

Calvo's SelectCare

www.calvos.net

(671) 477-9808

2013

A Health Maintenance Organization High Option

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 12 for requirements.

IMPORTANT

- Rates: Back Cover
- Changes for 2013: Page 13
- Summary of benefits: Page 75

Enrollment codes for this Plan:

B41 High Option - Self Only

B42 High Option - Self and Family



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**United States
Office of Personnel Management**

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

RI 73-874

**Important Notice from Calvo's SelectCare Health Plans About
Our Prescription Drug Coverage and Medicare**

The Office of Personnel Management (OPM) has determined that the Calvo's SelectCare prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. 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 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, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug 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 most other people pay. You may also have to wait until the next open enrollment period 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 1-800-772-1213 (TTY 1-800-325-0778).

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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of Calvo's SelectCare, underwritten by Tokio Marine Pacific Insurance (TMPI), under our contract (CS 2928) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for administrative offices is:

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

This brochure is the official statement of benefits. No oral 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 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, 2013, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or 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 first.
- 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 health care 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:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized 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 that 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/oig

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, DC20415-1100

- 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 he/she is disabled and incapable of self support).
- 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.
- 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 if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.
- 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.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. 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. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. 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 ask questions and understand answers.

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug allergies you have.

- 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 medicine 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 medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

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

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

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

- www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use Calvo's SelectCare's preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

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 reduce medical errors that should never happen called "Never Events". When a Never Event occurs, neither your FEHB plan nor you will incur cost 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.

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

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who 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 a *Guide to Federal Employees Health Benefits Plans*, 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 don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

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

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. 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 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 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 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 marry.

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, that person may not be enrolled in or covered as a family member by 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/lifeevents. If you need assistance, please contact your employing agency, personnel/payroll office, or retirement office.

• **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural and adopted children are covered until their 26 th birthday.
Foster Children	Foster children are eligible for coverage until their 26 th 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	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	Married children (but NOT their spouse or their own children) are covered until their 26 th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26 th birthday.

You can find additional information at www.opm.gov/insure

• **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 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 for 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 and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan’s Basic Option;
- 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 and Family 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 and Family in the Blue Cross and Blue Shield Service Benefit Plan’s Basic Option.

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 doesn't 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 your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. 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 paid according to the 2013 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2012 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 or 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 RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **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). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 26, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **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 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, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory. We give you the choice of enrollment in a High 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 emergency 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 copayments or coinsurance.

Plan / Participating Providers

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.

Specialty 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 Non-Plan/Non-Participating Providers of their choice through their out-of-network benefit. However, because we do not have contracts with 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*).

Non-Plan/Non-Participating Providers

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 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 non-Plan provider; however, the Plan pays a reduced benefit for certain services from non-Plan providers. You may have to pay for the services first and file a claim with us in order for the Plan to reimburse you (see Section 7 - *Filing a claim for covered services*).

When covered healthcare services are provided outside of the Service Area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the non-participating 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 non-participating 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, or a special negotiated payment, to determine the amount we will pay for services rendered by non-participating healthcare providers. In these situations, you will be liable for the difference between the amount that the non-participating 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 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. Your annual out-of-pocket expenses for in-network covered services, including deductibles and copayments, cannot exceed \$2,000 for Self Only enrollment, or \$6,000 family coverage. Additionally, your annual out-of-pocket expenses for in-network prescription drugs, including copayments, cannot exceed \$2,000 for Self Only enrollment, or \$4,000 family coverage. 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. We will also keep records of your coinsurance/copayments and track your catastrophic protection out-of-pocket maximums.

Your rights

OPM requires that all FEHB Pplans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (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 met all licensing requirements needed on Guam, the Commonwealth of the Northern Mariana Islands, and the Republic of Belau (Palau) to conduct business as an insurance company.
- Calvo's SelectCare has been operating on Guam for 12 years.
- We are a for-profit organization.

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 Web site at www.calvos.net.

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 being treated by a specialist.

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 2013

We are a new plan

This Plan is new to the FEHB Program. We are being offered for the first time during the 2012 Open Season.

Program-wide changes

- Annual limits on essential health benefits as described in section 1302 of the Affordable Care Act have been eliminated.
- FEHB Plans must provide coverage for routine patient costs for items and services furnished in connection with participation in an approved clinical trial.
- Additional coverage for preventive care and screenings for women provided in comprehensive guidelines adopted by the Health Resources and Services Administration (HRSA) has been added with no cost-sharing in network.

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. You may also request replacement cards through our Web site at www.calvos.net.

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 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.

• Plan providers

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 Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our web site.

• Plan facilities

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 web site.

• Non-plan providers

Non-Plan providers are physician and other health care professionals who are not under contract with this Plan. You can get care from 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.

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 health care, 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 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 group 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 from 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

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only 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 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 surgical procedures performed in a surgical facility
- Audiological exams
- Bariatric surgery
- Bone density studies
- Certain kinds of 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
- Mental Health and substance abuse services
- MRIs
- Oncology consultations
- Out-of-area hospitalization
- Plastic/reconstructive consultation and procedures
- Therapy treatments beyond five (5) sessions - occupational therapy, physical therapy, speech therapy

- Podiatry consultations and procedures
- Sleep studies
- Specialty care referrals, consultations and procedures
- Transplants
- Ultrasounds, sonograms including echocardiogram
- Other procedures including colonoscopy 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.

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 planned days of confinement

• 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 it is and urgent care claims by applying the judgement of a prudent layperson who 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 provide notice of the specific information we need to complete our review of the claim. We will allow up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the 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, then call us at 671-477-9808. If it is determined that your claim is an urgent care claim, we will hasten our review (if we have not yet responded to your claim).

- **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 telephone 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, then 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.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten 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** - \$500 for Self Only enrollment or \$1,500 for Self and Family enrollment each calendar year. Under family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family reach \$1,500.

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.

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

After your total medical out-of-pocket maximum of \$2,000 per person or \$6,000 per family enrollment in any calendar year, you do not have to pay any more for in-network covered services. **Additionally, after your total prescription drug out-of-pocket maximum of \$2,000 per person or \$4,000 per family enrollment in any calendar year is met, you do not have to pay any more for in-network covered services.** However, please note that the Plan does not have out-of-pocket maximums for any out-of-network services.

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

High Option Benefits

Page 72 is a benefits summary of the High option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High Option Benefits Overview

This Plan offers a High Option. Our benefit package is described in Section 5. Make sure that you review the benefits carefully.

The High Option 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 Option benefits, contact us at 671-477-9808 or at our Web site at www.calvos.net.

The High option offers unique features.

High Option

The High Option includes the most comprehensive benefits. Our FEHB High Option includes:

- Primary care office visit copayment - \$15
- Specialty care office visit copayment - \$40
- Copayment on inpatient admissions - \$200
- No copayment for most adult preventive care services and immunizations
- Drug copayments - Retail (30 day supply) - \$10 generic formulary, \$15 brand maintenance, \$25 brand formulary, 50% of AWP Non formulary, \$100 Specialty drugs
- Drug copayments - Mail Order (90 day supply) - \$0 generic formulary, \$0 brand maintenance, \$0 brand formulary, \$100 Non formulary, 20% coinsurance of AWP Specialty drugs
- Out-of-network coinsurance - 30% of Plan eligible charges and any difference between eligible charges and billed amount
- Chiropractic office visit copayment - \$25 for up to 10 visits per benefit year

If you would like more information about our benefits, please contact us at 671-477-9808 or visit our website at www.calvos.net.

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 Plan does not have a calendar year deductible for in-network covered services. However, the Plan does have a calendar year deductible of \$500 for Self Only and \$1,500 for family enrollment for out-of-network covered services.
- 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 Option
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • In an urgent care center • Office medical consultations • Second opinion 	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Off-island care which require precertification but rendered without prior authorization, except in the case of emergency</i> 	<p><i>All charges</i></p>
Lab, X-ray and other diagnostic tests	High Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • Electrocardiogram and EEG 	<p><i>In-network:</i> Nothing</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>

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

Benefit Description	You pay
Lab, X-ray and other diagnostic tests (cont.)	
<ul style="list-style-type: none"> • X-rays • Non-routine mammograms • Ultrasound <p>Note: Prior authorization required for ultrasound services.</p>	<p>In-network: \$15 copayment in addition to regular office visit</p> <p>Out-of-network: 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p>Prior authorization required for the following services:</p> <ul style="list-style-type: none"> • CT Scan • Echocardiogram • MRI 	<p>In-network: \$40 copayment in addition to regular office visit</p> <p>Out-of-network: 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
Preventive care, adult	
<p>Routine physical once a year which includes:</p> <p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 	<p>In-network: Nothing</p> <p>Out-of-network: 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p>Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</p>	<p>In-network: Nothing</p> <p>Out-of-network: 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p>Well woman - one annually; including, but not limited to:</p> <ul style="list-style-type: none"> • Routine pap test • Human papillomavirus testing for women age 30 and up once every three years • Counseling for sexually transmitted infections on an annual basis • Counseling and screening for human immune-deficiency virus on an annual basis • Contraceptive methods and counseling as prescribed • Screening and counseling for interpersonal and domestic violence 	<p>In-network: Nothing</p> <p>Out-of-network: 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	High Option
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	<i>In-network:</i> Nothing <i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges
Adult routine immunizations as endorsed by the CDC's Advisory Committee on Immunization Practices	<i>In-network:</i> Nothing <i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges
Note: In addition to the above services, other evidence-based items or services that have a rating of A or B by the United States Preventive Services Task Force (USPSTF) and women's preventive services as adopted by the Health Resources and Services Administration (HRSA) are covered benefits.	
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges</i>
Preventive care, children	High Option
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	<i>In-network:</i> Nothing <i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 21) • Examinations, such as: <ul style="list-style-type: none"> - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction, which include: - Examinations done on the day of immunizations (up to age 21) 	<i>In-network:</i> Nothing <i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges
Maternity care	High Option
Complete maternity (obstetrical) care, such as:	
<ul style="list-style-type: none"> • Prenatal care 	<i>In-network:</i> Nothing <i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges
<ul style="list-style-type: none"> • Delivery 	\$100 copayment for birthing center \$200 copayment for hospital

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	
<ul style="list-style-type: none"> Screening for gestational diabetes for pregnant women between 24 - 28 weeks gestation or first prenatal visit for women at a high risk 	<p><i>In-network:</i> Nothing</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<ul style="list-style-type: none"> Postnatal care 	<p><i>In-network:</i> Nothing</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> You do not need to precertify your normal delivery; 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 regular 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 and Family enrollment. 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. 	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Routine sonograms to determine fetal age, size, or sex.</i> 	<p><i>All charges.</i></p>
Family planning	
<p>Contraceptive counseling on an annual basis</p>	<p><i>In-network:</i> Nothing</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> Voluntary sterilization - tubal ligation (See Surgical procedures Section 5 (b)) Surgically implanted contraceptives Injectable contraceptive drugs (such as Depo provera) 	<p><i>In-network:</i> Nothing</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>

Family planning - continued on next page

Benefit Description	You pay
Family planning (cont.)	High Option
<p>Note: We cover oral contraceptives, contraceptive patches and rings, contraceptive diaphragms, cervical caps, and intrauterine devices (IUDs) under the Prescription Drug Benefit.</p>	<p>In-network: Nothing</p> <p>Out-of-network: 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Reversal of voluntary surgical sterilization • Genetic counseling except those services required by the United States Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). 	<p><i>All charges</i></p>
Infertility services	High Option
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: • intravaginal insemination (IVI) • intracervical insemination (ICI) • intrauterine insemination (IUI) • Fertility drugs <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p> <p>Note: See Section 5(b) <i>Surgical and anesthesia services</i> for information on surgery services related to the above treatments.</p>	<p>In-network: \$40 copayment per specialist visit</p> <p>Out-of-network: 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p> <p>Note: Injectable infertility drugs do not require an additional copayment.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: • in vitro fertilization • embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) • Services and supplies related to ART procedures • Zygote transfer • Cost of donor sperm • Cost of donor egg 	<p><i>All charges</i></p>
Allergy care	High Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>In-network: \$15 copayment per PCP office visit; \$40 copayment per specialist visit</p> <p>Out-of-network: 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p>Allergy Serum</p>	<p>In-network: Nothing</p> <p>Out-of-network: 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>

Benefit Description	You pay
Allergy care (cont.)	High Option
Note: Allergy testing and allergy serum require prior authorization.	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<i>All charges.</i>
Treatment therapies	High Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 38.</p>	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient facility</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV) / Infusion Therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: 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 <i>Other services requiring our prior approval.</i></p>	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient facility</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
Note: We cover self-administered injections and specialty drugs under the prescription drug benefit.	
Physical and occupational therapies	High Option
<p>Unlimited outpatient services and up to two (2) consecutive months per condition for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Note: Prior authorization for treatment beyond five (5) session is required.</p>	<p><i>In-network:</i></p> <p>\$40 copayment per specialist visit</p> <p>Nothing for home visits</p> <p>Nothing during covered inpatient admission</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs, lifestyle modification programs</i> 	<i>All charges</i>

Physical and occupational therapies - continued on next page

Benefit Description	You pay
Physical and occupational therapies (cont.)	High Option
<ul style="list-style-type: none"> • <i>Equipment, supplies or customized devices related to rehabilitative therapists, except those provided under Durable Medical Equipment</i> • <i>Services provided by schools or government programs</i> • <i>Developmental and Neuroeducational testing and treatment beyond initial diagnosis</i> • <i>Hypnotherapy</i> • <i>Psychological testing</i> • <i>Vocational rehabilitation</i> 	<p><i>All charges</i></p>
Cardiac rehabilitation	High Option
<p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 90 days for inpatient admission</p>	<p><i>In-network:</i></p> <p>\$40 copayment per specialist visit</p> <p>Nothing for home visits</p> <p>Nothing during covered inpatient admission</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
Speech therapy	High Option
<p>Unlimited visits for the services of:</p> <ul style="list-style-type: none"> • Qualified speech therapist <p>Note: All therapies are subject to medical necessity and require prior authorization for treatment beyond five (5) sessions.</p>	<p><i>In-network:</i> \$40 copayment per specialist visit</p> <p>Nothing for home visits</p> <p>Nothing during covered inpatient admission</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
Hearing services (testing, treatment, and supplies)	High Option
<ul style="list-style-type: none"> • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist <p>Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) <i>Preventive care, children.</i></p>	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>

Benefit Description	You pay
Vision services (testing, treatment, and supplies)	High Option
<ul style="list-style-type: none"> Medical and surgical benefits for the diagnosis and treatment of diseases of the eye <p>Note: For information on professional charges for surgery see Section 5(b) <i>Surgical and anesthesia services</i>.</p>	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p><i>Out-of-Network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<ul style="list-style-type: none"> Prescription eyeglasses or contact lenses <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p>	<p><i>In-network:</i> Member pays all charges above \$100.</p> <p><i>No Out-of-Network benefit.</i></p>

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

Benefit Description	You pay
Vision services (testing, treatment, and supplies) (cont.)	
<ul style="list-style-type: none"> Annual eye examinations 	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit and all charges over the plan's maximum allowance for a basic or comprehensive exam</p> <p><i>Out-of-Network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<ul style="list-style-type: none"> Refractions 	<p><i>In-network:</i> \$15 copayment per PCP office visit</p> <p><i>Out-of-Network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Eye exercise and orthoptics (vision therapy) Radial keratotomy and other refractive surgery, such as LASIK surgery 	<p><i>All charges</i></p>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p><i>Out-of-Network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> 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) 	<p><i>All charges</i></p>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> Artificial eyes Stump hose Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit plus an additional 10% of the cost of the device</p> <p>\$40 copayment per specialist visit plus an additional 10% of the cost of the device</p> <p><i>Out-of-network:</i>30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	High Option
<ul style="list-style-type: none"> • External hearing aids (limited to \$300 per ear every two years) • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Orthopedic devices such as braces • Band for vertical-banded gastroplasty <p>Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) <i>Surgical Procedures</i>. For information on the hospital and / or ambulatory surgery center benefits, see Section 5(c) <i>Services provided by a hospital or other facility, and ambulance services</i>.</p>	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit plus an additional 10% of the cost of the device</p> <p>\$40 copayment per specialist visit plus an additional 10% of the cost of the device</p> <p><i>Out-of-network:</i>30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Splints</i> • <i>Over-the-counter (OTC) items</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Other internal prosthetics such as heart valves, automatic implantable cardioverter defibrillator (AICD) and other implantable devices not specified above</i> • <i>Prosthetic replacements provided less than 3 years after the last one we covered</i> 	<p><i>All charges</i></p>
Durable medical equipment (DME)	High Option
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Manual hospital beds • Standard manual wheelchairs • Crutches • Walkers • Blood glucose monitors • CPAP (Continuous Positive Airway Pressure) • BIPAP (Bi-level Positive Airway Pressure) 	<p><i>In-network:</i> 20% coinsurance</p> <p><i>No out-of-network benefit</i></p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Motorized wheelchairs</i> • <i>Insulin Pumps</i> 	<p><i>All charges</i></p>
Home health services	High Option
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a 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: <ul style="list-style-type: none"> - oxygen therapy, intravenous therapy and medications - Services ordered by physician for members who are confined to the home - Nursing - Medical supplies included in the home health plan of care - Physical therapy, speech therapy, occupational therapy, and respiratory therapy <p>Note: Home Health Services require prior authorization.</p>	<p><i>In-network:</i> Nothing</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<p><i>All charges</i></p>
Chiropractic	High Option
<p>Chiropractic services - you may self refer to a participating chiropractor for up to 10 visits per calendar year. Services are limited to:</p> <ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	<p><i>In-network:</i> All charges above \$25 per visit and all charges after the 10th visit</p> <p><i>No out-of-network benefit</i></p>

Benefit Description	You pay
Alternative treatments	High Option
<i>No benefit</i>	<i>All charges</i>
Educational classes and programs	High Option
<p>Coverage is limited to programs administered through Calvo's SelectCare only:</p> <ul style="list-style-type: none"> • Cardiac risk management class • Diabetes self management • Wellness programs • Fitness program • Children's health improvement program 	<p>Some programs may have a nominal charge directly to member or may offer discounts.</p>
<ul style="list-style-type: none"> • Tobacco cessation programs including individual/group/telephone counseling and over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence • List of FDA approved cessation medications: <ul style="list-style-type: none"> - Nicotrol nasal spray - Nictrol inhaler - Chantix - Zyban - Bupropion hydrochloride - Nicorette Gum - Nicorette DS Gum - Habitrol Transdermal film - Nicoderm CQ transdermal system - Commit lozenge - Nicorette lozenge - Nicotine film - Nicotine polacrilex, gum, chewing buccal - Thrive (nicotine polacrilex) gum, chewing buccal - Nicotine Polacrilex, Trocher/Lozenge - Nicotine Patch - Varenicline 	<p>Nothing for counseling for up to two quit attempts per year</p> <p>Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence</p>

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 amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	High Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • 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; surgery to correct a condition that existed at or from birth and is a significant deviation but limited to protruding ear deformities, cleft lip, cleft palate, birth marks, and webbed fingers and toes • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications such as lymphedemas - breast prostheses and surgical bras and replacements • Surgical treatment of morbid obesity (bariatric surgery); surgery is limited to Roux-en-Y bypass and vertical banded gastroplasty 	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient surgical facility</p> <p>\$200 copayment per inpatient hospital admission</p> <p>Note: An additional 10% of the cost of a device will apply for the insertion of orthopedic or prosthetic devices. See Section 5(a) <i>Orthopedic / Prosthetic devices.</i></p> <p><i>Out-of-network:</i>30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	High Option
<ul style="list-style-type: none"> • Insertion of internal prosthetic devices . See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization - vasectomy • Treatment of burns <p>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, see Section 5(c) <i>Services provided by a hospital or other facility and ambulance services.</i></p>	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient surgical facility</p> <p>\$200 copayment per inpatient hospital admission</p> <p>Note: An additional 10% of the cost of a device will apply for the insertion of orthopedic or prosthetic devices. See Section 5(a) <i>Orthopedic / Prosthetic devices.</i></p> <p><i>Out-of-network:</i>30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> • <i>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</i> • <i>Surgeries related to sex transformation</i> • <i>Robotic surgery</i> 	<p><i>All Charges</i></p>
Oral and maxillofacial surgery	High Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • 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 	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures, such as the periodontal membrane, gingiva, and alveolar bone</i> 	<p><i>All charges</i></p>

Benefit Description	You pay
<p>Organ/tissue transplants</p> <p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, bilateral or lobar lung • Kidney • Liver • Pancreas • <u>Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis</u> • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	<p style="text-align: center;">High Option</p> <p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient surgical facility</p> <p>\$200 copayment per inpatient hospital admission</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan.</p> <ul style="list-style-type: none"> • Autologous tandem transplants for: <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myeloma (de nova and treated) - Recurrent germ cell tumors (including testicular cancer) 	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient surgical facility</p> <p>\$200 copayment per inpatient hospital admission</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description:</p> <p>Allogeneic transplants for</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin’s lymphoma (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Advanced neuroblastoma • Amyloidosis • Chronic lymphocytic leukemia/small lymphoma (CLL/SLL) 	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient surgical facility</p> <p>\$200 copayment per inpatient hospital admission</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> • Hemoglobinopathy • Infantile malignant osteoporosis • Kostman's syndrome • Leukocyte adhesion deficiencies • Marrow failure and related disorders (i.e. Fanconi's PNH, Pure red cell aplasia) • Mucopolysaccharudosis (e.g. Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharudosis (e.g. Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) • Myelodysplasia/Myelodysplastic syndromes • Myeloproliferative disorders • Paroxysmal Nocturnal hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Sickle cell anemia • X-linked lymphoproliferative syndrome <p>Autologous transplants for:</p> <ul style="list-style-type: none"> • Acute lymphocytic or nonlymphocytic (i.e. myelogenous) leukemia • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) • Amyloidosis • Breast cancer • Ependyoblastoma • Ewing's sarcoma • Medulloblastoma • Pineoblastoma • Neuroblastoma • Waldenstrom's macroglobulinemia 	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient surgical facility</p> <p>\$200 copayment per inpatient hospital admission</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p>Blood or marrow stem cell transplants (not subject to medical necessity):</p> <p>Allogeneic transplants for :</p> <ul style="list-style-type: none"> • Pagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) <p>Autologous transplants for:</p>	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient surgical facility</p> <p>\$200 copayment per inpatient hospital admission</p>

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> • Multiple myeloma • Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors 	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient surgical facility</p> <p>\$200 copayment per inpatient hospital admission</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p>Blood or marrow stem cell transplants (not subject to medical necessity, but may be limited to clinical trials):</p> <p>Autologous transplants for:</p> <ul style="list-style-type: none"> • Epithelial ovarian cancer • Childhood rhabdomyosarcoma • Advanced Ewing sarcoma • Advanced Childhood kidney cancers • Mantle Cell (non-Hodgkin lymphoma) 	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient surgical facility</p> <p>\$200 copayment per inpatient hospital admission</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p>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.</p> <p>Allogeneic transplants for:</p> <ul style="list-style-type: none"> • Acute lymphocytic or nonlymphocytic (i.e. myelogenous leukemia) • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Amyloidosis • Chronic lymphocytic leukemia/small lymphoma (CLL/SLL) • Hemoglobinopathy • Marrow failure and related disorders (i.e. Faconi's PNH, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic syndromes • Paroxysma Nocturnal Hemoglobinuria • Severe or very severe aplastic anemia <p>Autologous transplants for:</p>	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient surgical facility</p> <p>\$200 copayment per inpatient hospital admission</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> • Acute lymphocytic or nonlymphocytic (i.e. myelogenous) leukemia • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) • AL Amyloidosis • Multiple myeloma (de novo and treated) • Neuroblastoma • Recurrent germ cell tumors (including testicular cancer) 	<p>High Option</p> <p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient surgical facility</p> <p>\$200 copayment per inpatient hospital admission</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p>These blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols:</p> <p>Limited Benefits:</p> <ul style="list-style-type: none"> • Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved the Plan's medical director in accordance with the Plan's protocols • Bone marrow stem cell donor search and testing for compatible unrelated donors up to \$15,000 per procedure at a National Preferred Transplant Facility when the member is the intended recipient • Transportation, food and lodging - if the member lives over 60 miles from the transplant center and the services are pre-authorized by us: <ul style="list-style-type: none"> - Transportation limited to the member and one escort to a National Preferred Transplant Network or other Company Approved transplant facility - Lodging and food; member receives a \$125 allowance per day for housing and food. This allowance excludes liquor and tobacco. • Allogeneic transplants for <ul style="list-style-type: none"> - 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 	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient surgical facility</p> <p>\$200 copayment per inpatient hospital admission</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>

Organ/tissue transplants - continued on next page
High Option Section 5(b)

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> - Multiple myeloma - Multiple sclerosis - Sickle cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for: <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e. myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic leukemia/small lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocyte - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MPDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous transplants for: <ul style="list-style-type: none"> - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Childhood rhabdomyosarcoma - Advanced Ewing sarcoma - Advanced Childhood kidney cancers - Chronic myelogenous leukemia - Chronic lymphocytic leukemia/small lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle cell (non-Hodgkin's lymphoma) - Multiple sclerosis 	<p><i>In-network:</i></p> <ul style="list-style-type: none"> \$15 copayment per PCP office visit \$40 copayment per specialist visit \$100 copayment for outpatient surgical facility \$200 copayment per inpatient hospital admission <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> - Scleroderma - Scleroderma-SSc (severe, progressive) - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis 	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient surgical facility</p> <p>\$200 copayment per inpatient hospital admission</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	<p><i>All Charges</i></p>
Clinical Trial Coverage	High Option
<ul style="list-style-type: none"> • Routine patient costs for individual participation in phase I, II, III, IV clinical trials conducted to prevent, detect, or treat cancer is federally funded ; conducted under the investigational new drug application reviewed by FDA; or conducted as a drug trial exempt from the requirement of an investigational new drug application 	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient surgical facility</p> <p>\$200 copayment per inpatient hospital admission</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<ul style="list-style-type: none"> • Routine patient costs for individual participation in phase I, II, III, IV clinical trials conducted to prevent, detect, or treat life-threatening diseases or conditions that are federally funded ; conducted under the investigational new drug application reviewed by FDA; or conducted as a drug trial exempt from the requirement of an investigational new drug application 	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit;</p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient surgical facility</p> <p>\$200 copayment per inpatient hospital admission</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<ul style="list-style-type: none"> • If member is 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, hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. If Plan determines that additional services are medically necessary, the Plan will cover some extra costs, such as additional tests that a patient may need as part of the trial but not as part of the patient's routine care (if it is not provided by the clinical trial). 	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit</p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient surgical facility</p> <p>\$200 copayment per inpatient hospital admission</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>

Benefit Description	You pay
Anesthesia	High Option
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Office 	<p><i>In-network:</i> Nothing</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges.</p>

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).

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 Option
<p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	<p><i>In-network:</i> \$200 copayment per inpatient hospital admission</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • 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 	<p><i>In-network:</i> Nothing</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Any hospitalization for dental procedures</i> • <i>Blood and blood products, whether synthetic or natural</i> • <i>Custodial care</i> • <i>Internal prosthetics, except for those covered under Prosthetics and Orthopedic devices</i> • <i>Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home</i> 	<p><i>All Charges</i></p>

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	High Option
<ul style="list-style-type: none"> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> • <i>Take home items</i> 	<i>All Charges</i>
Outpatient hospital or ambulatory surgical center	High Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, 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 <p>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.</p>	<p><i>In-network:</i></p> <p>\$15 copayment per PCP office visit \$40 copayment per specialist visit \$100 copayment for outpatient surgical facility</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<i>Not covered: Blood and blood products whether synthetic or natural</i>	<i>All charges</i>
Extended care benefits/Skilled nursing care facility benefits	High Option
<p>Skilled nursing facility (SNF):</p> <p>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:</p> <ul style="list-style-type: none"> • 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 	<p><i>In-network:</i> Nothing up to 100 days per plan year</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Care beyond 100 days per plan year</i> 	<i>All Charges</i>

Benefit Description	You pay
Hospice care	High Option
<p>Supportive and palliative care for a terminally ill member is covered in the home 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.</p> <p>Services include:</p> <ul style="list-style-type: none"> • Inpatient and outpatient care • Family counseling 	<p><i>In-network:</i> Nothing</p> <p><i>No out-of-network benefit</i></p>
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<p><i>All Charges</i></p>
Ambulance	High Option
<p>Emergency ambulance service</p>	<p><i>In-network:</i> Nothing</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Non-emergency ground ambulance services</i> 	<p><i>All charges</i></p>

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.

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?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

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 within 48 hours unless it was not reasonably possible to do so.

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 an urgent care center.

Emergencies outside our service area: If you receive emergency or urgency care outside our service area, you must contact the Calvo's SelectCare Customer Service department at 671-477-9808 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.

Benefit Description	You pay
Emergency within our service area	High Option
<ul style="list-style-type: none"> • Emergency care at a doctor's office 	\$15 copayment per emergency room visit
<ul style="list-style-type: none"> • Emergency care at an urgent care center 	\$15 copayment per emergency room visit
<ul style="list-style-type: none"> • Emergency care as an outpatient at a hospital, including doctor's services 	\$100 copayment per emergency room visit
<p>Note: We waive the ER copay if you are admitted to the hospital.</p>	
<p><i>Not covered: Elective care or non-emergency care</i></p>	<p><i>All Charges</i></p>

Benefit Description	You pay
Emergency outside our service area	High Option
<ul style="list-style-type: none"> Emergency care at a doctor’s office 	\$50 copayment per emergency room visit
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$50 copayment per emergency room visit
<ul style="list-style-type: none"> Emergency care as an outpatient at a hospital, including doctor's services 	\$200 copayment per emergency room visit
<p>Note: We waive ER copay if you are admitted to the hospital.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>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</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All Charges</i>
Ambulance	High Option
<p>Emergency ambulance service</p> <p>Note: See 5(c) for non-emergency service.</p>	<p><i>In-network:</i> Nothing</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Air ambulance</i> <i>Non-emergency ground ambulance services</i> 	<i>All Charges</i>

Section 5(e). Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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.
- 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.

YOU MUST GET PREAUTHORIZATION OF THESE SERVICES. See the instructions after the benefits description below.

Benefit Description	You pay
Mental health and substance abuse benefits	High Option
<p>When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<p>Diagnosis and treatment of psychiatric conditions, mental illness or mental disorders, services include:</p> <ul style="list-style-type: none"> • Diagnostic evaluation • 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 alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy 	<p><i>In-network:</i></p> <p>\$40 copayment per specialist visit</p> <p>\$100 copayment for outpatient facility per visit</p> <p><i>Out-of-network:</i> 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services we have not approved.</i> • <i>Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary.</i> 	<p><i>All Charges</i></p>

Mental health and substance abuse benefits - continued on next page

Benefit Description		You pay
Mental health and substance abuse benefits (cont.)		High Option
<p>Note: 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 plan in favor of another.</p>		<i>All Charges</i>
Preauthorization	To be eligible to receive these benefits you must obtain a treatment plan and follow all network authorization processes.	
Limitation	We may limit your benefits if you do not obtain a treatment plan.	

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.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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 must write the prescription – or – A plan physician or licensed dentist must write the prescription. 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 may fill the prescription at a plan pharmacy or by mail. We pay a higher level of benefits when you use a network pharmacy. – or – 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 pre certification. 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 Dispense 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 preauthorization.
- 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 ophthalmic medication, or topical ointments or creams). Call 1-800-361-4542 for mail order customer service. You pay two (2) copayments for a 90-day supply of medication through mail order.

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.informedrx.com

Benefit Description	You pay
Covered medications and supplies	High Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Disposable needles and syringes for the administration of covered medications; lancets 	<p>Retail Pharmacy (30 day supply)</p> <p>\$10 for Generic Formulary \$15 for Brand Maintenance \$25 for Brand Formulary 50% of AWP for Non-Formulary \$100 for Specialty Drugs</p> <p>Mail Order (90 day supply)</p> <p>\$0 for Generic Formulary \$0 for Brand Maintenance \$0 for Brand Formulary \$100 for Non-Formulary 20% coinsurance of AWP for Specialty Drugs</p> <p>Note: If there is no generic equivalent available, you will still have to pay the non-formulary copayment.</p>
<ul style="list-style-type: none"> • Women's contraceptive drugs and devices (injectable and implantable contraceptive drugs are covered under <i>Family Planning</i>) 	<p>In-network: Nothing</p> <p>Out-of-network: 30% coinsurance of eligible charges and any difference between eligible charges and billed charges</p>
<ul style="list-style-type: none"> • Growth hormone 	<p>\$5 each</p>
<ul style="list-style-type: none"> • Drugs for sexual dysfunction are covered when Plan criteria is met • Oral fertility drugs 	<p>50% per prescription unit or refill up to the dosage limits and all charges above that limit</p>
<p>Note: Over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Drugs or substance not approved the Food and Drug Administration (FDA)</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Weight loss medications including anorexients, anti-obesity agents, appetite suppressants or anoerxiogenic agents</i> • <i>Non-prescription medicines</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> 	<p><i>All Charges</i></p>

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	High Option
<ul style="list-style-type: none">• <i>Replacement of lost, stolen or destroyed medication</i>	<i>All Charges</i>

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 services. However, the Plan does have a calendar year deductible of \$500 for Self Only and \$1,500 for family enrollment for out-of-network covered 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 Option
<p>Preventive services listed below:</p> <ul style="list-style-type: none"> • 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) • Treatment plan • X-rays (bite wing) • X-rays (full mouth, once every three years) 	<p>Nothing</p>
<p>We have no other dental benefits.</p>	

Section 5(h). Special features

Feature	Description
<p>Flexible benefits option</p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • 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 an extension of the time period, but regular contract benefits will resume if we do not approve your request. <p>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).</p>

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.

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 Discounts	Discounts at partner fitness facilities (for subscriber only)

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 *Emergency services/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 related to sex transformations;
- 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.

Section 7. Filing a claim for covered services

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 emergency 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. Physicians 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 – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name and ID number;
- Name and address of the physician 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;
- 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 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 health care 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 health care 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 be able to 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 visit www.calvos.net.

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 decision will not afford deference to the initial decision and will be conducted by a Plan representative who is neither the individual who make the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

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.

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

3

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 to file a disputed claim with OPM. Parties acting as your 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 your 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.

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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 sue. 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 sue 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 hasten 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 eligibility 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 health care 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 the NAIC web site at <http://www.NAIC.org>.

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 health care 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

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

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, 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

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.

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.

Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within eight months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **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 payer – We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other health care professionals.

We do not waive any costs if the Original Medicare Plan is your primary payer.

- **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 health care 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 our Medicare Advantage plan:

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), but 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 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	<ul style="list-style-type: none">• 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
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 20.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., coinsurance/copayments) for covered care you receive.
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	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 20.
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
Health care 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: <ul style="list-style-type: none">• 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:
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.

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 judge whether 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.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no Government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to from your salary to reimburse you for eligible dependent care and/or health care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – FSAFEDS

What is FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250. The maximum annual election for health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is \$2,500.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, 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) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files 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.

- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year) or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEXHCFSA and / or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic, evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as filling prefabricated stainless steel crowns, periodontal scaling, tooth extractions and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period for dependent children up to age 19.

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/vision and www.opm.gov/insure/dental. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337, (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help protect you from the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health conditions;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility visit www.pcip.gov and www.healthcare.gov or call 1-866-717-5826 (TTY): 1-866-561-1604.

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Summary of benefits for the High Option of Calvo's SelectCare - 2013

- **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. 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.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	<i>In-network:</i> \$15 copayment per PCP office visit; \$40 copayment per specialist visit	24
Services provided by a hospital:		
• Inpatient	<i>In-network:</i> \$200 copayment per inpatient hospital admission	45
• Outpatient	<i>In-network:</i> \$15 copayment per PCP office visit; \$40 copayment per specialist visit, \$100 copayment for outpatient surgical facility	46
Emergency benefits:		
• In-area	\$100 copayment per emergency room visit (hospital)	48
• Out-of-area	\$200 copayment per emergency room visit (hospital)	49
Mental health and substance abuse treatment:		
	Member's cost-sharing responsibilities are no greater than for other illnesses or conditions.	50
Prescription drugs:		
• Retail pharmacy (30 day supply)	\$10 copayment for Generic Formulary \$15 copayment for Brand Maintenance \$25 copayment for Brand Formulary 50% of AWP for Non-formulary \$100 copayment for Specialty Drug	53
Dental care:		
	Nothing for preventive dental care	55
Vision care:		
	<i>In-network:</i> \$15 copayment for annual eye exam	31
Protection against catastrophic costs (out-of-pocket maximum):		
	Medical - Nothing after \$2,000 for Self Only and \$6,000 for Self and Family Prescription Drugs - Nothing after \$2,000 for Self Only and \$4,000 for Self and Family	20

2013 Rate Information for Calvo's SelectCare Health Plans

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share

Guam, the Commonwealth of the Northern Mariana Islands, and the Republic of Palau

High Option Self Only	B41	184.55	61.51	399.85	133.28	40.60	46.14
High Option Self and Family	B42	424.95	221.65	920.73	480.24	174.43	186.24