may request pertinent medical records from the employee or medical records can already be attached to the Health Statement upon its initial submission.

	Less Than 10 Eligible Employees	11-19 Eligible Employees	20 and Over Eligible Employees
Medical	100% participation of all Eligible employees is required	80% participation of all Eligible employees is required	75% participation of all Eligible employees is required
Dental	100% participation of all Eligible employees is required	75% participation of all Medical enrolled employees is required	50% participation of all Medical enrolled employees is required
Vision	100% participation of all Eligible employees is required	100% participation of all Medical enrolled employees is required	100% participation of all Medical enrolled employees is required

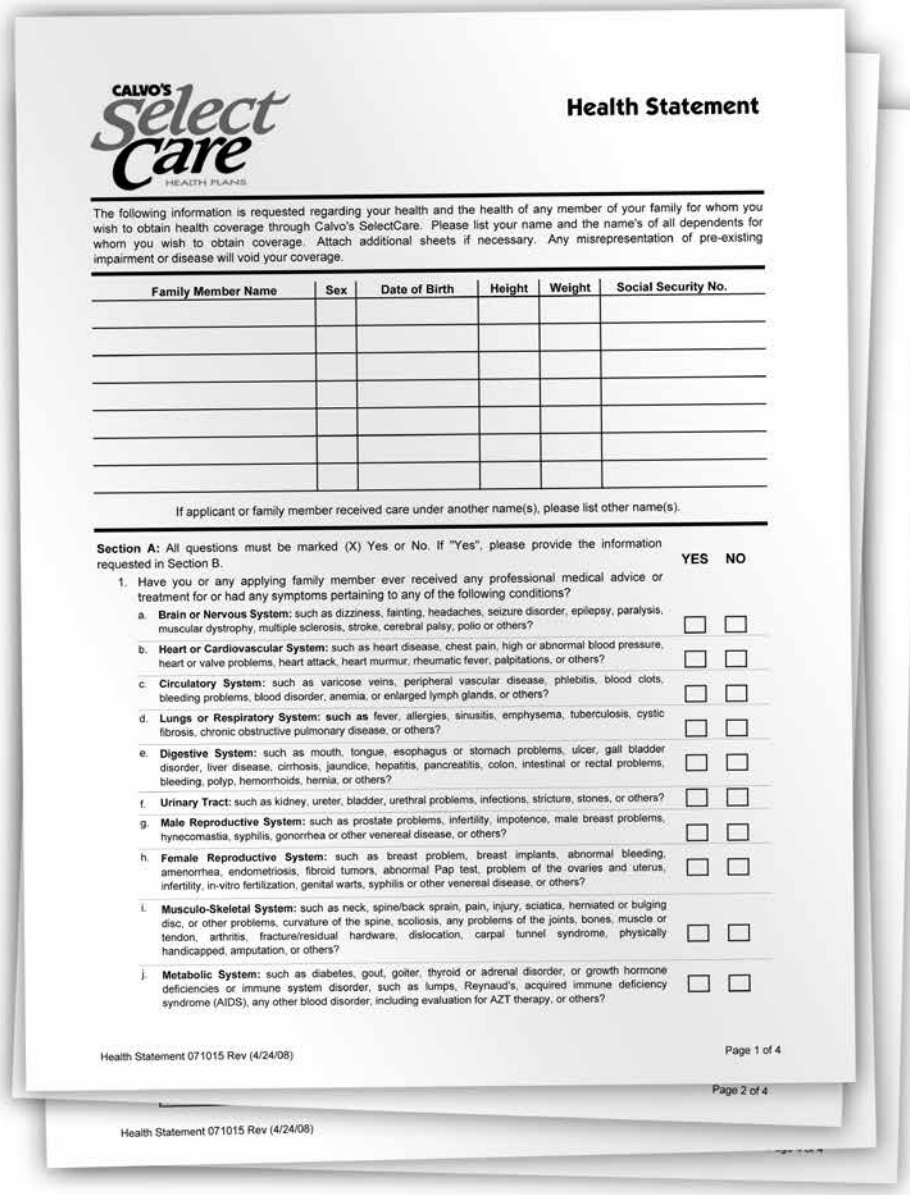
We will NOT cover claims related to any pre-existing conditions. However, the Health Insurance Portability and Accountability Act (HIPAA) limits what we are able to define as a pre-existing condition and the amount of time any exclusion applies.

HIPAA contains different rules covering different situations relating to the exclusions of pre-existing conditions. Any prior coverage and any breaks in prior coverage play an important role in these rules. For typical circumstances under HIPAA:

- We can only look back and review an applicant's medical history during the preceding six (6) months prior to the effective date of coverage to identify any pre-existing conditions.

- We can only exclude from coverage, a pre-existing condition for a maximum of twelve (12) months.

- However, the twelve (12) month exclusionary period can be reduced if the employee had coverage prior to enrolling under the plan. The length of the exclusionary period will depend on the length of any gap in coverage between their previous plan and their new plan. A Certificate of Prior Creditable Coverage from their previous plan will be required. If they did have prior health coverage and are having difficulty in acquiring a certificate, we can help obtain one from their prior plan or issuer. There are also other ways to show evidence of creditable coverage. Please contact us if employees need help demonstrating



CALVO'S Select Care HEALTH PLANS

Health Statement

The following information is requested regarding your health and the health of any member of your family for whom you wish to obtain health coverage through Calvo's SelectCare. Please list your name and the name's of all dependents for whom you wish to obtain coverage. Attach additional sheets if necessary. Any misrepresentation of pre-existing impairment or disease will void your coverage.

Family Member Name	Sex	Date of Birth	Height	Weight	Social Security No.

If applicant or family member received care under another name(s), please list other name(s).

Section A: All questions must be marked (X) Yes or No. If "Yes", please provide the information requested in Section B. YES NO

1. Have you or any applying family member ever received any professional medical advice or treatment for or had any symptoms pertaining to any of the following conditions?
   - a. **Brain or Nervous System:** such as dizziness, fainting, headaches, seizure disorder, epilepsy, paralysis, muscular dystrophy, multiple sclerosis, stroke, cerebral palsy, polio or others?
   - b. **Heart or Cardiovascular System:** such as heart disease, chest pain, high or abnormal blood pressure, heart or valve problems, heart attack, heart murmur, rheumatic fever, palpitations, or others?
   - c. **Circulatory System:** such as varicose veins, peripheral vascular disease, phlebitis, blood clots, bleeding problems, blood disorder, anemia, or enlarged lymph glands, or others?
   - d. **Lungs or Respiratory System: such as** fever, allergies, sinusitis, emphysema, tuberculosis, cystic fibrosis, chronic obstructive pulmonary disease, or others?
   - e. **Digestive System:** such as mouth, tongue, esophagus or stomach problems, ulcer, gall bladder disorder, liver disease, cirrhosis, jaundice, hepatitis, pancreatitis, colon, intestinal or rectal problems, bleeding, polyp, hemorrhoids, hernia, or others?
   - f. **Urinary Tract:** such as kidney, ureter, bladder, urethral problems, infections, stricture, stones, or others?
   - g. **Male Reproductive System:** such as prostate problems, infertility, impotence, male breast problems, hynecomastia, syphilis, gonorrhea or other venereal disease, or others?
   - h. **Female Reproductive System:** such as breast problem, breast implants, abnormal bleeding, amenorrhea, endometriosis, fibroid tumors, abnormal Pap test, problem of the ovaries and uterus, infertility, in-vitro fertilization, genital warts, syphilis or other venereal disease, or others?
   - i. **Musculo-Skeletal System:** such as neck, spine/back sprain, pain, injury, sciatica, herniated or bulging disc, or other problems, curvature of the spine, scoliosis, any problems of the joints, bones, muscle or tendon, arthritis, fracture/residual hardware, dislocation, carpal tunnel syndrome, physically handicapped, amputation, or others?
   - j. **Metabolic System:** such as diabetes, gout, goiter, thyroid or adrenal disorder, or growth hormone deficiencies or immune system disorder, such as lumps, Reynaud's, acquired immune deficiency syndrome (AIDS), any other blood disorder, including evaluation for AZT therapy, or others?

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prior creditable coverage.

- Should a pre-existing condition be excluded from coverage, the member will be provided with an exclusion notice imposed on their coverage.

For any pre-existing conditions which have not been properly disclosed in the Health Statement, we reserve the right to deny any claim for services incurred for or related to a medical condition that would have otherwise been excluded.

We will issue a Certificate of Coverage to participants upon termination of their coverage. Any certificate that we issue will reflect only coverage with Calvo's SelectCare.

SWICA Reports: We require copies of your Quarterly Wage Reports (SWICA) as part of our group and employee eligibility verification process. Please submit copies of your SWICA report to Calvo's SelectCare on a quarterly basis at the same time you would report to the tax authority.

Change of Status (COS) Procedures

An Enrollment Application/Change of Status (COS) Form is used to add or delete dependents such as a newborn or a new spouse. It is used to report any type of change in the employee's file history such as the mailing address or phone numbers. It is also used to report terminations or cancellations of coverage.

All required documents (i.e. affidavits, birth certificate or health statements) must accompany the COS Form when submitting to the Plan. Each COS Form should be reviewed for accuracy. It should also be reviewed to see if the request from the employee meets plan requirements and guidelines. Any issues regarding eligibility should be resolved with your employee before submitting forms and documentation to the plan. It is important to ensure that all COS Forms be signed by both the employee AND employer. Dependents may not sign the COS Form. In the occasional event you may be unable to secure the signature of the employee on the COS Form (if the employee has already terminated employment or is physically unable to sign the COS form), please submit the form with a brief note explaining the reason the employee was unable to sign the form.

Deadline for Submissions

All Enrollment Applications and COS Forms, complete with the required documentation, must be submitted and received by the plan no later than the twentieth (20th) of each month in order to become effective on the first day of the next month.

Please note that despite certain changes in status becoming effective in the middle of a month, such as the birth of a baby or the termination of employment, the change in monthly premium charge associated with any billing class changes cannot be made on a pro-rata basis and the new monthly premium charge will be due in full.

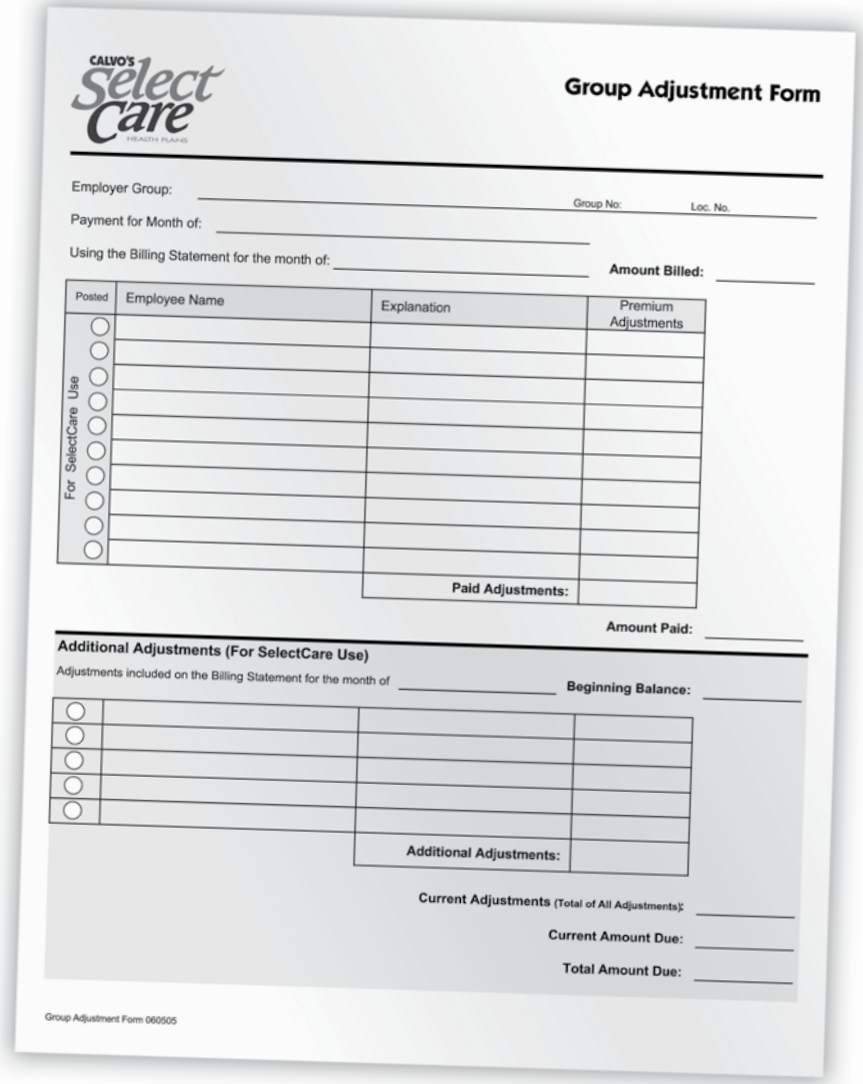
Termination of Coverage

Coverage under Calvo's SelectCare will be terminated at the following earliest occurrence:
We take reasonable steps to confirm any occurrence listed below and we afford members a reasonable opportunity to provide evidence of eligibility under their plan. In the event we terminate coverage later than an actual occurrence date, all premiums are due and payable up to the date we terminate coverage.

- Employment terminates (unless COBRA applies)
- The employee is no longer an eligible employee
- The group decides to terminate group health coverage with Calvo's SelectCare
- The group discontinues or suspends active business operations
- The group falls below the minimum of two (2) employees
- The group fails to make timely premium payments
- Calvo's SelectCare determines that a member has intentionally misrepresented any enrollment information
- A member fails to submit any required documents or information after reasonable notice from Calvo's SelectCare to submit such required documents or information
- A child reaches the attainment age of 19 years unless attending an institution of higher learning
- A child gets married or reaches the attainment age of 23 years

Billing Statement & Payment

The Group Billing Statement lists the charges and/or credits for all employees who were covered when the statement was prepared. An advanced billing statement will be transmitted to you on or about the twenty-fifth (25th) of the month. The billing statement will reflect current and prior billing information, including any changes in your group's eligibility which have been reported to Calvo's SelectCare since the last billing statement.



CALVO'S Select Care HEALTH PLANS

Group Adjustment Form

Employer Group: _____ Group No: _____ Loc. No. _____

Payment for Month of: _____

Using the Billing Statement for the month of: _____ **Amount Billed:** _____

Posted	Employee Name	Explanation	Premium Adjustments
For SelectCare Use			
		Paid Adjustments:	

Amount Paid: _____

Additional Adjustments (For SelectCare Use)

Adjustments included on the Billing Statement for the month of _____ **Beginning Balance:** _____

	Additional Adjustments:	

Current Adjustments (Total of All Adjustments): _____

Current Amount Due: _____

Total Amount Due: _____

Group Adjustment Form 060505

We request that you pay the "Total Amount Due" even though some recent changes you may have already submitted are not yet reflected on the latest billing statement. All changes and adjustments, which have not been reflected on the latest billing statement, should be shown on the next month's billing statement.

If you do not pay the "Total Amount Due" as indicated on the billing statement, it is absolutely necessary for you to provide Calvo's SelectCare with information detailing the difference in amount between the "Total Amount Due" on the billing statement and your actual payment. This information should accompany the payment. It can be communicated to us on our Group Adjustment Form or any other acceptable method of providing us with the necessary information.

The premium payment is then due on the 20th day of the month prior to coverage. A grace period of ten (10) days is allowed for late payments. If Calvo's SelectCare does not receive payment for premiums before they are due, your group coverage will be terminated and claims will not be paid if incurred after the effective date of termination. If a group is cancelled due to the non-

payment of premium, Calvo's SelectCare is not obligated to reinstate coverage in the event that all premiums due are subsequently paid.

Listed below, is a timeline pertaining to billing and payment deadlines:

Billing Statement transmitted to groups	25th of the month 45 days prior to coverage
Payment is due and payable to Calvo's SelectCare	20th of the month prior to coverage
Delinquent letters transmitted to groups	21st of the month prior to coverage
Group Termination Effective Date	End of the month prior to coverage

If you have any question about your bill, please contact your Account Executive or our Group Administration Department.

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.

When Calvo's SelectCare denies payment of a claim or pre-certification/authorization of a service and if members disagree with the decision, they need to let us know within 60 days of the denial. We urge them to contact our Customer Service department to see if we can resolve the concern.

If not, we have established a formal grievance process. Our grievance process may involve 3 stages of reviews and appeals – (1) The Internal Review, (2) The External Review, 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 the member 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
- The factual circumstances arising 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

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

The Grievance Coordinator will gather all material provided in the request for review, along with pertinent 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. Members will be notified of

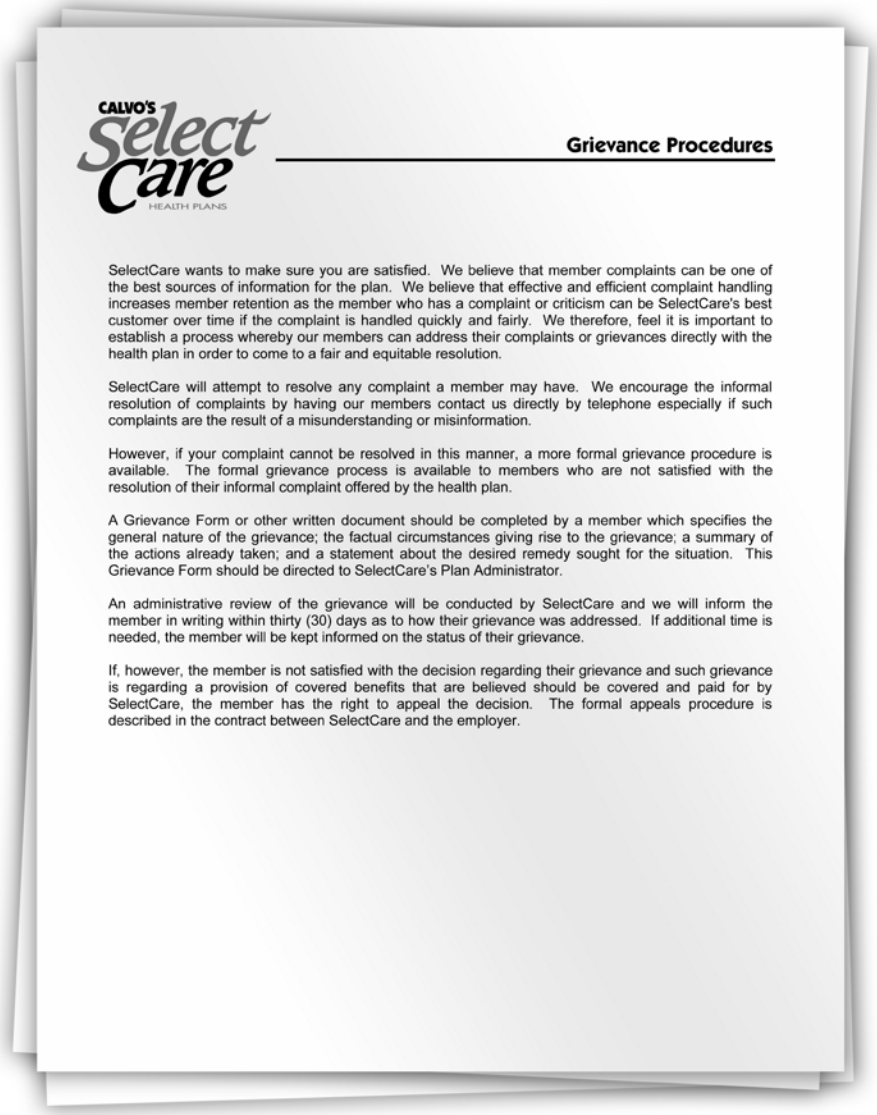
our decision in writing within 10-15 working days from receiving the complaint.

If the employee or authorized representative is dissatisfied with the Internal Review decision, they may request for an External Review. The External Review request must be made in writing to our Grievance Coordinator within 30 days of the Internal Review decision. The Coordinator will acknowledge the review request within 3 working days.

The External Review will be conducted by a Grievance Committee. The Grievance Committee shall consist of the following individuals in order to ensure that the member receives an unbiased evaluation.

- Calvo's SelectCare Plan Administrator or Associate Administrator
- Calvo's SelectCare Director of Utilization Management or Plan Medical Director
- Calvo's SelectCare Customer Service Manager
- Consumer Member
- Medical Provider
- Employer Group Representative

The committee will conduct a hearing within 45 days after the External Review request is received. The member or representative is encouraged to attend the hearing and will receive notice of the date and location at least 7 days prior to the hearing. The hearing is an informal meeting to promote a free exchange of information between the parties. The hearing format is relatively simple. The member or representative summarizes his or her concerns and desired remedies. The committee may ask questions. The health plan's representative then presents the Plan's response. Again, the committee asks any pertinent questions. Once the committee has received all available information, both parties are excused from the hearing. The committee discusses possible remedies. Committee decisions may be wholly for or against the member's position, partially for or against the member's position, or to mediate the grievance without rendering a decision. A vote is taken on the suggested resolutions, and the member is notified of the decision by letter within 5-7 working days after the hearing was conducted.



CALVO'S Select Care HEALTH PLANS

Grievance Procedures

SelectCare wants to make sure you are satisfied. We believe that member complaints can be one of the best sources of information for the plan. We believe that effective and efficient complaint handling increases member retention as the member who has a complaint or criticism can be SelectCare's best customer over time if the complaint is handled quickly and fairly. We therefore, feel 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.

SelectCare will attempt to resolve any complaint a member may have. We encourage the informal resolution of complaints by having our members contact us directly by telephone especially if such complaints are the result of a misunderstanding or misinformation.

However, if your complaint cannot be resolved in this manner, a more formal grievance procedure is available. The formal grievance process is available to members who are not satisfied with the resolution of their informal complaint offered by the health plan.

A Grievance Form or other written document should be completed by a member which specifies the general nature of the grievance; the factual circumstances giving rise to the grievance; a summary of the actions already taken; and a statement about the desired remedy sought for the situation. This Grievance Form should be directed to SelectCare's Plan Administrator.

An administrative review of the grievance will be conducted by SelectCare and we will inform the member in writing within thirty (30) days as to how their grievance was addressed. If additional time is needed, the member will be kept informed on the status of their grievance.

If, however, the member is not satisfied with the decision regarding their grievance and such grievance is regarding a provision of covered benefits that are believed should be covered and paid for by SelectCare, the member has the right to appeal the decision. The formal appeals procedure is described in the contract between SelectCare and the employer.

The member may appeal a hearing decision of the Grievance Committee through the process of Binding Arbitration. Binding Arbitration as contained in the Group Service Agreement is the process where those involved

agree to submit their dispute to an impartial third party for a final and binding decision. Disputes submitted to arbitration cannot be taken to court later.

Notice of Privacy Practices Protected Health Information

This notice is in effect as of April 14, 2003

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

Statement of Our Duties

Our organization is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the services we provide to you. We are required by law to maintain the privacy of your personal health information and to provide you with this notice of our privacy practices and legal duties. We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make any new provisions effective to all of the personal health information that we maintain about you. If we revise this notice, we will provide you with a revised notice by mail.

Statement of Your Rights

You have the right to know how we may use or disclose your personal health information. This notice informs you of those uses and disclosures. There are certain uses and disclosures of your personal health information that we are permitted or required to make by law without your permission. For all other uses and disclosures, we first must obtain your permission. In addition, you have the following rights:

- The right to request that we place additional restrictions on our uses and disclosures of your personal health information. However, we are not obligated to agree to impose any such additional restriction.
- The right to access, inspect and copy the protected information pertaining to you that we maintain in our files and the right to have us correct or amend any information that we create in error. Requests to access or amend your health information should be sent to the contact person and address provided below.
- The right to receive an accounting of the disclosures of your personal health information that we make for purposes other than activities related to your treatment and/or claim, or our payment functions or other health care operations.
- The right to request that you receive communications of personal health information in a confidential manner.

Information We Collect About You

We collect the following categories of information about you from the following sources:

- Information that we obtain directly from you, in conversation or on Request for Reimbursement Application, information to process your deductible or other forms that you fill out.
- Information that we obtain as a result of our transactions with you.
- Information that we obtain from your medical records or from medical professionals.
- Information that we obtain from other entities, such as health care providers or other insurance companies, in order to carry out other administration related needs.

Permissible Uses and Disclosures of Protected Information

The following categories describe different ways that we use and disclose PHI. We may use or disclose your health information without your permission to carry out activities relating to reimbursing you for the provision of health care, obtaining premiums, determining coverage, and providing benefits under your health insurance policy. Such functions may include reviewing health care services with respect to medical

necessity, coverage under the policy, appropriateness of care, or justification of charges. As an example of the ways in which we may use and disclose your information for our operations, our claims administrators may use your health information to evaluate the quality of care you received from your provider, or to conduct cost-management and business planning activities of our organization.

We may use or disclose your protected health information without your written permission for other purposes permitted or required by law, including:

- As authorized by and to the extent necessary to comply with workers compensation or other no-fault laws.
- To a health oversight agency for activities including audits or civil, criminal or administrative proceedings.
- To a public health authority for purposes of public health activities (such as to the Food and Drug Administration to report consumer product defects).
- To a law enforcement official for law enforcement purposes or in response to a court order or in the course of any judicial or administrative proceedings.
- To organ procurement organizations, or to other entities for approval research purposes.
- To a government authority, including a social service or protective services agency, authorized to receive reports of abuse, neglect or domestic violence.

We may use or disclose your protected health information after we have given you an opportunity to object and you have not objected. For example, if you do not object, we may use limited information about you to maintain an office directory, to notify family members or any other person identified by you regarding issues directly related to such person's involvement with your care or payment for that care, or claim or in emergency circumstances.

You are responsible for inappropriate use or disclosure of your information that occurs due to your selected method of transmitting this information (e.g. fax, e-mail, or any other electronic form).

All other uses or disclosures of your protected health information will be made only with your written permission which you may revoke at any time.

Complaints About Misuse of Health Information

You may complain either directly to Calvo's Insurance Underwriters, Inc. or to the Secretary of Health and Human Services if you believe that your rights with respect to our protection of your health information have been violated.

Our Practices Regarding Confidentiality and Security

We restrict access to nonpublic personal information about you to those employees who need to know that information in order to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

Our Policy Regarding Dispute Resolutions

Any controversy or claim arising out of our relating to our privacy policy, or the breach thereof, shall be settled by arbitration in accordance with the rules of the American Arbitration Association, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

Contact Person For Filing Complaint or Obtaining Further Information

If you want to file a complaint or have questions or need further assistance regarding this Notice, you may contact Calvo's Insurance Underwriters, Inc., Privacy Office by writing to:
Calvo's Insurance Underwriters, Inc.,
Attn: Rose Cruz
115 Chalan Santo Papa,
Hagatna, Guam 96932

Summary Descriptions of Federally Mandated Programs

The following is a brief summary of various federally mandated benefit programs that are required by health plans to provide to plan members.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The COBRA Act 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.

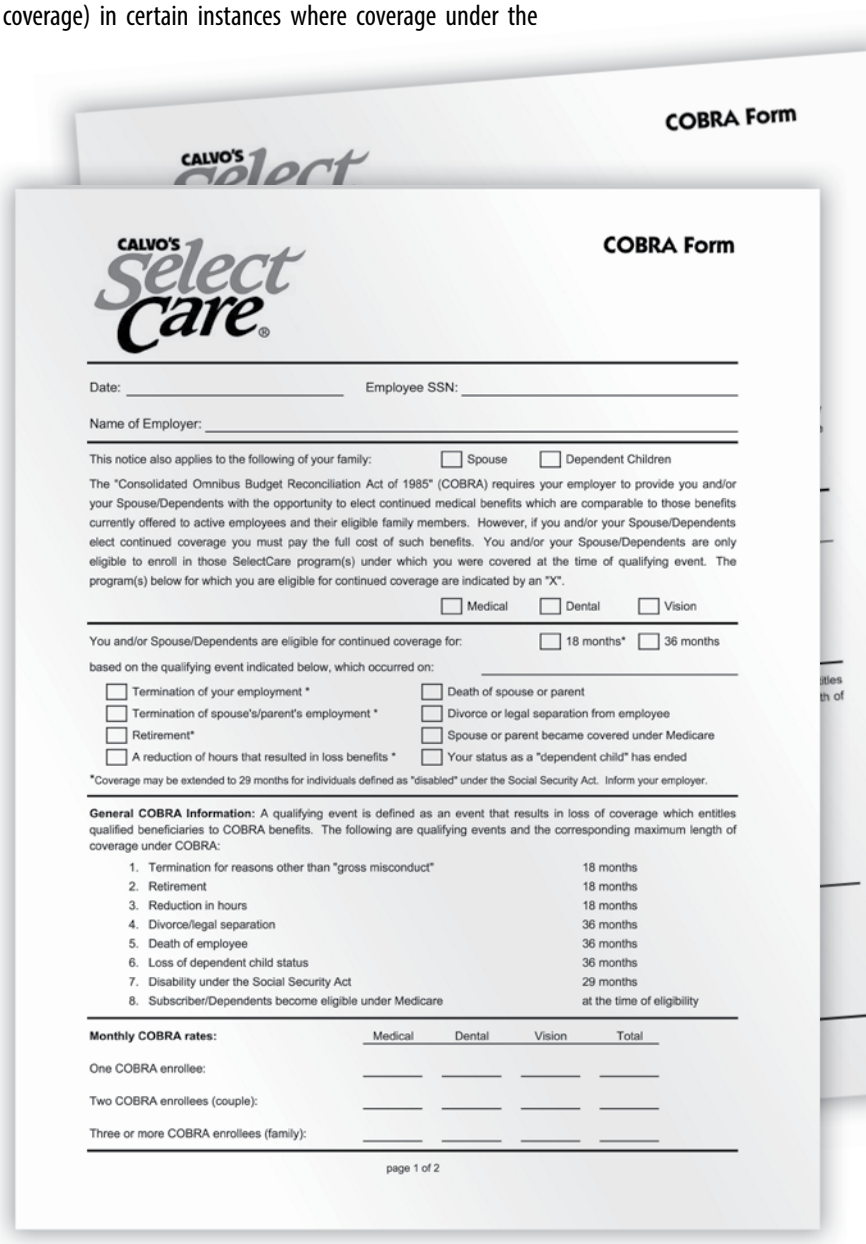
Further, COBRA requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the employee's plan would otherwise end.

COBRA is available to employees whose employer employs twenty (20) or more employees. COBRA continuance is not available for employer groups with less than nineteen (19) employees. An employee has up to sixty (60) days after the separation date from the employer to convert his or her enrollment to a non group policy. However, the effective date for coverage under COBRA must be the day after coverage as an employee terminates.

The employer must provide the employee with notice of opportunity to elect continuation coverage and administer the continuation coverage for the employee. The obligation to provide notice includes both general notification to employees of their right to elect continuation coverage and specific notification of the right to continuation coverage within a specific time period after the occurrence of the event which activates the continuation coverage option.

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

A qualifying event is defined as an event that results in a loss of coverage, which entitles qualified beneficiaries to COBRA benefits.



CALVO'S Select Care®

COBRA Form

Date: _____ Employee SSN: _____

Name of Employer: _____

This notice also applies to the following of your family: ☐ Spouse ☐ Dependent Children

The "Consolidated Omnibus Budget Reconciliation Act of 1985" (COBRA) requires your employer to provide you and/or your Spouse/Dependents with the opportunity to elect continued medical benefits which are comparable to those benefits currently offered to active employees and their eligible family members. However, if you and/or your Spouse/Dependents elect continued coverage you must pay the full cost of such benefits. You and/or your Spouse/Dependents are only eligible to enroll in those SelectCare program(s) under which you were covered at the time of qualifying event. The program(s) below for which you are eligible for continued coverage are indicated by an "X".

☐ Medical ☐ Dental ☐ Vision

You and/or Spouse/Dependents are eligible for continued coverage for: ☐ 18 months* ☐ 36 months

based on the qualifying event indicated below, which occurred on: _____

- ☐ Termination of your employment *
- ☐ Termination of spouse's/parent's employment *
- ☐ Retirement*
- ☐ A reduction of hours that resulted in loss benefits *
- ☐ Death of spouse or parent
- ☐ Divorce or legal separation from employee
- ☐ Spouse or parent became covered under Medicare
- ☐ Your status as a "dependent child" has ended

*Coverage may be extended to 29 months for individuals defined as "disabled" under the Social Security Act. Inform your employer.

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

1. Termination for reasons other than "gross misconduct"	18 months
2. Retirement	18 months
3. Reduction in hours	18 months
4. Divorce/legal separation	36 months
5. Death of employee	36 months
6. Loss of dependent child status	36 months
7. Disability under the Social Security Act	29 months
8. Subscriber/Dependents become eligible under Medicare	at the time of eligibility

Monthly COBRA rates:	Medical	Dental	Vision	Total
One COBRA enrollee:				
Two COBRA enrollees (couple):				
Three or more COBRA enrollees (family):				

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The following are qualifying events and the corresponding maximum length of COBRA coverage:

1.	Termination of employment	18 months
2.	Retirement	18 months
3.	Reduction in Hours	18 months
4.	Divorce/Legal Separation	36 months
5.	Death of employee	36 months
6.	Loss of dependent child status	36 months
7.	Disability under the Social Security Act	29 months

Every group or employer that is eligible and provides COBRA should have a Plan Administrator that may be the employer, or an individual employed by the company or an independent administrator. The Plan Administrator is responsible for ensuring COBRA regulations are adhered to, proper COBRA documentation is maintained and required notifications are done in a timely manner. Calvo's SelectCare does not serve as a Plan Administrator.

Family and Medical Leave Act (FMLA)

The Act entitles eligible employees to twelve (12) workweeks of unpaid leave during any twelve (12) month period for one or more of the following reasons.

- The birth of a child and care of the newborn child of the employee;
- The placement with the employee of a son or daughter for adoption or foster care;
- To care for an immediate family member (spouse, child, or parent) with a serious health condition;
- To take medical leave when the employee is unable to work because of serious health condition.

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

Employee Entitlement of Service member FMLA

The federal Family and Medical Leave Act or the FMLA now entitles eligible employees to take leave for a covered family member's service in the Armed Forces ("Service member FMLA").

Service member FMLA provides eligible employees unpaid leave for any one, or for a combination, of the following reasons:

- A "qualifying exigency" arising out of a covered family member's active duty or call to active duty in the Armed Forces in support of a contingency plan; and / or
- To care for a covered family member who has incurred an injury or illness in the line of duty while on active duty in the Armed Forces provided that such injury or illness may render the family member medically unfit to perform duties of the member's office, grad, rank or rating.

Duration of Service member FMLA

- When Leave is due to a "Qualifying Exigency", an eligible employee may take up to twelve (12) work weeks of leave during any twelve (12) month period.
- When Leave is to care for an injured or ill Service Member, an eligible employee may take up to 26 work weeks of leave during a single twelve (12)month period to care for the service member. Leave to care for an injured or ill service member, when combined with other FMLA-qualifying leave, may not exceed 26 weeks in a single twelve (12) month period.

- Service member FMLA runs concurrent with other leave entitlements provided under federal or local law.

The employer does have the right to obtain from the employee verification of any of the applied for FMLA leave entitlement requests. Once the federal government has further defined/clarified the Service member FMLA in its entirely, a revision of the current FMLA policy will be made.

Health Insurance Portability and Accountability Act (HIPAA)

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

HIPAA protects employees and their families by:

- Limiting exclusions for pre existing medical conditions to twelve (12) months or eighteen (18) months for late enrollees;
- Provides credit for prior health coverage;
- Provides rights that allow individuals to enroll for health coverage when they lose other health coverage or add a new dependent;
- Allows for a six (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 related factors;

Certificates of Creditable Coverage must be provided by the plan when an individual loses coverage under the plan or exhausts COBRA's continuation of coverage. Certificates of Creditable Coverage must be provided, if requested, before losing coverage or within twenty-four (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.

Mental Health Parity Act

The Mental Health Parity Act (MHPA) requires that annual or lifetime limits on mental health benefits be no lower than that of the dollar limits for medical and surgical benefits offered by a group health plan.

The Act generally requires parity of mental health benefits with medical /surgical benefits with respect to the application of aggregate lifetime and annual dollar limits under a group health plan; it provides for employers to retain discretion regarding the extent and scope of mental health benefits offered to employees (including cost sharing, limits on number of visits or days of coverage, and requirements relating to medical necessity).

Newborns' & Mothers' Health Protection Act

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 a mothers' or newborns' benefits for a hospital length of stay that is in connection with childbirth to less than forty-eight (48) hours following a vaginal delivery or ninety-six (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 the Act as described above.

Women's Health and Cancer Rights Act

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 Act may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan.

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

USERRA is a federal law intended to ensure that persons who serve or have served in the Armed Forces, Reserves, National Guard or other "uniformed services:" (1) are not disadvantaged in their civilian careers because of their service; (2) are promptly reemployed in their civilian jobs upon their return from duty; and (3) are not discriminated against in employment based on past, present, or future military service.

Notes

CALVO'S Select Care HEALTH PLANS

Bringing you a world of healthcare solutions.

GUAM

115 Chalan Santo Papa Hagatna, Guam
Telephone: (671) 477-9808
Fax: (671) 477-4141
P.O. Box FJ Hagatna, Guam 96932

SAIPAN

Oleai Center Building San Jose, Saipan
Telephone: (670) 234-5690/9
Fax: (670) 234-5693
P.O. Box 500035 Saipan, MP 96950-0035

PALAU

JR Professional Bldg., Suite 2
Telephone: (680) 488-7222
Fax: (680) 488-7333
P.O. Box 10248 Koror, Palau 96940

Administered by:

CALVO'S insurance

Underwritten by:
Tokio Marine Pacific Insurance Limited