CALVO'S Select Care HEALTH PLANS

## Welcome to Calvo's SelectCare!

We are committed to providing comprehensive and affordable health plans to the communities we serve. SelectCare is administered by Calvo's Insurance, Guam's oldest and largest insurance operation.

This Schedule of Benefits is a summary of your health care coverage under your plan. Please read this carefully as not all SelectCare plans are the same. For a complete and detailed description of all the benefits, limitations, terms and procedures, please refer to your policy contract. This is normally with your employer.

We also invite you to consult your Member Handbook and Provider Directory for general guidelines on how to use your plan and for information about doctors, hospitals and other medical providers which are available to you as a member under your SelectCare plan.

We want you to take full advantage of your health care coverage and stay healthy, so please call or come see us if you have any questions.

### Calvo's SelectCare Office

Corner of Rt. 4 and Chalan Santo Papa
P.O Box FJ, Hagatna, Guam 96910
Phone: (671) 477-9808
Fax: (671) 477-4141
Open 8:30 am - 5:00 pm Monday-Friday
and 8:30 am - 1:30 pm Saturday

** Off-Island Providers outside of Guam, CNMI and Micronesia are grouped into 4 categories. Access to off-island providers is limited ONLY to the category(ies) listed on this Schedule of Benefits. Please check your Member Handbook and Participating Provider Directory for a more detailed explanation. The abbreviation(s) listed mean the following:

1) COE-Phil: Centers of Excellence in the Philippines.
2) COE-US: Centers of Excellence in the United States Mainland.
3) Hawaii : Participating Providers in Hawaii
4) OPP: Other Participating Providers. Off-island providers in Asia and the U.S. including the US PPO network of Multiplan / PHCS.

**Services outside of the allowable Location Categories will be treated as Non-Participating.**

* UCR Charges are the "Usual, Customary, and Reasonable" charges of a provider for a service or supply in the geographic area where it was rendered not exceeding the amount ordinarily paid by Medicare for a comparable service or supply to their participating provider. Non-participating hospital charges will be based on Medicare's "Diagnosis Related Group" (DRG) charges paid to their participating hospitals. Drug charges are based on Average Wholesale Price (AWP) as listed on the most current Red Book published by Thomson Healthcare or other appropriate publication. Please see your Member Handbook for a more detailed explanation.

### Medical Exclusions

The following medical services and conditions are **NOT** covered by Calvo's SelectCare. You are responsible for all related charges.

- All benefits and services that are not specified as covered in this Handbook, the enclosed Schedule of Benefits or the agreement.
- All services prior to a member's start date of coverage or after a member's end date of coverage.
- Medical conditions which are noted as excluded from your policy.
- Any portion of an expense, charge or fee that exceeds the Usual, Customary, and Reasonable (UCR) expense.
- Any service, which in the judgment of Calvo's SelectCare is not medically necessary nor required.
- Air ambulance service.
- Airfare unless specifically covered under your plan.
- Allergy testing and treatment unless specifically covered under your plan.
- Amyotrophic Lateral Sclerosis (ALS) and conditions related to ALS.
- Benefits will not be paid if any material statement made in an application for coverage, in any enrollment of dependents or if any claim for benefits is false; and if the plan pays any benefits prior to learning of any such false statement, the Subscriber agrees to reimburse the plan for such payment.
- Biofeedback and other self-care or self-help training.
- All blood products except for whole blood and packed red cells.
- Care to which a member is entitled for by reason of past or present military duty.
- Care provided by local and federal government agencies or programs without cost to a member.
- Care and services for a condition for which a member is eligible for benefits under national health insurance, social security, workers' compensation or other similar law.
- Care and services normally covered by Medicare for which a member is eligible and entitled to at no cost, but has declined to enroll.

**SC-20 Plan HSA** (G23.37.24.03)

# Schedule of Benefits

## Guam Healthcare Development, Inc. (GRMC)

**January 1, 2024**

| What Calvo's SelectCare Covers… **Your Benefits** | When You Go to **Participating Providers** | When You Go To **Non-Participating Providers** |
|---|---|---|
| **Deductible per Individual (Class 1 only)** | **$1,600** | $1,600 |
| **Deductible per Family (Class 2 or Higher)** | **$4,800** | $4,800 |
| **Out-of-Pocket Maximums** | | |
| **Medical** | | |
| • Per Individual member per policy year **(Class 1 only)** | $3,600 | No Maximum |
| • Per Individual member per policy year **(Class 2 or more)** | $10,800 | No Maximum |
| **Prescription Drugs** | | |
| • Per Individual member per policy year **(Class 1 only)** | $3,600 | No Maximum |
| • Per Individual member per policy year **(Class 2 or more)** | $10,800 | No Maximum |
| **Coverage Maximums** | | |
| • Individual member total Annual Maximum | Unlimited | |
| **Off-island Providers for Services Outside of Guam, CNMI & Micronesia** Requires a Referral from your Doctor and Approval in advance from Calvo's SelectCare | Access is Limited to: **COE-Phil, COE-US, Hawaii,** | |
| **Accidental Death & Dismemberment Insurance** | $5,000 Benefit | |
| **Hospitalization & Inpatient Benefits -** Please check your Member Handbook for a more detailed explanation of the coverage provided. | | |
| • Guam, CNMI & Micronesia ** | 100% of Covered Charges after a $200 Co-Payment | 70% of UCR Charges * |
| • Centers of Excellence in the Philippines** | 100% of Covered Charges | 70% of UCR Charges * |
| • Hawaii ** | 80% of Covered Charges after a $200 Co-Payment | 70% of UCR Charges * |
| • Centers of Excellence in the U.S. Mainland ** | 100% of Covered Charges after a $200 Co-Payment | 70% of UCR Charges * |
| • Other Participating Providers (off-island)** | Not Covered | Not Covered |
| • Skilled Nursing Facility Limited to a maximum of 60 days per year | 100% of Covered Charges after a $100 Co-Payment | 70% of UCR Charges * |
| **Physician Care & Outpatient Benefits** | | |
| • Office visits, which includes Primary and Specialist Care, Laboratory and X-Ray Services | | |
| ◦ All applicable locations other than the Philippines** | $20 Co-Payment | 70% of UCR Charges * |
| ◦ Philippines** | 100% of Covered Charges | 70% of UCR Charges * |
| **Prescription Drugs** Limited to generic drugs only unless otherwise specified by your doctor | | |
| • Formulary Generic Drugs (per prescription unit) | $10 Co-Payment | 80% of AWP * |
| • Formulary Brand Name Drugs (per prescription unit) | $20 Co-Payment | 80% of AWP * |
| • Non-formulary Brand Name Drugs (per prescription unit) | Not Covered | Not Covered |
| • Mail Order Drugs (Excluding Non-Formulary or Specialty Drugs) | $0 Co-payment | Not Covered |
| • Prescription Drugs acquired in the Philippines Limited to a 30 day supply; Co-insurance does not apply towards your Out-of-Pocket Maximum | 80% of AWP* Treated as a Participating Provider | |
| • Specialty Drugs (per prescription unit) (Pre-Certification Required) | 80% of AWP* with a maximum of $400 co-insurance per fill | Not Covered |
| **Preventive Services & Well-baby Care** (for children up to age of 2) - Limited to one service per Plan Year– Outpatient Only Deductible and Co-payments do not apply to this benefit. Covered in accordance with the U.S. Preventive Services Task Force Guidelines with recommendation of Grades A or B. Including Recommended Immunizations. | | |
| • Guam, CNMI & Micronesia ** | 100% of Covered Charges | Not Covered |
| • Centers of Excellence in the Philippines** | 100% of Covered Charges | Not Covered |
| • Hawaii and Other Participating Providers (off-island)** | Not Covered | Not Covered |
| **Additional Coverage / Conditions / Limitations** | | |
| • Hyperbaric Oxygenation Limited to an annual maximum of: $10,000 (Pre-Certification Required) | 80% of Covered Charges | Not Covered |
| • Implantable Defibrillator (Pre-Certification Required) | 80% of Covered Charges | Not Covered |
| • Vision Coverage limited to a maximum of $150 per Policy Year. | $0 Co-payment | Not Covered |
| • Allergy Testing and Treatment Annual Max. $500 | $5 Co-Payment | Not Covered |
| • Sleep Medicine based on medical necessity Annual Max. $5,000 | 80% of Covered Charges | Not Covered |
| • Occupational Therapy limited to 10 visits per policy year. | 80% of Covered Charges | Not Covered |

**Medical Exclusions (continued)**

- Care or services furnished by members of your immediate family or household, except when furnished by a duly licensed medical practitioner employed by a health care provider.
- Charges that would have not been made if no coverage existed or charges that a member is not required to pay.
- Charges for organ transplant in which the member is the donor.
- Chronic brain syndrome or custodial care resulting from senile deterioration.
- Care which is primarily for rest cures, custodial, domiciliary or convalescent care.
- Chronic Orthopedic Conditions or Deformities unless specifically covered under your plan.
- Circumcision of adults for cosmetic or religious purposes.
- Damages or any expenses due to the negligence or other wrongful act or omission of any physician, hospital, hospital employee or other provider, or for any act or omission of any member.
- Dental care including any treatment in connection with mouth conditions due to abscess, periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar process, or gingival tissue or any dental care or treatment ordinarily performed by a dentist. This exclusion does not apply:
  - To oral surgery due to accidental injury to your natural teeth or jaw. Treatment of accidental injuries is limited to treatment that will alleviate acute symptoms and does not include any definitive restorative treatment such as crowns and bridgework, dentures, amalgam or acrylic restorations.
  - If coverage is provided by an accompanying SelectCare Dental Plan.
- Elective cosmetic surgery or procedures, including the treatment for acne.
- Emergency treatment provided outside the service area if the need for the care could have been foreseen before departing the service area.
- Experimental medical, surgical and other health care procedures and services related thereto. Procedures and services not covered by Medicare are considered experimental.
- Eye refractions and the purchase or fitting of eyeglasses. This exclusion does not apply if coverage is provided by an accompanying SelectCare Vision Plan or unless specifically covered under your plan.
- Vision correction procedures including but not limited to the use of surgery, lasers, radiofrequency or implants.
- Fertility and infertility procedures, including artificial insemination, in -vitro fertilization and embryo transfers, reversal of sterilization, and treatment or correction of infertility.
- Gastric bypass, stapling, or reversal; surgical correction of obesity.
- Hearing aids or hearing aid evaluations except as mandated by law.
- Hyperbaric Oxygen (HBO) treatment unless specifically covered by your plan.
- Implants, except for cardiac pacemakers and breast prosthesis in accordance with W.H.C.R.A. of 1998.
- Injuries sustained in the commission of an illegal act including, but not limited to drunk driving.
- Injuries sustained while participating in hazardous sports such as off-road racing and skydiving.
- Injuries or illnesses due to acts of war, declared or undeclared.
- Self-inflicted injuries or illness while sane or insane including injury or illness due to attempted suicide.
- Interrupted pregnancy (non-medically necessary); non life-threatening abortions unless medically necessary.
- Medical services provided through a telephone conference or interview during which the member is not seen for treatment.
- Nasal reconstruction except to correct a deformity due to:
  - Accidental injury, which occurred within 90 days of the date of surgery; or
  - The removal or treatment of cancer of the nose.
- Non-emergency ground ambulance service.
- Non-medical expenses including, but not limited to, living expenses, state/local taxes, transportation, hotel rooms, finance or interest fees.
- Personal comfort items such as, but not limited to, telephone, television, guest trays, electrical power, water and disposal systems, baths and pools or their installation.
- Non-medical treatment of obesity (e.g. camps, dietary or exercise counseling for weight control).
- Orthopedic and external prosthetic devices including, but not limited to intraocular lenses, artificial joints and limbs.
- Orthotic supplies and orthopedic appliances except for plaster and fiberglass casts.
- Over-the-counter drugs for which a prescription from a licensed physician is not required under U.S. Federal law.
- Physical exams required for insurance, schooling, government licensing, sports, or for obtaining or continuing employment.
- Long-term physical therapy and rehabilitation.
- Excluded Pre-existing conditions, if you belong to group with under 20 employees. Some pre-existing conditions, which are approved for coverage, may not be covered until your policy has been in force for 18 months.
- Temporomandibular (jaw) Joint Disorder (TMJ) and related diseases.
- Transsexual surgery and related services.
- Treatment, services and supplies related to sexual dysfunction.
- Treatment, services and supplies related to sleeping disorders.
- Treatment of end-stage renal disease, and hemodialysis.
- Treatment related to Tuberculosis.
- Robotic Surgery

| What Calvo's SelectCare Covers… **Your Benefits** | When You Go to **Participating Providers** | When You Go To **Non-Participating Providers** |
|---|---|---|
| **Airfare Benefit**<br>For members who meet qualifying conditions, Calvo's SelectCare provides roundtrip airfare. Requires prior approval by the Plan | Covered | Not Covered |
| **Alcohol/Substance Abuse Treatment**<br>Limited to an annual maximum of: **$8,000** | $20 Co-Payment | Not Covered |
| **Blood & Blood Derivatives**<br>Plan covers the cost, storage and administration of only whole blood and packed red cells. | 80% of Covered Charges | 70% of UCR Charges * |
| **Breast Reconstructive Surgery**<br>Coverage is limited to the requirements of the 1998 Women's Health and Cancer Rights Act. Please refer to your Member Handbook for details. | 80% of Covered Charges | 70% of UCR Charges * |
| **Chiropractic / Acupuncture Care**<br>Limited to an annual maximum (for both) of: **#300** | $20 Co-Payment | 70% of UCR Charges * |
| **Chronic Orthopedic Conditions**<br>Limited to an annual maximum of: **$2,000** | $20 Co-Payment | 70% of UCR Charges * |
| **Congenital Diseases Coverage**<br>Limited to an annual maximum of: **$15,000** | 80% of Covered Charges | 70% of UCR Charges * |
| **Diagnostic Testing - Pre-Certification Required**<br>Inclusive of the following: MRI, CT scan, and other diagnostic procedures (Limited to one test per year per anatomical region); Nuclear Medicine Testing; Audiological Testing. | 80% of Covered Charges | 70% of UCR Charges * |
| **Durable Medical Equipment (DME)**<br>Pre-Certification Required | 80% of Covered Charges | Not Covered |
| **Emergency / Urgent Care Benefits** | | |
| • Urgent Care Center | $20 Co-Payment | 70% of UCR Charges * |
| • Hospital Emergency Room, physician services, laboratory, x-rays | $100 Co-Payment | $100 Co-Payment* |
| • Emergency Ambulance Services (ground transportation only) | $50 Co-Payment | 70% of UCR Charges * |
| **Non-Emergency Treatment** in a Hospital Emergency Room<br>Co-insurance does not apply to your Out-of-Pocket Maximum | 60% of Covered Charges | Not Covered |
| **Home Health Care** | $20 Co-Payment | 70% of UCR Charges * |
| **Hospice Care -** Limited to daily maximum of: **$150** | $20 Co-Payment | 70% of UCR Charges * |
| **Injections** (other than Recommended Immunizations) | $20 Co-Payment | 70% of UCR Charges * |
| **Maternity Care** | | |
| • Pre-natal Visits & Routine Labs (per USPSTF guidelines) | 100% of Covered Charges | 70% of UCR Charges * |
| • First OB Ultrasound (subsequent Ultrasounds are treated as Diagnostic Testing above) | $20 Co-Payment | 70% of UCR Charges * |
| • Delivery at a Hospital | As per Hospitalization & Inpatient Benefits | 70% of UCR Charges * |
| • Delivery at a Birthing Center | $20 Co-Payment | 70% of UCR Charges * |
| **Mental Health Outpatient Care**<br>Groups under 50 Employees are limited to 10 visits per year.<br>Limited to an annual maximum of: **$25,000** | $20 Co-Payment | Not Covered |
| **Organ Transplants**<br>Limited to an annual maximum of: **$50,000** | 80% of Covered Charges | Not Covered |
| **Outpatient Surgery** (Pre-Certification Required)<br>Including Tubal Ligation and Vasectomy | | |
| • All applicable locations other than the Philippines** | $20 Co-Payment | 70% of UCR Charges * |
| • Philippines** | 100% of Covered Charges | 70% of UCR Charges * |
| **Physical Therapy** (Pre-Certification required for over 3 visits)<br>Limited to a maximum of 20 visits per year | | |
| • All applicable locations other than the Philippines** | $20 Co-Payment | 70% of UCR Charges * |
| • Philippines** | 100% of Covered Charges | 70% of UCR Charges * |
| **Radiation and Chemotherapy** (Pre-Certification Required)<br>Limited to an annual maximum (for both) of: N / A | 80% of Covered Charges | 70% of UCR Charges * |
| **Speech Therapy**<br>Limited to $20 per each 2-hour max. session and limited to a max. of 20 sessions per year. Max. of 100 sessions | $20 Co-Payment | Not Covered |