CALVO'S SelectCare INSURANCE, INC. | Optum Rx®

- Medical
- Vision
- Prescription Drugs



Government of Guam

Self-Funded

HEALTH PLAN

FY2027

PPO1500

MEMBER HANDBOOK

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Welcome to Your GovGuam Health Plan

Welcome to your Government of Guam Health Plan, administered by Calvo's SelectCare. The prescription drug benefits is administered by Optum RX through Calvo's SelectCare.

Your health and well-being are important to us. We are committed to providing you and your family with access to quality healthcare, dependable service, and the support you need to make informed decisions about your health.

This Member Handbook is designed to help you understand your health benefits, access medical services, find participating providers, and make the most of your coverage. It also explains your rights and responsibilities and provides important information about the programs and resources available to you.

At SelectCare, we recognize the important contributions of Government of Guam employees, retirees, and their families. We are proud to serve you and remain dedicated to making your healthcare experience as simple, accessible, and convenient as possible.

We encourage you to take a few moments to review this handbook and keep it as a reference throughout the year. Whenever you have questions or need assistance, our team is here to help.

Thank you for placing your trust in Calvo's SelectCare.
We look forward to serving you and your family.

Government of Guam Self-Insured Member's Rights and Responsibilities

As a member enrolled in the Government of Guam's Self-Insured Plan (Member) administered under Calvo's SelectCare 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 a member enrolled in the Government of Guam's Self-Insured Plan administered under Calvo's SelectCare you have the following responsibilities:

Government of Guam 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 the plan.
- Treat all health care providers, staff, and others respectfully.
- Become familiar with your coverage.

Health Care Terms & Definitions

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

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

A.C.A. is the acronym for the Affordable Care Act covered by your helath plan by Calvo's SelectCare under the terms of the TPA Agreement.

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.

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. Coinsurance 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. Copays 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.

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.).

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 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.

Employer shall mean the Government of Guam (GovGuam) and its agencies.

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 shall be defined as a person entitled to receive Covered Services pursuant to the Government of Guam Self-Funded Plan. A Covered Person shall reside in the Service Area and shall be:

- a bona fide employee of GovGuam who is classified as a full-time employee by GovGuam; or
- voluntarily working under the "Quality Time" program and classified as such by GovGuam pursuant to P.L. 25-72; or
- classified as a retiree of GovGuam by GovGuam; or
- classified as a survivor of a retired employee of GovGuam by GovGuam; or
- except as otherwise provided in this Agreement, a Covered Dependent.

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
- Preventive 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 under the Government of Guam's Self-Insured Plan under 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, copay, and/or coinsurance 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 to perform certain treatment plans or provide covered services such as diagnostic testing, home health care, physical therapy, or the procurement of durable medical equipment. More information is contained in the "General Information" section of this Handbook.

Premium shall be defined as the dollar amount paid to the Government of Guam's Self-Insured plan 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 defined as the Territory of Guam and the Commonwealth of the Northern Marianas.

U.C.R. is the "Usual, Customary and Reasonable" charge of a provider for a service or supply in the geographical area where it was rendered, not exceeding the amount ordinarily paid by Medicare for a comparable service or supply to their participating provider.

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 under the Government of Guam's Self-Insured Plan under Calvo's SelectCare, you and your dependents must first meet the eligibility requirements defined in the agreement between Calvo's SelectCare and GovGuam.

You must complete an Enrollment Application and submit it with any other required documentation during an Open Enrollment period or a qualifying event and within 31 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 182 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:
  - 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 31 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.
- Dependent children or children who reside outside the Service area who are between the ages of 19 through 25 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 court-appointed legal guardianship, you must provide the following:
  - Birth Certificate.
  - Parents' marriage certificate (when required).
- Court documentation signed by a judge ordering adoption or legal guardianship.
  - 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.
  - Legal guardianship terminates no later than age 26.
  - 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, for approval by the TPA.
  - 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 31 days from the date you first become eligible to enroll in the plan.
- Annual Open Enrollment Period.
- 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.
- Legal Guardianship.

Enrollment Applications or Change of Status (COS) Forms and any required documents must be submitted within 31 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 your Member this Handbook.

Adding Dependents and Changes to your Coverage
You are able to enroll your new dependent(s), if you get married, obtain court-appointed legal guardianship, 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 31 day period from when they first become eligible, you would have to wait to enroll them during the 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),
- Complete a "Health Statement" Form (when required by the plan),
- Submit all Required Documentation as outlined above,
- Make your request within 31 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 changes to your name, contact information or mailing address as well as any error on your Member ID Card.

If you receive a card and did not enroll, please report it to customer service, D.O.A. or your HR department.

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 the full premium directly to your department. These payments must include both your employer's share and your share. You must make full payment to your department prior to going on Leave Without Pay, otherwise you will be terminated and will not be allowed to enroll back into the plan until the next Open Enrollment Period following full payment of premiums.

If you are terminated, you will be responsible to repay any claims that the plan may have paid on your behalf after the termination date.

Deductible
Calvo's SelectCare offers 3 plans to GovGuam employees and retirees, The HSA2000, the PPO1500 and the Retiree Supplemental Plan. Each plan contains differences in the deductibles. Please refer to your Schedule of Benefits to determine the deductibles that apply under your plan. A new deductible is required for every Plan Year and must be met accordingly.

For charges within your deductible (or if a Coinsurance 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 copay, coinsurance, and excess provider charges.

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 120 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 coinsurance 50% or $5,500
- Total Plan Payment: $5,500

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

Copays & Coinsurances
After any applicable deductible is met, a Participating Provider should only collect the applicable copay or coinsurance from you and will bill Calvo's SelectCare for the remaining amount. Please refer to your Schedule of Benefits for the copay and coinsurance 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 copays and coinsurance 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.

Obtaining Care

You and your enrolled dependents may receive care and services from any of the participating medical, dental (medically necessary) 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.

Emergencies: *In the event of a medical emergency, members should seek immediate medical attention at the nearest appropriate emergency facility. Prior Authorization from Calvo's SelectCare is not required for covered emergency services. Members or their authorized representatives are encouraged to notify Calvo's SelectCare within 48 hours of emergency treatment or within 24 hours of an emergency hospital admission, when reasonably possible.*

If the member is medically unable to provide notification, notification should be made as soon as resonably possible.

Calvo's SelectCare covers emergency medical services provided by either Participating Providers or Non-Participating Providers. Although the copay/coinsurance 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 a Non-Participating Provider facility must be covered at the same benefit level as Participating Providers. So, we will cover all bona fide emergencies at 80% after deductible is met. However, the Eligible Charge we will use to determine the 80% of coverage will be the amount we would have been charged by our most similarly situated Participating Provider. This charge may be significantly lower than the actual charge of the Non-Participating Provider and they may "Balance Bill" you for the difference.

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
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 WILL NOT BE COVERED.

Inpatient Medical Benefits

This section includes an explanation of some key benefits received while hospitalized. Copays and coinsurance 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, 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
Administration of blood, blood and blood derivatives are covered. Refer to your plan's Schedule of Benefits for the maximum amount that Calvo's SelectCare will pay for the covered expenses.

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 31 days from the date of birth. Circumcisions provided within 31 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
The airfare benefit applies for certain catastrophic conditions that may not be available on Guam. In order to obtain this benefit, the member must be enrolled with the health plan for at least 4 months and must obtain a precertification and approval by the plan ahead of the services. The benefit is limited to services provided at our designated Centers of Excellence as they appear in the provider directory issued to you, which is updated from time to time.

When approved in advance, the airfare covers an economy round-trip for the insured patient, a companion if medically required, and a medical attendant if medically required.

The plan only pays if the service is for qualifying conditions such as open-heart surgery, Oncology Surgery for stage IV cancers, Aneurysmectomy, Pneumonectomy, Cranial Surgery and NICU level III services. Diagnostic procedures and/or second opinions are not covered under this benefit.

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 Copays or Coinsurance applicable to the specific benefits below.

Allergy Testing and Treatment
Allergy testing and treatment including allergy antigens and serums is covered up to $1,000 per member per plan year.

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.

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.

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, standard CPAP, suction machines, and portable oxygen tanks, refills and accessories once every three (3) years 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. Please check your schedule of benefits for the applicable copays and/or required deductibles.

Contraception & Sterilization
Contraceptive coverage:
- Depo-Provera, patch implants and Oral: The medication and injection are covered.
- Vasectomy & Tubal Ligation are covered

Contraception methods used for medical treatment do not apply to this therapy benefit.

Health Improvement through the Seventh Day Adventist Clinic Wellness Center (SDA)
Calvo's SelectCare is pleased to offer coverage for health improvement programs designed to help members manage their lifestyle and health risks. Government of Guam members are able to take advantage of the these programs.

SDA Programs must be coordinated with the SDA Wellness Center. Programs are limited and on a first-come first-served basis. The frequency and availability of programs may vary. Discounts are available to other SDA programs including SDA's full Newstart Program.

Calvo's SelectCare makes no guarantees as to availability, viability, or access to these programs. Please call our Customer Service Department for details.

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 established by the Advisory Committee on Immunization Practices.

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 dependent. Procedures intended solely for sex determination of an unborn child are not covered.

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 Copays 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.

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 devices designed to replace all or part of a missing, 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.

Short Term Rehabilitation
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. Please refer to the Schedule of Benefits on page 16.

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

Well Child Care
Preventive health services are covered up to age 17 in accordance with the guidelines established by the Bright Futures/American Academy of Pediatrics.

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, or the procurement of durable medical equipment. Referrals to specialists are not required.

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.

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

If pre-certification is not obtained, the plan is only responsible for 50% of eligible charges. However, this only applies to medically necessary procedures, otherwise, the bill will be the member's responsibility.

Explanation of Benefits (EOB)
An Explanation of Benefits (EOB) is a statement issued by a health insurance company or health plan administrator explaining how a medical claim was processed, what services were billed, how much the health plan allowed and paid, and what amount, if any, the member may be responsible for paying.

An EOB is not a bill. It is an informational statement that helps members understand their healthcare benefits and how their claims were processed.

Check the member portal (www.calvos.net) as it provides information on all claims processed on your behalf

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. It is important to update your COB record with the plan to avoid becoming responsible for any unpaid bills.

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.
- 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 CNMI 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 the Government of Guam's Self-Insured Plan 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.
- Do not maintain the following as family members 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 180 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 review and appeal, (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 Investigational, 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 the the urgent care facilities that are provided in your member handbook.

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

If you need medical guidance outside of regular office hours, you can call the Optum NurseLine or use Teladoc *(refer to Teladoc and Nurseline instructions on page 30)*. Both are available 24 hours a day, 7 days a week. Optum NurseLine puts you in touch with a registered nurse who can answer health questions and help you decide where to go for care. Teladoc lets you consult a licensed doctor by phone or video. **Note:** You must be registered with Teladoc before you can use it. We recommend setting up your account ahead of time so it's ready when you need it.

If you feel your After-hours Care is an emergency you should call 911 or proceed to the nearest emergency facility. (See page 34)

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 relief). Hospice care can be provided onsite at 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 care-giving. 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.

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A full list of the Medical Exclusions can be found in the Member Handbook. Visit calvos.net to download the PDF.

Your Benefits: What the plan covers	Participating Providers	Non-participating Providers
DEDUCTIBLE PER INDIVIDUAL MEMBER (Class 1)	$1,500	$3,000**
DEDUCTIBLE PER FAMILY MEMBER (Classes 2-4) If a member meets their $1,500, the plan begins to pay for covered services for that member	$3,000	$9,000**
COVERAGE MAXIMUMS Individual member lifetime maximum	Unlimited	Unlimited
OUT OF POCKET MAXIMUMS (including accumulated deductible, copays, & member coinsurance) Per Individual member per policy year Per Family per policy year	 $3,000 $9,000	 $30,000** $90,000**
Any Services in the Philippines, Hawaii, the U.S. Mainland, and any foreign participating providers (Pre-Certification Required)	Requires a referral from your doctor and approval in advance from the plan	

Deductible and Co-Pay do not apply to these benefits when you go to a Participating Provider	Participating Providers	Non-participating Providers after Deductible is met:
PREVENTIVE SERVICES (Out-Patient Only) • In accordance with the guidelines established by the U.S. Preventive Services Task Force (USPSTF) Grades A and B recommendations. • Members may choose to receive age appropriate annual physical in the Philippines • Annual exam includes preventive lab tests		
ANNUAL PHYSICAL EXAM One exam every 12 months	Plan pays 100%	Not Covered
IMMUNIZATIONS/VACCINATIONS In accordance with the guidelines established by the CDC Advisory Committee on Immunization Practices	Plan pays 100%	Not Covered
PRE-NATAL CARE Including Routine Labs and 1st ultrasound	Plan pays 100%	Not Covered
WELL-CHILD CARE In accordance with the Bright Futures/American Academy of Pediatrics recommendations for Preventive Pediatric Health Care Infancy (Newborn to nine months) Maximum seven visits Early Childhood (One to four years old) Maximum seven visits Middle Childhood / Adolescence (Five to 17 years old) Maximum one visit/year	Plan pays 100%	Not Covered
WELL-WOMAN CARE In accordance with the guidelines supported by the Health Resources and Services Administration (HRSA) Contraceptives including Sterilization and Tubal Ligation includes coverage of Breast Pumps (Limited to 1 per pregnancy up to $100)	Plan pays 100%	Not Covered
ROUTINE CANCER SCREENINGS Including any applicable lab work, for cervical, prostate, colorectal, and breast (in accordance with PL 34-02, 34-03, and 34-109)	Plan pays 100%	Plan pays 70%*, Member pays 30%
ANNUAL EYE EXAM One exam every 12 months including refraction and glaucoma testing	Plan pays 100%	Not Covered
VISION CARE SUPPLIES Frames, lenses, contact lenses, fitting	Plan pays 100% up to $150 per member per plan year Member pays anything beyond $150	
AIRFARE BENEFIT TO CENTERS OF EXCELLENCE ONLY For members who meet qualifying conditions, Plan provides roundtrip economy airfare (Plan Approval Required)	Plan pays 100%	Not Covered

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Deductible and Co-Pay do not apply to these benefits when you go to a Participating Provider	**Participating Providers**	**Non-participating Providers** after Deductible is met:
TRAVEL BENEFIT - Prior authorization (written approval) and coordination is required from Plan prior to departure from Guam - Applicable only to approved referrals for conditions not treatable on Guam - Airfare and/or lodging expenses coverage for eligible members for approved specialty care visits, consultations, treatments and hospitalization services at Participating Providers in the Philippines or in Taiwan - Executive check-ups preventive services, primary care services and dental care DO NOT QUALIFY for this benefit - Conditions and limitations apply as specified in the Member Handbook	Member pays all cost above $500 Limited to once per plan year	Not Covered

Deductible does not apply to these benefits when you go to a Participating Provider	**Participating Providers**	**Non-participating Providers** after Deductible is met:
OUTPATIENT PHYSICIAN CARE & SERVICES **PRIMARY OFFICE VISITS**	Member pays $20 copay	Plan pays 70%* Member pays 30%
SPECIALIST OFFICE VISITS	Member pays $40 copay	Plan pays 70%* Member pays 30%
OUTPATIENT LABORATORY Routine Laboratory	Member pays $20 copay	Plan pays 70%* Member pays 30%
Specialty/Diagnostic Laboratory	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
X-RAY SERVICES	Member pays $20 copay	Plan pays 70%* Member pays 30%
HOME HEALTH CARE 120 visits per plan year	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
HOSPICE CARE FACILITY OUTPATIENT maximum 180 days per plan year (Pre-Certification Required)	Plan pays 100%	Plan pays 70%* Member pays 30%
ALLERGY SERUM & INJECTIONS Does not include those on the Specialty Drugs List & Orthopedic injections	Plan pays 80%; Member pays 20%	Plan pays 70%* Member pays 30%
CHIROPRACTIC CARE 30 visits per member per plan year	$20 copayment	Plan pays 70%* Member pays 30%
MENTAL HEALTH AND SUBSTANCE ABUSE	Member pays $20 copay	Plan pays 70%* Member pays 30%
SHORT TERM REHABILITATION Includes coverage for Occupational, Physical and Speech Therapies; 60 combined visits per plan year	Member pays $40 copay	Plan pays 70%* Member pays 30%
URGENT CARE	Member pays $50 copay	Plan pays 70%* Member pays 30%
VOLUNTARY SECOND SURGICAL OPINION	Member pays $40 copay	Plan pays 70%* Member pays 30%
PRESCRIPTION FORMULARY DRUGS through Optum Rx® **PREVENTIVE FORMULARY DRUGS** (Deductible does not apply) In accordance with the guidelines established by the U.S. Preventive Services Task Force (USPSTF) Grades A and B recommendations.	***$0 Member copay 30 day supply***	***Plan Pays 70% of billed amount, based upon the Claims Administrators Maximum Plan Allowance (MPA)***
PREFERRED FORMULARY GENERIC DRUGS	***$15 copay per month supply $0 copay for 90-day Mail Order Drugs***	***Plan Pays 70% of billed amount, based upon the Claims Administrators Maximum Plan Allowance (MPA)***

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Deductible does not apply to these benefits when you go to a Participating Provider	**Participating Providers**	**Non-participating Providers** after Deductible is met:
PREFERRED FORMULARY BRAND NAME DRUGS	*$30 copay per month supply $30 copay for 90-day Mail Order Drugs*	*Plan Pays 70% of billed amount, based upon the Claims Administrators Maximum Plan Allowance (MPA)*
NON-PREFERRED FORMULARY GENERIC AND BRAND NAME DRUGS	*$100 copay per month supply $100 copay for 90-day Mail Order Drugs*	
SPECIALTY FORMULARY DRUGS (Medically Necessary Only and Pre-Certification Required)	*$100 Member Co-Pay (30 day supply)*	*Not Covered*
PRESCRIPTION FORMULARY DRUGS OUTSIDE GUAM/CNMI/USA	*Plan pays 80%; Member pays 20% not to exceed Average Wholesale Price (AWP)*	

Deductible must be met for these benefits when you go to a Participating and Non-Participating Provider	**Participating Providers**	**Non-participating Providers** after Deductible is met:
ACUPUNCTURE 30 visits per member per plan year	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
AIDS TREATMENT Exclusive of Experimental Drugs (Pre-Certification Required)	Plan pays 80% Member pays 20%	Not Covered
ALLERGY TESTING Maximum $1,000 per member per plan year (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
AMBULATORY SURGI-CENTER CARE (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
AUTISM SPECTRUM DISORDER (In compliance with Guam Law)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
BLOOD & BLOOD DERIVATIVES	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
BREAST RECONSTRUCTIVE SURGERY (In accordance with 1998 W.H.C.R.A) (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
CARDIAC SURGERY	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
CATARACT SURGERY Outpatient Only (including conventional lens)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
CHEMICAL DEPENDENCY	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
CHEMOTHERAPY BENEFIT (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
CONGENITAL ANOMALY DISEASES COVERAGE (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
DEEP TRANSCRANIAL MAGNETIC STIMULATION (Pre-Certification Required)	Plan pays 80% Member pays 20%	Not Covered
DIAGNOSTIC TESTING MRI, Pathology Labs, CT scan, and other diagnostic procedures (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
DURABLE MEDICAL EQUIPMENT Standard Equipment (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%

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Deductible must be met for these benefits when you go to a Participating and Non-Participating Provider	**Participating Providers**	**Non-participating Providers** after Deductible is met:
ELECTIVE SURGERY (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
EMERGENCY CARE For off-island emergencies, Plan must be contacted and advised within 48 hours 1. U.S. based and Out-of-U.S. emergency facility, physician services, laboratory, X-rays 2. Ambulance Services (Ground Transportation Only)	Plan pays 80% Member pays 20%	Plan pays 80%* Member pays 20%*
NON-EMERGENCY CARE In a hospital emergency room	Plan pays 50%* Member pays 50%	Plan pays 50%* Member pays 50%
END STAGE RENAL DISEASE / HEMODIALYSIS (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
HEARING AIDS Maximum $500 per member per plan year	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
HOSPITALIZATION & INPATIENT BENEFITS 1. Room & Board for a semi-private room, intensive care, and surgery 2. All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia and medication 3. Physician's hospital services 4. Inpatient Hospice (limited to 30 days)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
IMPLANTS (Limitations apply, please refer to contract) Limited to cardiac pacemakers, heart valves, stents, Intraocular lenses, orthopedic internal prosthetic devices	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
INHALATION THERAPY	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
MATERNITY CARE Labor and Delivery	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
NUCLEAR MEDICINE (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
ORGAN TRANSPLANT Including but not limited to: Heart, Lung, Liver, Kidney, Pancreas, Intestine, Bone Marrow, Cornea. Benefits include organ donor. (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
ORTHOPEDIC CONDITIONS Internal and External Prosthesis (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
RADIATION THERAPY (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
ROBOTIC SURGERY/ROBOTICS SUITE (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
SKILLED NURSING FACILITY Maximum 60 days per member per plan year (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
SLEEP APNEA Diagnostics and Therapeutic Procedure (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
STERILIZATION PROCEDURES Vasectomy (Outpatient Only)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%

* Eligible Charges for Non-Participating Providers are limited to the lesser of actual charges or Medicare's participating provider fee schedule in the geographic location where the service was rendered, unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible Charges. ** A separate deductible applies for services rendered by non-participating providers.

Medical Exclusions & Limitations

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

1. No benefits will be paid for Injury or Illness when: (a) the Covered Person is entitled to receive disability benefits or compensation (or forfeits his or her right thereto) under Worker's Compensation or Employer's Liability Law for such Injury or Illness; or (b) Services for an Injury or Illness are rendered to the Covered Person by any federal, state, territorial, municipal or other governmental instrumentality or agency without charge, or (c) when such Services would have been rendered without charge but for the fact that the person is a Covered Person under the Plan.

2. No benefits will be paid if any material statement made in an application for coverage, enrollment of any Dependent or in any claim for benefits is false. Upon identifying any such false statement, TPA shall give the Covered Person at least 30 days' notice that his or her benefits have been suspended and that his or her coverage is to be terminated. If the false statement is fraudulent or is an intentional misrepresentation of a material fact, such termination shall be retroactive to the date coverage was provided or continued based on such fraudulent statement or intentional misrepresentation of material fact. If the false statement was not a fraudulent statement or intentional misrepresentation of material fact, termination of coverage shall be effective no earlier than the date of the suspension. The Covered Person may dispute any termination of coverage by filing a claim under the grievance procedure provided for in this Certificate at §5.31. If a grievance is filed, the resolution of the matter shall be in accordance with the outcome of the grievance proceedings. If no grievance is filed for any retroactive termination and the Company paid benefits prior to learning of any such false statement, the Subscriber must reimburse the Company for such payment. Terminations of coverage shall be handled in accordance with the applicable claims procedure requirements of Section 2719 of the PHSA, as added by PPACA. Retroactive terminations of coverage shall not violate the applicable prohibitions on rescissions of Section 2712 of the PHSA, as added by PPACA, and rescissions shall be handled in compliance with PPACA's applicable claim denial requirements.

3. No benefits will be paid for confinement in a Hospital or in a Skilled Nursing Facility if such confinement is primarily for custodial or domiciliary care. (Custodial or domiciliary care includes that care which consists of training in personal hygiene, routine nursing services and other forms of self-care. Custodial or domiciliary care also includes supervisory services by a Physician or Nurse for a person who is not under specific medical or surgical treatment to reduce his or her disability and to enable that person to live outside an institution providing such care.) Company and not Covered Person shall be liable if the Company approves the confinement, regardless of who orders the service.

4. No benefits will be paid for nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

5. No benefits will be paid for private duty nursing. This provision does not apply to Home Health Care.

6. No benefits will be paid for special medical reports, including those not directly related to treatment of the Covered Person. (e.g., employment or insurance physicals, and reports prepared in connection with litigation.)

7. No benefits will be paid for services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.

8. No benefits will be paid for court ordered services, or those required by court order as a condition of parole or probation.

9. No benefits will be paid for Services and supplies provided to a Covered Person for Injuries incurred while the person was committing a criminal act.

10. Unless otherwise specifically provided in this Certificate, no benefit will be paid for, or in connection with, airfare, and the Company will not pay for the transportation from Guam to any off-island facility, nor for any other non-medical expenses such as taxes, taxis, hotel rooms, etc. In no event will the Company pay for air ambulance or for the transportation of the remains of any deceased person.

11. No benefits will be paid for living expenses for Covered Persons who require, or who of their own accord seek, treatment in locations removed from their home.

12. No benefits will be paid for Services and supplies provided to a dependent of a non-Spouse Dependent. Dependents of non-Spouse Dependents are not eligible for coverage. For example, when a Dependent, other than a Spouse of the Subscriber, has a child, that child is a dependent of a non-Spouse Dependent and is not eligible to become covered under the Plan, unless such child otherwise becomes eligible for enrollment.

13. No benefits will be paid for home uterine activity monitoring.

14. No benefits will be paid for services performed by an immediate family member for which, in the absence of any health benefits coverage, no charge would be made. Immediate family member is defined as parents, spouses, siblings, or children of the Covered Person.

15. If a member is covered under a Worker's Compensation law or similar law, and submits proof that the member is not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational" regardless of cause. The covered benefits under this Certificate for members eligible for Worker's Compensation are not designed to duplicate any benefit to which they are entitled under Workers' Compensation Law. All sums payable for Workers' Compensation services provided under this Certificate shall be payable to, and retained by Company. A Covered Person shall complete and submit to Company such consents, releases, assignments and other documents reasonably requested by Company in order to obtain or assure reimbursement under the Worker's Compensation Law.

16. Except for clinical trials and a Covered Person exercising his or her "Right to Try" as set forth in Public Law 115-176 (May 30, 2018), no benefits will be paid for:
    a. Drugs or substances not approved by the Food and Drug Administration (FDA), or
    b. Drugs or substances not approved by the FDA for treatment of the Illness or Injury being treated unless empirical clinical studies have proven the benefits of such drug or substance in treating the Illness or Injury, or
    c. Drugs or substances labeled "Caution: limited by federal law to investigational use."
    d. Any drug or substance which does not, by federal or state law, require a prescription order (i.e., an over-the-counter (OTC) drug).

17. Except for a Covered Person exercising his or her "Right to Try" as set forth in Public Law 115-176 (May 30, 2018), no benefits will be paid for experimental or investigational procedures, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes as determined by Company, unless prior authorization is obtained from the Company.

    Experimental and investigational treatments and procedures are those medical treatments and procedures that have not successfully completed a Phase III trial, have not been approved by the FDA and are not generally recognized as the accepted standard treatment for the disease or condition from which the patient suffers.

18. No benefits will be paid for services or supplies related to genetic testing, with the exception of BRAC1 Testing.

19. No benefits will be paid for services or supplies related to paternity testing.

20. No benefits will be paid for any item or substance that is available without a Physician's prescription even if prescribed by a Physician, except as otherwise provided herein and except for medication and supplies provided as part of Medically Necessary inpatient care.

21. No benefits will be paid in relation to the Robotic Suite or for Robotic Surgery.

22. No benefits will be paid for Services and supplies provided to perform transsexual surgery or to evaluate the need for such surgery. Evaluations and subsequent medications and Services necessary to maintain transsexual status are also excluded from coverage, as are complications or medical sequelae of such surgery or treatment.

23. No benefits will be paid for injuries incurred by the operator of a motorized vehicle while such operator is under the influence of intoxicating alcoholic beverage, or controlled drugs or substances. If a blood alcohol level or the DRAEGER ALCO TEST is available and shows levels that are equal to or exceed 0.08 grams percent (gms%) or that exceed the amount allowed by Guam law as constituting legal intoxication, no benefits will be paid.

24. No benefits will be paid for any medical Service or supply which is available to the Covered Person on Guam and which is paid by or reimbursable through a governmental agency or institution. However, notwithstanding the aforesaid, in no event will the Company consider the availability of benefits under Medicaid or Medically Indigent Program when paying benefits under this Certificate.

25. No benefits will be paid for audiograms, regardless of the reason for such tests.

26. To the extent permitted by PPACA and except as provided in the §4.51, no benefits will be paid for Services and supplies provided for the purpose of organ transplantation. Unless PPACA requires otherwise, all organ transplants are excluded from coverage, including but not limited to: heart, lung, liver, kidney, pancreas, bone marrow and cornea. Autologous bone marrow transplant (where the donor is also the recipient) is also excluded. Services and supplies directly related to the transplant, such as tissue typing and other pre-operative procedures are excluded as are Services and supplies provided post-operatively which are a consequence of the transplant surgery or the presence of the transplanted organ. This exclusion for post-operative supplies, to include anti-rejection or immunosuppressant medications, and Services continues for the life of the patient. Benefits directly related to the transplant will cease as of the time when it is determine that a transplant will be performed.

27. No benefits will be paid for Services and supplies provided in the course of organ donation whether for a Covered Person who is donating an organ or for someone who is donating an organ for transplantation into a Covered Person.

28. No benefits will be paid in connection with elective abortions unless Medically Necessary.

29. No benefits will be paid for vision care services and supplies, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for

binocular vision), Lasik, keratoplasty, and radial keratotomy, including related procedures designed to surgically correct refractive errors except as provided in this Certificate.

30. No benefits will be paid for eyeglasses or contact lenses or for Services and supplies in connection with surgery for the purpose of diagnosing or correcting errors in refraction with the exception of the benefit specifically provided for in this Certificate.

31. No benefits will be paid in connection with any injuries sustained while the Covered Person is operating any wheeled vehicle during an organized, off-road, competitive sporting event.

32. No benefits will be paid for personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies.

33. No benefits will be paid in connection with dialysis treatments which would not have been charged in the absence of the Plan.

34. No benefits will be paid for hypnotherapy.

35. No benefits will be paid for religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.

36. No benefits will be paid for cosmetic surgery, defined as any surgical procedure directed at improving appearance; or for treatment or Services relating to the consequences of, or as a result of, cosmetic surgery, or except when required for as soon medically feasible repair of accidental injury or for the improvement of the functioning of a malformed body member. This exclusion does not apply to:
    a. Breast Reconstruction. In accordance with the Women's Health and Cancer Rights Act, reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all states of mastectomy, including lymphedemas, are covered. Such re-constructive procedures are not limited to reconstructive procedures necessitated by mastectomies performed while covered under this Plan.
    b. Surgery required for the prompt (i.e., as soon as medically feasible) repair of accidental Injury;
    c. Surgery as a continuation of a staged reconstruction procedure, including but not limited to post-mastectomy reconstruction;
    d. Surgery for the improvement of the functioning of a malformed body member, including but not limited to correcting congenital defects necessary to restore normal bodily functions (e.g., cleft lip and cleft palate).

37. No benefits will be paid for routine foot/hand care, including routine reduction of nails, calluses and corns.

38. Except as otherwise provided in this agreement, no benefit will be paid for specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine auto injections.

39. No benefits will be paid for Services and supplies associated with growth hormone treatment unless the Covered Person is proven to have growth hormone deficiency using accepted stimulated growth hormone analyses and also shows an accelerated growth response to growth hormone treatment. Under no circumstances will growth hormone treatment be covered to treat short stature in the absence of proven growth hormone deficiency.

40. No benefits will be paid for Services and supplies provided for liposuction.

41. No benefits will be paid forweight reduction programs, or dietary supplements, except as pre-authorized by Company for the Medically Necessary treatment of morbid obesity.

42. No benefits will be paid for any drug, food substitute or supplement or any other product, which is primarily for weight reduction even if it is prescribed by a Physician.

43. If for aesthetic purposes, no benefits will be paid in connection with gastric bypass, stapling or reversal.

44. No benefits will be paid for surgical operations, procedures or treatment of obesity, except when Company has provided prior authorization.

45. No benefits will be paid for the treatment of male or female infertility, including but not limited to:
    a. The purchase of donor sperm and any charges for the storage of sperm;
    b. The purchase of donor eggs and any charge associated with care of the donor required for donor egg retrievals or transfers or gestational carriers;
    c. Charges associated with cryopreservation or storage of cryopreserved embryos (e.g. office, hospital, ultrasounds, laboratory tests, etc.);
    d. Home ovulation prediction kits;
    e. Injectable Infertility medications, including but not limited to, menotropins, hCG, GnRH agonists, IVIG;
    f. Artificial Insemination, including in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and intracytoplasmic sperm injection (ICSI), and any advanced reproductive technology ("ART") procedures or services related to such procedures;
    g. Any charges associated with care required for ART (e.g., office, hospital, ultrasounds, laboratory tests, etc.);

h. Donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
i. Any charge associated with a frozen embryo transfer including but not limited to thawing charges;
j. Reversal of sterilization surgery; and
k. Any charges associated with obtaining sperm for ART procedures.

46. No benefits will be paid for household equipment, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbed, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Covered Person's house or place of business, and adjustments to vehicles.

47. No benefits will be paid for outpatient supplies (except diabetic supplies), including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, and elastic stockings.

48. No benefits will be paid for Services and supplies provided for penile implants of any type.

49. No benefits will be paid in connection with any implants or organ transplants. This exception shall not apply to orthopedic, cardiac, and ear and eye surgeries including but not limited to: Single and dual pacemakers; intraocular lens implants; artificial eyes; heart valves, orthopedic internal prosthetic devices; cardiac stents; stump hose; cochlear implants; corrective orthopedic appliances; and braces.

50. No benefits will be paid for Services and supplies to correct sexual dysfunction.

51. Except as specifically provided, if a benefit is excluded, all Hospital, surgical, medical treatments, prescription drugs, laboratory services, and x-rays in relation to the excluded benefits are also excluded as of the time it is determined that the benefit is excluded.

52. Except as specifically provided in this Certificate, no benefits will be provided for Services and supplies not ordered by a Physician or not Medically Necessary.

53. Except as specifically provided in this Certificate, no benefits will be provided for:
    a. Orthopedic footwear: Orthopedic footwear unless attached to an artificial foot or unless attached as a permanent part of a leg brace.
    b. Motorized limbs: Motorized artificial limbs.

54. No benefits will be paid for Temporomandibular Joint (TMJ) disorder treatment, including treatment performed by prosthesis placed directly on the teeth, except as provided for in § 4.26 of this Certificate.

55. No benefits will be paid for Services for which the Covered Person is not legally obligated to pay.

56. No benefits will be paid for recreational or educational therapy.

57. No benefit will be paid for ambulance services when used for routine and convenience transportation to receive outpatient or inpatient services, unless deemed Medically Necessary with prior authorization obtained from Company.

58. Elective or voluntary enhancement procedures, surgeries, services, supplies and medications including, but not limited to, hair growth, hair removal, hair analysis, sexual performance, athletic performance, anti-aging, and mental performance, even if prescribed by a Physician.

59. No benefits will be paid for hospital take-home drugs.

60. No benefits will be paid for fees for any missed appointments or voluntary transfer of records as requested by the Covered Person.

61. No benefits will be paid for educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders including developmental and learning disorders associated with mental retardation, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a Covered Person, whose ability to speak has been lost or impaired, to function without that ability, are not covered.

62. No benefits will be paid for Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition.

63. No benefits will be paid for psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms or whether providing or receiving the Service.

64. No benefits will be paid for non-Medically Necessary services, including but not limited to, those Services and supplies:
    a. Which are not Medically Necessary, as determined by Company, for the diagnosis and treatment of Illness, Injury, restoration of physiological functions, or covered preventive services;
    b. That do not require the technical skills of a medical, mental health or a dental professional;
    c. Furnished mainly for the personal comfort or convenience of the Member, or any person who cares for the Member, or any person who is part of the Member's

family, or any Provider;

d. Furnished solely because the Member is an inpatient on any day in which the Member's disease or Injury could safely and adequately be diagnosed or treated while not confined;
e. Furnished solely because of the setting if the service or supply could safely and adequately be furnished in a Physician's or a Dentist's office or other less costly setting.

65. As required by HIPAA, no source-of-injury exclusion will apply if: a) the Injury resulted from an act of domestic violence, or b) the Injury resulted from a medical condition (including both physical and mental health conditions). There is no source-of-injury exclusion for intentionally self-induced or intentionally self-inflicted injuries resulting from a medical condition (including physical and mental health conditions).

Prescription Drug Exclusions

The following services are not covered by Calvo's SelectCare:

1. No benefits will be paid for Injury or Illness, (a) when the Covered Person is entitled to receive disability benefits or compensation (or forfeits his or her right thereto) under Worker's Compensation or Employer's Liability Law for such injury or Illness or (bl when Services for an Injury or Illness are rendered to the Covered Person by any federal, state, territorial, municipal or other governmental instrumentality or agency without charge, or (cl when such Services would have been rendered without charge but for the fact that the person is a Covered Person under the Plan.

2. No benefits will be paid if any material statement made in an application for coverage, enrollment of any Dependent or in any claim for benefits is false. Upon identifying any such false statement, Company shall give the Covered Person at least 30 day notice that his or her benefits have been suspended and that his or her coverage is to be terminated. If the false statement is fraudulent or is an intentional misrepresentation of a material fact, such termination shall be retroactive to the date coverage was provided or continued based on such fraudulent statement or intentional misrepresentation of material fact. If the false statement was not a fraudulent statement or intentional misrepresentation of material fact, termination of coverage shall be effective no earlier than the date of the suspension. The Covered Person may dispute any termination of coverage by filing a claim under the PPACA Claims Procedure for internal or external appeals, set out in §6.7 of this Certificate. If an appeal under §6:7 is filed, the resolution of the matter shall be in accordance with the outcome of the appeal proceedings. If no appeal is filed for any retroactive termination and the Company paid benefits prior to learning of ·any such false statement, the Subscriber must reimburse the Company for such payment. Termination of coverage shall be handled in accordance with the applicable claims procedure requirements of Section 2719 of the PHSA, as added by PPACA. Retroactive terminations of coverage shall not violate the applicable prohibitions on rescissions of Section 2712 of the PHSA, as added by PPACA, and rescissions shall be handled in compliance with PPACA's applicable claim denial requirements.

3. No benefits will be paid for confinement in a Hospital or in a Skilled Nursing Facility if such confinement is primarily for custodial or domiciliary care. (Custodial or domiciliary care includes that care which consists of training in personal hygiene, routine nursing services and other forms of self-care. Custodial or domiciliary care also includes supervisory services by a Physician or Nurse for a person who is not under specific medical or surgical treatment to reduce his or her disability and to enable that person to live outside an institution providing such care.) Company and not Covered Person shall be liable if the Company approves the confinement, regardless of who orders the service.

4. No benefits will be paid for nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)

5. No benefits will be paid for private Duty Nursing. This provision does not apply to Home Health Care.

6. No benefits will be paid for special medical reports, including those not directly related to treatment of the Member. (e.g., Employment or insurance physicals, and reports prepared in connection with litigation.)

7. No benefits will be paid for services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.

8. No benefits will be paid for court ordered services, or those required by court order as a condition of parole or probation.

9. No benefits will be paid for Services and supplies provided to a Covered Person for an Injury or Illness resulting from an attempted suicide by that Covered Person unless resulting from a medical condition (including physical or mental health conditions) or from domestic violence.

10. No benefits will be paid for Services and supplies provided in connection with intentionally self-induced or intentionally self-inflicted injuries or illnesses unless resulting from a medical condition (including physical or mental conditions) or from domestic violence.

11. No benefits will be paid for Services and supplies provided to a Covered Person for Injuries incurred while the person was committing a criminal act.

12. Unless otherwise specifically provided in the Agreement, no benefit will be paid for, or in connection with, airfare and the Company will not pay for the transportation from Guam to any off-island facility, nor for any other non-medical expenses such as taxes, taxis, hotel rooms, etc. In no event will the Company pay for air ambulance or for the transportation of the remains of any deceased person.

13. No benefits will be paid for living expenses for Covered Persons who require, or who of their own accord seek, treatment in locations removed from their home.

14. No benefits will be paid for Services and supplies provided to a dependent of a non-Spouse Dependent. Dependents of non-Spouse Dependents are not eligible for coverage. For example, when a Dependent, other than a Spouse of the Subscriber, has a child, that child is a dependent of a non-Spouse Dependent and is not eligible to become covered under the Plan, unless such child otherwise becomes eligible for enrollment.

15. No benefits will be paid for home uterine activity monitoring.

16. No benefits will be paid for services performed by an immediate family member for which, in the absence of any health benefits coverage, no charge would be made. Immediate family member is defined as parents, spouses, siblings, or children of the insured member.

17. No benefits will be paid for treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of] any work for pay or profit, or in any way results from a disease or injury which does. If a Member is covered under a Workers' Compensation law or similar law, and submits proof that the Member is not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational" regardless of cause. The Covered Benefits under the Group Health Insurance Certificate for Members eligible for Workers' Compensation are not designed to duplicate any benefit to which they are entitled under Workers' Compensation Law. All sums payable for Workers' Compensation services provided under the Group Health Insurance Certificate shall be payable to, and retained by Company. Each Member shall complete and submit to Company such consents, releases, assignments and other documents reasonably requested by Company in order to obtain or assure reimbursement under the Workers' Compensation Law

18. No benefits will be paid for:

a. Drugs or substances not approved by the Food and Drug Administration (FDA), or
b. Drugs or substances not approved by the FDA for treatment of the illness or injury being treated unless empirical clinical studies have proven the benefits of such drug or substance in treating the illness or injury, or
c. Drugs or substances labeled "Caution: limited by federal law to investigational use." or
d. Any drug or substance which does not, by federal or state law, require a prescription order (i.e., an over-the counter (OTC) drug).

19. No benefits will be paid for experimental or investigational Procedures, or ineffective surgical, medical, psychiatric, or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes, unless deemed medically necessary by the patient's physician and pre-authorized by the Company.

    Per PHSA sec. 2709(a)(2). added by PPACA sec 10103(c), the plan must pay for items and services furnished in connection with approved clinical trials, and cannot exclude such items and services based on an exclusion for experimental or investigational treatments. The requirement mandates coverage of all medically necessary charges associated with the clinical trial, such as physician charges, labs, X-rays, professional fees and other routine medical costs.

    An approved clinical trial is defined as:

    - Phase I, Phase II, Phase lll, or Phase IV clinical trial,
    - Being conducted in relation to the prevention, detection or treatment for Cancer or other life threatening disease or condition, and
    - Is one of the following:

1. A federally funded or approved trial.
2. A clinical trial conducted under an FDA investigational new drug application.
3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

20. No benefits will be paid for services or supplies related to Genetic Testing except as may be required by PPACA.

21. No benefits will be paid for any item or substance that is available without a Physician's prescription even if prescribed by a Physician, except as otherwise provided herein and except for medicines and supplies Medically Necessary for inpatient care.

22. No benefits will be paid for Services and supplies provided to perform transsexual' surgery or to evaluate the need for such surgery. Evaluations and subsequent medications and Services necessary to maintain tr_anssexual status are also excluded from coverage, as are complications or medical sequela of such surgery or treatment.

23. No benefits will be paid for injuries incurred by the operator of a motorized vehicle while such operator is under the influence of intoxicating alcoholic beverage, controlled drugs, or substances. If a blood alcohol level or the DRAEGER ALCO TEST is available and shows levels that are equal to or exceed 0.08 grams percent (gms%) or that exceed the amount allowed by law as constituting legal intoxication, no benefits will be paid.

24. No benefits will be paid for any medical Service or supply which is available to the Covered Person on Guam and which is paid by or reimbursable through a governmental agency or institution that provides medical and healthcare services to low-income or indigent persons, provided, however, this exclusion shall not apply to the treatment of any communicable disease as defined in Article 3 of Chapter 3, Title 10, Guam Code Annotated, and for which the Company shall pay for medical services and supplies as is medically necessary for the treatment of Covered Person. However, notwithstanding the aforesaid, in no event will the Company consider the availability of benefits under Medicaid or Medically Indigent Program when paying benefits under this Agreement.

25. No benefits will be paid in connection with elective abortions unless Medically Necessary.

26. No benefits will be paid for vision care services, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision). Lasik, keratoplasty, and radial keratotomy, including related procedures designed to surgically correct refractive errors except as provided in the Covered Benefits section of the Group Health Insurance Certificate.

27. No benefits will be paid for eyeglasses or contact lenses or for Services and supplies in connection with surgery for the purpose of diagnosing or correcting errors in refraction except as provided in the Schedule of Benefits.

28. No benefits will be paid in connection with any injuries sustained while the Covered Person is operating any wheeled vehicle during an organized, off-road, competitive sporting event.

29. No benefits will be paid for personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies.

30. No benefits will be paid for hypnotherapy.

31. No benefits will be paid for religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.

32. No benefits will be paid for cosmetic Surgery or other services intended primarily to improve the Member's appearance or treatment relating to the consequences of, or as a result of, Cosmetic Surgery. This exclusion does not apply to:

a. Medically Necessary reconstructive surgery as described in the Covered Benefits sections Mastectomy and Reconstructive Breast Surgery or Reconstructive Surgery.

b. surgery to correct the results of injuries causing an impairment.

c. surgery as a continuation of a staged reconstruction procedure, including but not limited to post-mastectomy reconstruction;

d. surgery to correct congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.

33. No benefits will be paid for routine foot/hand care, including routine reduction of nails, calluses and corns.

34. Except as otherwise provided in this agreement, no benefit will be paid for specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method). cytotoxicity testing (Bryan's Test]. treatment of non-specific candida sensitivity, and urine auto injections.

35. No benefits will be paid for Services and supplies associated with growth hormone treatment unless the Covered Person is proven to have growth hormone deficiency using accepted stimulated growth hormone analyses and also shows an accelerated growth response to growth hormone treatment. Under no circumstances will growth hormone treatment be covered to treat short stature in the absence of proven growth hormone deficiency.

36. No benefits will be paid for Services and supplies provided for liposuction.

37. No benefits will be paid for weight reduction programs, or dietary supplements, except as pre-authorized by Company for the Medically Necessary treatment of morbid obesity.

38. No benefits will be paid for any drug, food substitute or supplement or any other product, which is primarily for weight reduction even if it is prescribed by a Physician.

39. Except as provided in this Agreement, or unless medically necessary for the treatment of Morbid Obesity or other disease, no benefit will be paid for gastric bypass, stapling or reversal if for the purpose of weight reduction or aesthetic purposes.

40. No benefits will be paid for surgical operations, procedures or treatment of obesity, except when pre-authorized by Company.

41. No benefits will be paid for the treatment of male or female Infertility, including but not limited to:

a. The purchase of donor sperm and any charges for the storage of sperm;

b. The purchase of donor eggs and any charge associated with care of the donor required for donor egg retrievals or transfers or gestational carriers;

c. Charges associated with cryopreservation or storage of cryopreserved embryos (e.g. office, hospital, ultrasounds, laboratory tests, etc.);

d. Home ovulation prediction kits;

e. Injectable Infertility medications, including but not limited to, menotropins, hCG, GnRH agonists, IVIG;

f. Artificial Insemination, including in vitro fertilization (IVFI. gamete intrafallopian tube transfer (GIFTI, zygote intrafallopian tube transfer (ZIFTI. and intracytoplasmic sperm injection (ICSI). and any advanced reproductive technology ("ART") procedures or services related to such procedures;

g. Any charges associated with care required for ART (e.g., office, Hospital, ultrasounds, laboratory tests, etc.I;

h. Donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;

i. Any charge associated with a frozen embryo transfer including but not limited to thawing charges;

j. Reversal of sterilization surgery; and

k. Any charges associated with obtaining sperm for ART procedures.

42. Except as provided in this Agreement, no benefits will be paid for the purchase or rental of durable or disposable medical equipment and supplies, other than for:

a. Equipment and supplies used in a Hospital or Skilled Nursing Facility, or in conjunction with an approved Hospital or Skilled Nursing Facility confinement, or as otherwise noted in the Agreement or

b. Items covered as preventive care under well-women coverage such as breastfeeding supplies in accordance with reasonable medical management techniques.

43. No benefits will be paid for household equipment, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbed, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Member's house or place of business, and adjustments to vehicles.

44. No benefits will be paid for outpatient supplies (except diabetic supplies), including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, and elastic stockings.

45. No benefits will be paid for Services and supplies provided for penile implants of any type.

46. No benefits will be paid for Services and supplies to correct sexual dysfunction.

47. Except as specifically provided, if a benefit is excluded, all Hospital, surgical, medical treatments, prescription drugs, laboratory services, and x-rays in relation to the excluded benefits are also excluded as of the time it is determined that the benefit is excluded.

48. Except as specifically provided in this Agreement, no benefits will be provided for Services and supplies not ordered by a Physician or not Medically Necessary.

49. No benefits will be paid for temporomandibular joint disorder treatment [TMJ) including treatment performed by prosthesis placed directly on the teeth except as covered in the Covered Benefits Section

50. Except as specifically provided in this Agreement, no benefits will be paid for corrective appliances, artificial aids and durable equipment.

51. No benefits will be paid for Services for which the Covered Person or Subscriber is not legally obligated to pay.

52. No benefit will be paid for ambulance services when used for routine and convenience transportation to receive outpatient or inpatient services, unless deemed medically necessary with prior authorization obtained from Company.

53. Elective or voluntary enhancement procedures, surgeries, services, supplies and medications including, but not limited to, hair growth, hair removal, hair analysis, sexual performance, athletic performance, anti-aging, and mental performance, even if prescribed by a Physician.

54. No benefits will be paid for hospital take-home drugs.

55. No benefits will be paid for fees for any missed appointments or voluntary transfer of records as requested by the Covered Person.

56. No benefits will be paid for educational services. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, are not covered.

No benefits will be paid for Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition.

57. No benefits will be paid for Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms or whether providing or receiving the Service.

58. No benefits will be paid for non-medically necessary services, including but not limited to, those services and supplies:

a. Which are not Medically Necessary, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;

b. That do not require the technical skills of a medical or mental health professional;

c. Furnished mainly for the personal comfort or convenience of the Member, or any person who cares for the Member, or any person who is part of the Member's family, or any Provider;

d. Furnished solely because the Member is an inpatient on any day in which the Member's disease or injury could safely and adequately be diagnosed or treated while not confined;

e. Furnished solely because of the setting if the service or supply could safely and adequately be furnished in a Physician's or a dentist's office or other less costly setting.

59. As required by HIPAA, no source-of-injury exclusion, such as exclusion 4.29 for off-road sporting events, will apply if the accident resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions).

60. No benefits will be paid for any continued services if you do not substantially follow your treatment plan or do not follow medical advice.

Preventive Services

The information below is a synopsis of the covered preventive services in accordance with the U.S. Preventive Services Task Force (USPSTF), Grades A and B recommendations to clinicians. For a full listing and updates of the USPSTF A and B recommendations for adults and children, please go to: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Physical Exam Frequency

Age	Frequency & Recommendations
Infancy (Newborn to nine months)	Maximum 7 visits
Early Childhood (One to four years old)	Maximum 7 visits
Middle Childhood / Adolescence (Five to seventeen years old)	Maximum 1 visit every 12 months

Immunization vaccines for children from birth to age 18

Immunizations	Frequency & Recommendations
Diphtheria, Tetanus, Pertussis	At ages 2, 4, 6 and 18 months, once between 4 and 6 years, a single dose of Tdap for booster between ages 11 and 12 and subsequently every 10 years
Haemophilus Influenzae type B	At ages 2, 4, 6 and 15 to 18 months
Hepatitis A	Two doses at least six months apart at ages 12 to 23 months. From age 2 to 18 years, at physician's discretion: two doses at least six months apart if not vaccinated previously and at high risk
Hepatitis B	Three doses in the first 18 months. (First dose of Hep B to be administered to all newborns before leaving the hospital.) May begin three-dose series age 2 to 18 years if not vaccinated in infancy

Human Papillomavirus (HPV)	Three dose series at age 11 to 12 years
Inactivated Poliovirus	At ages 2, 4 and 6 to 18 months, once between ages 4 and 6 years
Influenza	For healthy children receiving the immunization for the first time, ages 6 months to 9 years, two doses separated by four weeks. Annually for children 2 years and older after first immunization
Measles, Mumps, Rubella (MMR)	Two vaccinations, the first at ages 12 to 15 months. MMR vaccinations should never be given less than one month apart. Second vaccination given between ages 4 and 6 years. After age 7, two doses if not previously vaccinated or no history of disease
Meningococcal	One dose for ages 2 to 10 years if high risk. One dose between 11 to 12 years. One dose 13 to 18 years if not previously vaccinated
Pneumococcal	For all children ages 23 months and younger, four doses at 2, 4, 6, and 12 to 15 months. For ages 2 to 6 years, a single dose, if not immunized previously for healthy children. One additional dose for children with underlying medical conditions who have already received three doses. Vaccinate high risk groups after age 7
Rotavirus	At 2, 4 and 6 months
Varicella	One vaccination between ages 12 and 18 months. Second dose to be given at 4 to 6 years. Two-dose series for children 7 years to adult if no history of varicella and no previous vaccination

Assessments and screenings for children from birth to age 18

Assessments, screenings and counseling	Frequency & Recommendations
Alcohol And Drug Use Assessments	All adolescents, during each visit for age 11 to 18 years
Anxiety & depression screening for youth	Anxiety-disorder screening for children and adolescents ages 8–18, and depression screening for adolescents ages 12–18, consistent with current USPSTF Grade B recommendations
Autism Screening	Children at 18 and 24 months
Blood Pressure	Beginning at 3 years
Breastfeeding Support, Supplies and Counseling	In conjunction with each birth
Cervical Dysplasia/Cancer Screening	At start of sexual activity for females
Chlamydia Infection, Gonorrhea And Syphilis Screenings	All sexually active adolescents to be screened for sexually transmitted infections (STIs)
Congenital Hypothyroidism Screening	Newborns
Contraceptive Methods and Counseling	As prescribed
Depression Screening and Behavioral Assessments	Children between ages 12 to 18
Developmental Screening	Children under the age of 3 to be checked at 9, 18 and 30 months
Dyslipidemia Screening	Risk assessment at 2, 4, 6, 8 and 10 years old, then annually through age 21. (Routine lab testing not recommended, but may be done for children identified as high risk)
Gonorrhea Preventive Medication	For the eyes of all newborns
Hearing Screening	0 to 90 days

Height, Weight and Body Mass Percentile Measurements	Height and weight at each visit up to 2 years. Starting at 2 years body mass percentile at each visit
Hematocrit or Hemoglobin Screening	Once at 12 months, once between ages 11 and 21, once annually for menstruating adolescents
HIV Screening	Adolescents and adults ages 15–65 (and others at increased risk)
Human Papillomavirus Testing	Screening should begin at 30 years of age and should occur no more frequently than every 3 years
Lead Screening	Children at risk of exposure. Risk assessment for lead exposure between ages 6 and 12 months and again at 24 months and assess for risk between ages 2 to 6. Blood tests for those identified as high risk
Medical History	All children throughout development
Newborn Screenings as identified by the Federal Health Resources and Services Administration	Once at birth, screenings include but are not limited to PKU and sickle cell screenings
Obesity Screening and Physical Activity and Nutrition Counseling	6 years and older
Oral Health Risk Assessment	12, 18, 24 and 30 months. 3 and 6 years
Interpersonal and Domestic Violence Screening and Couseling	
Sexually Transmitted Infection (STI) Prevention Counseling	Adolescents at higher risk, anticipatory guidance at physician discretion for ages 11 to 18 years
Tuberculin Testing	Children at high risk of tuberculosis
Vision Screening	Between the ages of 3 and 5 years, to detect the presence of amblyopia or risk factors

Immunization vaccines for adults

Immunizations	Frequency & Recommendations
Hepatitis A	Recommended if risk factors are present
Hepatitis B	Recommended if risk factors are present
Herpes Zoster	One dose at age 60 and older
Human Papillomovirus (HPV)	Three dose series at age 19 to 26 years on a zero, two and six-month schedule for females
Influenza	Annually
Measles, Mumps, Rubella (MMR)	One to two doses if not vaccinated previously or no history of disease. For high risk groups age 40 years and older
Meningococcal	For ages 19 to 24, one dose if not vaccinated previously. For high risk groups 24 years and older
Pneumococcal	For high risk groups under age 65. One after age 65
Tetanus, Diphtheria and Pertussis (Td/Tdap)	Every 10 years (One dose of Tdap if pertussis booster was not received previously) After 65 Td alone
Varicella	Two-dose series for adults if no history of varicella and no previous vaccination

Assessments and screenings for adults

Assessments, screenings and counseling	Frequency & Recommendations
Abdominal Aortic Aneurysm Screening	Men between ages 65 and 75 who have ever smoked, a one-time screening for abdominal aortic aneurysm
Alcohol Misuse Screening	All adults at physical exam
Anxiety Disorders Screening	Adults ages 19–64, including pregnant and postpartum persons
Blood Pressure Screening	All adults at physical exam
Chlamydia Infection, Gonorrhea And Syphilis Screenings	All sexually active adults to be screened for sexually transmitted infections (STIs)
Colorectal Cancer Screening	Adults ages 45–75 using an accepted method (stool-based test, flexible sigmoidos copy, or colonoscopy). For adults 76–85, screening is an individual decision
Depression & Suicide Risk Screening	All adults, including pregnant and postpartum persons
Prediabetes & Type 2 Diabetes Screening	Adults ages 35–70 who have overweight or obesity; refer those with prediabetes to preventive interventions
Diet Counseling	Adults at higher risk for chronic disease
Height, Weight And Body Mass Percentile Measurements	All adults during physical exam
Hematocrit or Hemoglobin Screening	Once every two years for adults
Hepatitis B & Hepatitis C Screening	Hepatitis C — all adults ages 18–79 Hepatitis B — adolescents and adults at increased risk
HIV Screening	Adolescents and adults ages 15–65 (and others at increased risk)
Lung Cancer Screening	Annual low-dose CT (LDCT) for adults ages 50–80 with a 20 pack-year smoking history who currently smoke or have quit within the past 15 years
Statin Use to Prevent Cardiovascular Disease	Adults ages 40–75 who have at least one CVD risk factor (high cholesterol, diabetes, high blood pressure, or smoking) and an estimated 10-year cardiovascular risk of 10% or greater are recommended a statin.
Obesity Screening and Counseling	All adults
Sexually Transmitted Infection (STI) Prevention Counseling	Adults at higher risk
Tobacco Use Screening	All adults during each visit (includes cessation interventions for tobacco users) expanded counseling for pregnant tobacco users
Tuberculin Testing	Adults at higher risk of tuberculosis

Women's Preventive Services

Assessments, screenings and counseling	Frequency & Recommendations
Bacteriuria (urinary tract or other infection screening)	Pregnant women
Breastfeeding Support, Supplies & Counseling	Each birth. Comprehensive lactation support & counseling by trained provider during pregnancy &/or in the post partum period, and costs for renting breastfeeding equipment
Cervical Cancer Screening	Ages 21–29 — cytology (Pap) every 3 years. Ages 30–65 — primary high-risk HPV testing every 5 years (preferred); alternatively, Pap every 3 years, or HPV + Pap co-testing every 5 years. Self-collected HPV samples are now an accepted screening option

Breast Cancer Chemoprevention Counseling	Women at high risk
BRCA Screening Counseling	Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes
Sexually Transmitted Infections Counseling	Annually for all sexually active women
Human Immunodeficiency Virus (HIV) Counseling & Screening	Annually for all sexually active women
Contraceptive Methods & Counseling	As prescribed. All FDA approved contraceptive methods, sterilization procedures & patient education & counseling for all women with reproductive capacity.` Subject to Plan Drug Formulary
Hepatitis B Screening	Pregnant women at their first prenatal visit
Human Papillomavirus Testing (HPV)	Screening begins at 30 years of age & should occur no more frequently than every 3 years. High-risk human papillomavirus DNA testing in women with normal cytology results
Iron Deficiency Anemia Screening	On a routine basis for pregnant women
Mammography	Screening mammography every 2 years for women ages 40–74. (Previously began at age 50)
Osteoporosis Screening	Bone density testing for all women ages 65 and older, and for postmenopausal women under 65 who are at increased risk
Rh Incompatibility Screening	All pregnant women on first visit and follow-up testing for women at higher risk
Gestational Diabetes Screening	Pregnant women between 24 & 28 weeks of gestation & at the first prenatal visit identified to be at high risk for diabetes
Interpersonal & Domestic Violence Screening & Counseling	Annually

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.

1	All diagnostic procedures performed or ordered by the same provider on a single patient two or more times	
2	All inpatient services (surgical/ non-surgical, skilled nursing, rehabilitation)	
3	All outpatient surgical procedures requiring the use of surgical facilities (except for female sterilization)	
4	All Diagnostic Procedures (including laboratory/ pathology) in excess of $500.00	
5	Applied Behavioral Analysis services	
6	BRCA Gene Testing (in accordance with the USPSTF Grade B Recommendation)	
7	Cardiac Catheterization and Procedures	
8	Carpal Tunnel Release, Monofilament Testing	
9	Chemotherapy and Radiation Therapy	
10	Durable Medical Equipment: Std. hospital bed, Std. wheelchairs, walkers, crutches, oxygen, suction machine	
11	EMG / NCT (upper extremities)/ Autonomic Testing	
12	Home Health, Hospice and Palliative Care Services	
13	Hyperbaric Oxygen Therapy & Wound Care Services	
14	Imaging (CT Scans, Dexa Scans, MRIs, MRAs, Angiographies, PET Scans, Ultrasounds – except first obstetric ultrasound)	
15	Immunotherapy (See Drug Formulary)	
16	Mammograms (except for routine screenings according to the guidelines of the American Cancer Society)	
17	MIBI Scan, Thallium Stress Test, Exercise Stress Test	
18	Nuclear Medicine Studies	
19	Ophthalmology Diagnostic Procedures	
20	Pain Management Studies & Treatment	
21	Preventive Services • Genetic Counseling and Evaluation for BRCA Testing; and BRCA Lab Screening • Computed Tomographic Colonography (Virtual Colonoscopy) • Screening for Lung Cancer with Low-Dose Computed Tomography	CPT CODES 81162, 81163, 81164, 81165, 81166, 81167, 81212, 81215, 81216, 81217 74263 71271
22	Physical Therapy, Occupational Therapy, and Speech Therapy	
23	Organ Transplant Services	
24	Orthotics/ Prosthetics and Implantable Devices	
25	Plastic/ Reconstructive procedures	
26	Sleep Studies	
27	Specialty/Biologic Injections (Ophthalmic, Orthopedic)	
28	Specialty Medications (See Drug Formulary)	

Urgent Care and Emergency Care

Knowing the difference can save you time and give you piece of mind

When should you go to Urgent Care?

- Symptom onset is gradual
- Conditions that are not life-or limb-threatening, but require immediate care
- Sprains
- Sore throat
- Urinary tract infections
- Mild asthma
- Rash without fever
- Broken bones of the wrist, hand, ankle or foot that have no obvious need to reset and have not broken the skin

When should you call 9-1-1?

Shortness of breath or difficulty breathing
Signs of a Stroke (slurred speech, severe headache)
Heart Attack Symptoms (chest pain, pain in the left arm)
Life- or Limb-threatening injury

When should you go to the Emergency Room?

- Broken bones and disclocated joints
- Deep cuts that require stiches – especially on the face
- Head or eye injuries
- Severe flu or cold symptoms
- Sudden change in mental state
- High fevers
- Fevers with rash
- Fevers in infants
- Fainting or loss of consciousness
- Severe pain, particularly in the abdomen or starting halfway down the back
- Bleeding that won't stop or a large open wound
- Vaginal bleeding with pregnancy
- Repeated vomiting
- Serious burns
- Seizures without a previous diagnosis of epilepsy

Telemedicine

Teladoc Health lets eligible members connect with healthcare professionals remotely for certain non-emergency medical needs, subject to their health plan benefits.

How to Get Started

Step 1. Download the Teladoc Health app
Go to the Apple App Store or Google Play Store and search for "Teladoc Health."

Step 2. Register or sign in
Create your account and provide the requested information to verify your eligibility. Have your Calvo's SelectCare member ID card available.

Step 3. Select the type of care
Choose from the available services, which may include general medical care, behavioral health, or other telehealth services, depending on your benefits.

Step 4. Request a consultation
Complete a brief health questionnaire, describe your symptoms, and request an available visit or appointment.

Step 5. Connect with a provider
Join your consultation through the app or website. If clinically appropriate and legally permitted, the provider may prescribe medication.

Helpful Information
Before your visit: Have your member ID card, medication list, medical history, and preferred pharmacy information ready.
Cost: Copayments and available services depend on your SelectCare benefit plan. Verify your eligibility and any charges before requesting care.

Note: Teladoc Health is not intended for medical emergencies. If you have severe chest pain, difficulty breathing, stroke symptoms, or any other emergency, seek emergency medical care immediately.

Teladoc provides Virtual Medical visits 24/7. No copay! No co-share!

Scan the QR Code to get started: https://www.teladochealth.com
*This network is not available to all plans. Check your specific plan for availability.

Teladoc HEALTH

United Healthcare

Teladoc® Virtual Visit Registration Instructions

Nurseline

Speak with a registered nurse for health guidance anytime, day or night, if the 24/7 nurse line is included in your health plan.

1. **Have your member ID card ready:** You may be asked for your name, date of birth, and member ID.
2. **Call the Nurseline at 1-866-874-3936**
   This is a special number just for Calvo's SelectCare members.
3. **Follow the prompts to reach a nurse**
4. **Explain your symptoms or question:** The nurse will give you guidance and help you decide whether to rest at home,
   see your doctor, use urgent care, or go to the ER.
5. **Have a pen handy to write down any instructions or next steps:** For a medical emergency, call 911 or go to the nearest emergency room.

Life-saving Benefits

$500 Travel Benefit: The Philippines or Taiwan

To be applied toward the cost of either (a) round trip airfare between Guam and Manila, Philippines or Taiwan; (b) ground transportation between the airport and the hospital or; (c) lodging in Manila or in Taiwan.

The following requirements apply:

- Calvo's SelectCare will reimburse members up to the $500 allowance under this travel benefit.
- One time, per member, per year.
- For pre-authorized, specialty care visits, consultations, treatments and hospitalization at participating providers in the Philippines or Taiwan. Applicable only to approved referrals for conditions not treatable on Guam.
- Excludes emergencies, Preventive Services/Executive Check-ups, home health, hospice, maternity and primary care services.
- Cannot be used in conjunction with the Airfare Benefit.
- Members are responsible for making their travel arrangements. Members are also responsible for any transportation and lodging expenses in excess of $500 and any penalties/fees incurred due to member changes.



Travel Benefit to The Philippines



Travel Benefit to Taiwan

Airfare Benefit



When certain critical conditions occur, you may qualify for round trip airfare to include:

- The member needing care
- An escort to provide assistance
- A medical escort, if medically necessary

This benefit applies to our Center of Excellence Network only. Pre-certification and Pre-approval is required.

Air Ambulance Discount

50% OFF
Air Ambulance Services!
The plan offers a 50% discount for qualifying conditions. Must be approved by the plan and air ambulance carrier.





Provider Directory

The Provider Directory is a comprehensive listing of healthcare professionals, hospitals, clinics, pharmacies, and other healthcare facilities that participate in the Calvo's SelectCare provider network. The directory includes information on Off-island providers in Asia, Continental U.S.A., and on-island.

The Provider Directory helps members:

Find convenient and accessible healthcare services.
Identify in-network providers and potentially reduce out-of-pocket expenses.
Locate specialists for specific medical conditions.
Access participating hospitals and healthcare facilities.
Make informed healthcare decisions.



PROVIDER DIRECTORY | GOVT. GROUPS

View or download the Provider Directory www.calvos.net

UnitedHealthcare

Through the partnership with UnitedHealthcare* GovGuam members have access to an extensive network throughout CONUS and in countries and globally.

- 1.1M+ UnitedHealth Premium Care Physicians
- 111K+ Doctors and Health Professionals
- 6,100+ Hospitals
- 1,700+ Convenience Care Centers



Facility/Provider Finder: Find Providers by category!
Doctors • Locations • Services • Specialties • Medical Conditions

Visit: us1.welcometouhc.com
All Off-Island Services must be pre-approved by Calvo's SelectCare

UnitedHealthcare

Off-Island Care: Step-by-Step

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

When care is not available on Guam, your Calvo's SelectCare plan provides access to Centers of Excellence in the Philippines and Taiwan, the UnitedHealthcare network across the U.S. mainland and Hawaii, and benefits toward the cost of traveling for care. This section describes the process from referral through return, in the order it occurs.

Step 1: Your doctor recommends off-island care

(begin at least 4 weeks out)
The process begins with a referral from your local doctor. Contact Customer Service at least four (4) weeks before your anticipated departure date to allow time for coordination.

Contact methods:

- Visit our office
- Call 671-477-9808
- Email service@calvos.com
- Message us through www.calvos.net
- For Philippine and Taiwan requests, submit an online request at appointment.calvos.net

Step 2: Gather your documents

Complete our Off-Island Appointment Request form and provide the following:

- Your off-island medical referral from your local doctor
- Medical records related to your illness
- Copies of diagnostic results — Ultrasound, X-Ray, MRI, CT Scan, Biopsy Reports, Pathology Slides, Angiogram CDs, and any other pertinent records
- Your most recent blood tests, laboratory, and pathology results
- If you were recently discharged: your Discharge Summary, Laboratory Results, and Operative Reports
- A completed Calvo's SelectCare authorization form allowing us to receive health information from your off-island provider
- Your Calvo's SelectCare Member ID Card and a valid picture ID

Step 3: We build and confirm your referral packet

After we receive your request and records, we will review the documents, generate the necessary paperwork, and confirm acceptance with a physician and/or facility. Delays are most often caused by appointment availability, schedule changes, or incomplete records.

When your packet is ready, we will call you for pickup. Allow approximately 30 minutes to review and sign the paperwork with our office.

Important: Do not purchase airline tickets until your off-island appointment is confirmed. A Guam Memorial Hospital Social Worker can assist with Hospital-to-Hospital transfers where applicable.

Step 4: Travel preparation

(after your appointment is confirmed)

Passport: Must be valid with more than 6 months before expiration, particularly where a medical evacuation may be necessary.

Advance Directive / Living Will: Prepare one so your wishes are followed if you become unable to make decisions. (Forms at www.lifecaredirectives.com; questions to 671-477-9808.)

Travel & lodging: Register with the Guam Medical Referral Office (671-475-9350) or its satellite offices in the Philippines, Hawaii, and California, which may assist with arrangements.

Fitness for Travel Form: May be required by the airline; obtain it from your referring physician up to 10 days before departure.

Oxygen: Confirm with your physician whether oxygen is needed during the trip or layovers; if so, coordinate with the Guam Medical Referral Office.

A companion is recommended: If a spouse, companion, or the Guam Medical Referral Office is to communicate with us on your behalf, you must sign our authorization to release Protected Health Information — verbal authorizations are not accepted.

Hand-carry your referral, complete medical records, and all diagnostic CDs and pathology slides.

Step 5: Receiving care off-island

Go to your designated facility on your scheduled date and time. If you are receiving care in the Philippines, you may coordinate with our Calvo's SelectCare offices at one of the following locations:

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

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

The Medical City: Pasig City
Business Center, 9th Floor
The Medical City, Ortigas Center
Pasig City, Philippines
Phone: (632) 650-0589

(For care in the U.S. mainland: access the UnitedHealthcare network — 1.1 million providers, 6,100 hospitals, and 560 Centers of Excellence — at us1.welcometouhc.com under "Option PPO." All off-island services must be pre-approved through Calvo's SelectCare.)

Step 6: Emergencies while off-island

For the plan to cover a bona fide emergency, you must notify us within 48 hours of the initial emergency service. Failure to notify may result in a denial of benefits.

Step 7: Return and claims

Before leaving your off-island provider, collect all medical records and reports from your care and present them to your local provider for continuity of care.

Submit receipts and claims within 120 days of the date of service, or the expenses will not be covered.

If you lose coverage for any reason during off-island care, you are responsible for reimbursing Calvo's SelectCare or any providers for charges incurred beyond the coverage period.

Completing the 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 have paid a deductible under your plan or 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 fully completed Deductible/Reimbursement Claim Form to include the required information below:

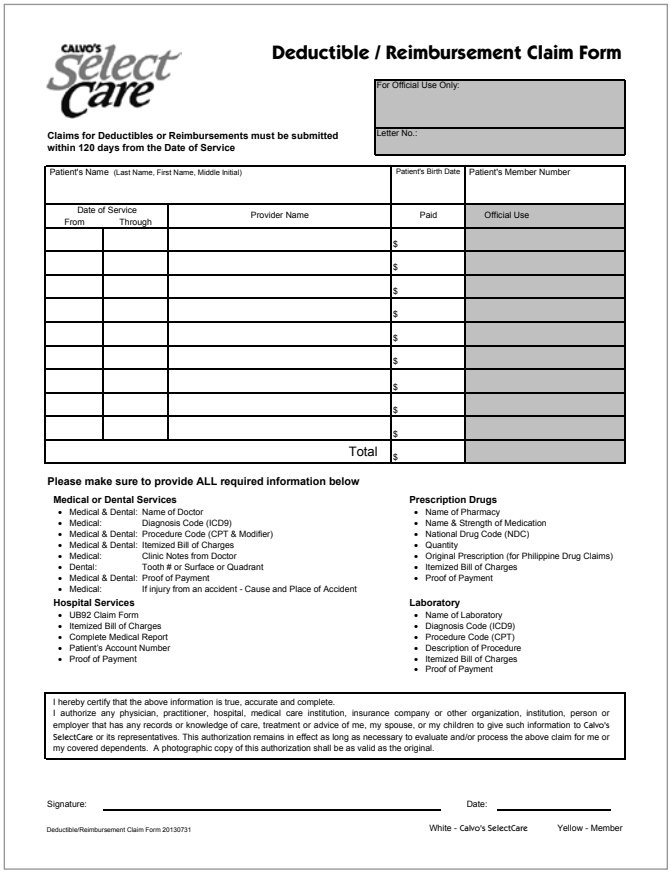
Medical or Dental Services
Medical & Dental: Name of Doctor, Procedure Code (CPT & Modifier), Itemized Bill of Charges, Proof of Payment
Medical: Diagnosis Code (ICD), Clinic Notes from Doctor, If injury from an accident - Cause and Place of Accident
Dental: Tooth # or Surface or Quadrant
Medical Certificate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

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, "Explanation of Benefits" from your Primary, Insurance such as Medicare / AARP Summary

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

Sample Deductible/Reimbursement Claim Form



CALVO'S Select Care

Deductible / Reimbursement Claim Form

For Official Use Only:

Letter No.:

Claims for Deductibles or Reimbursements must be submitted within 120 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

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

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 20130731

White - Calvo's SelectCare Yellow - Member

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

Please Note
Deductible/Reimbursement Claim Forms must be submitted within 120 days to assure complete and timely processing.

All deductibles 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.

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.

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.

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 a 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.
- 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 0f 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 coinsurance consistent with those established for other benefits under the plan.

Mental Health and Addiction Act of 2008

This act took effect on January 1, 2010. It requires employers 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, Copays, 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 Insurance, Inc. (CSCI) health benefit 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 CSCI on or after September 23, 2013.

The terms "we" or "us" as used throughout this Notice refer to Calvo's SelectCare Health Plans, CSCI 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 of 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 CSCI or the Plans. These third parties are "Business Associates" of CSCI or the Plans. Business Associates must protect any PHI they receive from, or create and maintain on behalf of, CSCI 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 CSCI 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 CSCI 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 CSCI, 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 CSCI 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 CSCI 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 CSCI'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 SelectCare Health Plans
Attn: Frank Campillo
P.O. Box FJ
Hagatña, Guam 96932

Wellness & Fitness

Our wellness programs provide a very dynamic and rewarding opportunity for our members to improve their lifestyle and become healthier.

Health Risk Assessments

Our Health Risk Assessment is an essential tool that identifies existing and future risk factors based on an individual's lifestyle habits. NCQA Certified and HIPAA compliant, the Health Risk Assessment evaluates the behaviors, medical history, mental well-being, and preventive care:

- Get reports uncovering risks you may not know about
- Identify health concerns that may need your attention
- Find out your next steps to getting and staying healthy
- Share your reports with your doctor

Wellness and Disease Management Programs

Guam Seventh-Day Adventist Clinic: Lifestyle Intervention, DiaBeatIt Program (Diabetes Education), Depression and Anxiety Recovery Program (DARP), Stop Smoking (Tobacco Cessation), Medical Nutrition Therapy (Prior authorization required)

Dr. Horinouchi Wellness Clinic: 12-Day Weight Management Program, 14-Day Detox, Medical Nutrition Therapy (Prior authorization required)

Dr. D Chiropractic and Nutrition: Nutritional Wellness Program

Pay-Less Health Smart: Nutrition Services, Diabetes Management Program, Medical Nutrition Therapy (Prior authorization required)

Weekday Workout

Members have access to EXCLUSIVE group classes offered by our gym partners for Free!

- Aqua Fitness classes!
- No membership required!
- Classes are on a first come, first served basis!
- Classes offered 7 Days a Week!

Health and Wellness Rewards

Earn up to $200 ($100 per person), Subscriber and spouse/domestic partner, by first completing the HRA and any one of the two remaining actions:

- Complete the Online Health Risk Assessment (Required)
- Get a Biometric Screening
- Complete the Health Management Program with a participating Wellness Provider

Once the action is complete, member must complete a deductible/reimbursement claim form and submit to Calvo's SelectCare or wellness@calvos.com along with proper documentation in order to claim reward. Services must be provided by a participating provider.

Fitness Partners

Full and Discounted Membership (18 yrs. and older)

Free Membership

- CrossFit Latte Stone
- Custom Fitness
- International Sports Center
- Paradise Fitness
- STEEL Athletics
- Synergy Studios
- Unified Fit

Discounted Membership

- Hilton Fitness Center: $15.00 a Month with upgrades
- Legacy Hybrid Center & Family Fitness: Adult Membership $45/month
  Youth Membership $35/month (Ages 6-13)
- Rockit Ride: 4 FREE PASSES and Discounted Rates
- TRIBE Guam Fitness: $22.50 a Month

***Note:** Members that utilize more than one gym membership simultaneously will be disqualified from the Rewards Program and are subject to paying full fees. Services are only covered for Members 16 years old and older unless otherwise indicated. Fitness Partners and fees are subject to change.

Gym/Fitness Reward

Members will be rewarded $75 for each fiscal year quarter by working out 10 days per month for three (3) consecutive months

Get as much as $300 Annually!

To earn the Gym/Fitness Reward, members must complete the following requirements:

- Enroll and complete the Calvo's SelectCare Health Risk Assessment
- Select one of our gym/fitness partners
- Work out at least ten (10) days per month at the selected gym/fitness partner
- For three consecutive months per fiscal year quarters: October to December, January to March, April to June, July to September
- Ensure you check in with the staff of your fitness center and/or you can also use the "Gym Check-In" function in your Lifestyle Club app and scan the QR code for validation of each day you workout.

***HRA must be completed prior to submission.**

Massage Benefits

Discounted Rates for Government of Guam Subscribers and Spouses/Co-habiting Partners

- H20 Spa: $20.00 Member Fee
- Lagoon Spa: $20.00 Member Fee
- Serenity Wellness Spa: $20.00 Member Fee
- Tenjudo Spa: $15.00 Member Fee
- Island Skin Spa: 10% Discount plus $35.00 off
- Beng Teng Spa: $25.00 Member Fee
- Spa & Wellness Guam: $20.00 Member Fee
- Natural Ginger Spa: $15.00 Member Fee
- Ruyi Spa: $20.00 Member Fee
- Top Care Spa: $25.00 Member Fee

***Note:** This benefit is limited to only ONE MASSAGE per month across the entire spa network. Fees may vary per spa facility. Services are limited to members over the age of 18. Does not accumulate to the Out-of-Pocket benefit. Massage Spas and fees are subject to change.

Digital Services

Providing digital tools and media to enhance the health and wellness initiatives of every member

Calvo's SelectCare online

- Enroll on desktop or mobile device
- View or print membership card
- Access Schedule of Benefits
- Access Member Handbook
- View Claims Record: Medical and Prescription Drug claims
- View Deductible Status and monitor out-of-pocket accumulators
- Access your Provider Directory to find a doctor or facility
- Access links to UnitedHealth and OptumRx
- Access Cost Estimators for medical services in the U.S., Guam, and Asia
- Submit Claims or other documents

Online Medical Appointment

A convenient and transparent process to schedule your appointments to the Philippines & Taiwan.

The appointment system will be expanded to include the U.S. Mainland soon.

Appointment Tool:
https://appointment.calvos.net/main

Members and providers can get information and access from our website and our mobile app!



Optum Mobile app available to download

A fast, easy and secure way to get information you need to make the most of your pharmacy benefit

- Financial & Pharmacy Resources and Education
- "Healthier You" Wellness Article Library
- On-demand Health & Wellness video Library
- Patient Support

The OptumRx Mobile App is designed for wellness on-the-go!

- Never miss dose
- Stay on top of medication refills
- Show your doctor exactly what medications you are taking
- Pull up your medication history anytime
- Learn about medication side effects & interactions and much more

Save Time and Money using the Optum Rx Mail Order Maintenance Program!
Save as much as $180 on Formulary Generic and Brand Name Drugs per year per drug.

Member Communications

Staying informed is important!
We provide frequent communications, including:

- Monthly Wellness Newsletters
- Provider Updates
- Benefit Updates
- Member Satisfaction Surveys
- Healthcare News

The Calvo's Lifestyle Club
The Lifestyle Club program was developed to give our members added value for insuring with us. This value-added benefit allows you to get special offers and discounts from our Calvo's Lifestyle Club Partners on Guam and Saipan.

Download the app or scan the QR code to view the many offers and display your card right on your mobile device.

Calvo's Lifestyle Club

In addition to the special offers, Government of Guam subscribers who partake in the Gym/Fitness Reward have an easier validation method!

Click on the "Gym Check-In" button and scan the QR code at the gym/fitness partner location!

Frequently Asked Questions



What do I need to do to schedule an appointment at a Participating Provider off-island, including Philippines?
Referral Procedures Contact Customer Service at least four (4) weeks before your anticipated departure date. You can:

- Visit our office;
- Call us at 671-477-9808;
- Email service@calvos.com;
- Send us a message through our online portal at www.calvos.net; or
- For Philippine requests, complete an online appointment request at https://appointment.calvos.net

You will be asked to complete our Off-Island Appointment Request form and to provide your medical referral, complete medical records, and compact discs of diagnostic images or pathology slides (as listed under Required Documents). It is not advisable to purchase airline tickets until your off-island doctor's appointment is confirmed.

When is Pre-Certification (prior approval) of a service or procedure required?
Pre-Certification is required when your physician requests certain services, including diagnostic procedures, home health care, physical therapy, durable medical equipment, brand-name drugs not listed in the Drug Formulary, or specialty drugs. Refer to the "List of Procedures & CPT Codes Requiring Pre-Certification" in your handbook.

How long does it take to receive a reimbursement for a claim I filed?
If you submitted all required documentation (see "Completing Your Deductible/Reimbursement Claim Form" in your handbook), your claim is processed within 10–12 working days for local providers and 20–30 working days for off-island/foreign providers. You will receive your reimbursement or an Explanation of Benefits (EOB) in the mail.

Why am I receiving a bill from the lab for my Annual Exam labs that should be covered at 100%? What Preventive services are covered by the plan?
The plan covers preventive labs in accordance with USPSTF Grade A and B recommendations. You can find the list of recommended preventive services in the Additional Resources section at www.calvos.net A service performed outside those recommendations may not be covered at 100%.

Will the plan pay for my lodging and transportation when I go to a Participating Provider off-island, including Philippines?
Lodging and transportation are not covered, except as specifically allowed under the $500 Travel Benefit and the Airfare Benefit. Both benefits have certain limits and conditions.

Can other individuals, such as family members, including the subscriber of my plan, obtain information on my Health Insurance account?
Your privacy is our priority. We will not release information about your account to anyone you have not authorized. To grant access, complete the HIPAA Privacy Authorization form in the Additional Resources section at www.calvos.net This authorization is limited and does not include disclosure of your personal claims information.

What if my member ID card is missing or stolen?
Call us at 671-477-9808 or email service@calvos.com to request a replacement. You should receive your new card in the mail within two weeks.

Up to what age can I cover my dependent child in my plan?
Your dependent children can remain on your health plan until age 26.

How do I find Participating Providers in my plan network?
Refer to your Calvo's SelectCare Member Handbook for a list of network providers, or download the current handbook anytime from www.calvos.net. Please note that not all plans have access to the same provider network.

How can I add my newborn child to my insurance plan?
Submit your child's birth certificate along with a completed Enrollment/Change of Status form within 30 days of the date of birth. You can obtain the form at www.calvos.net. If you miss the 30-day window, you will have to wait until the next Open Enrollment to add your child.

What is needed to file a Deductible / Reimbursement claim?
Please refer to the "Deductible/Reimbursement Request Form" in the Additional Resources section at www.calvos.net All required information and documentation listed on the form must be provided so we can accept, review, and reimburse your claim.

Medicare Part A & B are my Primary insurance, am I liable for paying my Medicare deductible and/or copay? How about my Medicare D deductible and/or copay?
Your plan will cover the cost of your Medicare Part A & B deductible and/or co-payment. However, you may still be liable for your Medicare Part D deductible and/or co-payment, depending on your plan.

How long is a standard Preventive Exam at St. Luke's Medical Center or The Medical City (TMC) in the Philippines?
For patients under 50, the exam usually takes only a few hours, with results available about three days later, when a wellness physician will discuss them with you. For patients 50 and older, allow up to a week in case additional procedures—such as a colonoscopy—are needed.

What does the plan cover if I want to have an "Executive Check-up" package offered by St. Luke's Medical Center or The Medical City (TMC)?
The plan will cover only the costs of the items included in the U.S. Preventive Service Task Force Recommendations A and B. You will have to pay for the excess cost of the package you select.

How can my child attending college in the U.S. establish a Primary Care Physician?
We have contracted with the UnitedHealthcare PPO network to extend services to dependents attending college on the U.S. mainland. To find a provider, visit http://us1.welcometouhc.com/home, choose a provider under "Option PPO," and then advise us of the provider's name so we can issue a verification and authorization to access care.

Do I have to notify the plan if I have an Emergency off-island?
Yes. For the plan to cover a bona fide emergency, you must notify us within 48 hours of the emergency. Failure to notify the plan will result in a denial of benefits.

How much money should I bring when seeking treatment at a Participating Provider off-island, including Philippines?
Bring enough to cover your remaining deductible and out-of-pocket expenses for the plan year, and remember to budget for lodging, food, and transportation in your chosen area. Please refer to the "Your Payment Responsibilities" section of your handbook for more information.

How long should I plan on staying when seeking treatment at a Participating Provider off-island, including Philippines?
For basic outpatient procedures, plan to stay at least a week. For more invasive procedures that require a longer recovery period or inpatient admission, plan to stay at least two weeks. We recommend that you consult your physician about your particular case.

Si Yu'os Ma'ase!

We look forward
to servicing you.

Guam
115 Chalan Santo Papa
P.O. Box FJ
Hagåtña, Guam 96932
Phone: 671-477-9808
Fax: 671-477-4141
Email: service@calvos.com

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