Calvo's SelectCare

www.calvos.net

Customer service: 671-477-9808

CALVO'S Select Care HEALTH PLANS

2022

Health Maintenance Organization High and Standard Options

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details. This plan is accredited. See page 12.

Serving: The Island of Guam, the Commonwealth of the Northern Mariana Islands, and the Republic of Palau

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 15 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2022: Page 16
- Summary of Benefits: Page 89

Enrollment codes for this Plan:

B41 High Option - Self Only
B43 High Option - Self Plus One
B42 High Option - Self and Family
B44 Standard Option - Self Only
B46 Standard Option - Self Plus One
B45 Standard Option - Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-874

Important Notice from Calvo's Select Care Health Plans About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Calvo's Select Care prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means that you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213, (TTY: 800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

• Visit www.medicare.gov for personalized help.
• Call 800-MEDICARE 800-633-4227, TTY 877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of Calvo's SelectCare, underwritten by Tokio Marine Pacific Insurance (TMPI), under contract (CS 2928) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 671-477-9808 or through our website: www.calvos.net. The address for Calvo's SelectCare administrative offices is:

Calvo's SelectCare
P.O. Box FJ
Hagatna, Guam 96932

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2021, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2020, and changes are summarized on page 16. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member, “we” means Calvo's SelectCare.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of healthcare for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your healthcare providers, or authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your 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 us at 671-477-9808 and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise);
  - Your child age 26 or over(unless they are disabled and incapable of self support prior to age 26).

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud includes falsifying a claim to obtain FEHB benefits, or trying to obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. Your provider may bill you for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

Calvo's SelectCare complies with applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964.

You can also file a civil rights complaint with the Office of Personnel Management by mail or phone at: Office of Personnel Management

Healthcare and Insurance Federal Employee Insurance Operations, Attention: Assistant Director, FEIO, 1900 E Street NW, Suite 3400-S,

Washington, D.C. 20415-3610

Preventing medical mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medication or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider’s portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.

- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - Exactly what will you be doing?
  - About how long will it take?
  - What will happen after surgery
  - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Patient Safety Links

For more information on patient safety, please visit

- http://www.jointcommission.org/speakup.aspx.The Joint Commission's Speak Up™ patient safety program.
- http://www.jointcommission.org/topics/patient_safety.aspx The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/The Agency for Healthcare Research and Quality provides information about patient safety, choosing quality healthcare providers, and improving the quality of care you receive.
- www.bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.
- www.leapfroggroup.org The Leapfrong Group is active in promoting safe practices in hospital care.
- www.ahqa.orgTheAmerican Health Quality Association represents organizations and health care professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called “Never Events” or “Serious Reportable Events.”

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurancefor enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you brochures for other plans; and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment;
  - How you can cover your family members;
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
  - When your enrollment ends; and
  - When the next Open Season for enrollment begins.

  We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.

- **Types of coverage available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee, and one or more eligible family membes. Family members include your spouse, and your dependent children under the age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your carrier to obtain a Certificate of Creditable Coverage (COCC) or to add a dependent when there is already family coverage.

Contact your employing or retirement office if you are changing from Self to Self Plus One or Self and Family or to add a newborn if you currently have a Self Only plan.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/insure/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue FEHB coverage into retirement (if eligible) and cannot cancel your coverage, Change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2022 benefits of your prior plan or option. If you have met (or pay cost-sharing that results in your meeting) the out-of-packet maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2021 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.

Any person covered under the 31-day extension of coverage who is confined in a hospital or other situation for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension

You may be eligible for spouse equity coverage or Temporary Continuation coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce**

If you are divorced from a Federal employee, Tribal employee, or an annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healtcare/plan-information/. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, regardless of marital status, etc.

You may not elect TCC if you are fired from your Federal job or Tribal due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan. as long as you apply within 30 days of losing FEHBP coverage.

The Affordable Care Act Health Insurance Marketplace is not available in our service area.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance marketplace in your state. For assistance in finding coverage, please contact us at 671-477-9808 or visit our website at www.calvos.net.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

The Affordable Care Act Health Insurance Marketplace is not available in our service area.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Calvo's SelectCare holds the following accreditation: Accreditation Association of Ambulatory Health Care. To learn more about this plan's accreditation, please visit the following websites: www.aaahc.org. We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. We give you the choice of enrollment in a High Option or a Standard Option.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan’s benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

In-Network/Plan Participating Providers

In-Network/Plan Provider means a physician employed by Calvo's SelectCare or any person, organization, health facility, institution or physician who has entered into a contract with Calvo's SelectCare to provide services to our members. Please view or download the most current Calvo's SelectCare Provider Directory at www.calvos.net for the most updated list of Participating Providers.

We encourage you to access your benefits through our Plan/Participating Providers to minimize higher out of pocket expenses for you and your dependents. When you go to a Plan provider, you are assured that your copayments or coinsurance will not be more than the amount shown in this brochure.

Medical, dental, and vision services outside our service area must be prior authorized and approved even if your Plan option has an out-of-network benefit. This is to ensure that these services are covered under your Plan, help you coordinate your care, and minimize your out of pocket expenses. (see Section 3, You need prior Plan approval for certain services). Members may coordinate services for their approved referrals with Out-of-Network/Non-Plan/Non-Participating Providers of their choice through their out-of-network benefit. However, because we do not have contracts with out-of-Network/Non-network providers, some may require payment from you at the time of service. If this occurs, you will need to seek reimbursement from Calvo's SelectCare for the eligible charges (see Section 7 - Filing a claim for covered services).

Out-of-Network/Non-Plan/Non-Participating Providers

Out-of-Network/Non-Plan providers means a physician not employed by Calvo's SelectCare or any person, organization health facility, institution, or physician who has not entered into a contract with Calvo's SelectCare to provide services to our members. Because Out-of-Network/Non-Plan providers are not under contract to limit their charges, Members will be held responsible for any charges in excess of eligible charges.

You may go to a Out-of-Network/non-Plan provider; however, the Plan pays a reduced benefit for certain services from Out-of-Network/non-Plan providers. You may have to pay for the services first and file a claim (which should include all required information and documentation, and translated in English if originals are not in English) with us in order for the Plan to reimburse you (see Section 7 - Filing a claim for covered services). Because Out-of-Network/Non-Plan providers are not under contract to provide specific services, should you decide to go to a Out-of-Network/Non-Plan provider, you may be responsible for coordinating and scheduling services with Out-of-network/Non-Plan providers. Certain services always require prior approval, regardless of whether they are rendered in-network or out-of-network (see Section 3 You need prior Plan approval for certain services). If you self-refer to a provider and/or facility for services which require prior authorization, those services will not be covered.

When covered healthcare services are provided outside of the Service Area by Out-of-Network/Non-Plan healthcare providers, the amount you pay for such services will generally be based on either the Out-of-Network/Non-Plan healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you will be liable for the difference between the amount the Out-of-Network/Non-Plan provider bills and the payment we will make for the covered services as set forth in this paragraph. Please be advised that some services may not be covered under your Plan.

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area and/or by an In-Network provider, or a special negotiated payment, to determine the amount we will pay for services rendered by Out-of-Network/Non-Plan healthcare providers. In these situations, you will be liable for the difference between the amount that the Out-of-Network/Non-Plan healthcare provider bills and the payment we will make for covered services as set forth in this paragraph. Please be advised that some services may not be covered under your Plan.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received from a network provider in our service area and the Philippines and in accordance with the guidelines set by United States Preventive Services Task Force (USPSTF), the American Academy of Pediatrics, the Health Resources and Services Administration (HRSA), and the Center for Disease Control's (CDC) Advisory Committee on Immunization Practices.

Catastrophic Protection

We protect you against catastrophic out-of-pocket expenses for covered services provided by in-network providers. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments to no more than $7,000 for Self Only enrollment, and $14,000 for a Self Plus One or Self and Family enrollment. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

The Plan does not have out-of-pocket maximums for any out-of-network covered services.

High Option: After your out-of-pocket expenses for services provided by in-network providers, including any applicable deductibles, copayments and coinsurance total $2,000 for Self Only, or $4,000 for a Self Plus One or $6,000 for Self and Family enrollment in any calendar year, you do not have to pay any more for in-network covered services. The maximum annual limitation on cost sharing for in-network services listed under Self Only of $2,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.

Standard Option: After your out-of-pocket expenses for services provided by in-network providers, including any applicable deductibles, copayments and coinsurance total $3,000 for Self Only, or $6,000 for a Self Plus One or $8,000 for Self and Family enrollment in any calendar year, you do not have to pay any more for in-network covered services. The maximum annual limitation on cost sharing for in-network services listed under Self Only of $3,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.

Example Scenario: Your plan has a High Option $2,000 Self Only maximum out-of-pocket limit for covered services provided by in-network providers, a $4,000 Self Plus One maximum out-of-pocket limit for covered services provided by in-network providers, and a $6,000 Self and Family maximum out-of-pocket limit for covered services provided by in-network providers. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $2,000 or more for the calendar year for covered services provided by in-network providers, any remaining qualified medical expenses provided by in-network providers for that individual will be covered fully by your health plan. With a Self Plus One enrollment out-of-pocket maximum of $4,000, the second family member, or an aggregate of enrollee and designated family member, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $4,000 for the calendar year before their qualified in-network medical expenses will begin to be covered in full. With a Self and Family enrollment out-of-pocket maximum of $6,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified in-network medical expenses up to a maximum of $6,000 for the calendar year before their qualified in-network medical expenses will begin to be covered in full.

High and Standard Options: There is a separate in-network out-of-pocket maximum for prescription drugs. After your out-of-pocket expenses for prescription drugs, including any applicable deductibles, copayments and coinsurance total $2,000 for Self Only, or $4,000 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for in-network covered prescription drugs. The maximum annual limitation on cost sharing at in-network providers listed under Self Only of $2,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.

However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments, coinsurance, and any difference between billed charges and eligible charges for these services:

- Expenses for services and supplies that exceed the stated maximum dollar or day limit
- Expenses from utilizing out-of-network providers
- Expenses for non-covered benefits

Please be advised that the Plan does not have out-of-pocket maximums for any out-of-network covered services.

Be sure to keep accurate records of your coinsurance/copayments to ensure the plan's calculation of your out-of-pocket maximum is reflected accurately.

Your rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Calvo's SelectCare has been operating on Guam for 20 years.
- We are a for-profit organization.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, www.calvos.net. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 671-477-9808, or write to us at P.O. Box FJ, Hagatna, Guam 96932. You may also contact us by fax at 671-477-4141 or visit our website at www.calvos.net.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website www.calvos.net to obtain our Notice of Privacy Practices. You can also contact us to request that we mail a you a copy of that Notice.

Your Medical and Claims Records are Confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice.

Our service area is: The island of Guam, the Commonwealth of the Northern Mariana Islands and the Republic of Belau (Palau).

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If your dependent lives out of the service area, he/she must still receive prior approval before receiving medical, dental, and/or vision services.

If you or a family member move outside of our services area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2022

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 (Benefits) Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- Effective in 2022, premium rates are the same for Non-Postal and Postal employees.

Changes to both High and Standard Options

- Telehealth Services (Medical and Behavioral) - The Plan is adding medical and behavioral healthcare via Teladoc©. There is no member cost share, visit limit, or preauthorization required for this benefit. Members will be provided several formats for access to Teladoc© providers inlcuding a toll-free number, Teladoc's mobile app (video) and Teladoc's© website (see page 32).
- Fertility Preservation - The Plan is adding fertility preservation coverage to help mitigate the risk of infertility in members undergoing medical therapies likely to result in infertility (see page 39).

Changes to High Option only

- Your biweekly share of the premium rate will increase by $1.65 for Self Only, or increase by $3.21 for Self Plus One, or increase by $4.36 for Self and Family. See back cover.

Changes to Standard Option only

- Your biweekly share of the premium rate will decrease by $5.87 for Self Only, or decrease by $11.57 for Self Plus One, or decrease by $17.05 for Self and Family. See back cover.

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 671-477-9808 or write to us at P.O. Box FJ, Hagatna, Guam 96932.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance. How much you pay depends on whether you use a Plan/ Participating provider and facility or non-network provider or facility. If you use your out-of-network program, you can get care from non-Plan providers but it will cost you more.

We look at some or all of the following criteria to determine if a provider is recognized and approved by us:

- Is the provider accredited by a recognized accrediting agency?
- is the provider appropriately licensed?
- Is the provider certified by the proper government authority?
- Are the services rendered within the lawful scope of the provider's respective licensure, certification, and/or accreditation?

Medicare beneficiaries may only receive covered services at a Plan participating Medicare-contracted facility in Guam, Saipan, Hawaii, and the Continental United States. Medicare eligible care and services which are rendered at a facility which is not a Medicare contracted facility, or which is rendered by a physician who is not a Medicare contracted physician will not be covered.

- **Out-of-Network/Non-Plan providers**

Out-of-Network/Non-Plan providers are physician and other health care professionals who are not under contract with this Plan. You can get care from Out-of-Network/non-Plan providers, but it will likely cost you more.

Certain services **always require prior approval**, regardless of whether they are rendered in-network or out-of-network (see Section 3 *You need prior Plan approval for certain services*). **If you self-refer to a provider and/or facility for services which require prior authorization, those services will not be covered.**

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in-network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

In-Network/Plan facilities

In-Network/Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

In-network/Plan providers

In-Network/Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential In-Network/Plan providers according to national standards.

We list In-Network/Plan providers in the provider directory, which we update periodically. The list is also on our website.

This plan recognizes that transsexual, transgender, and gender-non-conforming members require healthcare delivered by healthcare providers experienced in transgender health. While gender reassignment surgeons (benefit details found in Section 5(b)) and hormone therapy providers (benefit details found in Section 5(f)) play important roles in preventive care, you should see a primary care provider familiar with your overall healthcare needs. Benefits described in this brochure are available to al members meeting medical necessity guidelines.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- Primary care

Your primary care physician can be a family practitioner, internist, obstetrician/ gynecologist, or pediatrician for children under 18 years of age . Your primary care physician will provide most of your healthcare, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- Specialty care

Your primary care physician, and in some situations, a specialist, will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see an OB/GYN within our provider network without a referral.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.
- Your primary care physician will use our criteria when creating your treatment plan. The physician may have to get an authorization or approval beforehand.
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist.
- If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - Terminate our contract with your specialist for other than cause; or
  - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
  - Reduce our service area and you enroll in another FEHB Plan,

You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are hospitalized when your enrollment begins

We pay for covered services form the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 671-477-9808. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center;
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Your primary care physician arranges most referrals to specialists and inpatient hospitalization and sends the referrals to the Plan for approval. The pre-service claim approval process applies to care shown under *Other Services*.

The pre-service claim approval process for services is detailed in this Section. A pre-service claim is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits (1) requires pre certification or prior approval and (2) will result in a denial or reduction of benefits if you do not obtain precertification or prior approval.

- **Inpatient hospital admission**

Precertification is the process by which - prior to your inpatient hospital admission - we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician or specialist must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

- Allergy testing and allergy serum
- All diagnostic and surgical procedures performed in a surgical facility
- Audiological exams
- Bariatric surgery
- Bone density studies
- Certain drugs listed in our Prescription Drug Formulary (see Section 5(f))
- Chemotherapy Agents
- CT scans
- Durable medical equipment
- Genetic Testing

- Growth Hormone Therapy (GHT)
- Home Health services
- Hospitalization
- Infertility Services and Infertility Drugs
- MRIs
- Non-routine mammograms
- Off-island services (except for preventive service) and consultations
- Oncology consultations
- Orthopedic, Prosthetic, and Implantable devices
- Out-of-area hospitalization
- Plastic/reconstructive consultation and procedures
- Therapy treatment plans- occupational therapy, physical therapy, speech therapy
- Podiatry consultations and procedures
- Sleep studies
- Specialty care procedures
- Transplants
- Ultrasounds, sonograms including echocardiogram
- Other procedures including colonsocopy and endoscopy (except for preventive services)

Emergency services do not require pre-certification. However, you or your family member must notify the Plan within 48 hours, or as soon as is reasonably possible, in order for the services to be covered.

You or your representative must also contact us within two business days following the date of service or as soon as is reasonably possible when you receive primary or specialty care services from in-network or out-of-network providers when you are outside of the service area and that were not approved in advance by the Plan. Failure to notify the Plan may result in denial or reduction of benefits.

The list of services requiring prior approval may change periodically. To ensure your treatment or procedure is covered, call us at 671-477-9808.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, or your representative, must call us at 671-477-9808 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay

For any hospital admission outside of our service area and/or at non-participating providers, that was not prior authorized, you, your representative, the physician, or the hospital must contact us within two business days following the day of the admission or as soon as is reasonably possible, even if you have been discharged from the hospital. Failure to notify the Plan may result in a denial of benefits.

- **Non-urgent care claims**

  For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

  If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

  If you have an urgent care claim (i.e. when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is and urgent care claims by applying the judgement of a prudent layperson that possesses an average knowledge of health and medicine.

  If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) end of the time frame, whichever is earlier.

  We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

  You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 671-477-9808. You may also call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 671-477-9808. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

  A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

  If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

  - **Health Care FSA (HCFSA)** - Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, **physician-prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

- **The Federal Flexible Spending Account Program - *FSAFEDS***
  - FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider fiLE claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **Emergency inpatient admission**

  If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must contact us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **If your treatment needs to be extended**

  If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Failure to obtain prior approval may result in a denial of benefits if the services or devices do not meet Calvo's SelectCare payment determination criteria.

Circumstances beyond our control

Under certain circumstances such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

  Within six months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

  1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply, or
  2. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
  3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

  In the case of an appeal of a pre-service urgent care claim, within six months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file and appeal with OPM**

  After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Costs for Covered Services

This is what you will pay out-of-pocket for covered care:

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care.

Example: In our Plan, you pay 30% of eligible charges and any difference between eligible charges and billed charges for out-of-network services.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your primary care physician, you pay a copayment of $15 per office visit, and when you go in the hospital, you pay $200 per admission.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- **In-network** - No deductible.
- **Out-of-network** - The calendar year deductible is $500 per person under the High and Standard Option. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year out-of-network deductible for your enrollment reach $500 under High and Standard Option. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year out-of-network deductible for your enrollment reach $1,000 under High and Standard Option. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year out-of-network deductible for your enrollment reach $1,500 under High and Standard Option.

A Calvo's SelectCare deductible claim form should be filled out immediately and kept safe to ensure accurate and complete information on all doctors, lab or pharmacy visits. It is your responsibility to track and submit deductible expenses (e.g. encounter tickets, invoices, receipts) and the required documentation. All claims forms should be submitted to the Calvo's SelectCare Customer Service Department.

Difference between our Plan allowance and the bill

You should also see section Important Notice About Surprise Billing - Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Eligible Charges

For most medical services, we calculate our payment and your copayment/coinsurance based on eligible charges. The eligible charge is the lower of either the provider's actual charge or the amount we established as the *maximum allowable fee*.

Non-plan providers are not under contract to limit their charges to our eligible charges. You are responsible for any charges in excess of eligible charges.

Your catastrophic protection out-of-pocket maximum

High Option: After your medical copayments and coinsurance for in-network covered services total $2,000 for Self Only or $2,000 per person for Self Plus One or $6,000 per Self and Family enrollment in any calendar year, you do not have to pay any more for in-network covered medical services. However, please note that the Plan does not have out-of-pocket maximums for any out-of-network services.

Standard Option: After your medical copayments and coinsurance for in-network covered services total $3,000 for Self Only or $3,000 per person for Self Plus One or $8,000 per Self and Family enrollment in any calendar year, you do not have to pay any more for in-network covered medical services. However, please note that the Plan does not have out-of-pocket maximums for any out-of-network services.

There is a separate out-of-pocket maximum for prescription drugs. After your prescription copayments and coinsurance at in-network pharmacies total $2,000 for Self Only or $2,000 per person for Self Plus One or $4,000 per family enrollment in any calendar year, you do not have to pay any more for covered prescription drugs at in-network pharmacies.

Be sure to keep accurate records of your copayments/coinsurance. We will also keep records of your in-network coinsurance/copayments and track your in-network catastrophic protection maximums.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

When Government Facilities Bill Us

Facilities of the Department Government Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from for certain services and supplies they provide to you or a family member. They may not seek more than the governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing - Know Your Rights in the US

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" under certain circumstances. A surprise bill is an unexpected bill you receive from a nonparticipating healthcare provider, facility, or air ambulance service for healthcare. Surprise bills can happen when you receive emergency care - when you have little or no say in the facility or provider from whom you receive care. They can also happen when you receive non-emergency services at participating facilities but you receive some care from nonparticipating providers.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from unexpected bills.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.calvos.net or contact the health plan at (671) 477-9808.

High and Standard Option Benefits

See page 16 for how our benefits changed this year. Page 27 is a benefits summary of the High and Standard options. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High and Standard Option Benefits Overview

This Plan offers High and Standard Options. Both options are described in this Section. Make sure that you review the benefits that are available under the Option in which you are enrolled.

Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the General exclusions in **Section 6**; they apply to the benefits in the following subsections.

To obtain claim forms, claims filling advice, or more information about High and Standard Option benefits, contact us at 671-477-9808 or at our Website at www.calvos.net.

Each option offers unique features.

	You pay	
Benefit Description	**High**	**Standard**
Preventive Care Visit	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed amount per visit after deductible is met	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed amount per visit after deductible is met
Primary Care Office Visit	***In-network:*** $15 copayment per office visit ***Preferred Provider:*** $5 copayment per office visit *Copayment is waived at in-network providers in the Philippines* ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed amount per visit after deductible is met	***In-network:*** $20 copayment per office visit ***Preferred Provider:*** $10 copayment per office visit *Copayment is waived at in-network providers in the Philippines* ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed amount per visit after deductible is met
Specialist Care Office Visit	***In-network:*** $40 copayment per office visit *Copayment is waived at in-network providers in the Philippines* ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed amount per visit after deductible is met	***In-network:*** $40 copayment per office visit *Copayment is waived at in-network providers in the Philippines* ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed amount per visit after deductible is met
Emergency Services In Area • Doctor's Office or Urgent Care Center	$15 copayment per visit	20% coinsurance per visit
Emergency Services In Area • Hospital Emergency Room	$100 copayment per emergency room visit	20% coinsurance per emergency room visit

Benefit Description - continued on next page

	You pay	
Benefit Description (cont.)	**High**	**Standard**
Emergency Services Out of Area • Doctor's Office or Urgent Care Center	$50 copayment per visit	20% coinsurance of eligible charges
Emergency Services Out of Area • Hospital Emergency Room	$200 copayment per emergency room visit	20% coinsurance of eligible charges
Prescription Drugs	**Retail (30-day supply)** $10 for Generic $25 for Preferred Brand 50% of Average Wholesale Price (AWP) for Non-preferred Brand $100 for Specialty **Mail Order (90-day supply)** $10 for Generic $25 for Preferred Brand $100 for Non-Preferred Brand $200 for Specialty	**Retail (30-day supply)** $15 for Generic $40 for Preferred Brand 50% of Average Wholesale Price (AWP) for Non-Preferred Brand $150 for Specialty **Mail Order (90-day supply)** $20 for Generic $50 for Preferred Brand $150 for Non-Preferred $250 for Specialty
Outpatient Surgical facility	***In-network:*** $100 copayment (includes doctor's services) per visit *Copayment is waived at in-network providers in the Philippines.* ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed chargesafter deductible is met	***In-network:*** 20% coinsurance per visit *Coinsurance is waived at in-network providers in the Philippines.* ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met
Inpatient Hospital stay	***In-network:*** $200 copayment per admission *Copayment is waived at in-network providers in the Philippines.* ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met	***In-network:*** 20% coinsurance per admission *Coinsurance is waived at in-network providers in the Philippines.* ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met

Benefit Description - continued on next page

	You pay	
Benefit Description (cont.)	**High**	**Standard**
Chiropractic Services	***In-network:*** All charges above $25 per visit and all charges after 20th visit **No out-of-network benefit.**	***In-network:*** All charges above $25 per visit and all charges after 20th visit **No out-of-network benefit.**
Prescription eyeglasses or contact lenses	Member pays all charges above $100	Member pays all charges above $100
Dental services	***In-network:*** Nothing for preventive services. All other dental services are not covered. ***Out-of-network:*** 30% coinsurance of covered charges for preventive services plus any difference between eligible charges and billed charges. All other dental services are not covered.	***In-network:*** Nothing for preventive services. All other dental services are not covered. ***Out-of-network:*** 30% coinsurance of covered charges for preventive services plus any difference between eligible charges and billed charges. All other dental services are not covered.
Your catastrophic protection for out-of-pocket expenses	After your out-of-pocket expenses for in-network services, including any applicable deductibles, copayments and coinsurance total $2,000 for Self Only, or $4,000 for a Self Plus One or $6,000 Self and Family enrollment in any calendar year, you do not have to pay any more for in-network covered services. ***The maximum annual limitation on cost sharing for in-network services listed under Self Only of $2,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***	After your out-of-pocket expenses for in-network services, including any applicable deductibles, copayments and coinsurance total $3,000 for Self Only, or $6,000 for Self Plus One or $8,000 Self and Family enrollment in any calendar year, you do not have to pay any more for in-network covered services. ***The maximum annual limitation on cost sharing for in-network services listed under Self Only of $3,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family***.

Benefit Description - continued on next page

	You pay	
Benefit Description (cont.)	**High**	**Standard**
	There is a separate out-of-pocket maximum for prescription drugs obtained at in-network pharmacies. After your out-of-pocket expenses for in-network prescription drugs obtained at in-network pharmacies, including any applicable deductibles, copayments and coinsurance, total $2,000 for Self Only, or $4,000 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered prescription drugs obtained at in-network pharmacies. ***The maximum annual limitation on cost sharing for in-network services listed under Self Only of $2,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***	There is a separate out-of-pocket maximum for prescription drugs obtained at in-network pharmacies. After your out-of-pocket expenses for prescription drugs obtained at in-network pharmacies, including any applicable deductibles, copayments and coinsurance total $2,000 for Self Only, or $4,000 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered prescription drugs obtained at in-network pharmacies. ***The maximum annual limitation on cost sharing for in-network services listed under Self Only of $2,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The services listed below are for the charges billed by a physician or other health care professional for medical services and supplies. See Section 5(b) for charges associated with surgical and anesthesia services provided by physicians and other health care professionals. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- The Plan does not have a calendar year deductible for in-network covered services. However, for out-of-network covered services the Plan does have a calendar year deductible of $500 for Self Only and $1,500 for Self Plus One and Self and Family enrollment.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
Diagnostic and treatment services	**High**	**Standard**
Outpatient professional services of physicians • In physician's office • In an urgent care center • Office medical consultations • Second opinion • Advance care planning • Injections - intramuscular and subcutaneous • IV Infusion therapy • Growth Hormone (GHT) therapy	***In-network:*** $15 copayment per PCP office visit $40 copayment per specialist visit ***Preferred In-network:*** $5 copayment per PCP office visit ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Additional copayments shall apply (e.g. administration of medication, laboratory services, per diagnostic/ imaging service, facility fees, etc.) Note: Infusion therapy and injections (except for contraceptive injections) require a separate copayment.	***In-network:*** $20 copayment per PCP office visit $40 copayment per specialist visit ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Additional copayments or coinsurance shall apply (e.g. administration of medication, laboratory services, imaging services, facility fees, etc.) Note: Infusion therapy and injections (except for contraceptive injections) require an additional separate copayment or coinsurance. Note: Copayment is waived at in-network providers in the Philippines.

Diagnostic and treatment services - continued on next page

Benefit Description	You pay	
Diagnostic and treatment services (cont.)	**High**	**Standard**
	Note: Copayment is waived at in-network providers in the Philippines.	
Inpatient professional services of physicians • During a hospital stay • In a skilled nursing facility	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.	***In-network:*** 20% coinsurance per Inpatient Hospital admission ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Coinsurance is waived at in-network providers in the Philippines.
Not covered: Medical services and supplies required for obtaining or continuing employment or insurance, attending schools or camp, or travel. *Not covered: Certain medical supplies such as surgical trays.*	*All charges*	*All charges*
Telehealth Services	**High**	**Standard**
Telehealth consultations through the following telehealth vendor: • Teladoc® - available to members for medical conditions via Teladoc's mobile app (video), Teladoc's website or by telephone at Teladoc's toll-free number	Nothing	Nothing
Lab, X-ray and other diagnostic tests	**High**	**Standard**
• Blood tests • Urinalysis • Non-routine pap tests • Pathology • Electrocardiogram and EEG • X-rays Note: See Section 5 (c) for Services billed by a facility for inpatient and outpatient services.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Coinsurance is waived at in-network providers in the Philippines.
• CT Scan • Echocardiogram • MRI • Non-routine mammograms • Ultrasound	***In-network:*** $40 copayment in addition to regular office visit	***In-network:*** 20% coinsurance

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests (cont.)	**High**	**Standard**
Note: Prior authorization is required for ultrasounds and all high end radiology procedures, such as but not limited to CT scans, echocardiogram, PET scans, MRIs, and other diagnostic tests. See Section 3 *Other Services* for more information. Note: See Section 5 (c) for Services billed by a facility for inpatient and outpatient services.	***In-network:*** $40 copayment in addition to regular office visit ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Coinsurance is waived at in-network providers in the Philippines.
Not covered: Medical services and supplies required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*	*All charges*
Preventive care, adult	**High**	**Standard**

Routine physical once a year
 	
The following preventive services are covered at the time interval recommended at each of the links below:
• Immunizations such as Pneumococcal, influenza, shingles, tetanus/DTaP, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/
• Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org
• Individual counseling on prevention and reducing health risks
• Well woman care such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of Well Women preventive care services please visit the Health and Human Services (HHS) website at https;//www.healthcare.gov/preventive-care-women/
• To build your personalized list of preventive services go to https://health.gov/myhealthfinder
	In-network: Nothing
	
	Out-of-network: 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.
		In-network: Nothing
		
		Out-of-network: 30% coinsurance of eligible charges and any difference between eligible charges and billed charges
		after deductible is met.

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High**	**Standard**
Routine mammogram – covered for women	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.
Adult immunizations as endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. **Note:** Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*	*All charges*
Preventive care, children	**High**	**Standard**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures guidelines go to https://brightfutures.aap.org • Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html • You can also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**High**	**Standard**
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.
Maternity care	**High**	**Standard**
Complete maternity (obstetrical) care, such as: • Prenatal care - doctor's visits and labs only	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**High**	**Standard**
• Delivery	***In-network:*** $100 copayment for birthing center $200 copayment for hospital ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.	***In-network:*** 20% coinsurance for birthing center, 20% coinsurance for inpatient hospital admission ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.
• Screening for gestational diabetes for pregnant women	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.
• Postnatal care - doctor's visits and labs only	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.
Breastfeeding support and counseling for each birth Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery unless you will be receiving services outside of our service area and/or services will be provided by non-participating providers; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment.	Nothing	Nothing

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**High**	**Standard**
• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). • The newborn must be enrolled within 60 days of birth. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. Note: Breast pump and supplies are limited to: • Purchase or rental of breastfeeding equipment up to a value of $100 per pregnancy. Member is responsible for all charges above $100.	Nothing	Nothing
Not covered: • *Sonograms that are deemed not medically necessary, including 3-D and 4-D*	*All charges*	*All charges*
Family planning	**High**	**Standard**
Contraceptive counseling on an annual basis	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.
A range of voluntary family planning services, limited to: • Voluntary sterilization - tubal ligation (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) Note: We cover oral contraceptives, contraceptive patches and rings, contraceptive diaphragms, cervical caps, and intrauterine devices (IUDs) under the Presecription Drug Benefit, Section 5(f) *Prescription Drug Benefits.*	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Additional copayments shall apply (e.g. administration of medication, laboratory services, per diagnostic/ imaging service, facility fees, etc.)	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Additional copayments shall apply (e.g. administration of medication, laboratory services, per diagnostic/ imaging service, facility fees, etc.)

Family planning - continued on next page

Benefit Description	You pay	
Family planning (cont.)	**High**	**Standard**
Note: For copayment information on professional fees for surgery and anesthesia services see Section 5 (b) *Surgical and Anesthesia Services* and for copayment information on hospital and / or ambulatory surgery center benefits see Section 5(c) *Services provided by a hospital or other facility.*	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Additional copayments shall apply (e.g. administration of medication, laboratory services, per diagnostic/ imaging service, facility fees, etc.)	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Additional copayments shall apply (e.g. administration of medication, laboratory services, per diagnostic/ imaging service, facility fees, etc.)
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling except those services required by the United States Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA).*	*All charges*	*All Charges*
Infertility services	**High**	**Standard**
Diagnosis and treatment of infertility such as: • Artificial insemination: • intravaginal insemination (IVI) • intracervical insemination (ICI) • intrauterine insemination (IUI) • Fertility drugs Note: Prior authorization is required for infertility services. Note: We cover injectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit for drugs related to the above-mentioned services. Note: For copayment information on professional fees for surgery and anesthesia services related to the above-mentioned services see Section 5(b) *Surgical and Anesthesia Services* and for copayment information on hospital and / or ambulatory surgery center benefits see Section 5(c) *Services provided by a hospital or other facility.*	***In-network:*** $40 copayment per specialist visit ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Injectible infertility drugs do not require an additional copayment.	***In-network:*** 50% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High**	**Standard**
Benefits for fertility preservation due to medical procedures that may cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a physician: • Collection of sperm • Cryo-preservation of sperm • Ovarian simulation, retrieval of eggs and fertilization • Oocyte cryo-preservation • Embryo cryo-preservation Note: Coverage Limitations and Exclusions include the following: • Benefits are not available for embryo transfer. • Benefits are not available for long-term storage costs (greater than one year) • Benefits for egg harvesting or embryo implantation procedures are not available beyond two attempts • Provider access limited to direct-contract network providers Note: Prior authorization is required for infertility services. Note: We cover inectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit for drugs related to above-mentioned services. Note: For copayment information on professional fees for surgery and anesthesia services related to the above-mentioned services see Section 5(b) *Surgical and Anesthesia Services* and for copayment information on hospital and/or ambulatory surgery center benefits see Section 5(c) *Services provided by a hospital or other facility.*	***In-network:*** $40 copayment per specialist visit ***Out-of-network***: 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Injectible infertility drugs do not require additional copayment.	***In-network:*** 50% coinsurance per specialist visit ***Out-of-network***: 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.
Not covered: • *Assisted reproductive technology (ART) procedures and services, such as:* - *In vitro fertilization (IVF) (including pre-treatment drugs)* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) and zygote intra-fallopian transfer (ZIFT)*	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High**	**Standard**
- *Cost of donor sperm* - *Cost of donor egg* - *Services and supplies related to ART procedures (including IVF procedures)*	*All charges*	*All charges*
Allergy care	**High**	**Standard**
• Testing and treatment • Allergy injections	***In-network:*** $15 copayment per PCP office visit $40 copayment per specialist visit ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Additional copayments shall apply (e.g. administration of medication, laboratory services, per diagnostic/imaging service, facility fees, etc.) Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Additional copayments or coinsurance all apply (e.g. administration of medication, laboratory services, per diagnostic/imaging service, facility fees, etc.) Note: Coinsurance is waived at in-network providers in the Philippines.
Allergy Serum **Note:** Allergy testing and allergy serum require prior authorization.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met
Not covered: • Provocative food testing • Sublingual allergy desensitization	*All charges.*	*All charges*

Benefit Description	You pay	
Treatment therapies	**High**	**Standard**
• Chemotherapy and radiation therapy • Dialysis – hemodialysis and peritoneal dialysis • Respiratory and inhalation therapy • Cardiac rehabilitation (for more information please see Section 5(a) page 38). • Intravenous (IV) / /Infusion Therapy • Growth hormone therapy (GHT) • Hyperbaric Oxygen therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 51. Note: Growth hormone is covered under the prescription drug benefit. We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. See Section 3 *Other services requiring our prior approval.* Note: For information on prescription drug benefits and copayments see Section 5(f) *Prescription Drug Benefits.* *Note: We cover self-administered injections and specialty drugs under the prescription drug benefit.*	***In-network:*** $40 copayment per specialist treatment $100 copayment for outpatient facility ***Out-of-network:*** 30% coinsurance of eligible charges and any diffeence between eligible charges and billed charges after deductible is met. Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Coinsurance is waived at in-network providers in the Philippines.
Physical and occupational therapies	**High**	**Standard**
Outpatient services of each of the following: • qualified physical therapists and • occupational therapists Note: We only cover therapy when a physician: • orders the care • identifies the specific professional skills the patient requires and the medical necessity for skilled services, and • indicates the length of time the services are needed. Note: Prior authorization of treatment plan required.	***In-network:*** $15 copayment per visit Nothing for home visits Nothing during covered inpatient admission ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Coinsurance is waived at in-network providers in the Philippines.
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs, lifestyle modification programs*	*All charges*	*All charges*

Physical and occupational therapies - continued on next page

Benefit Description	You pay	
Physical and occupational therapies (cont.)	**High**	**Standard**
• *Equipment, supplies or customized devices related to rehabilitative therapists, except those provided under Durable Medical Equipment* • *Services provided by schools or government programs* • *Developmental and Neuroeducational testing and treatment beyond initial diagnosis* • *Hypnotherapy* • *Psychological testing* • *Vocational rehabilitation*	*All charges*	*All charges*
Cardiac rehabilitation	**High**	**Standard**
Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 90 days for inpatient admission	***In-network:*** $15 copayment per treatment Nothing for home visits Nothing during covered inpatient admission ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Coinsurance is waived at in-network providers in the Philippines.
Habilitative Services	**High**	**Standard**
Medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. Not covered: Services such as, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind.	***In network:*** Member cost-share will be at parity with cost-share for rehabilitative services.	***In-network:*** Member cost-share will be at parity with cost-share for rehabilitative services.
Speech therapy	**High**	**Standard**
Unlimited visits for the services of: • Qualified speech therapist Note: All therapies are subject to medical necessity and require prior authorization of treatment plans.	***In -network:*** $15 copayment per treatment ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.

Speech therapy - continued on next page

Benefit Description	You pay	
Speech therapy (cont.)	**High**	**Standard**
	Note: Copayment is waived at in-network providers in the Philippines.	Note: Coinsurance is waived at in-network providers in the Philippines.
Hearing services (testing, treatment, and supplies)	**High**	**Standard**
For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.* Note: For copayment information on professional fees for surgery and anesthesia services see Section 5 (b) Surgical and Anesthesia Services and for copayment information on hospital and / or ambulatory surgery center benefits see Section 5(c) Services provided by a hospital or other facility.	***In-network:*** $40 copayment per specialist visit ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Additional copays shall apply (e.g. administration of medication, laboratory services, per diagnostic /imaging service, facility fee, etc). Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** $40 copayment per specialist visit ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Additional copays or coinsurance shall apply (e.g. administration of medication, laboratory services, imaging servcies, facility fee, etc). Note: Copayment is waived at in-network providers in the Philippines.
Vision services (testing, treatment, and supplies)	**High**	**Standard**
For the diagnosis and non-surgical treatment of diseases of the eye • Annual eye exam - includes refraction exam Note: For copayment information on professional fees for surgery and anesthesia services see Section 5 (b) Surgical and Anesthesia Services and for copayment information on hospital and / or ambulatory surgery center benefits see Section 5(c) Services provided by a hospital or other facility.	***In-network:*** $15 copayment per PCP office visit $40 copayment per specialst visit ***Out-of-Network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Additional copays shall apply (e.g. administration of medication, laboratory services, per diagnostic/imaging service, facility fee, etc). Note*:* Copayment is waived at in-network providers in the Philippines.	***In-network:*** $20 copayment per PCP office visit $40 copayment per specialst visit ***Out-of-Network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Additional copays or coinsurance shall apply (e.g. administration of medication, laboratory services, imaging servcies, facility fee, etc). Note*:* Copayment is waived at in-network providers in the Philippines.
• Prescription lenses, eyeglass frames or contact lenses	Member pays all charges above $100.	Member pays all charges above $100.

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay	
Vision services (testing, treatment, and supplies) (cont.)	**High**	**Standard**
Note: See *Preventive care, children* for eye exams for children.	Member pays all charges above $100.	Member pays all charges above $100.
Not covered: • *Eye exercise and orthoptics (vision therapy)* • *Radial keratotomy and other refractive surgery, such as LASIK surgery*	*All charges*	*All charges*
Foot care	**High**	**Standard**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes and other podiatric services Note: For copayment information on professional fees for surgery and anesthesia services see Section 5 (b) *Surgical and Anesthesia Services* and for copayment information on hospital and / or ambulatory surgery center benefits see Section 5(c) *Services provided by a Hospital or Other Facility.*	***In-network:*** $15 copayment per office visit ***Out-of-Network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** $40 copayment per office visit ***Out-of-Network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Copayment is waived at in-network providers in the Philippines.
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*
Orthopedic, Prosthetic and Implantable devices	**High**	**Standard**
• Artificial eyes • Intraocular Lens (benefit is limited to conventional type) • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. (benefit is limited to two per benefit year) • Internal prosthetic devices, such as artificial joints, single and dual chamber pacemakers, and surgically implanted breast implant following mastectomy. • Cardiac stents	***In-network:*** 10% of the cost of the device ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: A benefit maximum for Hearing Aids applies.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: A benefit maximum for Hearing Aids applies.

Orthopedic, Prosthetic and Implantable devices - continued on next page

Benefit Description	You pay	
Orthopedic, Prosthetic and Implantable devices (cont.)	**High**	**Standard**
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • External hearing aids (benefit is limited to $300 per ear every two years) • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants (limited to direct-contracted network providers) • Orthopedic devices such as braces • Band for vertical-banded gastroplasty Note: Prior authorization is required for orthopedic, prosthetic, and implantable devices. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical Procedures.* For information on the hospital and / or ambulatory surgery center benefits, see Section 5(c) *Services provided by a hospital or other facility, and ambulance services.*	***In-network:*** 10% of the cost of the device ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: A benefit maximum for Hearing Aids applies.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: A benefit maximum for Hearing Aids applies.
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Over-the-counter (OTC) items* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Other internal prosthetics such as heart valves, automatic implantible carioverter defibrillator (AICD) and other implantable devices not specified above* • *External prosthetic replacements provided less than 3 years after the last one we covered* • *Services and supplies related to devices that are not covered*	*All charges*	*All charges*

Benefit Description	You pay	
Durable medical equipment (DME)	**High**	**Standard**
Rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Manual hospital beds *(replacement limited to every 5 years)* • Standard manual wheelchairs *(replacement limited to every 5 years)* • Crutches *(replacement limited to every 5 years)* • Walkers *(replacement limited to every 5 years)* • Blood glucose monitors *(replacement limited to every 3 years)* • CPAP (Continuous Positive Airway Pressure) - *(replacement limited to every 5 years)* • BIPAP (Bi-level Positive Airway Pressure) - *(replacement limited to every 5 years)* • Oxygen and equipment for its administration *(replacement supplies every three months)* Note: Prior authorization required for durable medical equipment. Note: Supplies limited to initial dispensing of CPAP and BIPAP. Note: Call us at 671-477-9808 as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	***In-network:*** 20% coinsurance **No out-of-network benefit**	*All charges*
Not covered: • *Motorized wheelchairs and scooters* • *Insulin Pumps* • *Devices or equipment not specified above*	*All charges*	*All charges*
Home health services	**High**	**Standard**
• Home healthcare ordered by a Plan physician and provided by a plan physician, registered nurse (R. N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide while under an active treatment plan with a home health agency. • Services include: - oxygen therapy, intravenous therapy and medications - Services ordered by physician for members who are confined to the home - Nursing	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.

Home health services - continued on next page

Benefit Description	You pay	
Home health services (cont.)	**High**	**Standard**
- Medical supplies included in the home health plan of care - Physical therapy, speech therapy, occupational therapy, and respiratory therapy Note: Home Health Services require prior authorization.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*	*All charges*
Chiropractic	**High**	**Standard**
Chiropractic services - you may self refer to a participating chiropractor for up to 20 visits per calendar year. Services are limited to: • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	***In-network:*** All charges above $25 per visit and all charges after the 20th visit **No out-of-network benefit**	***In-network:*** All charges above $25 per visit and all charges after the 20th visit **No out-of-network benefit**
Alternative treatments	**High**	**Standard**
Acupuncture services - Member may self refer to a participating acupuncture practitioner for up to 20 visits per calendar year.	**In network:** All charges above $25 per visit and all charges after 20th visit. **No out-of-network benefit.**	**In network:** All charges above $25 per visit and all charges after 20th visit. **No out-of-network benefit.**
Educational classes and programs	**High**	**Standard**
Coverage is limited to programs administered through Calvo's SelectCare only: • Cardiac risk management class • Diabetes self management • Wellness programs • Fitness program • Children's health improvement program	Some programs may have a nominal charge directly to member or may offer discounts.	Some programs may have a nominal charge directly to member or may offer discounts.
• Tobacco cessation programs including individual/group/telephone counseling and over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence	Nothing for counseling for up to two quit attempts per year Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence	Nothing for counseling for up to two quit attempts per year Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- The Plan does not have a calendar year deductible for in-network covered services. However, for out-of-network covered services, the Plan does have a calendar year deductible of $500 per person ($1,000 per Self Plus One enrollment or $1,500 per Self and Family enrollment).

YOUR PHYSICIAN MUST GET PRIOR PLAN APPROVAL FOR SURGICAL PROCEDURES. Please refer to the precertification and prior approval information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification and prior approval.

Benefit Description	You pay	
Surgical procedures	**High**	**Standard**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Circumcision - up to 90 days from date of birth • Removal of tumors and cysts • Correction of congenital anomalies (*Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery); surgery is limited to Roux-en-Y bypass and vertical banded gastroplasty • Insertion of internal prosthetic devices . See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization - vasectomy • Insertion of internal prosthetic and implantable devices • Treatment of burns	***In-network:*** $15 copayment per PCP office visit $40 copayment per Specialist office visit Inpatient hospital admission - $200 copayment (includes doctors' services) Outpatient surgical facility - $100 copayment (includes doctors' services) ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Coinsurance is waived at in-network providers in the Philippines.

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High**	**Standard**
Note: This section provides information on the professional charges for surgery or to insert an implant. For information on the hospital and/or ambulatory surgery center benefits and copayments, see Section 5(c) *Services provided by a hospital or other facility and ambulance services.* Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. Note: Prior authorization required for surgical procedures.	***In-network:*** $15 copayment per PCP office visit $40 copayment per Specialist office visit Inpatient hospital admission - $200 copayment (includes doctors' services) Outpatient surgical facility - $100 copayment (includes doctors' services) ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Coinsurance is waived at in-network providers in the Philippines.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; (see Foot care)* • *Robotic surgery*	*All Charges*	*All charges*
Reconstructive surgery	**High**	**Standard**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts;	***In-network:*** $15 copayment per PCP office visit $40 copayment per Specialist office visit Inpatient hospital admission - $200 copayment (includes doctors' services) Outpatient surgical facility - $100 copayment (includes doctors' services) ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Coinsurance is waived at in-network providers in the Philippines.

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	**High**	**Standard**
- Treatment of any physical complications, such as lympedemas; - Breast prostheses and surgical bras and replacemetns (see *Prosthetic devices*) Note. If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. *Not covered:* • *Cosmetic surgery - any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury.* • *Surgeries related to gender reassignment.*	***In-network:*** $15 copayment per PCP office visit $40 copayment per Specialist office visit Inpatient hospital admission - $200 copayment (includes doctors' services) Outpatient surgical facility - $100 copayment (includes doctors' services) ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met. Note: Coinsurance is waived at in-network providers in the Philippines.
Oral and maxillofacial surgery	**High**	**Standard**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • TMJ surgery and other related non-dental treatment	***In-network:*** Inpatient hospital admission - $200 copayment (includes doctors' services) Outpatient surgical facility - $100 copayment (includes doctors' services) ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance per outpatient surgical facility and inpatient hospital admission ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Coinsurance is waived at in-network providers in the Philippines.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures, such as the periodontal membrane, gingiva, and alveolar bone*	*All charges*	*All charges*

Benefit Description	You pay	
Organ/tissue transplants	**High**	**Standard**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney - pancreas • Liver • Lung: Single, bilateral or lobar lung • Pancreas	***In-network:*** Inpatient hospital admission - $200 copayment (includes doctors' services) Outpatient surgical facility - $100 copayment (includes doctors' services) ***Out-of-netowrk:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Coinsurance is waived at in-network providers in the Philippines.
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to other *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de nova and treated) - Recurrent germ cell tumors (including testicular cancer)	***In-network:*** Inpatient hospital admission - $200 copayment (includes doctors' services) Outpatient surgical facility - $100 copayment (includes doctors' services) ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Coinsurance is waived at in-network providers in the Philippines.
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia • Acute myeloid leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed)	***In-network:*** Inpatient hospital admission - $200 copayment (includes doctors' services) Outpatient surgical facility - $100 copayment (includes doctors' services)	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Coinsurance is waived at in-network providers in the Philippines.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High**	**Standard**
• Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Advanced Myeloproliferative Disorders (MPDs) • Advanced neuroblastoma • Amyloidosis • Chronic lymphocytic leukemia/small lymphoma (CLL/SLL) • Hemoglobinopathy • Infantile malignant osteoporosis • Kostman's syndrome • Leukocyte adhesion deficiencies • Marrow failure and related disorders (i.e. Fanconi's Paroxysmal Nocturnal Hemoglobinuria, Pure red cell aplasia) • Mucolipidosis (e.g. Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysacharudosis (e.g. Hunter's sydrome, Hurler"s syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal hemoglobinuria • Phagocytic/Hemophagocytic deficiency diseases (e.g. Wiskott-Aldrich syndrome) • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Sickle cell anemia • X-linked lymphoproliferative syndrome Autologous transplants for: • Acute lymphocytic or nonlymphocytic (i.e. myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Breast Cancer • Ependymoblastoma • Epithelial ovarian cancer • Ewing's sarcoma • Multiple myeloma • Medulloblastoma	***In-network:*** Inpatient hospital admission - $200 copayment (includes doctors' services) Outpatient surgical facility - $100 copayment (includes doctors' services) ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Coinsurance is waived at in-network providers in the Philippines.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High**	**Standard**
• Pineoblastoma • Neuroblastoma • Scleroderma • Scleroderma-SSc (severe progressive) • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	***In-network:*** Inpatient hospital admission - $200 copayment (includes doctors' services) Outpatient surgical facility - $100 copayment (includes doctors' services) ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Coinsurance is waived at in-network providers in the Philippines.
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members over 60 years of age with a diagnosis listed below are subject to medical necessity review by the Plan. Allogeneic transplants for: • Acute lympocytic or nonlymphocytic (i.e. myelogenous leukemia) • Acute myeloid leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced Myeloproliferative Disorders (MPDs) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Chronic lymphocytic leukemia/small lymphoma (CLL/SLL) • Hemoglobinapathy • Marrow failure and related disorders (i.e. Faconi's PNH, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic syndromes • Paroxysma Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia Autologous transplants for: • Acute lymphocytic or nonlymphocytic (i.e. myelogenous) leukemia	***In-network:*** Inpatient hospital admission - $200 copayment (includes doctors' services) Outpatient surgical facility - $100 copayment (includes doctors' services) ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Coinsurance is waived at in-network providers in the Philippines.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High**	**Standard**
• Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Neuroblastoma	***In-network:*** Inpatient hospital admission - $200 copayment (includes doctors' services) Outpatient surgical facility - $100 copayment (includes doctors' services) ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Coinsurance is waived at in-network providers in the Philippines.
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trail. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for: - Acute lymphocytic or nonlymphocytic (i.e. myelogenous) leukemia	***In-network:*** Inpatient hospital admission - $200 copayment (includes doctors' services) Outpatient surgical facility - $100 copayment (includes doctors' services) ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Coinsurance is waived at in-network providers in the Philippines.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High**	**Standard**
- Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic leukemia/small lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocyte - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodyplastic Syndromes - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous transplants for: - Advanced Chidhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphoma - Breast cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic leukemia/small lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle cell (non-Hodgkin's lymphoma) - Multiple sclerosis - Small cell lung cancer - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	***In-network:*** Inpatient hospital admission - $200 copayment (includes doctors' services) Outpatient surgical facility - $100 copayment (includes doctors' services) ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Coinsurance is waived at in-network providers in the Philippines.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High**	**Standard**
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	***In-network:*** Inpatient hospital admission - $200 copayment (includes doctors' services) Outpatient surgical facility - $100 copayment (includes doctors' services) ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Coinsurance is waived at in-network providers in the Philippines.
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All Charges*	*All charges*
Anesthesia	**High**	**Standard**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Office	***In-network:*** Nothing *Out-of-network:* 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Coinsurance is waived at in-network providers in the Philippines.

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- The Plan does not have a calendar year deductible for in-network covered services. However, for out-of-network covered services, the Plan does have a calendar year deductible of $500 per person ($1,000 per Self Plus One enrollment or $1,500 per Self and Family enrollment).

YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
Inpatient hospital	**High**	**Standard**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Note: Pre-certification of hospital stay is required.	***In-network:*** $200 copayment per inpatient hospital admission (includes doctors' services) ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance per inpatient hospital admission ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Coinsurance is waived at in-network providers in the Philippines.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Rehabilitative therapies	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met	***In-network:*** 20% coinsurance per inpatient hospital admission ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Coinsurance is waived at in-network providers in the Philippines.
Not covered: • *Any hospitalization for dental procedures* • *Blood and blood products, whether synthetic or natural, if not included in contracted facility packages*	*All Charges*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High**	**Standard**
• *Custodial care* • *Internal prosthetics, except for those covered under Prosthetics and Orthopedic devices* • *Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Take home items*	*All Charges*	*All charges*
Outpatient hospital or free-standing ambulatory facility	**High**	**Standard**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays and other radiology services, and pathology services • Administration of blood: blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	***In-network:*** $100 copayment for outpatient facility (includes doctors' services) ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Copayment is waived at in-network providers in the Philippines.	***In-network:*** 20% coinsurance for outpatient facility ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met Note: Coinsurance is waived at in-network providers in the Philippines.
Not covered: Blood and blood products whether synthetic or natural, if not included in contracted facility packages	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High**	**Standard**
Skilled nursing facility (SNF): The Plan provides a comprehensive range of benefits when full-time skilled nursing care and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered including: • Bed, board, and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor	***In-network:*** Nothing up to 100 days per plan year ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met	***In-network:*** 20% coinsurance up to 60 days per calendar year ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits (cont.)	**High**	**Standard**
Not covered: *<u>High Option</u>* • *Custodial care* • *Care beyond 100 days per plan year* *<u>Standard Option</u>* • *Custodial care* • *Care beyond 60 days per plan year*	*All Charges*	*All Charges*
Hospice care	**High**	**Standard**
Supportive and palliative care for a terminally ill member is covered in the home, hospital or hospice facility when approved by the Utilization Department. Services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. Services include: • Inpatient and outpatient care • Family counseling	***In-network:*** Nothing **No out-of-network benefit**	***In-network:*** 20% coinsurance **No out-of-network benefit**
Not covered: Independent nursing, homemaker services	*All Charges*	*All charges*
Ambulance	**High**	**Standard**
Emergency ambulance service	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met	***In-network:*** 20% coinsurance **No out-of-network benefit**
Not covered: • *Non-emergency ground ambulance services* • *Air ambulance*	*All charges*	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The Plan does not have a calendar year deductible for in-network covered services. However, for out-of-network covered services, the Plan does have a calendar year deductible of $500 per person ($1,000 per Self Plus One enrollment or $1,500 per Self and Family enrollment).
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

An emergency medical condition is a medical condition so severe that a prudent layperson could reasonably expect that the lack of immediate medical attention would result in (a) placing the patient's health in serious jeopardy, (b) seriously impairing the patient's physical or mental functions, or (c) seriously impairing any of the patient's bodily organs or parts. Medical emergencies include heart attacks, cardiovascular accidents, loss of consciousness or respiration, convulsions, and such other acute conditions that we determine to be medical emergencies.

What to do in case of emergency: In a life or limb threatening emergency, call 911 or go to the nearest hospital emergency room or other facility for treatment. You do not need authorization from your primary care physician (PCP) before you go. A true emergency is covered no matter where you are.

Emergencies within our service area: If you receive emergency care within our service area that results in your hospitalization, you must contact the Calvo's SelectCare Customer Service Department at 671-477-9808 or by email at service@calvos.com within 48 hours unless it was not reasonably possible to do so.

When you are sick or injured, you may have an **urgent care** need. An urgent care need is one that requires prompt medical attention, but is not a medical emergency. When you need urgent care while you are in our service area, call your PCP. Your PCP can assess the situation and decide what type of care you need. Ask your PCP about after-hours and "on-call" procedures now, before you need these services. If you PCP's office is closed, you may access a clinic that provides urgent care services or an urgent care center.

Emergencies / Urgent Care outside our service area: If you receive emergency or urgent care outside our service area, you must contact the Calvo's SelectCare Customer Service department at 671-477-9808 or by email at service@calvos.com within 48 hours, unless it was not reasonably possible to do so, to let us know what has happened and where you went for care. Failure to notify the Plan may result in denial of benefits.

Benefit Description	You pay	
Emergency within our service area	**High**	**Standard**
• Emergency care at a doctor’s office	$15 copayment per doctor's office visit	20% coinsurance per doctor's office visit
• Emergency care as an outpatient at a hospital, including doctor's services	$100 copayment per emergency room visit	20% coinsurance per emergency room visit
• Urgent Care Services at Primary Care or Urgent Care Clinics	***In-network:*** $15 copayment per clinic visit	***In-network:*** $20 copayment per clinic visit

Emergency within our service area - continued on next page

Benefit Description	You pay	
Emergency within our service area (cont.)	**High**	**Standard**
	Out-of-network: 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.	***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligibile charges and billed charges after deductible is met.
• Urgent Care Services as an outpatient in Hospital Urgent Care department **Note:** We waive the ER copay if you are admitted to the hospital.	***In-network:*** $50 copayment per visit ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges after deductible is met.	***In-network:*** $75 copayment per clinic visit ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligibile charges and billed charges after deductible is met.
Not covered: Elective care or non-emergency care	*All Charges*	*All charges*
Emergency outside our service area	**High**	**Standard**
• Emergency care at a doctor's office	$50 copayment per doctor's office visit and any difference between eligible charges and billed charges	20% coinsurance per doctor's office visit and any difference between eligible charges and billed charges
• Emergency care as an outpatient at a hospital, including doctor's services	$200 copayment per emergency room visit and any difference between eligible charges and billed charges	20% coinsurance per emergency room visit and any difference between eligible charges and billed charges
• Urgent Care Services at Primary Care Clinic or Urgent Care Center **Note:** We waive ER copay if you are admitted to the hospital.	***In-network:*** $15 copayment per clinic visit ***Out-of-network:*** 30% coinsurance per clinic visit and any difference between eligible charges and billed charges	***In-network:*** $20 copayment per clinic visit ***Out-of-network:*** 30% coinsurance per clinic visit and any difference between eligible charges and billed charges
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All Charges*	*All charges*

Benefit Description	You pay	
Ambulance	**High**	**Standard**
Emergency ambulance service Note: See 5(c) for non-emergency service.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges	***In-network:*** 20% coinsurance ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Air ambulance* • *Non-emergency ground ambulance services*	*All Charges*	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The Plan does not have a calendar year deductible for in-network covered services. However, for out-of-network covered services, the Plan does have a calendar year deductible of $500 per person ($1,000 per Self Plus One enrollment or $1,500 per Self and Family enrollment).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment in favor of another.

Benefit Description	You pay	
Professional services	**High**	**Standard**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.

Professional services - continued on next page

Benefit Description	You pay	
Professional services (cont.)	**High**	**Standard**
Telehealth consultations through the following telehealth vendor: • Teladoc® - available to members for mental health/ **substance use** disorders via Teladoc's mobile app (video), Teladoc's website or by telephone at Teladoc's toll-free number.	Nothing	Nothing
Applied Behavioral Therapy Benefit • Required Diagnosis of ASD (Autsm Spectrum Disorder) by a provider qualified to make the diagnosis: Board Certified Behavior Analyst (BCBA), psychiatrist, pediatrician. • Initiation of treatment and on-going treatment and intensity of treatment must be medically necessary and appropriate for the child. • Available to children through age 21 (coverage limitations apply). • A Functional Behavioral Assessment must be submitted prior to treatment and must demonstrate appropriateness of ABA Therapy. • Services must be directed by a Board Certified Behavior Analyst and services may be provided by Board Certified Assistant Behavior Analysts (BCaBA) or Registered Behavior Technicians (RBTs). • Approval of on-going services requires demonstrated and documented involvement by family. • Services provided by the school are not reimbursable by the Plan.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions. Coverage is limited to $75,000 for eligible dependent children through age 15 and $25,000 for children age 16 through 21 based on Guam mandated benefit.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions. Coverage is limited to $75,000 for eligible dependent children through age 15 and $25,000 for children age 16 through 21 based on Guam mandated benefit.
Diagnostics	**High**	**Standard**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered entity	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.

Benefit Description	You pay	
Inpatient Hospital or other covered facility	**High**	**Standard**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Outpatient hospital or other covered facility	**High**	**Standard**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Not covered: *Services that require pre-authorization but are not pre-authorized before the services are rendered.*	*All charges*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their prescribers**obtain prior approval / authorizations for certain prescription drugs and supplies** before coverage applies. Prior approval/authorization must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- The Plan does not have a calendar year deductible for in-network covered services. However, for out-of-network covered services, the Plan does have a calendar year deductible of $500 per person ($1,000 per Self Plus One enrollment or $1,500 per Self and Family enrollment).
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed / certified providers with prescriptive authority prescribing within their scope of practice. Your provider must obtain prior approval for certain drugs (see Section 3 *You need prior Plan approval for certain services)*
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication.
- **We use a formulary.** The Calvo's SelectCare Formulary is a list of prescription drugs that Plan physicians use as a guide when prescribing medications for patients. The list of name brand and generic drugs includes a preferred list of drugs that have been selected to meet patients' clinical and financial needs.The formulary plays an important role in providing safe, effective and affordable prescription drugs to Calvo's SelectCare members. It also allows us to work together with physicians and pharmacies to ensure that our members are getting the drug therapy they need. Certain drugs require prior authorization from the Plan. A Plan physician may initiate the prior authorization request simply by phoning, faxing, or emailing the request. Discuss your options with your physician when you need a new prescription.
- **These are the dispensing limitations.** Prescription drugs will be dispensed for up to a 30-day supply or one commercially prepared unit per copayment (i.e. one inhaler, one vial of ophthalmic medication, one tube of ointment). For drugs that could be habit forming, the prescription unit is set at a smaller quantity for the protection and safety of our members.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispensed as Written for the name brand drug, you have to pay the non-formulary copayment.
- Updating of prior authorizations may be required. Clinical edits (limitations) can be used for safety reasons, quantity limitations and benefit plan exclusions and may require prior authorization.
- Prescription drugs can also be obtained through the mail order program for up to a 90-day supply of oral medication: six vials of insulin or three commercially prepared units (i.e. inhaler, vials of opthalmic medication, or topical ointments or creams). Call 1-800-881-1966 for mail order customer service. You pay **one** copayment for a 90-day supply of medication through mail order.
- For **prescription drugs purchased at overseas pharmacies**, reimbursement is limited to a 30-day supply. Members are responsible for coinsurance. Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription. To file a claim for covered drugs and supplies you purchase from pharmacies outside the United States, Guam, and the Commonwealth of the Northern Mariana Islands, send a completed Calvo's Selectcare Deductible / Reimbursement Form, along with an original prescription, official itemized pharmacy receipts to: Calvo's SelectCare, P.O. Box FJ, Hagatna, Guam 96932 or submit to our office at 115 Chalan Santo Papa, Hagatna, Guam 96910. Reimbursement requests must be submitted within 90 days of the service.

Why use generic drugs? Generic drugs on the formulary are the therapeutically equivalent to the brand name drugs and are less expensive. You may reduce your out-of-pocket costs by choosing to use a generic drug.

When you do have to file a claim. Refer to Section 7 *Filing a claim for covered services*

Our Pharmacy Benefit Manager website: www.optumrx.com

Benefit Description	You pay	
Covered medications and supplies	**High**	**Standard**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Disposable needles and syringes for the administration of covered medications; • Diabetic supplies including - Disposable needles, syringes, lancets, urine and blood glucose testing reagents; a copayment charge applies per item per each 30-day supply • Drugs to treat gender dysphoria	**Retail Pharmacy (30-day supply)** $10 for Generic $25 for Preferred Brand 50% of Average Wholesale Price (AWP) for Non-Preferred Brand $100 for Specialty **Mail Order (90-day supply)** $10 for Generic $25 for Preferred Brand $100 for Non-Preferred Brand $200 for Specialty Note: If there is no generic equivalent available, you will still have to pay the non-preferred copayment. Note: For prescription drugs purchased at overseas pharmacies, members are responsible for a 20% coinsurance of the cost of the medication.	**Retail Pharmacy (30-day supply)** $15 for Generic $40 for Preferred Brand 50% of Average Wholesale Price (AWP) for Non-Preferred Brand $150 for Specialty **Mail Order (90-day supply)** $20 for Generic $40 for Preferred Brand $150 for Non-Preferred Brand $250 for Specialty Note: If there is no generic equivalent available, you will still have to pay the non-formulary copayment. Note: For prescription drugs purchased at overseas pharmacies, members are responsible for a 20% coinsurance of the cost of the medication.
• FDA-approved Women's contraceptive drugs and devices (injectable and implantable contraceptive drugs are covered under *Family Planning*)	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges
• Growth hormone Note: Growth hormone therapy (GHT) - in limited circumstances for treatment of children with Turner Syndrome or classical growth hormone deficiency, only with prior authorization by Plan.	$100 copayment for 30-day supply	$100 copayment for 30-day supply

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High**	**Standard**
• Drugs for sexual dysfunction are covered when Plan criteria is met • Oral fertility drugs	50% per prescription unit or refill up to the dosage limits and all charges above that limit	50% per prescription unit or refill up to the dosage limits and all charges above that limit
Preventive Care medications to promote better health as recommended by ACA The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a healthcare professional and filled at a network pharmacy. • Asprin (81 mg) for men age 45 - 79 and women age 55 - 79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 6 months - 1 year • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Fluoride tablets, solution (not toothpaste, rinses) for children age 0 - 6 • Statin Use for the Primary Prevention of Cardiovascular Disease in Adults Note: To receive this benefit a prescription from a doctor must be presented to pharmacy. Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BroseRec/Index/browse-recommendations **Note:** Over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation benefit.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Drugs not approved the Food and Drug Administration (FDA)* • *Medical supplies such as dressings and antiseptics*	*All Charges*	*All Charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High**	**Standard**
• *Non-prescription and over-the-counter (OTC) medications* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them* • *Replacement of lost, stolen or destroyed medication*	*All Charges*	*All Charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 *Coordinating Benefits with other coverage.*
- Plan dentists must provide or arrange your care.
- The Plan does not have a calendar year deductible for in-network covered dental services.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Dental Benefits	You Pay	
Service	**High**	**Standard**
Accidental Injury Benefit - We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Note: If you are outside the service area and receive services from an out-of-network dentist, we will reimburse you up to $100.00	**In network:** Nothing **Out-of-network:** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges	**In network:** Nothing **Out-of-network:** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges
Preventive services listed below: • Exams (once every six months) • Fluoride treatment (for children age 15 and under, once a year) • Prophylaxis (cleaning of teeth once every six months) • Sealants (for permanent molars of children age 15 and under) • Space maintainers (for children age 15 and under, includes adjustments within six months of installation • X-rays (bite wing) • X-rays (full mouth, once every three years) We have no other dental benefits.	**In network:** Nothing **Out-of-network:** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges	**In network:** Nothing **Out-of-network:** 30% coinsurance of eligible charges and any difference between eligible charges and billed charges

Section 5(h). Wellness and Other Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for a stated time period (unless circumstances change). You may request and extension of the time period, but regular contract benefits will resume if we do not approve your request. Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Airfare Benefit	The airfare benefit applies when a member has a catastrophic illness which requires Qualified Medical Treatment or Procedures that are not available on Guam.This benefit cannot be used in conjunction with the Travel Benefit. When approved in advance by Calvo's SelectCare, the Airfare Benefit specifically covers the economy round-trip airfare for the member, a companion, and a medical attendant, if required. If the member qualifies for the Airfare Benefit, Calvo's SelectCare will only pay or reimburse the member the actual cost or the lowest medical economy rate, whichever is lower. Airfare penalties are excluded from this benefit. The Plan will only pay charges under this benefit if the proposed services are performed at direct-contracted Network Providers AND if the proposed services meet one of the following Qualifying Conditions / Procedures: Open Heart Surgery, Oncology Surgery, Aneurysmectomy, Pneuctomy, Intra-cranial Surgery, Acute Leukemia, Gamma Knife Surgery, NICU level III care. FEHB Members covered by Medicare: Medicare beneficiaries may only receive services at a Plan participating Medicare-contracted facility in Guam, Saipan, Hawaii, and the Continental United States. Medicare eligible care and services which are rendered at a facility which is not a Medicare contracted facility, or which is rendered by a physician who is not a Medicare contracted physician will not be covered. FEHB members with Medicare as their primary payer **are only eligible** for the Airfare Benefit **to** direct-contracted Network providers in the Continental United States. For more information about this benefit, contact Calvo's SelectCare Customer service at (671) 477-9808.
Travel Benefit	For pre-authorized, elective, in-patient or out-patient • Surgical procedures • High-level specialist consultations (including but not limited to cardiology, gastroenterology, hepatology, hematology, nephrology, neurology, oncology, orthopedic services, pulmonology, etc.)

	• High-level radiology diagnostic services (including but not limited to PET scans, MRIs, etc.) at participating providers in the Philippines and Taiwan, (excluding emergencies, preventive services, home health, hospice or maternity-related services), Calvo's SelectCare offers a **travel benefit** of up to **$500** per member (one travel benefit per member per year) on a **reimbursement** basis and to be applied toward the cost of round-trip airfare between Guam and Manila, Philippines or between Guam and Taipei, Taiwan, or ground transportation between airport and the hospital or lodging in the Philippines or Taiwan during the same time period as the procedure / consultation / diagnostic service. This benefit cannot be used in conjunction with the Airfare Benefit. Benefit is limited to one (1) travel benefit per member per year. Some services may not be eligible for the travel benefit reimbursement. In order for the procedure, service or specialist consultation to be prior authorized as a covered benefit and eligible for the travel benefit, the following are required: • Referrals and medical notes from primary care providers (or specialists, if applicable) to determine medical necessity • Must meet medical necessity criteria • Must be a covered benefit and • Approval request for the procedure/consultation/diagnostic service must be submitted to and approved by Plan prior to departure to the Philippines or Taiwan Upon return from the Philippines or Taiwan, members must submit to Calvo's SelectCare the following documents for reimbursement: • Completed Calvo's SelectCare reimbursement form • Pre-authorization document from the Plan • Letter of authorization from the Plan's Philippine offices or Guam office , and • Receipts for airfare or lodging or transportation which clearly detail dates of travel / stay / transfers, amounts paid, and names of persons who made payments 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. Calvo's SelectCare will reimburse members up to the $500 allowance under this travel benefit. FEHB members covered by Medicare: Medicare beneficiaries may only receive services at a Plan participation Medicare-contracted facility in Guam, Saipan, Hawaii, and the continental United States. Medicare eligible care and services which are rendered at a facility which is not a Medicare contracted facility or which is rendered by a physician who is not a Medicare contracted physcian will not be covered. FEHB members with Medicare as their primary payer **are not eligible for the Travel Benefit to the Philippines or Taiwan.**

Non-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 671-477-9808 or visit their website at www.calvos.net.

Air Ambulance Discount	A fifty percent (50%) discount is offered for air ambulance transportation services from Guam, the CNMI, and Palau to the Philippines, Japan, Taipei, or Honolulu for certain qualifying medical conditions. Pre-arrangements must be made with the plan and the air ambulance company.
Gym Membership	Calvo's SelectCare provides 100% coverage of the cost of gym memberships (subscribers and dependents) only at partner fitness centers . Coverage is limited to benefit year (January to December 2022). Members are limited to enrolling in one partner gym per year.
Calvo's Lifestyle Club Membership	The Lifestyle Club is a Membership Rewards Program for Calvo's SelectCare FEHB members (subscriber and one adult dependent only). Members enjoy benefits and discounts from participating shopping, dining, gym, gas partners. Go to www.calvosinsurance.com for more information about the program.
Wellness Incentives	Calvo's SelectCare provides a program that offers members the encouragement and rewards to help members, 18 years old and above, improve or maintain their health. The Plan offers multiple wellness incentives that will allow members to earn up to a maximum of $75 per member, $150 per self plus one enrollment and $200 for self and family enrollment per benefit year for completing preventive services such as the online health risk assessment, annual physicals, doctor's visits for chronic conditions, breast cancer screening, cervical cancer screening, colorectal cancer screening, and smoking cessation classes. Incentive amounts will be calculated 60 days after the end of the current policy period and checks will be processed within 30 days after the calculation date. Members must complete a claim reimbursement form and submit to Calvo’s SelectCare along with proper documentation in order to claim benefit. Claims must be submitted to us no later than 90 days after the end of the policy period.

Supplemental Dental Coverage	Calvo's SelectCare offers a dental plan to supplement the dental coverage provided in the Calvo's SelectCare FEHB plan option you have selected. Supplemental dental coverage will be coordinated with your FEHB dental coverage. Enrollment in supplemental dental coverage is required every Open Season. This coverage does not automatically renew. The supplemental dental plan provides coverage as follows:

Supplemental Dental Benefits	Member Pays	
Covered Services	**In-network**	**Out-of-network**
DEDUCTIBLE	Nothing	Nothing
RESTORATIVE SERVICES, SIMPLE EXTRACTIONS, ENDODONTICS, PERIODONTICS, ORAL SURGERY	20% coinsurance of covered charges	60% coinsurance of Usual, Customary, and Regular (UCR) charges plus and difference between UCR charges and billed charges
PROSTHODONTICS	50% coinsurance of covered charges	75% coinsurance of Usual, Customary, and Regular (UCR) charges plus and difference between UCR charges and billed charges
SEDATION	20% coinsurance of covered charges	40% coinsurance of Usual, Customary, and Regular (UCR) charges plus and difference between UCR charges and billed charges
ORTHODONTICS	$1,500 Lifetime maximum payable to provider in quarterly installments of $187.50	All charges

Dental Plan Maximum - The supplemental dental plan will pay a maximum benefit of $1,500 per member per calendar year.

For more information on rates, payment arrangements, terms and conditions, and enrollment please see the Calvo's SelectCare Supplemental Dental Plan flyer.

Section 6. General Exclusions – Services, Drugs and Supplies We Do Not Cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergencyservices/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service;
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.
- Services or supplies we are prohibited from covering under the Federal Law.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs, or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Provider must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 671-477-9808.

When you must file a claim – such as for services you received outside the Plan's service area and/or from non-participating providers – submit it on the HCFA-1500 or a claim form that includes the information shown below. Claims forms, bills and receipts should be itemized, translated in English when originals are in another language and show:

- Covered member's name and ID number;
- Name and address of the provider or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- Medications
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN);
- Receipts, if you paid for your services;
- Medical records

Mail your claims to: Calvo's SelectCare Customer Service, P.O. Box FJ, Hagatna, Guam 96932

Or

Submit your claims at: Calvo's SelectCare Customer Service, 115 Chalan Santo Papa, Hagatna, Guam 96910

Prescription drugs

Mail your claims to: Calvo's SelectCare Customer Service, P.O. Box FJ, Hagatna, Guam 96932

Or

Submit your claims at: Calvo's SelectCare Customer Service, 115 Chalan Santo Papa, Hagatna, Guam 96910

Other supplies or services

Mail your claims to: Calvo's SelectCare Customer Service, P.O. Box FJ, Hagatna, Guam 96932

Or

	Submit your claims at: Calvo's SelectCare Customer Service, 115 Chalan Santo Papa, Hagatna, Guam 96910
Deadline for filing your claim	Send us all of the documents for your claim as soon as possible. You must submit the claim and all required information (translated in English when originals are in another language) by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.
When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a healthcare professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situation in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7, and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing us at Calvo's SelectCare Customer Service, P.O. Box FJ, Hagatna, Guam 96932 or calling our Customer Service Department at 671-477-9808.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgement (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

1 Ask us in writing to reconsider our initial decision. You must:

a) Write to us within 6 months from the date of our decision; and

b) Send your request to us at Calvo's SelectCare Customer Service Department, P.O. Box FJ, Hagatna, Guam 96932; and

c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us our email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim; or

b) Write to you and maintain our denial; or

c) Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3

If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after your first wrote to us--if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms:
- Copies of all letters you sent to us about the claim; and
- Your daytime phone number and the best time to call
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right fo file a disputed claim with OPM. Parties acting as you representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without yrou express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to file a lawsuit. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 671-477-9808. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibiity issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Worker's Compensation programs if you are receiving Worker's Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under any other health plan or have automobile insurance that pays healthcare expenses without regard to fault. This is called “double coverage.”

When you have double 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 insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.calvos.net.

When we are the primary payer, we will pay the benefits described in this brochure.

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.

TRICARE and CHAMPVA

TRICARE is the healthcare program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums). For information on suspending your FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Worker's Compensation

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these state programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgement, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connections with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgement, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 877-888-3337, (TTY 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 671-477-9808 or see our Web site at www.calvos.net.

We waive some costs if the Original Medicare Plan is your primary payor - We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other healthcare professionals
- Outpatient surgery

Please review the following table. It illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor. Members must use providers who accept Medicare's assignment.

Benefit Description: Deductible
You pay without Medicare: $0
You pay with Medicare Part B: $0

Benefit Description: Primary Care Physician
You pay without Medicare: $15 copay High Option / $20 copay Standard Option
You pay with Medicare Part B: $0

Benefit Description: Specialist
You pay without Medicare: $40 copay High Option / $40 copay Standard Option
You pay with Medicare Part B: $0

Benefit Description: Inpatient Hospital
You pay without Medicare: $200 copayment High Option / 20% coinsurance Standard Option
You pay with Medicare Part B: $200 copayment High Option / 20% coinsurance Standard Option

Benefit Description: Outpatient Surgery -Hospital
You pay without Medicare: $100 copay (includes professional fees) High Option / 20% coinsurance Standard Option
You pay with Medicare Part B: $0

Benefit Description: RX (30-day supply)
You pay without Medicare: High Option: $10 for generic, $25 for preferred brand, 50% of AWP for non-preferred brand, $100 for Specialty Standard Option:$20 for generic, $40 for preferred brand, $100 for non-preferred brand, $250 for Specialty
You pay with Medicare Part B: High Option: $10 for generic, $25 for preferred brand, 50% of AWP for non-preferred brand, $100 for Specialty Standard Option:$20 for generic, $40 for preferred brand, $150 for non-preferred brand, $250 for Specialty

Benefit Description: RX - Mail order (90-day supply - one copay)
You pay without Medicare: High Option: $10 for generic, $25 for preferred brand, 50% of AWP for non-preferred brand, $200 for Specialty
Standard Option:$20 for generic, $40 for preferred brand, $100 for non-preferred brand, $250 for Specialty
You pay with Medicare Part B: High Option: $10 for generic, $25 for preferred brand, 50% of AWP for non-preferred brand, $200 for Specialty Standard Option:$20 for generic, $40 for preferred brand, $100 for non-preferred brand, $250 for Specialty

You can find more information about how our plan coordinates benefits with Medicare at www.calvos.net.

Tell us about your Medicare coverage

You must tell us if you or a covered family member has Medicare coverage and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have as this coverage may affect the primary / secondary status of this plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation		✓*
9) Are a Federal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in This Brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical trials cost categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

See Section 4, page 23.

Copayment

See Section 4, page 23.

Cost-sharing

See Section 4, page 23.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial Care

Helps you meet your daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Custodial care lasting 90 days or more is sometimes known as long term care.

Deductible

See Section 4, page 23.

Experimental or investigational service

Services, supplies, devices, procedures, drugs, or treatment that is not yet accepted as common medical practice.

Group health coverage

An insurance plan that provides health care coverage to a select group of people

Healthcare professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity

Medical necessity refers to medical services or hospital services which are determined by us to be:

- Rendered for the treatment or diagnosis of an injury or illness; and
- Appropriate for the symptom, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and
- Not furnished primarily for the convenience of the member, the attending physician, or other provider of service; and
- Furnished in the most economically efficient manner which may be provided safely and effectively to the member.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:

	The payment we would make if the healthcare services had been obtained within our Service Area and/or by an In-Network provider, or a special negotiated payment or Medicare rates. You should also see Important Notice About Surprise Billing - Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Us/We	Us and We refer to Calvo's SelectCare
You	You refers to the enrollee and each covered family member.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately without the care or treatment that is the subject of the claim. Urgent care claim usually involve Pre-service claims and not Post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgement of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department by telephone at 671-477-9808 or by mail at P.O. Box FJ, Hagatna, Guam 96932. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Index

Summary of Benefits for the High and Standard Option of Calvo's SelectCare - 2022

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. You can obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.calvos.net/FEHB.aspx. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- The Plan does not have a calendar year deductible for in-network covered services. However, for out-of-network covered services the Plan does have a calendar year deductible of $500 for Self Only and $1,500 for Self Plus One and Self and Family enrollment.

High and Standard Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in doctor's office	**High Option** ***In-network:*** $15 copayment per PCP office visit; $40 copayment per specialist visit ***Preferred In-network****: $5 copayment per PCP office visit* **Standard Option** ***In-network:*** $20 copayment per PCP office visit; $40 copayment per specialist visit ***Preferred In-network****: $10 copayment per PCP office visit*	31
Services provided by a hospital: • **Inpatient**	**High Option** ***In-network:*** $200 copayment per inpatient hospital admission (includes doctors' services) **Standard Option** ***In-network:*** 20% coinsurance per inpatient hospital admission	57
Services provided by a hospital: • **Outpatient**	**High Option** ***In-network:*** $100 copayment per outpatient surgical facility (includes doctors' services) **Standard Option** ***In-network:*** 20% coinsurance per outpatient surgical facility visit	58
Emergency benefits: • **In-area**	**High Option** $100 copayment per emergency room visit (hospital) **Standard Option**	60

	20% coinsurance per emergency room visit (hospital)	
Emergency benefits: • **Out-of-area**	**High Option** $200 copayment per emergency room visit (hospital) and any difference between eligible charges and billed charges **Standard Option** 20% coinsurance per emergency room visit (hospital) and any difference between eligible charges and billed charges	61
Mental health and substance use disorder treatment:	**High and Standard Options** Member's cost-sharing responsibilities are no greater than for other illnesses or conditions.	63
Prescription drugs: • Retail pharmacy (30-day supply)	**High Option** $10 copayment for Generic $25 copayment for Preferred Brand 50% of Average Wholesale Price (AWP) for Non-Preferred Brand $100 copayment for Specialty **Standard Option** $15 copayment for Generic $40 copayment for Preferred Brand 50% of Average Wholesale Price for Non-Preferred $150 copayment for Specialty	66
Dental care:	**High Option** Nothing for preventive dental care **Standard Option** Nothing for preventive dental care	70
Vision care:	**High Option** ***In-network:*** $15 copayment per PCP visit, $40 per specialist visit for annual eye exam (includes refraction) **Standard Option**	43

	In-network: $20 copayment per PCP visit, $40 per specialist visit for annual eye exam (includes refraction)	
Special Features: Airfare Benefit	**High and Standard Options** When criteria are met and when approved in advance by Calvo's SelectCare, the Airfare Benefit covers only the economy round-trip airfare for the member, a medical attendant and a companion, if required. This benefit cannot be used in conjunction with the Travel Benefit.	71
Special Features: Wellness Incentives	**High and Standard Options** Incentives to reward you for completing a Health Risk Assessment (HRA) and other selected health screenings.	73
Special Features: Travel Benefit	**High and Standard Options** The Plan will reimburse members up to $500 (one time per member per year) for round-trip airfare, ground transportation, or lodging in the Philippines. This benefit covers pre-authorized, elective in-patient or out-patient procedures at participating providers in the Philippines, excluding emergencies, preventive services, home health, hospice, or maternity-related services. This benefit cannot be used in conjunction with Airfare Benefit.	71
Protection against catastrophic costs (out-of-pocket maximum)**:**	**High Option** Medical - Nothing after $2,000 for Self Only, $4,000 for Self Plus One, and $6,000 for Self and Family Prescription Drugs - Nothing after $2,000 for Self Only and $4,000 for Self Plus One and Self and Family **Standard Option** Medical - Nothing after $3,000 for Self Only, $6,000 for Self Plus One, and $8,000 for Self and Family Prescription Drugs - Nothing after $2,000 for Self Only and $4,000 for Self Plus One and Self and Family	13

2022 Rate Information for Calvo's SelectCare Health Plans

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or **www.opm.gov/Tribalpremium.**

Premiums for Tribal employees are shown under Monthly Premium Rate column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Guam, Northern Marianas Islands, Palau					
High Option Self Only	B41	$185.52	$61.84	$401.96	$133.99
High Option Self Plus One	B43	$362.04	$120.68	$784.42	$261.47
High Option Self and Family	B42	$491.38	$163.79	$1,064.66	$354.88
Standard Option Self Only	B44	$131.16	$43.72	$284.18	$94.73
Standard Option Self Plus One	B46	$258.55	$86.18	$560.19	$186.73
Standard Option Self and Family	B45	$381.08	$127.03	$825.68	$275.23