Provider Manual

December 2019

TOKIO MARINE PACIFIC
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ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

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CALVO'S Select Care HEALTH PLANS

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Section 1: General Information

Introduction

Welcome to Calvo's SelectCare. We are pleased to have you in our network of providers and look forward to a long, mutually satisfying relationship.

Calvo's SelectCare is underwritten by Tokio Marine Pacific Insurance, Ltd. (TMPI) and provides services to the population of the Guam, the Commonwealth of the Northern Mariana Islands (CNMI) and the Republic of Palau under the brand "Calvo's SelectCare Health Plans".

This manual is designed as a reference source to conduct any interactions and transactions with us in the most efficient manner possible. If you have any questions about the information or material in this manual or about any of our policies or procedures, please do not hesitate to contact the Provider Relations Department.

We greatly appreciate your participation in our program and the care you provide to our Members.

Important Information Regarding the Use of this Guide
In the event of a conflict or inconsistency between any regulatory requirements and this manual, the provisions of the regulatory requirements will control, except with regard to benefit contracts outside the scope of that regulatory requirement. Additionally, in the event of a conflict or inconsistency between your contractual agreement and this manual, the provisions of your contract will control.

Key Contact Information

Our lines are open weekdays from 8:30 a.m. to 5:30 p.m. Please have the following information available when you call:

- Your Tax Identification Number (TIN)
- Your patient's identification number (if applicable)

Department	Information
Claims	Adjustment of claim Claim denials (i.e., no referral, duplicate) Claim status Coding questions Prior claims balances
Coordination of Benefits	Coordination of benefits Overpayments and subrogation
Customer Service	Member benefits Member eligibility
Provider Relations	Adding or deleting a Provider from billing group Change in provider information Fee schedule requests Administrative policies/ procedures Participating Provider Agreement and Addendums questions Change of Provider Status Claims reconciliations/appeals status
Utilization Management	Coordination of off-island care Prior authorization/ precertification status

Contact Information:

Guam

Physical Address
115 Chalan Santo Papa
Hagatna, Guam 96910

Mailing Address
P.O. Box FJ
Hagatna, Guam 96932

Phone: (671) 477-9808

Fax: (671) 477-4141

Saipan

Physical Address
Oleai Center Bldg, San Jose
Saipan, MP 96950

Mailing Address
P.O. Box 500035
Saipan, MP 96950

Phone: (670) 234-5690/9

Fax: (670) 234-5696

Section 2: Member Related Information

Customer Service Department

The Customer Service Department is available for members and providers and to respond to questions about benefits, policies and procedures. Customer Service Representatives are available each business day from 8:30am to 5:30pm to assist with the following types of questions:

- Eligibility for benefits
- Approval of non-emergency services
- Member requests for PCP changes
- Complaints or grievances

Member Rights, Responsibilities and Protections

Calvo's SelectCare is dedicated to the care and customer service to our members. As a contracted provider, please familiarize yourself and your staff with the following members' rights, responsibilities and protections to provide the best possible care. Calvo's SelectCare and contracted providers will comply with all requirements concerning member rights. You are encouraged to post these (or other authorized) Member Rights, Responsibilities and Protections in a conspicuous location, or provide a copy to Members, upon request. If there are any questions, please call Member Services.

Members of Calvo's SelectCare HMO or PPO Plans have the following rights:

Information

- Know the names and qualifications of health care professionals involved in your medical treatment.
- Get updated information about the services covered and any limitations or exclusions
- Know how your plan decides what services are covered.
- Get information about copayments and fees that you must pay.
- Get updated information about providers that participate in the plan.
- Get information on how to file a complaint or appeal with the plan.
- Know how the plan pays for service to in-network and out-of-network health care professionals
- Receive information from health care professionals about your medications, how to take them, and possible side effects.
- Receive information from health care professionals about any proposed treatment or procedure, as you may need in order to consent to or refuse a course of treatment. Except during an emergency, this information should include a description of the proposed procedure or treatment, the potential risks and benefits involved, any alternate course of treatment (even if not covered) or non-treatment and the risks involved in each, and the name of the health care professional who will carry out the procedure or treatment.
- Be informed by participating health care professionals about continuing health care requirements after you are discharged from inpatient or outpatient facilities.
- Be informed if a health care professional plans to use an experimental treatment or procedure in your care. You have the right to refuse to participate in research projects.
- Receive an explanation about non-covered services.
- Receive a prompt reply when you ask the plan questions or request information.
- Receive a copy of the plan's Member Rights and Responsibilities Statement.

Access to care

- Obtain primary and preventive care from the primary care physician you chose from the plan's network.
- Change your primary care physician to another available primary care physician who participates in the plan.

- Get necessary care from participating network specialists, hospitals and other health care professionals.
- Get referrals to participating network specialists who are experienced in treating your chronic illness.
- Be advised by your health care professionals on how to schedule appointments and get health care during and after office hours. This includes continuity of care.
- Be told how to get in touch with your primary care physician or a back-up physician 24 hours a day, every day.
- Call 911 (or any available emergency response service) or go to the nearest emergency facility when you have a medical condition with acute symptoms that are severe enough that a prudent layperson, who has average knowledge of health and medicine, could reasonably expect the lack of immediate medical attention to result in serious danger to the person's health.
- Receive urgently needed medically necessary care.

The freedom to make decisions

- Use these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, genetic information, or source of payment for your care.
- Have any person who has legal responsibility to make medical care decisions for you make use of these rights on your behalf.
- Refuse treatment or leave a medical facility, even against the advice of doctors (providing you accept responsibility and the consequences of the decision).
- Complete an Advance Directive, Living Will or other directive and give it to your health care professionals.
- Know that you or your health care professional cannot be punished for filing a complaint or appeal.

As member of the Calvo's SelectCare HMO or PPO Plans you have the following responsibilities:

Member responsibilities

- To provide complete and accurate information to the best of your ability about your health, medications (including over-the-counter products and dietary supplements), and any allergies and sensitivities.
- Agree to follow the treatment plan prescribed by your provider and to participate in your care.
- Inform the provider about any living will, medical power of attorney, or other directive that could affect your care.
- Accept personal financial responsibility for any charges not covered by insurance, if applicable.
- Treat all health care providers, staff, and others respectfully.
- To become familiar with your coverage and the rules that must be followed to get care as a member.

You can request a copy of this Statement of Rights and Responsibilities by calling Calvo's Customer Service Department.

Member Identification Cards

Calvo's SelectCare Members should receive a new Membership Identification (ID) card prior to his/her effective date. However, if a Member does not receive an ID card prior to their effective date, you can access Member eligibility information by using the Faxback system, online web portal or contacting the Customer Service Department.

The ID card does not guarantee eligibility. It is for identification purposes only. Eligibility must be verified each time services are received. Most recent Member eligibility information can be accessed as indicated above. This procedure is essential because:

- Member may no longer be eligible
- Benefits may change
- Fraudulent use may occur

Steps to Verify Eligibility

- Ask Members to present their Calvo's SelectCare ID card.
- If unable to determine eligibility by Member ID, please use the faxback or web portal.
- If unable to determine eligibility via faxback or web portal contact the Customer Service Department.

Faxback to Verify Member Eligibility

Providers may utilize the Faxback system to verify Member's Eligibility and Benefits. Provider should send his/her request for set-up via email to providers@calvos.com. Please indicate the following information in your request:

1. Provider/ Clinic Name
2. Phone Number
3. Number of the fax machines you intend to use and the fax number for each machine
4. Which benefit category your clinic provides (i.e. Medical, Dental and/or Vision)

The Provider Relations Department will process the request and assign a unique Provider Number for each fax machine and benefit category you intend to use. If your clinic provides all three benefit categories and you have one fax machine, you will need three Provider numbers.

Should you change fax numbers or need to make any changes to the information assigned to your Provider Number, please send a written notification to our Provider Relations Department via fax at 477-4141 or email to providers@calvos.com.

Instructions:

- **Guam Providers:** Dial (671) 472-6826 and listen to the auto attendant.
- **CNMI Providers:** Dial (670) 234-2586 and listen to the auto attendant.
- Enter your 4-digit Provider number.
- You will need to enter the **Subscriber's/ Dependent's 12 Digit Member Number or 9 Digit Social Security Number (SSN)**
  - **FOR MEMBER NUMBERS:** Enter the 12 digit subscriber Member number, including any leading zeros (i.e. 00111 00111 00).
  - **For SOCIAL SECURITY NUMBERS (SSN):** Enter Member's 9 digit SSN + "**#**" (i.e. 586 99 9999 #).
- You will be able to make up to 5 Member inquiries for each phone call.
- Simply hang-up to end the call.

Additional FaxBack Information:

- If a Member's employer GROUP IS TERMINATED or your patient is not found in our system, the voice prompt will state "Invalid Entry," and you will not receive a fax message.
- If a MEMBER IS TERMINATED OR SUSPENDED, but the employer group is active, the fax output will indicate "Ineligible Member" below the Member, Coverage & Eligibility Information box. The TERMINATION DATE will be indicated within the box.
- **For Members with Dual Coverage with Calvo's SelectCare**, you may inquire on their eligibility using their Social Security Number to receive BOTH active account outputs. If you input their specific Member Number, then only that specific account coverage will be sent.

Web Portal to Verify Member Eligibility

Providers may utilize the Provider Web Portal to verify Member's Eligibility and Benefits. Instructions for signing up are below:

1. Access the **Providers** tab at www.calvos.net
2. Click **Log In** and then **Proceed to our sign up process**
3. Input your information to complete the sign up process**.**
4. An email will be sent to the website administrator to verify and approve request.
5. Once approved, you will receive an email confirmation.

Member Cost Share Responsibility

Cost-Sharing for Members

Calvo's SelectCare Members are only responsible for the costs indicated in the Schedule of Benefits (for covered services). A Participating Provider shall collect from the Member any applicable costs. Reasonable efforts to collect should include, but are not limited to, referral to a collection agency and, where appropriate, court action. Documentation of the collection efforts must be maintained and made available to the Plan upon request.

Co-payments

Calvo's SelectCare Members have no copayments for annual preventive services. For all other services, copayment varies due to Member's benefit coverage. Please utilize the faxback system, online web portal or contact the Customer Service Department to determine Member's copayment for certain services.

Non-payment of Copayment

A Participating Provider cannot refuse to provide Medically Necessary Services to a Member due to a Member's failure to pay. When a Member does not pay the applicable copayment at the time services are rendered, the physician has the following options:

- Render the service, and pursue Member payment of cost sharing at a future time.
- Reschedule the appointment (unless the visit is for urgent/emergent care). Contact the Customer Service Department for assistance if the Member refuses to pay copayments.

Coordination of Benefits

Coordination of Benefits (COB) is designed to avoid duplicate payment for covered services. COB is applied whenever the Member covered by the Plan is also eligible for health insurance benefits through another policy. The Plan recommends the copayment not be collected until the second payer has paid the claim in order to prevent a possible overpayment.

As a Participating Provider, you agree to cooperate with the Plan toward the effective implementation of COB procedures, including identification of services and individuals for which there may be a financially responsible party other than the Plan, and assist in efforts to coordinate payments with those parties.

How to file:

- When the Plan is primary, submit directly to us.
- When the Plan is secondary, submit to primary carrier first, then, submit the Explanation of Benefits (EOB) with the claim to the Plan for consideration within ninety (90) days from the receipt of payment or denial from the primary carrier. Refer to "Claims Submission Rules" in this manual.

Notice of Privacy Practices

Pursuant to regulations under the Health Insurance Portability and Accountability Act (HIPAA), all providers must provide notice of the provider's privacy practices. Providers should have such notice available at their office upon request by any member, and should post the notice in a clear and prominent location. A copy of the Notice of Privacy Practices that may be used for this purpose and is compliant with HIPAA regulations can be found in Section 12: Appendix of this manual.

Member Satisfaction

Calvo's SelectCare and its network providers are committed to providing and maintaining a consistently high level of member satisfaction. All PCPs and their office staff are expected to maintain a friendly and professional image and office environment for members, other physicians and the public. PCPs must maintain adequate levels of staff to provide for timely and effective services for Calvo's SelectCare members.

Calvo's SelectCare Health Plan conducts annual surveys to determine current levels of member satisfaction with the health plan, providers and specialists to identify areas of potential plan improvement. PCPs and their office staff are expected to cooperate and assist Calvo's SelectCare with obtaining data for these surveys. PCPs will be notified in advance of their required participation and the time frames in which the annual surveys will be conducted.

Member Grievances and Appeals

The Calvo's SelectCare Customer Service Department is responsible for receiving and resolving verbal member complaints (grievances). If the member is not satisfied with the resolution offered by Customer Service, the member may file a written grievance with the Grievance and Appeals Department. The Customer Service Department will assist members who need help in preparing a written appeal/grievance. Members must submit grievances within sixty (60) calendar days after the event that initiated the grievance:

- Matters involving a health plan provider, including complaints about the quality of services they receive.
- Delivery of care, including issues involving waiting time, physician behavior adequacy of facilities or other similar member concerns.
- Enrollment/disenrollment issues.
- Any problems involving the delivery of Plan benefits package/materials.
- Disagreement with our decision to process a request for service or to continue a service under the standard 14-day time frame rather than the expedited/72-hour time frame.
- Disagreement with our decision to process an appeal for a service request under the thirty (30) calendar day time frame rather than the expedited/72-hour time frame.

Calvo's SelectCare will take prompt, appropriate action, including a full investigation of the grievance, as expeditiously as the member's case requires, based on the member's health status, but no later than thirty (30) calendar days from the date Plan receives the grievance. The thirty (30) calendar day timeframe may be extended by up to fourteen (14) business days when a member requests the extension or if Plan justifies a need for additional information is required to properly complete review of the grievance.

Calvo's SelectCare will respond to all Expedited Grievances relating to Plan decision to extend the timeframe to make an organization determination or reconsideration or Plan refusal to grant a request for an expedited organization determination within twenty-four (24) hours.

The Calvo's SelectCare Medical Director or designee is responsible for the triage of all formal quality of care grievances to determine if there is a quality of care issue involved. All grievances identified as a

quality of care issue become the responsibility of the Medical Director. All quality related grievances are tracked by the Grievance and Appeals Department to ensure compliance with time guidelines set by statutes and/or regulatory agencies.

Appeals Process

Plan is committed to fair and accurate adjudication of appeals. Plan members, their authorized or appointed Representatives, may file a request for reconsideration (appeal) with Plan within sixty (60) calendar days from the date of receiving an adverse organization determination notice from Plan. An adverse organization determination may be a denial of a claim payment request, a denial of a request for service, or a dispute about a copayment. If a party shows good cause, Plan may extend the time frame for filing a request for reconsideration.

Calvo's SelectCare will designate someone other than the person involved in the initial denial to review the appeal request. If the original denial was based on a lack of medical necessity, the appeal decision will be made by a physician with expertise in the field of medicine that is appropriate for the services at issue.

Calvo's SelectCare will apply the prudent layperson standard in cases involving emergency services. For standard (non-expedited) appeals of service denials, Plan will decide as expeditiously as the member's health condition requires, and in no event later than thirty (30) calendar days from the date Plan receives the appeal request. For claim payment denials or copayment disputes, Plan will make its decision within sixty (60) calendar days. Calvo's may extend this time frame by up to fourteen (14) business days if Plan needs additional information and the delay is in the member's interest.

NOTE: There are special rules for "expedited appeals" where the standard timeframes for the appeals procedure would seriously jeopardize the member's life, health or ability to regain maximum function.

Calvo's Grievance and Appeals Process, including where and how to file a grievance/appeal, is described in the Member Handbook, Plan Brochure and on the Plan website.

Interpretive Services

Calvo's can arrange for an interpreter to speak to a member in any language, free of charge. A member may call Customer Service at (671) 477-9808 to inquire about interpretive services. Many doctors in Calvo's SelectCare's network speak multiple languages. A member can find out if a provider speaks their preferred language by contacting our office or by contacting the Provider's office directly.

Advance Directives

Advance Directives are written instructions that tell a member's doctor what kind of care he or she would like to have if they were in a serious medical situation that would make them unable to make medical decisions. They do not take away a member's right to decide about his or her current healthcare needs.

Advance Directives include the following:

- **Living Will** allows a member to specify or limit the kinds of life-prolonging procedures he or she would wish to receive if he or she becomes unable to make medical decisions.
- **Life Prolonging Declaration** allows a member to specify his or her wish to receive life-prolonging procedures that would extend his or her life if he or she becomes terminally ill and unable to make medical decisions.
- **Health Care Surrogate Designation** allows a member to name someone else to make health care decisions should he or she become unable to make health care decisions. The other person can be a husband, wife or friend.

- **Appointment of Durable Power of Attorney for Healthcare** allows a member to name an agent or proxy (substitute person) to make health care decisions if the time comes that he or she is unable to do so.

The Guam legislature has provided statutes governing the content and use of a living will declaration. Refer to Guam Health and Safety Code, Title 10, Div. 4, Chapter §9110 to §9117 for specific information.

Please talk with your patients about Advance Directives, provide them resources to complete an Advance Directive, and be sure you have a copy of your patients' Advance Directive documents in their medical record. To download an Advance Directive form, go to www.lifecaredirectives.com.

Section 3: Member Benefit Information

Member Benefits and Services

Calvo's SelectCare has a comprehensive benefit package available to members. For a list of covered benefits and services please refer to the appropriate Member Handbook available on the Calvo's SelectCare web site.

Pharmacy Benefit Management

Calvo's SelectCare has contracted with a national Pharmacy Benefit Manager (PBM). The PBM provides Calvo's SelectCare with a pharmacy network, pharmacy claims management services, drug formulary and pharmacy claims adjudication. Prior to authorizing any drug benefit, each member's eligibility is determined.

The Pharmacy Benefit Manager provides support for contracting, claim payments, and fees through Provider Relations at 1-800-880-1188 or email provider.relations@optum.com. Providers should contact Calvo's SelectCare directly regarding any pharmaceutical, medication administration or prescribing issues.

Each Provider will receive a copy of the Calvo's SelectCare Pharmacy Drug Formulary. The drug formulary is also available on our website. This drug formulary should be accessible and be referred to when prescribing medications for Calvo's SelectCare members. All providers must prescribe from within the drug formulary unless a drug prior authorization is obtained from Calvo's SelectCare. There are also a few specialized medications in the drug formulary identified as requiring a prior authorization.

Obtaining a Drug Prior Authorization

If a provider wishes to prescribe a drug that requires prior authorization and/or a drug is not in the drug formulary, he/she must complete a Calvo's SelectCare Pre-Certification Form. This form must be faxed to the Calvo's SelectCare Utilization Management Department at (671) 477-7304

In emergency situations, please call Calvo's SelectCare at (671) 477-9808.

Prior authorizations must be obtained before providing the member with a written prescription. If a prior authorization is not obtained in advance, the member will not be able to have the prescription filled at their pharmacy, causing a delay for the member in obtaining their medication.

Emergency Services

Definition of "Emergency"

Emergency medical conditions refers to a medical condition manifesting itself by acute symptoms, including severe pain, of sufficient severity such that, in the judgment of a reasonable lay person, the absence of immediate medical attention could be reasonably expected to result in:

- Serious jeopardy to the health of a Member;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

Procedure

Generally, a member is able to receive emergency care from a Calvo's SelectCare network hospital. However, if a member is unable to reach a plan hospital, he/she should go to the nearest hospital emergency room for treatment. Calvo's SelectCare applies the "prudent layperson" standard when determining whether claims for emergency room visits should be covered.

Reimbursement for emergency care rendered by a non-contracted hospital is based on the

requirements of the Affordable Care Act.

Follow-up Treatment
The PCP should perform or arrange follow-up evaluation and treatment required after emergency care.

Emergency Transfer
The attending physician should refer the member to a participating provider hospital if an emergency transfer is required.

Hospital Emergency Room Copayment
Most benefit plans require a copayment for using the hospital emergency room. This copayment is waived if the member is admitted as an inpatient to the hospital directly from the emergency room.

Section 4: Provider Responsibilities

Primary Care/ Managed Care

Calvo's SelectCare utilizes a Primary Care Provider (PCP) Managed Care system. In this system the PCP is responsible for the comprehensive management of each member's health care. This may include, but is not limited to, ensuring that all medically necessary care is made available and delivered, facilitating the continuity of member health care, promoting and delivering the highest quality health care. Calvo's SelectCare providers are responsible for knowing and complying with network policies and procedures.

PCP Prior Authorization and Referral Procedures

PCPs are responsible for initiating all necessary medical referrals for their assigned members. SelectCare requires specialists to communicate to the PCP regarding treatment plan and referrals to other specialists. This allows the PCP to better coordinate the member's care and ensures that the PCP is aware of the additional service request. To ensure continuity of care, every participating specialist provider must provide the referring PCP with consultation reports and other appropriate member records (i.e. test results).

Details on the procedures for prior authorizations are in Section 4 of this manual.

Medical Care Access Standards

Calvo's SelectCare recognizes that providing medical care is not always a predictable experience. Emergencies and episodic increases in the demand for services will challenge the ability of an office to meet the expectations for medical care access. However, in the normal course of providing medical care, provider offices should regularly meet these expectations.

Office Visit Appointments

Calvo's SelectCare has established the following appointment access standards for emergent, urgent and routine care:

- **Emergencies will be seen immediately;**
- **Urgent cases will be seen within 24 hours;**
- **Routine symptomatic cases will be seen within two weeks;**
- **Routine non-symptomatic cases will be seen as soon as possible.**

Office Hours and After-Hours

Calvo's SelectCare Providers are required to post hours of operation, including what a patient should do in case of needed care during 'after hours.' Provider Relations staff will review this during on-site visits.

This requirement may be met via posting hours of operation on the front door, how to contact 911, referring to the Provider's website, and using after hours messaging systems on the phone message or answering services.

Acceptable after-hours access mechanisms include:

- Answering service
- On-call beeper
- Call forwarded to physician's home or other location
- Recorded telephone message with instructions for urgent or non-life threatening conditions. Message must direct members to a practitioner

This message should not instruct members to obtain treatment at the emergency department for non-life threatening emergencies.

24-hour PCP Member Responsibility

Through practitioner agreements, Calvo's SelectCare PCPs have 24-hours a day, seven days a week responsibility and accountability to their Calvo's SelectCare members/patients.

Guidelines:

1. PCPs must be available to address member/patient medical needs on a 24-hours a day, seven days a week basis. The PCP may delegate this responsibility to another Calvo's SelectCare physician or provider on a contractual basis for AFTER-HOURS, HOLIDAY and VACATION COVERAGE.
2. If the PCP site utilizes a different contact phone number for an on-call or after-hours service, the PCP site must provide Calvo's SelectCare with the coverage information and the contact phone or beeper number. Please notify the Provider Relations Department with any changes in PCP medical care coverage.
3. PCPs may employ other licensed physicians who meet the credentialing requirements of Calvo's SelectCare for patient coverage as required and necessary. It is the responsibility of the PCP to notify Calvo's SelectCare each time a new physician is added to a PCP's practice to assure that all physician providers are credentialed to Calvo's SelectCare standards. PCPs may employ licensed/certified Physician Assistant (PA) or registered Nurse Practitioners (NP) to assist in the care and management of their patient practice. If PAs or NPs are utilized, the PCP or the designated and credentialed physician must be readily available for consultation via telephone or beeper, within a 15-minute call back time. They must also be able to reach the site where the PA or NP is within 30 minutes.
4. Non-professional healthcare staff shall perform their functions under the direction of the licensed PCP, credentialed physician, or other appropriate health care professionals such as a licensed PA or a NP.

Office Waiting Times

To assure that members have timely access to patient care and services, Calvo's SelectCare providers are expected to monitor waiting room times. PCP offices will be surveyed periodically regarding this process. Member waiting room times should be less than 30 minutes. If a longer wait is anticipated, office staff members should explain the reason for the delay and offer to book the patient for another appointment.

Facility Site Reviews

Calvo's SelectCare may conduct provider site visits for any of the following reasons:

- When a member complaint/grievance is received about the quality of a practitioner's office (physical accessibility, physical appearance or adequacy of waiting or examining room)
- Member satisfaction results indicate an office site may not meet Calvo's SelectCare standards
- Other data is required for quality improvement purposes and cannot be reasonably collected using other methods
- Other circumstances as deemed necessary

A Calvo's SelectCare staff member or a designated representative with the appropriate training will perform the site visit once the determination is made that a site visit is warranted. The representative will:

- Use a site inspection evaluation review tool that clearly defines the criteria to conduct an onsite review to address at least the following:

- Patient access, including physical access for the disabled and access to appointments and to medical advice in a timely manner;
- The office's public health policies and procedures concerning infection control, hazardous materials, and medication; and
- The office's safety standards concerning policies and procedures for fire safety, emergency procedures, laboratory, and medical equipment maintenance.

- Conduct a review of a random sample of at least one Plan member's medical record to ensure:
  - Organization, completeness, and consistency in format;
  - Evidence of proper documentation;
  - Relevant information concerning patients' history, diagnosis, treatment, and allergies;
- Provide a summary of the onsite review standards and process to provider.

Medical Records

The medical record communicates the Member's current and past health status, past medical treatments and treatment plans for future health care. Therefore, the medical record may reflect all services provided by the primary care practitioner, ancillary services, diagnostic tests, and therapeutic services that the Member receives. Sometimes medical records need to be reviewed by Calvo's SelectCare to determine claims payment. The content and quality of information documented in the medical record is important in facilitating communication, continuity and coordination of care and promoting efficiency and effectiveness of treatment. It is important that the Member's medical record be available to the practitioner at the time of the Member's appointment. The confidentiality of the medical record information must be assured.

Medical records and patient information shall be supplied at the request of the Plan or appropriate regulatory agencies as required for claims payment and medical management. The Provider is not allowed to charge the Plan or the Member for copies of medical records provided for claims payment or medical management. The Provider may charge the Member for records provided at the Member's request. **Providers are not allowed to charge the Plan or the Member for records provided when a Member moves from one primary care Provider to another.**

Medical Record Documentation Standards

Calvo's SelectCare providers must adhere to clinical record documentation standards, including the following:

- An individual clinical record is established for each person receiving care.
- Each patient record will contain sufficient information to clearly identify the patient.
- Forms requiring patient signature should be explained and signed prior to the administration of any medication.
- Each patient's record will reflect compliance with physician's orders, reflect knowledge of and adherence to Continuous Quality Improvement standards, and communicate status of patient's condition.
- Each patient's record will reflect documentation that the patient has been assessed and observed at appropriate intervals by appropriate practitioners.
- Patient records will be confidential, current, and accurate and may be used to provide legal evidence in court.
- A Problem List of past and current diagnoses is documented to facilitate on-going provision of care.
- All entries in the patient's record must be legible. They may be written or printed.
- Times of all entries in the patient's record are recorded.
- Ditto marks are not used in notations made in the patient's record.
- Only approved abbreviations are used in the patient's record.
- Erasures are not made in the patient's record.
- If an error is made in the patient's record, a single line is drawn through it, the word "error" usually written above it, and the initials of the person making the entry written next to the word "error."

- Entries in the patient's record which require a signature are signed with the person's first initial, last name, and abbreviation of title, e.g., M. McCabe, R.N.; G. Glenister, L.P.N.; P. Howard, C.S.T.; M. Glenn, S.T.
- Entries in a patient's medical record for each visit should include, but not be limited to:
    - Complete patient name, date of birth, sex, identification number, insurance, responsible party, and demographic information.
    - Date of service.
    - Chief complaint, diagnosis, or impression.
    - Medical history and physical examination prior (medical history should include prevalent diseases, chronic conditions, behavioral health, etc.).
    - Ordered diagnostic tests, laboratory and x-rays with reports when appropriate.
    - Therapies administered.
    - The presence or absence of allergies and untoward reactions to drugs and materials is recorded in a prominent and uniform location on a current basis.
    - Physician progress notes, if appropriate.
    - A complete, detailed description of clinical findings
    - All medication and treatment orders in writing and signed by the authorized party. Telephone and verbal orders are signed and dated by a legally designated person, and countersigned by the ordering practitioner in a timely manner.
    - Instructions given patient for follow-up care.
    - Missed and cancelled appointments should have follow-up documentation.
    - Any significant medical advice given to a patient by phone.
    - Discussions with the patient concerning the necessity, appropriateness, and risks of proposed treatment and treatment alternatives, if applicable
- Except when otherwise required by law, the context and format of clinical records, including the sequence of information are uniform. Records are organized in a consistent manner that facilitates continuity of care.

Clinical Record Audits

Calvo's SelectCare performs clinical record documentation audits no less than every two years. A random sample of primary care practitioners' medical records is collected and reviewed. A performance goal of 85% must be met for the Plan aggregate and individual practitioner's office performance. Results and recommendations are reported to the Calvo's Quality Improvement Committee and to individual practitioner offices. Corrective action is required for practitioner offices that score below the 85% goal.

Section 5: Provider Credentialing and Contracting

Credentialing

Credentialing is an important process Calvo's SelectCare uses to ensure we offer quality care to our members.

The Governing Body makes all credentialing and re-credentialing decisions. The Provider Relations Department coordinates this process to assist in determining, based on a practitioner's credentials, which health care practitioners are eligible to participate in Calvo's SelectCare's Participating Provider Network. Practitioners are required to complete the credentialing process, and be approved by the Governing Body, prior to treating Calvo's SelectCare members.

Credentialing is not required for practitioners who practice exclusively within the inpatient setting, such as hospital based providers, physical, speech and occupational therapists, anesthesiologists (unless they provide pain management services in their office), radiologists and pathologists.

Provider Credentialing

Practitioners wanting to participate in the Plan must contact our office at (671) 477-9808 and complete a participating provider application packet. When a decision is made to offer a practitioner an opportunity to be considered for participation, the practitioner will be contacted with further information and instructions. The application process includes submission of the following documents:

- Completed signed Preferred Provider Application and Attestation
- Letter of Intent (please indicate anticipated/ effective date of practice)
- Current state(s) license
- Current DEA (federal) certificate
- Current CSR certificate
- Current Board Certification(s) – If Applicable
- Current professional liability insurance (face sheet) – If Applicable
- Current Curriculum Vitae (CV) / Resume
- Completed W-9 Form
- Government issued picture ID
- Proposed Fee Schedule
- Authorization for Agent/Representative – If Applicable

Calvo's will verify credentials according to local and accreditation standards. This includes performing primary source verification on credentials, as applicable, such as license, schools, training / education, board certification, DEA, Medicare/Medicaid sanctions and exclusions, hospital privileges, and any other areas deemed necessary and appropriate. Peer references are verified via phone, fax or mail and made part of the credentialing packet. Further, the National Practitioner Data Bank is queried for evidence of malpractice cases. All of this information is presented to the Medical Director, Credentialing Committee (if applicable), then to the Governing Body for final determination.

The credentialing process typically takes between 90-180 business days from the time Calvo's SelectCare receives the completed application.

The completed application is presented to the Provider Relations Department, which reviews the completed file and deems it complete. If not complete, Provider Relations will contact the applicant to gather missing information.

Credentialing is for a 3 year term. Calvo's reserves the right to re-credential providers at any time during the credentialing process at its discretion.

The process for re-credentialing follows the same primary source verification as for initial credentialing with the exception of graduation from medical / dental school. Additionally, peer review data will be considered in areas such as complaints, grievances, adverse incidents, quality of care concerns, results of member satisfaction surveys, results of office site reviews (as applicable), or any other data collected during the credentialing period.

Calvo's ensures the provision of high quality care by conducting routine clinical record reviews of network providers. The clinical records may be those received in the plan's office, reviewed during a quality of care concern or adverse incident case, or during a routine provider office site visit. The results of this review are considered at time of re-credentialing.

Any issues of sub-standard performance, when identified, will be handled through a corrective action process, including implementation of appropriate interventions.

Calvo's will notify licensing and/or disciplinary bodies or other appropriate entities when a network provider's privileges are suspended and/or terminated and such notification is required. This may include notification to the National Practitioner Data Bank.

Written notification and correction of Information

If, during the process of credentialing, the Plan discovers information that varies substantially from that which was initially provided, the Plan will notify the clinician, dentist, or facility and offer an opportunity to correct the information. Responses must be made in writing to the Plan.

Once the corrected information is verified, it becomes part of the applicant's file and is maintained in the same manner as all other credentialing material. Provider(s) or Facilities have the right to review information submitted to support their credentialing application; the right to correct erroneous information; the right to be informed of their credentialing status, upon request; and the right to be informed of their rights. Please note that it is essential that you provide updated demographic information as changes occur.

Credentialing Confidentiality Policy

Access to information obtained during the credentialing process will be carefully monitored and will not be released to outside parties without permission of the practitioner involved, or as permitted by law. Access to the credentialing data in Calvo's SelectCare's provider database is limited to those with "a need to know."

An individual practitioner may request to review the information contained in his/her file. To request a review, the practitioner should contact the Provider Relations Department who will schedule an appointment.

Altering Participation Status

When a practitioner is identified with performance, license or sanction issues, the Plan has the right to restrict, suspend or terminate the practitioner's participation status. Practitioners who are subject to an adverse action will be offered an appeal of the Plan's decision.

Appeals will be presented to the Provider Relations Department for presentation to the Governing Body. The network practitioner will be given the opportunity to present evidence and discuss the adverse decision with the Department by telephone or in person. The Governing Body's decision will be by majority vote. The network practitioner will be notified by certified mail of the decision.

If the network practitioner disagrees with the decision s/he has 10 days from the date of the decision to request arbitration. A request for arbitration must be in writing. For further information, the Provider may refer to the dispute resolution found in his/her contractual agreement. At any time a practitioner's participation status changes with the Plan, the practitioner shall provide all necessary information in a timely manner to ensure continuity of care for the Members.

Change Notification

Any change in your Provider information should be reported as soon as possible. Some examples of these changes are practice location, Tax Identification Number or practice status regarding acceptance of new patients. All changes must be in writing and delivered at the Calvo's SelectCare respective address as it appears on the signature sheet of your Provider contractual agreement. Such changes can also be faxed to (671) 477-4141. For your convenience, you may also fill out the Provider Information Sheet, provided in this manual and fax or email it to the Provider Relations Department.

If terminating your participation, you must submit a termination notification to us in the time frames stated in your Provider contractual agreement. Provider Relations will work with all terminating providers to coordinate care for members in a current course of treatment. All notices must be in writing and delivered either personally or sent by certified mail with postage prepaid. If mailed, such notice shall be deemed to be delivered, when deposited in the United States mail, at the Calvo's SelectCare respective address as it appears on the signature sheet of your Provider contractual agreement.

If services covered by the contractual agreement are added or discontinued, the Provider is responsible for notifying the Plan prior to such discontinuation or addition. The Plan will review the changes requested to ensure adequacy of Member access for service. If the need for additional service exists, the Provider must comply with Plan credentialing requirements for that new service. A current Provider contractual agreement will not automatically include a new location. Each request will be evaluated on an individual basis.

Contracting

A Participating Provider Agreement will be executed between Calvo's SelectCare and the providers and that have been approved in the credentialing process. The standard agreement varies between medical, dental and hospital providers, while a Memorandum of Understanding (MOU) is usually issued regarding a Member who is receiving services at an allotted time from a specific non-participating provider. The reimbursement policy also varies depending on the specialty of the practitioner and is based on the following references:

- Medicare Physician Fee Schedule
- Wasserman's Physicians Fee Reference
- Resource-Based Relative Value Scale
- Ambulatory Surgical Center payment rates
- National Dental Advisory Service

Addendums to the Participating Provider Agreement may also be executed, upon the review and approval of the Provider Relations Department at the written request of the Provider. These addendums are typically issued regarding the addition or update of CPT/HCPCS code(s), additional physician or non-physician provider, or the provider's current reimbursement policy. Note that the Provider should include either one or all of the following with their request for an addendum:

- The exact CPT/HCPCs code(s) and the proposed fee schedule
- Invoices when negotiating the rates for injectables/ drugs
- Letter of introduction and all other documents indicated in the Provider Application Checklist, if adding a provider.

For more information on the Participating Provider Agreement, Memorandum of Understanding and Addendum, contact the Provider Relations Department.

Section 6: Claims and Billing Procedures

Calvo's SelectCare is committed to meeting the standard goal of processing claims within thirty days, but no later than forty-five (45) days of receipt. We thank you in advance for helping us process your claims efficiently and accurately by using the following procedures:

Medical/Dental Claims Format

When submitting medical/dental claims, please remember the following:

- Submit claims, alongside a transmittal and all pertinent documentation, within your contractual filing limit.
- Use HCFA/ CMS-1500, UB forms, or other mutually acceptable billing forms, making sure all information is clear and precise.
- Information should be lined up appropriately on the form when printed so nothing touches the lines on the form. Printing should not be light and characters should be clear and well-formed. This facilitates the imaging process.
- Use current and appropriate CPT procedure codes, ICD diagnosis codes, HCPCS codes, and revenue codes.
- Include a description when miscellaneous/ unspecified codes are used.
- Indicate the DRG in the appropriate box for all inpatient claims when using the UB form.
- Attach the primary insurance carrier's explanation of benefits (EOB) form, if applicable.
- Submit medical notes for the following claims:
    - All level 4 and 5 visits
    - Requiring justification for modifiers
    - Operative reports for all surgeries
    - Consisting of an injury diagnosis
- If the member's injury is due to an accident, details of the accident should accompany the claim. Additionally, ensure that all medical notes are legible to prevent claims from being rejected or denied for payment due to illegible notes.
- Note that if a patient was seen for a work-related condition, Calvo's SelectCare will not be liable for the bill.

Claims Submission Guidelines

To expedite processing and to ensure that all types of claims are processed accurately, Calvo's SelectCare requests that you do the following:

- Include the Member's current *Member identification number* in the subscriber number field.
- Put all dates of service on one claim form, not to exceed six lines, when submitting a HCFA form.
- Submit only one provider of service per claim.
- Therapy services must have individual dates of service. Date ranges cannot be used.
- Include the appropriate *Tax Identification Number (TIN).*
- Indicate the facility where services were rendered.
- Do not write on the claim form with red ink or dark highlighter.
- If a highlighter must be used, use yellow and send the *original claim.*
- If a copy must be sent, *make the copy* and then highlight with yellow.

Claim Processing Time

Please allow forty-five (45) days before inquiring about claims status. The standard turn-around time for clean claims is forty-five (45) days, measured from date of receipt.

Claims Submission Rules

Claims must be submitted no later than ninety (90) days from the date that Member receives services, except for claims for which Plan is the secondary insurer. The claims should be submitted to the following:

Mailing Address		**Physical Address**
P.O. Box FJ	OR	115 Chalan Santo Papa
Hagatna, Guam 96932		Hagatna, Guam 96910

*Failure to submit claims within the contract filing limit may result in non-payment.

Claims may also be submitted electronically. Please contact the Claims Department for more information on the Electronic claims submission process.

Coordination of Benefits (COB)

Patients may have dual coverage. For example, more than one carrier may be involved or there may be other types of coverage, such as Workers Compensation insurance. To help us determine payment responsibility, please check for the following:

Coverage	Action
Calvo's SelectCare is the secondary carrier	• Submit claim to the primary carrier first. • After the primary carrier pays, submit claim and Explanation of Benefits (EOB) to Calvo's SelectCare for consideration. • Calvo's SelectCare will allow up to ninety (90) days from payment or denial date by the other carrier, to submit a secondary claim. • Calvo's SelectCare will allow up to 18 months from the service date for claims in which Medicare is primary.
If it is unclear whether Calvo's SelectCare is the primary or secondary carrier, or if Calvo's SelectCare receives an erroneous "primary" carrier claim	• Submit the claim to both carriers. • If review shows Calvo's SelectCare is primary, we will process the claim for benefit determination. • If review shows Calvo's SelectCare is secondary, we will deny and inform you and the member that Calvo's SelectCare is not the primary carrier. We must have an EOB from the primary carrier to determine Calvo's SelectCare's liability.

Balance Billing

The balance billing amount is the difference between eligible charges and the Provider's actual charges to the patient. Calvo's SelectCare Members cannot be balance billed for covered services in accordance with any applicable Guam and federal laws.

Services to Members cannot be denied for failure to pay co-payments. If a Member requests a service that is not covered by Calvo's SelectCare, Providers should have the Member sign a release form indicating understanding that the service is not covered by Calvo's SelectCare and the Member is financially responsible for all applicable charges.

In addition, the Participating Provider Agreement further explains that Providers are prohibited from balance billing a Member for service(s) in excess of the contracted amount, other than applicable copayments, coinsurances and/or deductibles.

Span Dates

Exact dates of service are required when the claim spans a period of time. Please indicate the specific dates of service in Box 24 of the HCFA/CMS 1500, Box 45 of the UB-04, or the Remarks field.

Effective Date / Termination Date

Coverage will be effective on the date the Member is effective with the Plan. Coverage will terminate on the date the Member's benefit plan terminates with the Plan. If a portion of the services or confinement takes place prior to the effective date or after the termination date, an itemized split bill will be required. Please be aware that effective dates for Members can be revised. Provider should verify eligibility at each visit to ensure coverage for services. For more information on determining member's eligibility, refer to the identification cards/ eligibility verification and faxback sections in this manual.

Locum Tenens

In instances when a network physician has a locum tenens covering for a short period of time, i.e. less than ninety (90) days, it will be the Provider's responsibility to notify the Plan and to ensure appropriate licensure and other pertinent information is validated prior to allowing the locum tenens to treat patients. Failure to notify Plan of such coverage may result in the denial of claims.

Claims should be submitted under the Participating Provider's TIN and attending physician's name.

Allied Health Professional Billing

If your office employs an "Allied Health Professional" (i.e. Nurse Practitioner, Physician Assistant, etc.) who is providing services to Calvo's SelectCare Members, the claim must be submitted to the Plan under the supervising physician's Tax Identification Number, however the allied health professional's name must be indicated on the claim form.

Overpayments

If an overpayment is identified, contact the Provider Relations Department to submit an overpayment request. Further instructions on submitting reimbursement to the plan will be advised.

If the plan identifies an overpayment, an overpayment notification will be sent to the provider requesting for reimbursement. Payment should be submitted as soon as possible, but no later than 10 business days from the date the notification is received. If reimbursement is not received within this time frame, the plan may off-set the amount from future payments due to the provider.

Subrogation

The Plan will not override timely filing denials based on decisions received from third-party carriers on subrogation claims. At the time of service, please submit all claims to the Plan for processing. Through recovery efforts, we will work to recoup dollars related to subrogation. In addition, if your office receives a third-party payment, notify the Plan's Coordination of Benefits Department and the overpayment will be recouped.

Timely Filing and Late Bill Criteria

Claims must be submitted and received by the Plan within ninety (90) days from the date of service as stated in your Provider contractual agreement. Claims that are filed untimely may be denied, and the

account will be considered fully closed and no longer billable to Plan or Member, as per your Provider contractual agreement. The claim filing deadline is based on the date services were rendered, or receives a claim response from the primary payer.

Secondary claim submissions must be submitted with a copy of the primary health payer's remittance. If we receive a claim and return it to the Provider for additional information, the Provider must resubmit the claim with the proper documentation included within one-hundred eighty (180) days of receipt of payment or denial as outlined in the Provider's contractual agreement. You can send these resubmitted claims and all pertinent documentation to the Provider Relations Department. Ensure that claims are submitted with a transmittal.

Reconsideration requests

If you have questions relating to claims payments, please contact the Claims Department.

If you are submitting an appeal, in which you believe that a claim was erroneously processed, you can send the request to the Provider Relations Department within 180 days from the original payment or denial date. Ensure that claims are submitted with a transmittal.

A copy of the claim and supporting documentation will be required for review. It is important to mark the claim as an “Appeal” to make sure the claim is routed to the appropriate area for review.

Provider Complaints and Claims Payment Disputes

A procedure is in place for the resolution of any disputes between the Plan and Participating Providers involving either partially or totally denied claims that result in written Provider requests for reconsideration. A claim dispute must be in writing and include any documentation that supports the request for reconsideration (i.e. claim, remit, medical records, correspondence, etc.).

If you have questions relating to claims payments, please contact the Provider Relations Department. A representative may be able to assist you without requiring additional administrative work. Provider complaints for other issues are also handled by the Provider Relations Department.

Compliance Hotline

If you suspect a potential fraud, waste, or abuse incident, or simply wish to notify Calvo’s of any instance of impropriety, please call the Calvo’s Compliance Hotline at (671) 477-9808. You may contact this number anonymously without fear of retaliation.

Section 7: Utilization Management and Care Coordination

Referrals and Pre-Certifications

Calvo's SelectCare does not require written approval prior to accessing specialty care from an in-network specialist (except for members under an HMO plan). Some medical services, supplies and equipment, and all out-of-plan requests require Pre-Certification (see section below on Pre-Certifications).

Out-of-Network Referrals

When the primary care provider or treating provider recommends services from a provider who is not part of the Calvo's SelectCare network, the provider must complete a Prior Authorization Request Form. This request must be submitted to and approved by Calvo's SelectCare before a non-participating provider renders care.

Pre-Certification Policy

Pre-Certification procedures are required for all services listed on the following page. Participating Providers shall ensure that a completed Pre-Certification Form for all applicable services along with any required documentation be provided to and approved by the Plan prior to such services being rendered. Upon approval, Providers shall only provide services within the scope and duration as specifically contained and outlined in the Authorized Pre-Certification.

Pre-Certification requests can be faxed to the Utilization Management Department at (671) 477-7304. To facilitate prompt processing of Pre-Certification requests, they should be accompanied by the following:

- Appropriate ICD and CPT codes
- Medical information (History and Physical Examination) to justify the request
- Laboratory, Imaging and other Diagnostic results relevant to the present illness

For routine non-emergency procedures, Pre-Certification requests should be submitted at least three (3) to five (5) business days prior to the intended date of service. These requests will be processed within the standard 72-hour period.

Calvo's SelectCare has established the following timeframes for utilization management decisions:

Type of Review	Standard timeframe
Urgent care pre-service	72 hours
Non-urgent care pre-service	15 days
Concurrent review	24 hours
Post-service care review	30 days

Approved Pre-Certifications are valid for thirty (30) days from the date of approval.

STAT procedures should be performed without delay. The Pre-Certification process, however, is still required for these procedures. We require the submission of a completed Pre-Certification Form and all required documentation within ten (10) days of the STAT procedure. Upon receipt of the request, a retrospective review will be conducted to verify the validity of medical necessity based on the MCG and Medicare Guidelines.

Please be advised that STAT pre-certifications should only be requested when an individual's life is at risk if the procedure is not performed, otherwise, the request should not be labeled as STAT and it should go through the normal 72-hour processing period. If it is determined that a request does not

meet the requirements of a STAT procedure, the pre-certification and claim will be denied, and the Member will not be held responsible for payment.

Please be aware that:

- Failure to obtain Pre-Certification approval for those services or benefits requiring Pre-Certification from SelectCare may result in a disallowance of up to 50% of allowable charges or denial of claim.
- Services exceeding the authorized scope or duration shall not be paid by the Plan.
- Pre-Certification is only a determination of medical necessity, not an assurance of coverage, or guarantee of payment.

List of Procedures & CPT Codes Requiring Pre-Certification:

Procedures that are not specifically listed will be evaluated based on Medical Necessity and the Member's plan benefits. Medicare CCI rules apply

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

Disease Management

Calvo's SelectCare offers disease management (DM) programs for the following conditions:

- Diabetes
- Asthma
- Cardiovascular Disease/ Congestive Heart Failure (CVD/CHF) – includes: hypertension, hyperlipidemia, hypercholesterolemia, acute myocardial infarction, ischemic vascular disease or post cardiac event such as CABG or percutaneous coronary interventions (PCI)
- COPD

These disease management programs were developed to assist your patients with diabetes, asthma, CVD/CHF and/or COPD to better understand their condition, update them on new information about their disease and provide them with assistance from our staff to help them manage their disease. The programs are designed to reinforce your treatment plans for the patient.

Members of Calvo's SelectCare do not have to enroll; they are automatically enrolled when we identify them as members with one or more of the above diseases through claims, the UM/CM program, pharmacy information or Health Risk Assessments (HRA).

If you would like to enroll a Calvo's SelectCare member who is not yet in a program, please contact the Calvo's SelectCare Utilization Management Department.

DM programs provide the following services:

- Support from Calvo's SelectCare nurses and other healthcare staff to ensure that your patients can understand how to best manage their condition and periodically evaluate their health status
- Periodic newsletters to keep the patients informed of general information regarding their disease and ways to self-manage
- Educational and informational materials that can assist your patients in understanding and managing the medications you prescribe, how to effectively plan for visits to see you and reminders as to when those visits should occur
- Educational classes offered through the Seventh Day Adventist Medical Center

Enrollment in these Calvo's SelectCare disease management programs is voluntary.

Case Management and Care Coordination

Case Management and Care Coordination program provides patient-focused, individualized case management for those members with active disease processes, those who require extensive utilization of resources and those at high risk for health complications. Activities focus on:

- Insuring coordination of appropriate and effective care and treatment.
- Developing individualized care plans that correspond to the unique needs of the member.
- Reinforcing and motivating members toward positive lifestyle behaviors.
- Serving as a liaison for the member in the treatment and management process.
- Influencing appropriate treatment and medication compliance.
- Coordinating care for members transitioning from one setting to another.
- Coordinating care for members requiring off-island specialty care or hospitalization.

Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost effective outcomes. It is one component used to control, direct, and approve access to the services available to members in their benefit packages. Case Management helps members with multiple and/or complex conditions or who have experienced a critical event or diagnosis and need extensive resources, navigate through the system and access care.

- All members that meet criteria for case management are enrolled in the program, however, the program is strictly optional and members may choose to enroll or dis-enroll at any time.
- Providers may request enrollment for their members who have complex or on-going healthcare needs into the case management program by calling Health Services.
- The Case Management team is comprised of specially qualified nurses who assess the Member's risk factors and develop an individualized treatment plan in collaboration with the PCP, specialists, member/caregiver and members of the healthcare team. The care plan is based on a health needs assessment and identifies immediate, short-term and long-term goals, monitors outcomes and evaluates whether the goals remain appropriate and realistic, and what actions may be implemented to enhance positive outcomes.
- Plan has incorporated Case Management programs that manage members who have complex or ongoing healthcare needs, preventive health and lifestyle issues or coordination of care/care transition needs. Members may also be referred to our programs that are designed to educate the member on self-management of their chronic condition utilizing evidence based guidelines.
- Plan has adopted clinical practice guidelines that are based on valid and reliable clinical evidence from agencies such as the American Diabetes Association (ADA) for diabetic management. Plan utilizes The Case Management Society of America (CMSA) Standards of Practice as a guideline for case management practice.

Second Medical Opinion

Calvo's members may request a second medical opinion if it is believed the member is not responding to the current treatment plan in a satisfactory manner within a reasonable amount of time. This may include if the member disagrees with his/her treating physician about a proposed surgery or is subject to a serious injury or illness that is failing to respond to the current treatment plan in a reasonable amount of time. The member or provider may contact Calvo's to arrange for a second medical opinion. Unless an emergency condition exists, all second medical opinions require pre-certification.

Section 8: Clinical Practice and Preventive Health Guidelines

Calvo's adopts nationally recognized clinical practice and preventive health guidelines that are relevant to member needs. Guidelines are reviewed and revised at least every 2 years. The plan analyzes performance against clinical practice and preventive guidelines and takes action in cases of substandard performance.

Below is a list of Calvo's clinical practice and preventive health guidelines along with web links.

Clinical Practice Guidelines

Diabetes:

Standards of Medical Care in Diabetes from the American Diabetes Association (ADA)
http://care.diabetesjournals.org/content/suppl/2015/12/21/39.Supplement_1.DC2

Hypertension:

2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults, Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC 8), American Medical Association (AMA)
http://jamanetwork.com/journals/jama/fullarticle/1791497

Kidney disease

National Kidney Foundation Guidelines and Commentaries – Evidence-based clinical practice guidelines for all stages of chronic kidney disease
http://www.kidney.org/professionals/kdoqi/guidelines_commentaries.cfm

Practical Approach to Detection and Management of Chronic Kidney Disease for the Primary Care Clinician, The American Journal of Medicine, Vol 129, No 2, February 2016
http://www.amjmed.com/article/S0002-9343(15)00855-4/pdf

Asthma:

National Heart, Lung and Blood Institute, Expert Panel Report3: Guidelines for the Diagnosis and Management of Asthma, Full Report 2007
http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines

COPD:

American College of Physicians (ACP) Diagnosis and Management of Stable Chronic Obstructive Pulmonary Disease: A Clinical Practice Guideline Update from the American College of Physicians, American College of Chest Physicians, American Thoracic Society and European Respiratory Society
http://annals.org/aim/article/479627/diagnosis-management-stable-chronic-obstructive-pulmonary-disease-clinical-practice-guideline

Depression Screening:

US Preventive Services Task Force: Depression in Adults: Screening
https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1

Preventive Health Guidelines

Adult Immunizations-recommended immunization schedule for adults 19 years and older
Advisory Committee on Immunization Practices (ACIP)
http://www.cdc.gov/vaccines/schedules/hcp/adult.html

Childhood Immunizations- recommended immunizations for persons aged 0 through 18 years (2016)
http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html

U.S. Preventive Services Task Force (USPSTF) Preventive Health Guidelines
https://www.uspreventiveservicestaskforce.org/Home/GetFileByID/989

Section 9: Quality Improvement and Risk Management

Introduction

Quality Improvement (QI) at Calvo's SelectCare is a process of continuous assessment and monitoring of the service provided to Calvo's SelectCare members. Based on quality indicator measurements and continuous evaluation of the program components, opportunities for improvement are identified. These opportunities enhance the quality of care and service provided to our members by improving efficiency, increasing the span of healthy life and reducing disparities in the healthcare provided. Components of the QI Program include all plan types (Commercial HMO, Commercial PPO and Federal HMO), unless otherwise specified. All medical utilization management activities are conducted at the health plan. The pharmacy utilization is delegated to our PBM, Optum Rx.

QIP Goals and Objectives

The goals of the Calvo's SelectCare QI program include:

- Establish standards of clinical care and service for members and measure performance outcomes
- Identify opportunities to enhance clinical care and service for members
- Respond with appropriate interventions to prioritized opportunities to improve clinical care and service
- Measure the effectiveness of interventions and implement actions as needed to improve

The objectives of the Calvo's SelectCare QI program include:

- Utilize a population-based approach to measuring and addressing continuous quality improvement for clinical care and service for members
- Maintain data systems capable of providing systematic, reliable, and meaningful data for use in the QI program
- Facilitate a partnership between providers, members, and Calvo's SelectCare for maintaining and improving plan-wide services
- Measure access, availability, and trends in member satisfaction for improving service
- Develop and maintain approaches to providing high-quality clinical care, including disease management, practice guidelines, utilization criteria and guidelines, complex case management, peer review, medical technology review, pharmaceutical management procedures, medical record criteria, and processes to enhance communication and continuity of care between practitioners and providers
- Develop and maintain a Utilization Management (UM) program that incorporates nationally recognized criteria, use of appropriate clinical professionals, risk management, member and practitioner appeal rights, and appropriate handling of denials of service. In the case of Medicare plans, the reviewer complies with national coverage decisions, general Medicare coverage guidelines and written coverage decisions of local Medicare contractors.
- Maintain a pharmaceutical management program that includes the development of policies and procedures, processes for restrictions and preferences, patient safety, review and update of procedures, participation of pharmacists and physicians, notification to practitioners, and prior authorization processes including denials and appeals or delegates these functions to the contracted PBM.
- Maintain a credentialing and re-credentialing program for individual practitioners and provider organizations that adhere to federal and local regulations, as well as standards for accreditation.
- Provide members with information regarding rights and responsibilities, health plan policies and procedures, benefit and coverage information, and ensure appropriate oversight of procedures that protects the privacy and confidentiality of member information and records.
- Develop and promote preventive health standards and programs to encourage members and practitioners to utilize appropriate guidelines and early detection services for prevention of illness.
- Provide an appeals process designed to protect the rights of the member, physician and hospital as fully as possible.

- Establish standards and processes for maintenance and oversight of delegated activities, if applicable.

Program Scope

The scope of the Calvo's SelectCare QI program is designed to fulfill the goals and objectives of the program, while efficiently utilizing resources to promote and enhance integration of quality activities. The scope of the QI program includes, but is not limited to:

Clinical Care

- Preventive health activities
- Clinical quality improvement activities
- Clinical management criteria and guidelines
- Disease management
- Credentialing and re-credentialing
- Inpatient care review for inpatient, surgical and behavioral health care admissions
- Discharge planning
- Preauthorization review for medical necessity
- Personal health coordination, including complex case management

Service

- Member complaints and appeals
- Trends in member dissatisfaction/satisfaction (including CAHPS surveys)
- Network Adequacy
- Written and verbal communications with members
- Care transitions

Patient Safety

- Continuity and coordination of care between practitioners and providers
- Tracking and trending of adverse events
- Evaluation of clinical care against aspects of evidence based guidelines that improve safe practices
- Implementation of health management systems that support timely delivery of care
- Medication management evaluation through case management program

The process of integrating the quality improvement initiatives with various Calvo's SelectCare departments and committees is accomplished, in part, through appointment of representatives to the committees listed in the structure of the quality improvement program with a diversity of knowledge and skills. It is the primary responsibility of the QI Department to disseminate quality initiatives throughout the organization.

Quality Improvement Committee Structure

Calvo's committee structure is designed to promote company-wide participation and the involvement of network providers in the development, implementation, and evaluation of quality management and other activities. Standing committees include:

Quality Improvement Committee (QIC):
The QIC's primary responsibility is to provide direction, implementation, oversight and coordination of quality improvement initiatives throughout Calvo's SelectCare.

Responsibilities include:

- Identify and initiate quality improvement activities as they relate to the enrolled Calvo's SelectCare population.

- Continuously monitor data from quality improvement activities as outlined in the annual work plan and recommend appropriate action.
- Evaluate and allocate resources for quality improvement activities.
- Evaluate the quality improvement structure and complete a formal QI Plan and QI Evaluation on an annual basis.
- Delegate any of the above activities to sub-committees with appropriate oversight.
- Adopt, develop, and implement overall preventive health and clinical guidelines.
- Oversee all quality improvement initiatives as described in the annual plan.

Utilization Management and Case Management Committee

The UM and CM Committee's role is to assure the appropriate management of healthcare services utilizing clinical criteria and guidelines. Collaborate with other committees such as the Medical Policy Committee and the Pharmacy & Therapeutics Committee. Provide oversight for the case management to ensure an integrated member/provider approach in the coordination of quality and cost effective health care services in the most appropriate setting. To identify differentiation for Commercial and Medicare Advantage plan members' needs, when applicable.

Responsibilities include:
- Review utilization patterns and trends for inpatient, outpatient and services
- Evaluate for over/under utilization of services
- Evaluate and analyze inpatient LOS
- Evaluate types of services
- Review appeal overturn decisions for comparison against the guidelines and or criteria used to make the initial determination
- Review member grievances that cannot be handled informally and are not appropriate for standard internal processing
- Defines new methods to identify members for case management, as appropriate
- Develops and implements screening and engagement tools
- Measures program effectiveness
- Integrates activities with provider specific initiatives
- Ensure call monitoring of all case managers and action plans developed, if appropriate

Credentialing Committee

Primary responsibility is to review all credentialing and re-credentialing files and determine approval or denial of individual practitioners and facilities at the time of initial credentialing and re-credentialing.

Responsibilities include:
- Review all materials, including patient safety/quality issues, relevant to an applicant regarding credentialing and re-credentialing issues as identified in the credentialing policies and procedures.
- Determine approval or denial status as a Calvo's SelectCare participating practitioner or facility.
- Review and revise all policies and procedures related to credentialing and re-credentialing activities at a minimum annually.

Medical Policy Committee (MPC)

The MPC reviews and provides practitioner input on new and updated criteria, medical policies, and policies and procedures.

Responsibilities Include
- Review case requests for new technology based on literature with recommendations based on area of expertise
- Review and updates to policy and procedures with recommendations based on area of expertise

Members' Rights and Responsibilities Committee (MRRC)

Role is to assist in maximizing the value of our members' health care by monitoring available reports and information and making recommendations for improvement to the Quality Improvement Committee. Information reviewed includes but is not limited to: complaints and appeals data, policies and procedures, member communications, prospective member communications, member satisfaction survey results, provider satisfaction survey results, employer satisfaction survey results, disenrollment survey results, provider access data, and service-related Key Performance Indicators.

Responsibilities:

- Facilitate mutually respectful relationships with members and providers through an established statement of members' rights and responsibilities.
- Review member complaints and appeals data and provider appeals (at least semi-annually) to identify trends, provide recommendations for improvement as needed. Monitor development, implementation and tracking of applicable policies and procedures.
- Ensure member and prospective member communications clearly outline benefits and contain information needed to understand benefit coverage and how to obtain care via review of survey results.
- Review findings of member and practitioner satisfaction surveys (at least annually) to identify trends and opportunities for improvement.
- Support development and implementation of action plans and monitor progress and subsequent data to determine effectiveness.

Network providers are invited and encouraged, to serve on the Credentialing Committee or the Medical Advisory team. If you are interested in learning more about these opportunities, please contact the Provider Relations Department.

Risk Management and Incident Reporting

Plan has a risk management program which includes investigation and analysis of Adverse Incidents and quality of care grievances. Physicians and other health care providers have an affirmative duty to report any Adverse Incident involving a Calvo's member occurring at their offices and outside of hospitals, outpatient ambulatory, skilled nursing, and rehabilitation facilities.

An Adverse Incident is an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred. Adverse incidents include, but are not limited to:

- Death
- Brain or Spinal Injury
- Surgery on the wrong patient or wrong site
- Medically unnecessary surgery or surgery unrelated to the member's condition/diagnosis
- Surgery to remove foreign objects left from a surgical procedure
- Surgery to repair damage from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the member and documented through the informed-consent process
- Permanent disfigurement
- Fractures or dislocation of joints or bones

Refer to Section 12: Appendix of this manual for the Incident Report Form.

In addition, participating providers should report other occurrences/events to Calvo's, including:

- Complication of drug, treatment, or service prescribed.
- Patient dissatisfaction angrily expressed with threats.
- Delay in diagnosis or referral.
- Breach of confidentiality.

- A request for medical records by an attorney other than for motor vehicle accident.
- Actual or potential Quality of Care issues involving a Plan member.
- Hospital-acquired infections.
- Falls occurring in contracted facilities.

NOTE: All Occurrences should be reported to the Plan Risk Manager within three (3) business days, using the Plan Incident Report Form included in Section 12: Forms Appendix or on the website in the Provider Reference Section.

The information submitted to Plan is used to investigate potential quality issues and for risk management review. All information reported to Plan will remain strictly confidential in accordance with Plan policies and procedures on confidentiality.

Section 10: Health Education and Wellness

Program Scope

Calvo's is committed to helping its members take an active part in their overall health and wellness. The Plan provides and makes available health education and health promotion services to meet the needs of its population. The program is broad in scope and considers the medical, psychological, social, and cultural needs of Plan members. These services are provided in accordance with ethical and professional practices and legal requirements. Health education and wellness promotion services are offered by personnel that have the necessary and appropriate training, education, credentials, skills and continuing education to carry out their responsibilities. In an effort to improve program performance, collaborative processes and outcomes are developed, measured and assessed in a timely manner.

Wellness Program Contents

Monthly Wellness Newsletters

Distribution of monthly wellness newsletters to keep members current on health and medical information provided via email and as printed materials. Example of newsletters to include but not limited to: Wellnotes, Health Challenge, Ask the wellness doctor, Healthy Living Guidelines, Wellness program class schedules and Fitness center class schedules.

Online Health Risk Assessment (HRA)

Calvo's offers a free, confidential Health Risk Assessment questionnaire to all members. The questionnaire includes questions regarding nutrition, weight, physical activity, stress, safety and mental health. The Plan will then summarize the answers and review them with each member. This allows the member to understand and identify potential areas for improvement in both their physical and mental health. The Plan will then help coordinate future activities and interventions with the member's providers.

Areas surveyed include Injury Prevention, Nutrition Improvement, Physical Activity/Exercise, Sleep Improvement, Stress Management, Tobacco Cessation, Weight Management, Blood Pressure Management, Cholesterol Management, Depression Management, Alcohol Use, Medication Management and Readiness to Change.

Diabetes Education

Program focus is on preventing the costly complications associated with poorly controlled Diabetes. Emphasis is placed on preventing diabetes related progression of nerve damage, amputation risk, blindness, kidney failure, renal dialysis, heart attacks, and strokes. The Diabetes Program is a no-cost program. The above services are on a "first come, first served basis."

Stop-Smoking

The Stop-Smoking program is available to all members who smoke and want to quit. This program takes participants through a five-day step-by-step program to change daily habits and achieve their goal to quit smoking. Through psychological motivations and physical changes (such as dietary modifications), the five-day plan works to break the participant's smoking routine and eliminate cigarette cravings. Members may self-refer to the program by calling the SDA Wellness Clinic directly at 648-2533.

Members may also be advised to use the Tobacco Free Guam Quitline. Members may call the Tobacco Free Guam Quitline at 1-800-QUIT-NOW (1-800-784-8669) or visit www.quitnow.net/guam

Members may also call Department of Public Health and Social Services at 735-7334 for more information about the TFG Quitline.

Weight Management Program

Members are taught how to make healthy food choices, the importance of a physically active lifestyle and other weight loss tips. The Weight Management Program is available to eligible overweight and obese who would like to reduce the negative health consequences associated with these conditions. The 7-Day Detox, Seven Day Shape-Up, and NEWSTART Programs are share-cost programs in which the member will be required to pay 50% of the program cost.

1. 7– Day Detox Program

   Seven days of meals to shrink fat cells and eliminate waste products by enhancing the body's natural cleansing systems. Topics include how to increase daily physical activities, serving sizes, My Plate, food label reading, psychosocial issues involved in weight loss, and stress management. There will be pre and post screening during the program to include BMI, weight, height, fat percentage, body water percentage, muscle mass and waist-to-hip ratio.

2. Seven Day Shape-up Program

   This program is designed to boost the metabolism, reduce hunger and cravings and improve vital organs' function**.** Other healthy lifestyle habits are also emphasized during the program including, sufficient water intake, consistent exercise, proper rest, and stress management**.** The program also includes a nutritionally balanced diet that is lower than average caloric intake per day. There will be pre and post screening during the program to include BMI, weight, height, fat percentage, body water percentage, muscle mass and waist-to-hip ratio.

3. Comprehensive Lifestyle Intervention Program (NEWSTART)

   Program designed with a holistic approach to successfully regain health and wellness that will last a lifetime. Program examines the primary health-related causes of death, elucidates the lifestyle factors leading to morbidity and mortality, and educates regarding the nutrition, physical activity, Stress Management, and other proven methods of preventing and/or reversing chronic diseases. There will be pre and post screening during the program to include BMI, weight, height, fat percentage, body water percentage, muscle mass and waist-to-hip ratio.

Cholesterol and Hypertension

The Cholesterol and Hypertension Program is available to Members who have been diagnosed with high cholesterol, high blood pressure, or health risks associated with heart disease by their doctor. The program focus is on preventing heart attacks, strokes, congestive heart disease, and other circulatory disorders. The program will guide step by step in lowering unhealthy fats and help patients effectively improve their blood pressure.

Stress Management

Stress management is available to all members and equips participants with the education and training to help individuals manage stressors and stress symptoms. The program focuses on improving overall lifestyle habits will be incorporated for developing permanent coping skills for reducing stress and related health problems.

Substance Abuse and Violence Prevention

Calvo's SelectCare will provide information on evidence based care guidelines, treatment options, and community based program resources related to substrance abuse and violence prevention. These community based services are no-cost programs.

1. PEACE Project
   - Oasis Prevention Empowerment Network (OPEN)
   - Community Voices Coalition/Community Services & Resources
   - Magof Health Coalition
   - Sanctuary, Incorporated

2. Guam Coalition Against Sexual Assault & Family Violence
    - Need Help Call: VARO 24-Hr Hotline: (671) 477-5552.
    - National Domestic Violence Hotline: 1−800−799−SAFE (7233) or TTY 1−800−787−3224
    - National Sexual Assault Hotline: 1-800-656-HOPE (4673)
    - http://www.guamcoalition.org/

Wellness Incentives

Calvo's offers specific groups a wellness incentive program for members taking proactive steps to maintain their health. To be eligible, Calvo's must be the primary payor for health benefits and the member must obtain one or more of the following medical services to monitor their health: Routine physical examination, Hemoglobin A1C blood test, LDL test, Colorectal Cancer Screening, Participated in a Smoking Cessation program.

Fitness Promotion Programs

Fitness Promotion

Calvo's SelectCare has partnered with several Fitness Centers to provide free or discounted access while they are insured under the plan. Fitness Centers are to provide the following described fitness, wellness services, programs, equipment, and facilities to Members: Fitness Assessments upon the Subscriber's enrollment into the facility, Cardiovascular Training/Machines, Resistance and Strength Training/Machines, Circuit Weight Machines/Free Weight Area, Flexibility Training by Certified Personal Trainers, Regular Group Exercise Classes, Nutritional services by Certified Nutritionists.

Fitness Center Partners

Paradise Fitness Center, Hagatna, Tumon and Dededo, Guam (3 locations)

Synergy Studios, East Hagatna and Hagatna, Guam (2 locations)

Custom Fitness, Piti, Guam

Unified, Inc., Tamuning, Guam

Providers and/or members who are interested in participating in or obtaining additional information about any of the Calvo's SelectCare Health Education and Wellness Promotion Programs/ Activities may contact our Wellness Department at (671) 477-9808.

Section 11: Glossary of Terms

AGREEMENT – refers to the Agreement executed by and between Plan and Provider, which this schedule A is attached and incorporated therein.

CERTIFICATE – refers to the evidence of insurance provided to an insured under a group or individual Plan.

CLEAN CLAIM – refers to a claim that can be processed without obtaining additional information from the Provider who provided the service or from a third party.

COINSURANCE – refers to the set percentage amount of the applicable fee schedule amount that the Member's Plan requires the Member to pay for a Covered Service. Where the Member's Plan provides for payment of co-payment, coinsurance or deductibles by the Member, payment by Plan for Covered Services shall be the maximum allowable amount less the applicable co-payment, coinsurance and/or deductible.

CO-PAYMENT – refers to a fixed dollar amount, of the applicable fee schedule amount that the Member's Plan requires the Member to pay for a Covered Service. Physician may collect such co-payments at time of service. Where the Member's Plan provides for payment of co-payment, coinsurance or deductibles by the Member, payment by Plan for Covered Services shall be the maximum allowable amount less the applicable co-payment, coinsurance and/or deductible.

COORDINATON OF BENEFITS – refers to a provision in the plan that allows for the coordination of payments for covered medical services when a Member is covered under more than one plan. With these circumstances, one Plan normally pays the benefits in full as the primary Payer and the other plan pays a reduced benefit as the secondary Payer. The Plan shall determine which coverage is primary according to the U.S. National Association of Insurance Commissioner's guidelines. If the Plan is the Primary payer, Plan will pay the full benefits for which Member is covered. If the Plan is the secondary Payer, the Plan will determine the allowance. After the primary Plan pays, the Plan, as a secondary Payer, will pay what is left of our allowance and nothing more than such allowance.

COVERED SERVICES – refers to those health services and supplies provided to Members by Participating Providers, including Physicians, which qualify, for payment under the terms of a Member's Plan, as described in the applicable Certificate or policy, including any amendments thereto.

CREDENTIALING/RECREDENTIALING – refers to the processes employed by Plan to determine whether a physician meets the Plan's criteria for initial or continued participation in a network.

DEDUCTIBLE – refers to the aggregate dollar amount that the Member must pay each calendar or contract year before Plan begins to make payments.

DRUG FORMULARY – refers to a list of preferred drugs covered by the Plan.

EMERGENCY – refers to a medical condition manifesting itself by acute symptoms, including severe pain, of sufficient severity such that, in the judgment of a reasonable lay person, the absence of immediate medical attention could be reasonably expected to result in: (i) serious jeopardy to the health of a Member; (ii) serious impairment of bodily functions; or (iii) serious dysfunction of any bodily organ or part.

EXCLUSION – refers to the specific conditions or circumstances listed in the Standard Rules for which the Calvo's SelectCare plan will not provide coverage reimbursement.

GROUP PRACTICE – refers to a group of physicians and/or other health care Providers who provide services using the same tax identification number.

HIPAA – refers to the Health Insurance Portability and Accountability Act of 1996, as amended by PPACA, all provisions codified at 42 U.S.C. §300gg, and the regulations promulgated thereunder.

INSURANCE CARRIER – refers to Tokio Marine Pacific Insurance Limited (TMPI).

MEDICALLY NECESSARY – refers to health care services or supplies that a physician applying the applicable community standard of care would provide to a patient for the purpose of preventing, diagnosing or treating and illness, injury, disease or its symptoms in a manner that: 1) comports with generally accepted standards of medical practice; 2) is supported by current scientific evidence; 3) is the most clinically appropriate service or supply in terms of type, frequency, extent, site, and duration; and 4) is not primarily for the convenience of the patient, patient's family, Physician or other health care Provider; and 5) is not experimental.

MEMBER – refers to a person covered by Plan.

MEMBER CONTRACT – refers to the Group Service Agreement Description that is the contract between Self-Insured Entity or Insurance Carrier and the Covered Individual which sets forth the contractual rights and obligations of the parties thereto and which describes Covered Services, Co-payments, Deductibles and / or coinsurance requirements, limitations and exclusions of the Preferred Provider Organization benefit plan set forth therein.

NON-COVERED SERVICES – refers to services for which benefits are not payable under a Member's Plan and for which the Member is financially responsible.

PARTICIPATING PROVIDER – refers to any hospital, physician or other institutional or professional health care Provider who has contracted with Plan, directly or through intermediaries, to furnish Covered Services to Members.

PLAN – refers to the health insurance programs underwritten by Tokio Marine Pacific Insurance Limited and administered by Calvo's Insurance Underwriters, Inc.

PRIOR AUTHORIZATION/ PRE-CERTIFICATION – refers to approval in advance for of services being rendered. Certain covered services need prior authorization. Additional information can be found in the Pre-Certification Guidelines section of this manual.

PROVIDER NETWORK – refers to a network of Participating Providers that have contracted with Plan to furnish services to Members in accordance with specific payment and related policies and procedures established by Plan for that network.

REFERRAL – refers to the formal recommendation by the Provider for a Member to receive services from a specialist, consultant, or an off-island facility.

SPECIALTY DRUGS – refers to high-cost injectable, infused, oral or inhaled drugs that generally require a special storage or handling and close monitoring of the patient's drug therapy. Most Specialty Drugs are used to treat chronic diseases. Specialty Drugs are identified on the Specialty Drug List section of the Drug Formulary.

UCR – refers to the "Usual, Customary and Reasonable" charge of a Provider for a service or supply in the geographical area where it was rendered, not exceeding the amount ordinarily paid by Medicare for a comparable service or supply to their Participating Provider.

Section 12: Appendix

Participating Provider Applications
Provider Information Sheet
Pre-Certification Form
Incident Reporting Form
Notice of Privacy Practices

Participating Provider Application

Thank you for your interest in the Calvo's SelectCare Participating Provider Network. **To ensure appropriate referrals and to facilitate timely payment of claims, we ask that you complete all items on this form.** Items marked with an asterisk (*) will be kept confidential.

The items listed below are also required and must accompany this application:

- Letter of Intent (please indicate anticipated/ effective date of practice)
- Copy of current state(s) license
- Copy of current DEA (federal) certificate
- Copy of current CSR certificate
- Copy of current Board Certification(s) – If Applicable
- Copy of current professional liability insurance (face sheet) – If Applicable
- Current Curriculum Vitae (CV) / Resume
- Completed W-9 Form
- Copy of Government issued picture ID
- Proposed Fee Schedule
- Authorization for Agent/Representative – If Applicable

Upon the submission of all the required documents, Calvo's SelectCare will review your application and will inform you of the status via mail, email, or phone. If erroneous information or documents are provided, corrections must be submitted to our office in writing.

If you need assistance completing this form, please contact our Provider Relations Department via email at providers@calvos.com or via phone at (671) 477-9808.

Please type or print.

I. Provider Identification

Please provide practice information for each office in which you see patients and billing information for each tax identification number under which you currently bill. Attach additional sheets if necessary.

A. Please indicate if applying as a group or individual practice. ☐ Group ☐ Individual

B. Group/Practice Name _____

C. Tax ID No. * _____

D. Provider's Name _____ ☐ Male ☐ Female
(First) (M.I.) (Last)

Former/ Other Names _____
(First) (M.I.) (Last)

E. Date of Birth * _____

F. Social Security No.* _____

G. Medicare Provider No. _____

H. Medicaid Provider No. _____

I. National Provider Identifier (NPI)* (Individual Provider) _____

(Organizational Provider) _____

J. Physical Address _____

_____

K. Mailing Address (if different from physical address) _____

_____

L. Contact Numbers: Phone _____ Fax _____

II. Practice and Billing Information

A. Practice Information

1. Common Name of Group / Practice _____
2. If this a **group practice**, please indicate the practice types provided. _____

   _____
3. Is your practice at this office open to new patients? ☐ Yes ☐ No
4. Are you accepting new Medicare Patients? ☐ Yes ☐ No ☐ N/A
5. Are you accepting new Medicaid Patients? ☐ Yes ☐ No ☐ N/A
6. Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

7. Urgent Care Hours (if applicable)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

8. Clinic Manager/ Contact Person * _____

   E-mail address * _____
9. Preferred Payment Delivery Method *

   ☐ Mailed to the address indicated above

   ☐ Pick-up by authorized personnel (Please provide an authorization letter listing such personnel)

B. Billing Company Information (Complete only if contracted with a billing agency) *

1. Name of Billing Company _____

   Contact Person/ Title _____

   E-mail address _____
2. Mailing Address _____

   _____
3. Contact Numbers: Phone _____ Fax _____

III. Credentialing

Complete the following information regarding your education, licensure and training.

A. Professional degree (e.g., M.D., M.A., and D.M.D.) _____

B. Name of college or university which corresponds with the professional degree indicated above:

_____
College or University City/State

_____
Country Year of Graduation

C. Complete the following information regarding your training:

1. Internship _____

   Address _____

   Attended from (MM/YY) _____ to (MM/YY) _____ Specialty _____

2. Residency/ Post _____

   Address _____

   Attended from (MM/YY) _____ to (MM/YY) _____ Specialty _____

3. Fellowship _____

   Address _____

   Attended from (MM/YY) _____ to (MM/YY) _____ Specialty _____

D. Complete the following information regarding your Board Certification(s):

Certifying Board _____

Specialty _____ Expiration Date _____

Certifying Board _____

Specialty _____ Expiration Date _____

E. List professional license(s) for those states in which you currently practice. Please enclose a copy of your license(s):

State _____ Number _____ Expiration Date _____

State _____ Number _____ Expiration Date _____

F. List all hospitals or other facilities at which you practice and the privilege type (i.e. Full, Visiting, Courtesy, Consulting or Affiliate) for each.

_____
Hospital or Facility Privilege Type

_____
Hospital or Facility Privilege Type

G. Do you administer or prescribe controlled substance (Schedule II, III, or V medications)?

☐ Yes, DEA License# _____ ☐ No, I do not have a DEA license.

H. If you are a physician provider, select your primary specialty to determine how you will be listed in the directory.

- ☐ **Cardiology**
- ☐ **Family Practice**
- ☐ **Geriatrics**
- ☐ **Internal Medicine**
- ☐ **Nephrology**
- ☐ **Neurology**
- ☐ **Obstetrics & Gynecology**
  - ☐ Gynecology
  - ☐ Gynecological Surgery
  - ☐ Obstetrics
- ☐ **Oncology**
- ☐ **Ophthalmology**
- ☐ **Orthopedic Surgery**
  - ☐ Orthopedic Surgery/ Sports Medicine
  - ☐ Pediatric Orthopedics
- ☐ **Otolaryngology**
  - ☐ Pediatric Otolaryngology
  - ☐ Maxillofacial Surgery
- ☐ **Pediatrics**
- ☐ **Psychiatry**
- ☐ **Radiology**
- ☐ **Surgery**
  - ☐ Cardiac & Thoracic
  - ☐ General
  - ☐ Head & Neck
  - ☐ Surgical Oncology
  - ☐ Other _____
- ☐ **Urology**
- ☐ **Other** _____

I. If you are a non-physician provider, please choose a field or title that best describes your clinical practice.

- ☐ **Chiropractic**
- ☐ **Dentistry**
  - ☐ Endodontic
  - ☐ General Dentistry
  - ☐ Orthodontics
  - ☐ Pediatric Dentistry
  - ☐ Periodontics
- ☐ **Diet/Nutrition**
- ☐ **Medical Transport**
- ☐ **Mental Health**
  - ☐ Addiction Counseling
  - ☐ Chemical Dependency
  - ☐ Child & Adolescent
  - ☐ Psychology
  - ☐ Marriage & Family
  - ☐ Mental Health Counseling
- ☐ **Nurse**
  - ☐ Certified Nurse Anesthetist
  - ☐ Certified Nurse Specialist
  - ☐ Midwifery/Nursing
  - ☐ Nurse Practitioner
- ☐ **Occupational Therapy**
- ☐ **Optometry**
- ☐ **Physical Therapy**
- ☐ **Physician's Assistant**
- ☐ **Podiatry**
- ☐ **Other** _____

IV. Professional Liability Insurance (Please provide copy of face sheet)

Insurance carrier name: _____

Name/Entity to whom policy is issued _____

Policy number _____ Expiration date _____

Amount of coverage (per occurrence/aggregate)_____

V. Referral Patterns

List providers to whom you regularly refer patients.

Name	Specialty	Facility

VI. Attestation Questions

This section is to be completed by the Provider. Modification to the wording or format of these Attestation Questions will invalidate this application.

If your answer to any of the following questions is "yes," please provide details and reasons, as specified in each question, on a separate sheet. **Please sign and date each additional sheet.**

Attestation Questions	**YES**	**NO**
1. Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction **ever been** denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you **ever been** fined or received a letter of reprimand or is any such action pending or under review?		
2. Have you **ever been** suspended, fined disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?		
3. Have you **ever been** denied clinical privileges, membership, or contractual participation by any health care related organization*, or have clinical privileges, membership, participation or employment at any such organization **ever been** placed on probation, suspended, restricted, revoked, or voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?		
4. Have you **ever** surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from a health care related organization* while under investigation or potential review?		
5. Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization* **ever been** withdrawn on your request prior to the organization's final action?		
6. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization **ever been** revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?		
7. Have you **ever** voluntarily or involuntarily left or been discharged from medical school or subsequent training programs?		
8. Have you **ever** had board certification revoked?		
9. Have you **ever been** the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?		
10. Have you **ever been** charged with or convicted of a crime (other than a minor traffic offense) in any state or country and/or do you have any criminal charges pending other than minor traffic offenses in any state or country?		
11. Do you presently use any illegal drugs?		
12. Do you now have, or have had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation, the privileges requested?		
13. Have you, under any current or former name or business entity, ever had adverse legal actions imposed against you? If yes, attach a copy of the adverse legal action documentation(s), including the resolution(s).		
14. Has your professional liability insurance **ever been** terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you **ever been** denied professional liability insurance.		
15. Have any professional liability lawsuits been filed against you during the past ten years (including those closed)?		
16. Has any judgment or payment of claim or settlement ever been made against you in any professional liability cases?		
E.g.** ***hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system		

VII. Contact Information

Please list the name of the individual completing application or the person to be contracted if clarifying information is needed about this application.

Last Name	First Name	M.I.	Phone

VIII. Testimonial and Information Release

I am submitting an application for credentialing with Calvo's SelectCare. In submitting my application to Calvo's SelectCare, I agree to the following:

- I certify that all information in my application is accurate and complete. I understand that falsification of any information on this application may result in denial or termination of affiliation.
- During the application process and during any period in which I am an affiliated provider, I agree to immediately update Calvo's SelectCare on any changes in the information submitted in my application and agree to provide and execute such additional information as may be requested by Calvo's SelectCare to evaluate my professional qualifications, competence and conduct.
- In addition, I agree to notify Calvo's SelectCare of any circumstances that would change my status in licensure, DEA, Medicare participation, liability insurance coverage, board certification status, or hospital privileges.
- I hereby signify my willingness to appear for interviews in regard to my application and I authorize Calvo's SelectCare, its agents, representatives, and employees to consult with any third party that I have been associated with who may have information about me including references named in my application and persons, hospitals, institutions, or practices with which I have been associated to obtain information regarding my professional competence, ability to deliver safe and efficient quality care, professional education and training, licensing, certification, character, ethical qualifications, ability to work cooperatively with others, professional liability claims history, and/ or insurance or other qualifications for the purpose of evaluating my initial application and for ongoing evaluation. This authorization includes the right to inspect all records and documents that may be pertinent to an evaluation of my qualifications and competence.
- I hereby release from liability all representatives of Calvo's SelectCare in their individual and collective capabilities for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications. I hereby release from any liability any and all individuals and organizations who provide information to Calvo's SelectCare in good faith and without malice concerning my professional competence, ethics, character, and other qualifications.
- As an applicant for credentialing with Calvo's SelectCare, I have the right to review the information submitted in support of my credentialing application. I acknowledge that Calvo's SelectCare will notify me if there are discrepancies in the information received during the credentialing process, and I will be allowed an opportunity to add information to my application.
- I agree to administer Calvo's SelectCare policies without regard to race, color, national origin, ancestry, handicap, sex, marital status, age or sexual orientation.
- I agree to provide continuous care for Calvo's SelectCare members, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.
- I further authorize a photocopy or facsimile of the requests, authorizations and releases to this application to serve as the original.

Signature of Provider Date

Name (please type or print)

Participating Provider Application
Hospitals/Facilities

Thank you for your interest in the Calvo's SelectCare Participating Provider Network. **To ensure appropriate referrals and to facilitate timely payment of claims, we ask that you complete all items on this form.** Items contained in this application will be kept confidential.

The items listed below are also required and must accompany this application:

- List of licensed services offered
- Copy of current state(s) license
- Copy of current professional liability insurance (face sheet)
- Copy of current accreditation organization's letter indicating accreditation status & level
- If NOT ACCREDITED, please submit a copy of full CMS or other audit report, plan or correction, and Post Certification Revisit Report (if applicable)
- Completed W-9 Form
- Provider Roster (include practitioner name, specialty and individual NPI)
- Proposed Fee Schedule
- Authorization for Agent/Representative – If Applicable

Upon the submission of all the required documents, Calvo's SelectCare will review the application and will inform you of the status via mail, email, or phone. If erroneous information or documents are provided, corrections must be submitted to our office in writing.

If you need assistance completing this form, please contact our Provider Relations Department via email at providers@calvos.com or via phone at (671) 477-9808.

Please type or print.

I. General Information

A. Legal Name _____

B. DBA Name _____

C. Tax ID No. _____

D. Medicare Provider No. _____

E. Medicaid Provider No. _____

F. National Provider Identifier (NPI) _____

G. Physical Address _____

_____

H. Mailing Address (if different from physical address) _____

_____

I. Contact Numbers: Phone _____ Fax _____

J. Website _____

II. Billing Information

A. Name of Billing Company _____

Contact Person/ Title _____

E-mail address _____

B. Mailing Address _____

_____

C. Contact Numbers: Phone _____ Fax _____

III. Services

A. Facility Type

☐ **Audiology**	☐ **Hospice**	☐ **Portable X-Ray Supplier**
☐ **Behavioral Health**	☐ **Hospital**	☐ **Rural Health Clinic**
☐ **CORF**	☐ **Laboratory**	☐ **Skilled Nursing Facility**
☐ **Dialysis**	☐ **Nursing Home**	☐ **Surgical Center**
☐ **FQHC**	☐ **DSME Training**	☐ **Urgent Care Center**
☐ **Home Health**	☐ **Outpatient PT/OT/SLT**	☐ **Other** _____

B. Total number of licensed beds _____

C. Is the facility accepting new Medicare Patients? ☐ Yes ☐ No ☐ N/A

D. Is the facility accepting new Medicaid Patients? ☐ Yes ☐ No ☐ N/A

E. Is the facility wheelchair accessible? ☐ Yes ☐ No

F. Hours of Operation

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

G. Facility Contact Person _____

E-mail address _____

IV. Preferred Payment Delivery Method

☐ Mailed to the address indicated above

☐ Pick-up by authorized personnel (Please provide an authorization letter listing such personnel)

V. Licensure/ Certifications

Complete the following information regarding licensure.

A. State _____ Number _____ Expiration Date _____

B. Medicare Certification No. _____ Expiration Date _____

C. Accrediting Organization _____ Expiration Date _____

VI. Professional Liability Insurance (Please provide copy of face sheet)

Insurance carrier name _____

Name/Entity to whom policy is issued _____

Policy number _____ Expiration date _____

Amount of coverage (per occurrence/aggregate)_____

VII. Attestation Questions

The following must be answered by the appropriate Hospital/ Facility designee. If answering "Yes" to any of the following questions, please provide details and reasons, as specified in each question, on a separate sheet. **Please sign and date each additional sheet.**

Modification to the wording or format of these Attestation Questions will invalidate this application.

QUESTIONS	YES	NO
1. Does the Provider/ Facility have any pending misdemeanor and/ or felony charges?		
2. Has the Provider/senior management of the organization ever been convicted of a felony?		
3. Has the Provider/Facility license ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned, or otherwise limited?		
4. Has the Provider/Facility ever been reprimanded or disciplined by a professional licensing agency or board?		
5. Has your Physician's DEA certification and/or state controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited?		
6. Has your participation in Medicare, Medicaid or any other government program ever been limited, curtailed or have you voluntarily excluded yourself from any of these programs?		
7. Has your participation in an HMO and/or an Insurance Company network ever been limited or terminated?		
8. Has any malpractice carrier ever made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf or are any medical malpractice suits pending against you?		
9. Has your professional liability insurer ever placed conditions or restrictions on your coverage or ability to obtain coverage?		

VII. Contact Information

Please list the name of the individual completing application or the person to be contacted if clarifying information is needed about this application.

Last Name First Name M.I. Phone

VIII. Testimonial and Information Release

In submitting this application to Calvo's SelectCare:

- I certify that I have answered the questions above on this application, truthfully, correctly and completely to the best of my knowledge.
- I understand that any misrepresentations, misstatement or omission of a relevant fact in connection with this application may result in denial of the application or termination of participation in the Plan.
- I understand that it is my responsibility to promptly advise the Plan in writing within 30 days of any changes or additions to the information contained in this application.
- I agree that Calvo's SelectCare, its affiliates and the employees, agents and representatives thereof have permission to obtain information about the facility's licensing, competence, ethics, and other qualifications.
- I consent to the release of such information, whether in the form of records, tapes, letters, photocopies/duplications of any of the foregoing, or verbal statements, state licensing boards or regulatory bodies (by whatever name known in their respective jurisdictions), clinics, or other individuals or organizations who or which possess information about the facility. Such information may be released to the above named entity and its affiliates or to representatives of such entity and its affiliates.
- I hereby release from liability and agree to hold harmless any person or entity who or which provides the above described information as authorized herein.
- I hereby release from liability and agree to hold harmless all employees, agents and representatives of the above named entity and its affiliates for their acts performed and statements made in connection with obtaining, reviewing and evaluating the facility's credentials and qualifications.
- I further acknowledge cooperation by consenting to the production of such information about the facility as a provider of services to its members or enrollees. The determination of whether the facility is qualified to serve as a provider of services is the reason such information is needed for review and evaluation by the above named organization and their representatives.
- I have the right to review the information submitted in support of the credentialing application. I acknowledge that Calvo's SelectCare will notify me if there are discrepancies in the information received during the credentialing process, and I will be allowed an opportunity to add information to my application.
- I agree to administer Calvo's SelectCare policies without regard to race, color, national origin, ancestry, handicap, sex, marital status, age or sexual orientation.
- I agree to provide continuous care for Calvo's SelectCare members, until the facility/patient relationship has been properly terminated by either party, or in accordance with contract provisions.
- I authorize a photocopy or facsimile of the requests, authorizations and releases to this application to serve as the original

Signature of Provider Date

Name (please type or print) Position

Provider Information Sheet

Provider Name	Provider ID# *

Service Address

Service Address						
Street Address						
City	State		Zip Code			
Phone	Fax					
Office Hours						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Email: _____

Should your Billing/Mailing Address differ from the Service Address, please enter the information below.

Billing / Mailing Address (*)

Billing/Mailing Address		
Street Address		
City	State	Zip Code
Phone	Fax	

Authorized by:
Signature: _____

Print Name: _____

Title: _____
Date: _____

Note: *Calvo's SelectCare* is committed to helping both providers and insured persons access *Calvo's SelectCare* network providers. To ensure appropriate referrals and facilitate timely payment of claims, we ask that you complete this form. Items marked with an asterisk (*) will be kept confidential.

Pre-Certification Form

CALVO'S SelectCare HEALTH PLANS
P.O. Box FJ • Hagatna, Guam 96932
Phone: (671) 479-7995 • Fax: (671) 477-7304

Pre-Cert. No.:

Referring Provider: _____ Today's Date: _____

Phone: Fax: E-mail:

Consulting Physician: _____

Phone: Fax: E-mail:

Patient / Member Name: _____ Date of Birth: _____

SelectCare Member No.: _____ SSN: _____ Phone Nos. home: _____

Subscriber's Name: _____ work: _____

Please complete and attach the supporting documentation for the Surgery, Procedure, Imaging Study requested

Diagnosis / ICD Codes:

Requested Imaging Study, Surgery, Procedure, Service, Medication (Include CPT Codes):

Symptoms / Clinical Findings / Clinical Management:

Place of Service: _____ Date of Service: _____ Est. LOS/No. of Visits _____

- **Reimbursement Will Be Based On Contracted Fees For Par Providers or "UCR" (Medicare Rates) For Non-Par Providers and According To The Applicable Plan Benefits.**
- **This Authorization Is Valid Only For The Specific Services Authorized And Shall Be Void 30 Days After The Date Of Approval**

_____
Physician's Signature

For SelectCare Use

◯ **Approved** ◯ Anesthesia NOT Required ◯ Assistant Surgeon NOT Required

Reimb for Facility: ◯ Participating ◯ Non-Participating

Reimb for Prof Fees: ◯ Participating ◯ Non-Participating

POS: ◯ Clinic ◯ SurgCntr ◯ Other _____

Primary Coverage ◯ Medicare ◯ Other GHP _____

Member Effective Date: _____

◯ **NOT Approved** ◯ Not a Covered Benefit ◯ Does Not Meet Criteria ◯ Not Medically Necessary ◯ Other

Exclusions / Comments _____

_____
Utilization Management Date

1

INCIDENT REPORT FORM

INCIDENT # _____

Incident Information

INCIDENT DATE: ____/_____/_____ TIME OF INCIDENT: _____

WHO FIRST REPORTED THE INCIDENT: _____

LOCATION OF INCIDENT: _____

Provide a clear and concise description of the incident (Include WHO, WHAT, WHERE, HOW Elements):

_____

_____

_____

_____

_____

Witness(es) (List Persons Directly Involved)

Name	Position	Address	Phone #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____

_____

_____

_____

_____

Full Name of Individual Completing Form: _____ PH#: _____

Title: _____ Office/Location: _____

Signature: _____ Date: _____

_____

Notice of Privacy Practices

Protected Health Information (PHI)

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

This Notice describes the privacy policies of Calvo's SelectCare (CSC) Tokio Marine Pacific Insurance Limited ("TMPI") and health benefit plans underwritten by TMPI (the "Plans"), and how that information may be used or disclosed in administering the Plans. It is intended to describe the policies that protect medical information relating to your past, present and future medical conditions, health care treatment and payment for that treatment ("PHI"). This notice applies to any information created or received by the Plans on or after the September 23, 2013 that would allow someone to identify you and learn something about your health. It does not apply to information that contains nothing that could reasonably be used to identify you. It applies to you if you are insured by TMPI on or after September 23, 2013.

The terms "we" or "us" as used throughout this Notice refer to Calvo's SelectCare Health Plans, TMPI or the Plan. The terms "you" and "your" refer to each individual participant in the Plans.

Our Legal Duties:

- We are required by law to maintain the privacy of your PHI.
- We are required to provide you this Notice of Privacy Practices.
- We are required to abide by the terms of this Notice until we officially adopt a new notice.

How we may use or disclose your PHI:

We may use your PHI, or disclose your PHI to others, for a number of different reasons. This notice describes the categories of reasons for using or disclosing your information. For each category, we have provided a brief explanation, and in many cases have provided examples. The examples given do not include all of the specific ways we may use or disclose your PHI. However, any time we use or disclose your information in administration of the Plans, it will be for one of the categories of listed below.

Treatment: We may use or disclose PHI for treatment purposes. For example, we may use or disclose your PHI to coordinate or manage your health care with your doctors, nurses, technicians, or other personnel involved in taking care of you.

Payment: We may use and disclose PHI for purposes related to payment for health care services. For example, we may use your PHI to anyone who helps pay for your care, to settle claims, to reimburse health care Plans for services provided to you or disclose it to another health plan to coordinate benefits.

Health Care Operations: We may use and disclose PHI for plan operations. For example, we may use or disclose your PHI for quality assessment and improvement activities, case management and care coordination, to comply with law and regulation, accreditation purposes, patients' claims, grievances or lawsuits, health care contracting relating to our operations, legal or auditing activities, business management and general administration, underwriting, obtaining re-insurance and other activities to operate the Plans.

To Business Associates: We may hire third parties that may need your PHI to perform certain services on behalf of TMPI or the Plans. These third parties are "Business Associates" of TMPI or the Plans. Business Associates must protect any PHI they receive from, or create and maintain on behalf of, TMPI or the Plans.

Plan Sponsor: We may disclose certain health and payment information about you to the sponsor of your Plan (the "Plan Sponsor") to obtain premium bids for the Plan or to modify, amend or terminate the Plan. We may release other health information about you to the Plan Sponsor for purposes of Plan administration, if certain provisions have been added to the Plan to protect the privacy of your health information, and the Plan Sponsor agrees to comply with the provisions. Note, however, that your Plan is prohibited from, and will not, use or disclose protected health information that is genetic information of an individual for underwriting purposes.

Family and Friends: We may disclose your PHI to a member of your family or to someone else who is involved in your medical care or payment for care. We may notify family or friends if you are in the hospital, and tell them your general condition. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object and you notify us that you object. We may also disclose PHI to your personal representatives who have authority to act on your behalf (for example, to parents of minors or to someone with a power of attorney).

Treatment Options: We may use your PHI to provide you with additional information. This may include giving you information about treatment options or other health-related services that are available for you based on your medical condition.

Public Health Oversight: We may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; licensure or disciplinary actions (for example, to investigate complaints against health care Plans); inspections; and other activities necessary for appropriate oversight of government programs (for example, to investigate Medicaid fraud). This also includes such activities as preventing or controlling disease, and notifying persons of recalls, exposures to disease.

Plan Government Programs Providing Public Benefits: We may disclose your health information relating to eligibility for or enrollment in the Plans to another agency administering a government program providing medical or public benefits, as long as sharing the health information or maintaining the health information in a single or combined data system is required or otherwise authorized by law.

To Report Abuse: We may disclose your PHI when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

Legal Requirement to Disclose Information: We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the health care system. For instance, we may be required to disclose your PHI, and the information of others, to a state department of health.

Law Enforcement: We may disclose your PHI for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your PHI to a federal agency investigating our compliance with federal privacy regulations.

For Lawsuits and Disputes: We may disclose PHI in response to an order of a court or administrative agency, but only to the extent expressly authorized in the order. We may also disclose PHI in response to a subpoena, a lawsuit discovery request, or other lawful process, but only if we have received adequate assurances that the information to be disclosed will be protected.

Specialized Purposes: We may disclose your PHI for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security and intelligence purposes. We may disclose the PHI of members of the armed forces as authorized by military command authorities. We also may disclose PHI about an inmate to a correctional institution or to law enforcement officials to provide the inmate with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution. We may also disclose your PHI to your employer or as otherwise authorized or required by law for purposes of workers' compensation and work site safety laws (OSHA, for instance). We may disclose PHI to organizations engaged in emergency and disaster relief efforts.

In our effort to better serve your complete insurance needs, we may use the information we collect about you to better understand your relationship with us when assessing your needs, providing you services, and determining what products you may want to know more about.

To Avert a Serious Threat: We may disclose your PHI if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

Research: We may disclose your PHI in connection with medical research projects if allowed under federal and state laws and rules. The Plans may also disclose PHI for use in a limited data set for purposes of research, public health or health care operations, but only if a data use agreement has been signed.

Your Rights:

Authorization: We will ask for your written authorization if we plan to use or disclose your PHI for reasons not covered in this notice, including but not limited to uses and disclosures relating to psychotherapy notes, marketing activities, and any sale of your PHI. If you authorize us to use or disclose your PHI, you have the right to revoke the authorization at any time. If you want to revoke an authorization, send a written notice to the Privacy Official listed at the end of this notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have already given out your information or taken other action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other laws may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization.

Request Restrictions: You have the right to request that we restrict how we use or disclose your PHI for treatment, payment, or health care operations. You must make this request in writing. We will consider your request, but we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law. We may end the restriction if we tell you.

An important note regarding your right to request restrictions at your health care providers

You have a right to restrict your provider from disclosing protected health information to insurers or health plans because you paid for provider services or items out of pocket and in full. If you choose to use a medical expense reimbursement/flexible spending

account (FSA) or a health savings account (HSA) to pay for the health care items or services that you wish to have restricted, you may not restrict disclosure to the FSA or HSA necessary to substantiate or effectuate that payment or reimbursement. That means you will still be required to provide the necessary substantiation of the expenses in order to receive payment.

Confidential Communication: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you may ask that we contact you only at home or only by mail. If you want us to communicate with you in a special way, you will need to give us details about how to contact you, including a valid alternative address. You also will need to give us information as to how payment will be handled. We may ask you to explain how disclosure of all or part of your health information could put you in danger. We will honor reasonable requests. However, if we are unable to contact you using the requested ways or locations, we may contact you using any information we have.

Access to and Copies of PHI: With certain exceptions (i.e., psychotherapy notes, information collected for certain legal proceedings, and health information restricted by law), you have a right to access the PHI held by TMPI or the Plans in their enrollment, payment, claims adjudication, and case or medical management records systems that are used by the Plans in making decisions about you (the "Designated Record Set"). To the extent PHI is maintained electronically, you have a right to request an electronic copy of those records. We may charge a reasonable, cost-based fee for copying, mailing, and transmitting the records, and the cost of any specific media you request, to the extent allowed by state and federal law.

To ask to inspect your records, or to receive a copy, send a written request to the Privacy Official listed at the end of this notice. Your request should specifically list the information you want copied. We will respond to your request within a reasonable time, but generally no later than 30 days. If your Health Plan cannot respond to your request within 30 days, an additional 30 days is allowed if that Health Plan provides you with a written statement of the reason(s) for the delay and the date by which access will be provided. We may deny you access to certain information, such as if we believe it may endanger you or someone else, in which case we will also explain how you may appeal the decision.

Amend PHI: You have the right to ask us to amend PHI contained in the Designated Record Set held by TMPI or the Plans if you believe that PHI is not correct, or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We will respond to your request in writing within 30 days. Any amendment we agree with will be made by an addendum. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

Accounting of Disclosures: You have a right to receive an accounting of certain disclosures of your information to others. The list will include dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must request this list in writing, and indicate the time period you want the list to cover. We cannot include disclosures made prior to the most recent 6 year period (the longest period that records of disclosures are maintained). Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or health care operations; disclosures incident to a permitted use or disclosure; disclosures as part of a limited data set; disclosures to your family members, other relatives, or friends who are involved in your care or who otherwise need to be notified of your location, general condition, or death; disclosures for national security purposes; certain disclosures to correctional or law enforcement personnel; disclosures that you have authorized; and disclosures made directly to you or your representatives.

Right to Notification of Breach of Unsecured PHI: We will comply with the requirements of HIPAA and its implementing regulations to provide notification to affected individuals, HHS, and the media (when required) if TMPI, a Plan or a business associate discovers a breach of unsecured PHI.

Rights More Stringent Than HIPAA: In certain instances, protections afforded under applicable state or territorial law may be more stringent than those provided by HIPAA and are therefore not preempted. We will comply with applicable state or territorial law to the extent it is more stringent than HIPAA with regard to requested disclosures of records (i.e., if we receive a subpoena for your PHI, and the state or territory in which you live requires your written consent or a court order to disclose the type of records requested).

Paper Copy of this Privacy Notice: You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the office of the Privacy Official listed at the end of this notice.

Future Changes to this Notice: We reserve the right to change this Notice and the privacy practices of TMPI or the Plans covered by this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future.

If this Notice is maintained by TMPI or the Plans on a website, material changes will be prominently posted on that website, and information regarding the updated Notice will be made available in TMPI's or your Plan's next annual mailing. If the Notice is not

maintained on a website, copies of the revised Notice will be made available to you within 60 days of a material change.

Complaints: You have a right to complain if you think your privacy has been violated. We encourage you to contact our Privacy Official. You may also file a complaint with the Secretary of the Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Office of the Privacy Official: If you have any questions regarding this Notice or if you wish to exercise any of your rights described in this Notice, you may contact the Privacy Official at:

Calvo's Insurance Underwriters, Inc.,
Attn: Frank Campillo
P.O. Box FJ
Hagatña, Guam 96932