



MEDICAL PLANS

PP01500, HSA2000, RSP

Fiscal Year 2023

Updated 09.08.2022

GOVGUAM Open Enrollment Booklet



Our Island, Your Health PlanSM

Member Benefits Handbook
GOVERNMENT OF GUAM

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Hafa Adai GovGuam Employees and/or Retirees!

Welcome to TakeCare's Health Plan!

Thank you for considering TakeCare Insurance Company, Inc. ("TakeCare") for your health care needs. At TakeCare, we are committed to delivering quality and affordable health care benefits and services that focuses on you and your family needs. We work in collaboration with your medical provider to ensure that you receive the island's best health care.

We encourage you to thoroughly read through this informational benefits booklet and the related member handbook to better understand your TakeCare's health plan and benefits. This booklet provides a summary of your benefit coverage, your payment responsibilities (co-payment, co-insurance, deductible, and/or charges for non-covered services), plan exclusions and benefit limitation specific to your TakeCare health plan option. You will also find a list of in-network/participating providers, including an exclusive access to the FHP Health Center services and TakeCare's wellness and fitness programs and offerings that were made available to you.

TakeCare encourages you to access electronic versions of our GovGuam materials or enroll virtually/online through TakeCare's 2023 GovGuam page at www.takecareasia.com/govguam2023 or scan the QR code below.

Important Note: GovGuam's FY2023 Prescription Benefit Coverage will be administered by TakeCare. Please refer to the separate booklet titled "Prescription Benefit Program" for details.

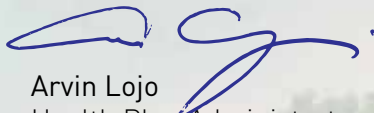
For your convenience and our dedication to provide you with the timely and quality services, we have the following dedicated GovGuam specific phone lines for any of your healthcare needs:

- For health plan benefit coverage, eligibility & enrollment and/or provider network inquiries:
(671) 649-0468 (0GOV) (TakeCare Insurance)

We hope you find the information provided in this booklet useful to help you choose TakeCare health plans for your healthcare needs. If you need additional assistance, please contact our Customer Service Department at **1(671) 647-3526** or **1(877) 484-2411** (toll free), Monday through Friday 8am to 5pm ChST, or by email at: CustomerService@takecareasia.com.

Si Yu'us Ma'ase and Thank You!

Sincerely,



Arvin Lojo
Health Plan Administrator
TakeCare Insurance Company, Inc.

GOVGUAM



SCAN ME

The TakeCare Advantage



You can count on us to deliver comprehensive insurance coverage and quality health care when and where you need it.

- Payroll deduction as low as **\$2.04** bi-weekly¹
- **\$5 Primary Care Copay** at FHP Health Center³
- **\$10 X-Ray Services Copay** at FHP Health Center. \$20 at other in-network providers³
- **\$10 Primary Copay** at AMC, Dr Shieh's Clinic, and MPG. \$20 at other in-network providers³
- **\$10 Generic Medication Copay** at K-Mart, Superdrug, MegaDrug III (FHP). \$15 at other in-network pharmacies³
- **100% Coverage** of Preventive Services, Screenings, Immunizations
- **100% Coverage** for Routine Laboratory Services²
- **100% Coverage** for Disease Management and Wellness Programs²
- Access to expanded Guam provider network including **FHP Health Center, Guam SDA Clinic, Guam Regional Medical City (GRMC), and Guam Radiology Consultants**
- **Access to expanded off-island provider network** including Cedars Sinai, Children's Hospital of Los Angeles, Shriners Hospital for Children, The Queen's Medical Center, Mayo Clinics, MD Anderson Cancer Centers, Bumrungrad Hospital in Thailand, Ascot/Mercy Hospitals in New Zealand
- **100% coverage** for prior authorized services from in-network providers in the Philippines including covered medications at select Mercury Drug & MedExpress Pharmacy locations
- **\$500 Travel Allowance Benefit** available for each approved referral to the Philippines.⁴ Other limitations may apply
- **Wellness and Fitness incentives** up to **\$600** per individual / **\$1,200** per family to reward and encourage you to live a healthy, balance lifestyle.
- **Dedicated Customer Service** (671) 647-3526 or 1(877) 484-2411 (Toll Free). TakeCare Hotline: **(671) 649-0468** (OGOV) FHP Hotline: **(671) 647-0468** (OGOV)
- **My TakeCare Member Portal** gives you access to your claims/benefit information **24/7** and the ability to print your member card at any time
- **TakeCare Mobile App** provides mobile access to your member ID Card, Provider Directory, Wellness Programs, Affinity Wellness Partners & helps you manage your Wellness & Fitness Incentives

¹Employee Only, HSA2000 Active

²Deductible waived on PPO1500, HSA2000

³Subject to deductible on HSA2000

⁴Deductible waived on PPO1500 only

For more information, call 671.647.3526.

Visit our dedicated GovGuam webpage.
SCAN QR CODE OR VISIT LINK BELOW:
www.takecareasia.com/govguam2023



takecareasia.com



Our Island, Your Health Plan™

GovGuam Open Enrollment

Fiscal Year 2023 PLAN RATES

ACTIVE RATE SHARE (Bi-Weekly)

CLASS	PP01500	HSA 2000
I: EMPLOYEE	\$ 77.36	\$ 2.04
II: EMPLOYEE+SPOUSE/DOMESTIC PARTNER	\$ 193.51	\$ 45.08
III: EMPLOYEE & CHILD(REN)	\$ 145.71	\$ 36.21
IV: EMPLOYEE + FAMILY	\$ 239.13	\$ 58.83

RETIREE RATE SHARE (Semi-Monthly)

CLASS	PP01500	HSA 2000	RSP
I: EMPLOYEE	\$ 83.81	\$ 2.21	\$ 0.00
IIa: EMPLOYEE+SPOUSE/DOMESTIC PARTNER	\$ 209.64	\$ 48.84	\$ 0.00
IIb: RSP SUBSCRIBER+SPOUSE/DOMESTIC PARTNER	N/A	N/A	\$194.44
III: EMPLOYEE & CHILD(REN)	\$157.85	\$ 39.23	\$ 74.01
IV: EMPLOYEE + FAMILY	\$259.06	\$ 63.73	N/A
IVa: RSP SUBSCRIBER + FAMILY	N/A	N/A	\$ 0.00
IVb: RSP SUBSCRIBER + FAMILY	N/A	N/A	\$ 452.41

Deduction Classes

Class I - Subscriber Only (No Dependent/s)

Class II - Subscriber + Legal Spouse (Domestic Partner) / RSP Plan both enrolled in Medicare A & B

Class IIb - RSP Subscriber + Non Medicare Spouse/Domestic Partner

Class III - Subscriber + Child(ren) Only - No Spouse (Domestic Partner) / RSP Medicare enrolled RSP Subscriber + Non Medicare Child(ren)

Class IV - Subscriber + Family (Legal Spouse/Domestic Partner & Child(ren))

Class IVa - RSP Subscriber + RSP Spouse/Domestic Partner & Child(ren)

Class IVb - RSP Subscriber + Non Medicare Spouse/Domestic Partner & Child(ren)

GOVGUAM

EMPLOYEES, RETIREES
& SURVIVORS!



OPEN ENROLLMENT SCHEDULE

September 13-26, 2022

TakeCare Hosted Virtual Benefit Briefings Schedule

Every Monday through Friday during Open Enrollment.

Morning Sessions	Afternoon Sessions
10:00 AM-10:45 AM	2:00 PM-2:45 PM

Virtual Presentation Link

Scan QR Code for the online presentation session you choose to view.

GG VIRTUAL



<http://tiny.cc/GovGuamVirtual>



takecareasia.com



Elevating the member/patient experience

TakeCare
The first accredited
health plan on Guam!

Health Plan Accredited by



ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

What does accreditation mean to you?

Achieving health plan accreditation encourages **confidence** that the services available to members meet the established, measurable **quality standards**.

It assures that a **neutral, external party** (AAAHC) has made the evaluation, finding the **quality of service & internal processes** to be satisfactory, based upon appropriate **peer expertise**.

Health plan accreditation is a reliable indication of the **high value and quality of services** provided by the accredited organization.

Through health plan accreditation, you can count on TakeCare to deliver comprehensive insurance coverage with the highest quality and standards of care when and where you need it. Take control of your health care.



takecareasia.com

Connect with us     

 Customer Service (671) 647-3526

Our Island, Your Health Plan™



GovGuam Medical Plan Options

PP01500, HSA2000, RSP

SCHEDULE OF BENEFITS

GovGuam Fiscal Year 2023





GOVGUAM PPO 1500

MEDICAL BENEFITS

Your Benefits: What TakeCare covers	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Deductible Per Individual Member (Class 1) Combined Medical and Prescription.	\$1,500	\$3,000
Deductible Per Family (Class 2, 3, & 4) Combined Medical and Prescription. If a member meets their \$1,500, the plan begins to pay for covered services for the individual.	\$3,000	\$9,000
Coverage Maximums Individual member annual maximum	Unlimited	
Out of Pocket Maximums (including accumulated deductible, copayment, and co-insurance) Combined Medical and Prescription. Per Individual member per policy year Per Family per policy year	\$3,000 \$9,000	No Maximum No Maximum
Any Services in the Philippines, Hawaii & the U.S. Mainland, Japan, Taiwan and Foreign Participating Providers (Prior Authorization Required)	Requires a Referral from your Doctor and approval in advance from TakeCare	

Deductible and Co-Pay do not apply to these Benefits when you go to a Participating Provider	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS After deductible is met
Preventative Services (Out Patient Only) In accordance with the guidelines established by the U.S. Preventive Services Task Force (USPSTF) Grades A and B recommendations. <ul style="list-style-type: none"> Annual Physical Exam <ul style="list-style-type: none"> Members may choose to receive age appropriate annual physical in the Philippines with no dollar limit Breast Pumps (In accordance with Women's Preventive Health guidelines) Includes preventive lab tests 	Plan Pays 100%	Not Covered
Annual Eye Exam (once per member every 12 months)	Plan Pays 100%	Not Covered
Cancer Screenings , including any applicable lab work, for cervical, prostate, colorectal, and breast (in accordance with PL 34-02, 34-03, and 34-109)	Plan Pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%
Immunizations/Vaccinations In accordance with the guidelines established by the Advisory Committee on Immunization Practices of the CDC	Plan Pays 100%	Not Covered
Pre-Natal Care Including Routine Labs and First Ultrasound	Plan Pays 100%	Not covered
Well-Child Care <ul style="list-style-type: none"> Infancy (newborn to nine months) up to 7 visits per plan year Early childhood (one to four years old) up to 7 visits per plan year Middle Childhood/Adolescence (five to seventeen years old) up to one visit per plan year <ul style="list-style-type: none"> In accordance with the Bright Futures/American Academy of Pediatrics recommendations for Preventive Pediatric Health Care 	Plan Pays 100%	Not Covered
Well-Woman Care (In accordance with the guidelines supported by the Health Resource and Service Administration (HRSA)) <ul style="list-style-type: none"> Contraceptive including Sterilization and Tubal Ligation if prescribed. 	Plan Pays 100%	Not Covered
Vision/Optical Hardware Coverage for pair of contact lenses or eyeglasses lens/frames – maximum of \$150 per member per benefit year	Member Pays All Charges above \$150 per benefit year	Not Covered



Deductible does not apply to these benefits
when you go to a Participating Provider

PARTICIPATING PROVIDERS

NON-PARTICIPATING PROVIDERS
After deductible is met

Outpatient Physician Care & Services

1. Primary Care Visits	\$5 Member Co-Payment at FHP Clinic, \$10 Member Co-Payment at Preferred Provider, \$20 Member Co-Payment at Non-Preferred Provider	Plan Pays 70% of Eligible Charges, Member pays 30%
2. Specialist Care Visits	\$40 Member Co-Payment	Plan Pays 70% of Eligible Charges, Member pays 30%
3. Voluntary Second Surgical Opinion	\$40 Member Co-Payment	Plan Pays 70% of Eligible Charges, Member pays 30%
4. Home Health Care Visit, maximum 120 visits	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
5. Hospice, maximum 180 days (Prior Authorization Required)	Plan Pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%
6. Mental Health Care	\$5 Member Co-Payment at FHP Clinic, \$10 Member Co-Payment at Preferred Provider, \$20 Member Co-Payment at Non-Preferred Provider	Plan Pays 70% of Eligible Charges, Member pays 30%
7. Outpatient Laboratory		
Routine and Preventive Laboratory	Plan pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%
Specialty Laboratory	\$20 Member Co-Payment	Plan Pays 70% of Eligible Charges, Member pays 30%
8. X-ray Services	\$10 Member Co-Payment at FHP Clinic \$20 Member Co-Payment outside FHP	Plan Pays 70% of Eligible Charges, Member pays 30%
9. Allergy/serum and Injections (Does not include those on the Specialty Drugs Lists and Orthopedic injections)	Plan Pays 80% Member Pays 20% (Not Subject to Deductible)	Plan Pays 70% of Eligible Charges, Member pays 30% (Not Subject to Deductible)
10. Urgent Care	\$50 Member Co-Payment	Plan Pays 70% of Eligible Charges, Member pays 30%

Deductible must be met for the following services

PARTICIPATING PROVIDERS
After deductible is met

NON-PARTICIPATING PROVIDERS
After deductible is met

Acupuncture (Limited to 30 visits per member per benefit year)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Airfare Benefit to Preferred Providers only TakeCare provides emergency hospital to hospital transportation coverage. For members who meet qualifying conditions. Plan provides roundtrip airfare (Plan Approval Required). (Prior Authorization Required)	Plan Pays 100%	Not Covered
Allergy Testing/Treatment \$1,000 maximum benefit per member per plan year	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Ambulatory Surgi-center Care (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Autism Spectrum Disorder Diagnosis, treatment and behavioral therapy is limited per plan year to \$75,000 up to age 15 years and \$25,000 from ages 16 to 21 years. (Referral from your Primary Care Physician is required and Prior Authorization from TakeCare.)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%

Deductible must be met for the following services	PARTICIPATING PROVIDERS After deductible is met	NON-PARTICIPATING PROVIDERS After deductible is met
Blood & Blood Derivatives	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Breast Reconstructive Surgery (Prior Authorization Required) (In accordance with 1998 W.H.C.R.A)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Cardiac Surgery (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Cataract Surgery (Prior Authorization Required) Outpatient only, including conventional lens	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Chemical Dependency	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Chemotherapy Benefit (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Chiropractic Care	\$40 Member Co-Payment (Not Subject to Deductible)	Plan Pays 70% of Eligible Charges, Member pays 30%
Congenital Anomaly Disease Coverage (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Diagnostic Testing MRI, CT Scan and other diagnostic procedures (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Durable Medical Equipment (DME) The lesser amount between Purchase or Rental of crutches, walkers, wheelchairs, hospital beds, suction machines, nebulizer machine, oxygen, CPAP (excluding disposable supplies), oxygen and accessories when prescribed by a Physician (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Elective Surgery (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Emergency Care (For on and off island emergencies, Plan must be contacted and advised within 48 hours) 1. On/Off Island emergency facility, physician services, laboratory, x-rays 2. If a non-participating provider is used for Emergency Care, your out of pocket expense (applicable deductible, copayment) will be no greater than what it would have been if a participating provider had been utilized. Learn more at www.takecareasia.com/nsa 3. The co-payment is waived if you are admitted to the hospital from emergency room 4. Ambulance Services (Ground Transportation only)	Plan Pays 80% Member Pays 20% (Not Subject to Deductible)	Plan Pays 80% Member Pays 20% (Not Subject to Deductible)
Non-emergency care in a hospital emergency room	Plan Pays 50% Member Pays 50%	Plan Pays 50% Member Pays 50%
End Stage Renal Disease / Hemodialysis (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Hearing Aids Maximum \$500 benefit per member per plan year	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Hospitalization & Inpatient Benefits (Prior Authorization Required) 1. Room & Board for a semi-private room, intensive care, coronary care and surgery 2. All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia and medication 3. Physician's hospital services 4. Inpatient Hospice limited to 30 days	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%

Deductible must be met for the following services	PARTICIPATING PROVIDERS After deductible is met	NON-PARTICIPATING PROVIDERS After deductible is met
Implants (Prior Authorization Required) Limited to cardiac pacemakers, heart valves, stents, Intraocular lenses, orthopedic internal prosthetic devices; (Limitations apply, please refer to contract and certificate of insurance)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Inhalation Therapy	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Maternity Care Labor and Delivery	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Nuclear Medicine (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Occupational Therapy Limited to a total of 60 visits per member per plan year combined with Speech and Physical Therapy. (PCP referral required. Prior Authorization required only for off island referrals.)	\$40 Member Co-Payment (Not Subject to Deductible)	Plan Pays 70% of Eligible Charges, Member pays 30%
Organ Transplant – coverage based on Medicare including but not limited to the following organs. Includes coverage for donor expenses. <ol style="list-style-type: none"> 1. Heart 2. Lung 3. Liver 4. Kidney 5. Pancreas 6. Intestine 7. Bone Marrow 8. Cornea (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan pays 70%. Member Pays 30%
Orthopedic Conditions (Prior Authorization Required) Internal and External Prosthesis such as but not limited to artificial joints, limbs and spinals segments	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Physical Therapy Limited to a total of 60 visits per member per plan year combined with Occupational and Physical Therapy. (PCP referral required. Prior Authorization required only for off island referrals.)	\$40 Member Co-Payment (Not Subject to Deductible)	Plan Pays 70% of Eligible Charges, Member pays 30%
Radiation Therapy (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Robotic Surgery/Robotic Suite (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Skilled Nursing Facility Maximum 60 days per member per plan year (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Sleep Apnea Diagnostic and Therapeutic Procedure (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Speech Therapy Limited to a total of 60 visits per member per plan year combined with Occupational and Physical Therapy. (PCP referral required. Prior Authorization required only for off island referrals.)	\$40 Member Co-Payment (Not Subject to Deductible)	Plan Pays 70% of Eligible Charges, Member pays 30%
Sterilization Procedures (Prior Authorization Required) <ol style="list-style-type: none"> 1. Vasectomy (Outpatient Only) 	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%



Additional Benefits: What TakeCare covers	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Wellness & Fitness Benefit		
1. Wellness Benefits at TakeCare Wellness Center	Plan Pays 100%	Not Covered
2. TakeCare's Wellness and Disease Management Programs and Incentives	Plan Pays 100%	
3. Gym Benefit – TakeCare Preferred Fitness Partner For list of gym partners, please contact TakeCare's Customer Service Department. Be advised that several gyms have maximum enrollment caps and is on a first come first serve basis.	Plan pays 100% for Gym Access per each eligible member while enrolled in a GovGuam medical plan offered by TakeCare.	Not Covered
Outpatient Executive Check-up		
Services are covered at Participating Providers in the Philippines up to the cost but not exceeding Php17,050 per member per plan year. Benefit is not convertible to cash if unused during a plan year and cannot be applied towards any other services. Deductible does not apply.	Plan Pays Up to Php 17,050 Member Pays All Charges Above Plan Payment (Deductible does not apply to these benefits)	Not Covered
Participating Provider Benefit in the Philippines (Prior Authorization is Required)		
Applicable copayment and co-insurance are waived for eligible and covered in-patient and out-patient services after meeting the deductible for covered medical services	Plan Pays 100%	Not Covered
Travel Benefit		
<ul style="list-style-type: none"> - Prior authorization (written approval) and coordination is required from Plan prior to departure from Guam. - Applicable only to approved referrals by TakeCare's Medical Management Department. - Airfare and/or lodging expenses coverage for eligible members for any approved specialty care visits, consultations, treatments and hospitalization services to Participating Philippine providers. - Executive check up, preventive services and/or primary care services do not qualify for this benefit. -Needs to meet coverage requirements and criteria. 	Plan pays up to \$500 per occurrence for prior authorized and approved services	Not Covered



GOVGUAM HSA 2000

MEDICAL BENEFITS

Your Benefits: What TakeCare covers	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Deductible Per Individual Member (Class 1) Combined Medical and Prescription.	\$2,000	\$4,000
Deductible Per Family (Class 2, 3 & 4) Combined Medical and Prescription. If an individual member of a family meets \$3,000 in covered expenses, the plan begins to pay for covered services for that individual.	\$4,000	\$12,000
Coverage Maximums Combined Medical and Prescription. Individual member annual maximum.	Unlimited	
Out of Pocket Maximums (including accumulated deductible, copayment, and co-insurance) Combined Medical and Prescription. Per Individual member per policy year Per Family per policy year	\$4,000 \$12,000	No Maximum No Maximum
Any Services in the Philippines, Hawaii & the U.S. Mainland, Japan, Taiwan and Foreign Participating Providers (Prior Authorization Required)	Requires a Referral from your Doctor and approval in advance from TakeCare	

Deductible and Co-Pay do not apply to these Benefits when you go to a Participating Provider	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS After deductible is met
Preventive Services (Out Patient Only) In accordance with the guidelines established by the U.S. Preventive Services Task Force (USPSTF) Grades A and B recommendations. <ul style="list-style-type: none"> • Annual Physical Exam <ul style="list-style-type: none"> ○ Members may choose to receive age appropriate annual physical in the Philippines with no dollar limit • Breast Pumps (In accordance with Women's Preventive Health guidelines) • Includes preventive lab tests 	Plan Pays 100%	Not Covered
Annual Eye Exam (once per member every 12 months)	Plan Pays 100%	Not Covered
Cancer Screenings , including any applicable lab work, for cervical, prostate, colorectal, and breast (in accordance with PL 34-02, 34-03, and 34-109)	Plan Pays 100%	Plan Pays 50% of Eligible Charges, Member pays 50%
Immunizations/Vaccinations In accordance with the guidelines established by the Advisory Committee on Immunization Practices of the CDC	Plan Pays 100%	Not Covered
Pre-Natal Care Including Routine Labs and First Ultrasound	Plan Pays 100%	Not covered
Well-Child Care <ul style="list-style-type: none"> • Infancy (newborn to nine months) up to 7 visits per plan year • Early childhood (one to four years old) up to 7 visits per plan year • Middle Childhood/Adolescence (five to seventeen years old) up to one visit per plan year <ul style="list-style-type: none"> ○ In accordance with the Bright Futures/American Academy of Pediatrics recommendations for Preventive Pediatric Health Care 	Plan Pays 100%	Not Covered
Well-Woman Care (In accordance with the guidelines supported by the Health Resource and Service Administration (HRSA)) <ul style="list-style-type: none"> • Contraceptive including Sterilization and Tubal Ligation if prescribed. 	Plan Pays 100%	Not Covered
Vision/Optical Hardware Coverage for pair of contact lenses or eyeglasses lens/frames – maximum of \$150 per member per benefit year	Member Pays All Charges above \$150 per benefit year	Member Pays All Charges above \$150 per benefit year



Deductible must be met for the following services	PARTICIPATING PROVIDERS After deductible is met	NON-PARTICIPATING PROVIDERS After deductible is met
Acupuncture (Limited to 30 visits per member per benefit year)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Airfare Benefit to Preferred Providers only TakeCare provides emergency hospital to hospital transportation coverage. For members who meet qualifying conditions. Plan providers roundtrip airfare (Plan Approval Required). (Prior Authorization Required)	Plan Pays 100%	Not Covered
Allergy Testing/Treatment \$1,000 maximum benefit per member per year.	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Ambulatory Surgi-center Care (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Autism Spectrum Disorder Diagnosis, treatment and behavioral therapy is limited per Plan Year to \$75,000 up to age 15 years and \$25,000 from ages 16 to 21 years. (Referral from your Primary Care Physician is required and Prior Authorization from TakeCare.)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Blood & Blood Derivatives	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Breast Reconstructive Surgery (Prior Authorization Required) (In accordance with 1998 W.H.C.R.A)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Cardiac Surgery (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Cataract Surgery (Prior Authorization Required) Outpatient only, including conventional lens	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Chemical Dependency	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Chemotherapy Benefit (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Chiropractic Care	\$40 Member Co-Payment	Plan Pays 50% of Eligible Charges, Member pays 50%
Congenital Anomaly Disease Coverage (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Diagnostic Testing MRI, CT Scan and other diagnostic procedures (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Durable Medical Equipment (DME) The lesser amount between Purchase or Rental of crutches, walkers, wheelchairs, hospital beds, suction machines, nebulizer machine or oxygen, CPAP (excluding disposable supplies), oxygen and accessories when prescribed by a Physician (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Elective Surgery (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Emergency Care (For on and off island emergencies, Plan must be contacted and advised within 48 hours) 1. On/Off Island emergency facility, physician services, laboratory, x-rays 2. If a non-participating provider is used for Emergency Care, your out of pocket expense (applicable deductible, copayment) will be no greater than what it would have been if a participating provider had been utilized. Learn more at www.takecareasia.com/nsa 3. The co-payment is waived if you are admitted to the hospital from emergency room 4. Ambulance Services (Ground Transportation only)	Plan Pays 80% Member Pays 20% (Not Subject to Deductible)	Plan Pays 80% Member Pays 20% (Not Subject to Deductible)
Non-emergency care in a hospital emergency room	Plan Pays 50% Member Pays 50%	Plan Pays 50% Member Pays 50%
End Stage Renal Disease / Hemodialysis (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%



Deductible must be met for the following services	PARTICIPATING PROVIDERS After deductible is met	NON-PARTICIPATING PROVIDERS After deductible is met
Hearing Aids Maximum \$500 benefit per member per year	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Hospitalization & Inpatient Benefits (Prior Authorization Required) 1. Room & Board for a semi-private room, intensive care, coronary care and surgery 2. All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia and medication 3. Physician's hospital services 4. Inpatient Hospice limited to 30 days	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Implants (Prior Authorization Required) Limited to cardiac pacemakers, heart valves, stents, Intraocular lenses, orthopedic internal prosthetic devices; (Limitations apply, please refer to contract and certificate of insurance)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Inhalation Therapy	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Maternity Care Labor and Delivery	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Nuclear Medicine (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Occupational Therapy Limited to a total of 60 visits per member per plan year combined with Speech and Physical Therapy. (PCP referral required. Prior Authorization required only for off island referrals.)	\$40 Member Co-Payment	Plan Pays 50% of Eligible Charges, Member pays 50%
Organ Transplant – coverage based on Medicare including but not limited to the following organs. Includes coverage for donor expenses. 1. Heart 2. Lung 3. Liver 4. Kidney 5. Pancreas 6. Intestine 7. Bone Marrow 8. Cornea (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan pays 50%. Member Pays 50%
Orthopedic Conditions (Prior Authorization Required) Internal and External Prosthesis such as but not limited to artificial joints, limbs and spinal segments	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Outpatient Physician Care & Services		
1. Primary Care Visits	\$5 Member Co-Payment at FHP Clinic, \$10 Member Co-Payment at Preferred Provider, \$20 Member Co-Payment at Non-Preferred Provider	Plan Pays 50% of Eligible Charges, Member pays 50%
2. Specialist Care Visits	\$40 Member Co-Payment	Plan Pays 50% of Eligible Charges, Member pays 50%
3. Voluntary Second Surgical Opinion	\$40 Member Co-Payment	Plan Pays 50% of Eligible Charges, Member pays 50%
4. Home Health Care Visit, maximum 120 visits	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
5. Hospice Care, maximum 180 days (Prior Authorization Required)	Plan pays 100%	Plan Pays 50% of Eligible Charges, Member pays 50%



Deductible must be met for the following services

PARTICIPATING PROVIDERS
After deductible is met

NON-PARTICIPATING PROVIDERS
After deductible is met

Outpatient Physician Care & Services

6. Mental Health Care	\$5 Member Co-Payment at FHP Clinic, \$10 Member Co-Payment at Preferred Provider, \$20 Member Co-Payment at Non-Preferred Provider	Plan Pays 50% of Eligible Charges, Member pays 50%
7. Outpatient Laboratory		
Routine and Preventive Laboratory	Plan pays 100% (Not subject to deductible)	Plan Pays 50% of Eligible Charges, Member pays 50%
Specialty Laboratory	\$20 Member Co-Payment	Plan Pays 50% of Eligible Charges, Member pays 50%
8. X-ray Services	\$10 Member Co-payment at FHP Clinic \$20 Member Co-payment outside FHP	Plan Pays 50% of Eligible Charges, Member pays 50%
9. Allergy testing /serum and Injections (Does not include those on the Specialty Drugs Lists and Orthopedic injections)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
10. Urgent Care	\$50 Member Co-payment	Plan Pays 50% of Eligible Charges, Member pays 50%
Physical Therapy Limited to a total of 60 visits per member per plan year combined with Occupational and Physical Therapy. (PCP referral required. Prior Authorization required only for off island referrals.)	\$40 Member Co-Payment	Plan Pays 50% of Eligible Charges, Member pays 50%
Radiation Therapy (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Robotic Surgery/Robotic Suite (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Skilled Nursing Facility Maximum 60 days per member per plan year (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Sleep Apnea Diagnostic and Therapeutic Procedure (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Speech Therapy Limited to a total of 60 visits per member per plan year combined with Occupational and Physical Therapy. (PCP referral required. Prior Authorization required only for off island referrals.)	\$40 Member Co-Payment	Plan Pays 50% of Eligible Charges, Member pays 50%
Sterilization Procedures (Prior Authorization Required) 1. Vasectomy (Outpatient Only)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%



Additional Benefits: What TakeCare covers	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Wellness & Fitness Benefit		
1. Wellness Benefits at TakeCare Wellness Center	Plan Pays 100%	Not Covered
2. TakeCare's Wellness and Disease Management Programs and Incentives	Plan Pays 100%	
3. Gym Benefit – TakeCare Preferred Fitness Partner For list of gym partners, please contact TakeCare's Customer Service Department. Be advised that several gyms have maximum enrollment caps and is on a first come first serve basis.	Plan pays 100% for Gym Access per each eligible member while enrolled in a GovGuam medical plan offered by TakeCare.	Not Covered
Outpatient Executive Check-up		
Services are covered at Participating Providers in the Philippines up to the cost but not exceeding Php17,050 per member per plan year. Benefit is not convertible to cash if unused during a plan year and cannot be applied towards any other services. Deductible does not apply.	Plan Pays Up to Php 17,050 Member Pays All Charges Above Plan Payment (Deductible does not apply to these benefits)	Not Covered
Participating Provider Benefit in the Philippines (Prior Authorization is Required)		
Applicable copayment and co-insurance are waived for eligible and covered in-patient and out-patient services after meeting the deductible for covered medical services	Plan Pays 100%	Not Covered
Travel Benefit		
<ul style="list-style-type: none"> - Prior authorization (written approval) and coordination is required from Plan prior to departure from Guam. - Applicable only to approved referrals by TakeCare's Medical Management Department. - Airfare and/or lodging expenses coverage for eligible members for any approved specialty care visits, consultations, treatments and hospitalization services to Preferred Philippine providers. - Executive check up, preventive services and/or primary care services do not qualify for this benefit. -Needs to meet coverage requirements and criteria. 	Plan pays up to \$500 per occurrence for prior authorized and approved services	Not Covered



Retiree Supplemental Plan (RSP)

MEDICAL BENEFITS

This supplemental plan is offered for all eligible retirees, spouses of retirees, and survivors, who are age 65 and older and who are enrolled in Medicare Parts A & B, and to eligible retirees and survivors who are under age 65 years of age with a disability or ESRD under Medicare. Non-Medicare dependents will be covered either under the PPO 1500 or HSA 2000 plan.

Your Benefits: What TakeCare covers

<p><u>Plan Description</u></p>	<p>Medicare A & B is primary. The GovGuam plan pays secondary. Medicare covered services should be incurred at a Medicare provider. Services not covered by Medicare, but covered by the plan, should be received at a carrier in-network provider. Carrier will pay primary in this circumstance.</p> <p>Out-of-Network services are not covered unless referred and pre-approved by an in-network provider.</p>
<p><u>Out of Area Service</u> Any Services in the Philippines, Hawaii, U.S. Mainland, Japan, Taiwan, and any foreign participating providers. (Prior Authorization Required)</p>	<p>Requires a referral from your doctor and approval in advance from the plan; When Medicare is not payable (outside U.S.), covered services under the plan are paid at the copay or coinsurance listed and the Plan pays primary in this circumstance. There is no deductible under this plan.</p>
<p>Plan Maximum (Individual member annual maximum)</p>	<p>Unlimited</p>
<p>Deductible and Co-Pay do not apply to these Benefits when you go to a Participating Provider Retiree Supplemental Plan pays¹</p>	
<p><u>Preventative Services (Out Patient Only)</u> In accordance with the guidelines established by the U.S. Preventive Services Task Force (USPSTF) Grades A and B recommendations.</p> <ul style="list-style-type: none"> • Annual Physical Exam <ul style="list-style-type: none"> ◦ Members may choose to receive age appropriate annual physical in the Philippines with no dollar limit • Includes preventive lab tests • Counseling and health screenings 	<p>Medicare covers; When Medicare is not primary, the plan pays 100%</p>
<p><u>Immunizations/Vaccinations</u> In accordance with the guidelines established by the Advisory Committee on Immunization Practices of the CDC</p>	<p>Medicare covers; When Medicare is not primary, the plan pays 100%</p>
<p><u>Well-Woman Care</u> In accordance with the guidelines supported by the Health Resources and Services Administration (HRSA) and the Woman Health and Cancer Act</p> <p><u>Contraceptive including Sterilization and Tubal Ligation</u></p>	<p>Medicare covers; When Medicare is not primary, the plan pays 100%</p>
<p><u>Vision/Optical Hardware</u> Coverage for pair of contact lenses or eyeglasses lens/frames – maximum of \$150 per member per benefit year</p>	<p>Member Pays All Charges above \$150 per benefit year</p>

¹ If a benefit is covered by Medicare, the RSP will cover the Part A or B deductible and the 20% coinsurance. If a benefit is NOT COVERED by Medicare, the RSP will cover the percentage indicated on the Schedule of Benefits.



Deductible and Co-Pay do not apply to these Benefits when you go to a Participating Provider

Retiree Supplemental Plan pays after Primary Insurance ¹

Annual Eye Exam (one exam per member per plan year)
Covered in Guam only

Plan Pays 100%

Outpatient Physician Care & Services

1. Primary Care Visits

Plan pays Medicare Part B deductible, and Medicare 20% coinsurance
Member pays Nothing;
Plan pays 80% when approved outside of Medicare

2. Specialist Care Visits

Plan pays Medicare Part B deductible, and Medicare 20% coinsurance
Member pays Nothing;
Plan pays 80% when approved outside of Medicare

3. Voluntary Second Surgical Opinion

Plan pays Medicare Part B deductible, and Medicare 20% coinsurance
Member pays Nothing;
Plan pays 80% when approved outside of Medicare

4. Home Health Care Visit

Medicare covers;
Member pays Nothing;
Plan pays 80% when approved outside of Medicare

5. Hospice Care, maximum 180 days (Prior Authorization Required)

Plan pays 80%; Member pays 20%

6. Mental Health Care Visit

Plan pays Medicare Part B deductible, and Medicare 20% coinsurance
Member pays Nothing
Plan pays 80% when approved outside of Medicare

7. Outpatient Laboratory (diagnostic or non-preventive labs)

Medicare covers;
Member pays Nothing;
Plan pays 80% when approved outside of Medicare

8. X-Ray Services

Plan pays Medicare Part B deductible, and Medicare 20% coinsurance;
Member pays Nothing;
Plan pays 80% when approved outside of Medicare

9. Injections (Does not include those on the Specialty Drugs lists and Orthopedic injections)

Plan pays Medicare 20% coinsurance;
Member pays Nothing;
Plan pays 80% when approved outside of Medicare

10. Urgent Care

Plan pays Medicare Part B deductible, and Medicare 20% coinsurance;
Member pays Nothing;
Plan pays 80% when approved outside of Medicare

¹ If a benefit is covered by Medicare, the RSP will cover the Part A or B deductible and the 20% coinsurance. If a benefit is NOT COVERED by Medicare, the RSP will cover the percentage indicated on the Schedule of Benefits.



Retiree Supplemental Plan pays after Primary Insurance ¹

<p>Acupuncture (Limited to 30 visits per member per benefit year)</p>	<p>Medicare Primary: Plan pays 100% per visit Outside of Medicare: Plan pays 80% per visit Member pays 20% per visit</p>
<p>Airfare Benefit to Preferred Providers only TakeCare provides emergency hospital to hospital transportation coverage. For members who meet qualifying conditions. Plan providers roundtrip airfare (Plan Approval Required). (Prior Authorization Required)</p>	<p>Plan pays 100%</p>
<p>Allergy Testing/Treatment \$1,000 maximum benefit per member per plan year</p>	<p>Medicare Primary: Plan pays 100% per visit Medicare Secondary: Plan pays 80% per visit outside of Medicare, Member pays 20% per visit</p>
<p>Ambulatory Surgi-center Care (Prior Authorization Required)</p>	<p>Plan pays 80%; Member pays 20%</p>
<p>Blood & Blood Derivatives</p>	<p>Plan pays 80%; Member pays 20%</p>
<p>Breast Reconstructive Surgery (Prior Authorization Required) (In accordance with 1998 W.H.C.R.A)</p>	<p>Plan pays 80%; Member pays 20%</p>
<p>Cancer Screenings, including any applicable lab work, for cervical, prostate, colorectal, and breast (in accordance with PL 34-02, 34-03, and 34-109)</p>	<p>Medicare covers; When Medicare is not primary, the plan pays 100%</p>
<p>Cardiac Surgery (Prior Authorization Required)</p>	<p>Plan pays 80%; Member pays 20%</p>
<p>Cataract Surgery (Prior Authorization Required) Outpatient Only, including conventional lens</p>	<p>Plan pays 80%; Member pays 20%</p>
<p>Chemical Dependency</p>	<p>Plan pays 80%; Member pays 20%</p>
<p>Chemotherapy Benefit (Prior Authorization Required)</p>	<p>Plan pays 80%; Member pays 20%</p>
<p>Chiropractic Care</p>	<p>Plan pays 80%; Member pays 20%</p>
<p>Congenital Anomaly Disease Coverage (Prior Authorization Required)</p>	<p>Plan pays 80%; Member pays 20%</p>
<p>Diagnostic Testing MRI, CT Scan and other diagnostic procedure (Prior Authorization Required)</p>	<p>Plan pays 80%; Member pays 20%</p>
<p>Durable Medical Equipment (DME) The lesser amount between Purchase or Rental of crutches, walkers, wheelchairs, hospital beds, suction machines, nebulizer machine, CPAP (excluding disposable supplies), oxygen and accessories when prescribed by a Physician (Prior Authorization Required)</p>	<p>Plan pays 80%; Member pays 20%</p>
<p>Elective Surgery (Prior Authorization Required)</p>	<p>Plan pays 80%; Member pays 20%</p>
<p>Emergency Care (Plan must be contacted and advised within 48 hours for on and off island emergencies) 1. On/Off Island emergency facility, physician services, laboratory, x-rays 2. If a non-participating provider is used for Emergency Care, your out of pocket expense (applicable deductible, copayment) will be no greater than what it would have been if a participating provider had been utilized. Learn more at www.takecareasia.com/nsa 3. The co-payment is waived if you are admitted to the hospital from emergency room 4. Ambulance Services (Ground Transportation only)</p>	<p>Plan pays 80%; Member pays 20%</p>
<p>End Stage Renal Disease / Hemodialysis (Prior Authorization Required)</p>	<p>Plan pays 80%; Member pays 20%</p>
<p>Hearing Aids Maximum \$500 benefit per member per plan year</p>	<p>Plan pays 80%; Member pays 20%</p>
<p>Hospitalization & Inpatient Benefits (Prior Authorization Required) 1. Room & Board for a semi-private room, intensive care, coronary care and surgery 2. All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia and medication 3. Physician's hospital services 4. Inpatient Hospice limited to 30 days</p>	<p>Medicare Primary: Plan pays 100% per admission Outside of Medicare: Plan pays 80% per admission, Member pays 20% per admission</p>

¹ If a benefit is covered by Medicare, the RSP will cover the Part A or B deductible and the 20% coinsurance. If a benefit is NOT COVERED by Medicare, the RSP will cover the percentage indicated on the Schedule of Benefits.

Implants (Prior Authorization Required) Limited to cardiac pacemakers, heart valves, stents, Intraocular lenses, orthopedic internal prosthetic devices; (Limitations apply, please refer to contract and certificate of insurance)	Plan pays 80%; Member pays 20%
Inhalation Therapy	Plan pays 80%; Member pays 20%
Nuclear Medicine (Prior Authorization Required)	Plan pays 80%; Member pays 20%
Occupational Therapy Limited to a total of 60 visits per member per plan year combined with Speech and Physical Therapy. (PCP referral required. Prior Authorization required only for off island referrals.)	Medicare Primary: Plan pays 100% per admission Outside of Medicare: Plan pays 80% per admission, Member pays 20% per admission
Optical Benefit Coverage for pair of contact lenses or eyeglasses lens/frames – maximum of \$150 per member per benefit year	Member Pays All Charges above \$150 per benefit year
Organ Transplant – coverage based on Medicare including but not limited to the following organs. Includes coverage for donor expenses. 1. Heart 2. Lung 3. Liver 4. Kidney 5. Pancreas 6. Intestine 7. Bone Marrow 8. Cornea (Prior Authorization Required)	Medicare Primary: Plan pays 100% Outside of Medicare: Plan pays 80%; Member pays 20%*
Orthopedic Conditions (Prior Authorization Required) Internal and External Prosthesis such as but not limited to artificial joints, limbs and spinals segments	Plan pays 80%; Member pays 20%
Physical Therapy Limited to a total of 60 visits per member per plan year combined with Occupational and Physical Therapy. (PCP referral required. Prior Authorization required only for off island referrals.)	Medicare Primary: Plan pays 100% per admission Outside of Medicare: Plan pays 80% per admission, Member pays 20% per admission
Radiation Therapy (Prior Authorization Required)	Plan pays 80%; Member pays 20%
Robotic Surgery/Robotic Suite (Prior Authorization Required)	Plan pays 80%; Member pays 20%
Skilled Nursing Facility Maximum 60 days per member per plan year (Prior Authorization Required)	Plan pays 80%; Member pays 20%
Sleep Apnea Diagnostic and Therapeutic Procedure (Prior Authorization Required)	Plan pays 80%; Member pays 20%
Speech Therapy Limited to a total of 60 visits per member per plan year combined with Occupational and Physical Therapy. (PCP referral required. Prior Authorization required only for off island referrals.)	Plan pays 80%; Member pays 20%
Sterilization Procedures (Prior Authorization Required) 1. Vasectomy (Outpatient Only)	Plan pays 80%; Member pays 20%

¹ If a benefit is covered by Medicare, the RSP will cover the Part A or B deductible and the 20% coinsurance. If a benefit is NOT COVERED by Medicare, the RSP will cover the percentage indicated on the Schedule of Benefits.



Additional Benefits: What TakeCare covers	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Wellness & Fitness Benefit		
1. Wellness Benefits at TakeCare Wellness Center	Plan Pays 100%	Not Covered
2. TakeCare's Wellness and Disease Management Programs and Incentives	Plan Pays 100%	
3. Gym Benefit – TakeCare Preferred Fitness Partner For list of gym partners, please contact TakeCare's Customer Service Department. Be advised that several gyms have maximum enrollment caps and is on a first come first serve basis.	Plan pays 100% for Gym Access per each eligible member while enrolled in a GovGuam medical plan offered by TakeCare.	Not Covered
Travel Benefit		
<ul style="list-style-type: none"> - Prior authorization (written approval) and coordination is required from Plan prior to departure from Guam. - Applicable only to approved referrals by TakeCare's Medical Management Department. - Airfare and/or lodging expenses coverage for eligible members for any approved specialty care visits, consultations, treatments and hospitalization services to Preferred Philippine providers. - Executive check up, preventive services and/or primary care services do not qualify for this benefit. -Needs to meet coverage requirements and criteria. 	Plan pays up to \$500 per occurrence for prior authorized and approved services	Not Covered

¹ If a benefit is covered by Medicare, the RSP will cover the Part A or B deductible and the 20% coinsurance. If a benefit is NOT COVERED by Medicare, the RSP will cover the percentage indicated on the Schedule of Benefits.



MEDICAL EXCLUSIONS

The following services are not covered by TakeCare:

1. No benefits will be paid for Injury or Illness, (a) when the Covered Person is entitled to receive disability benefits or compensation (or forfeits his or her right thereto) under Worker's Compensation or Employer's Liability Law for such Injury or Illness or (b) when Services for an Injury or Illness are rendered to the Covered Person by any federal, state, territorial, municipal or other governmental instrumentality or agency without charge, or (c) when such Services would have been rendered without charge but for the fact that the person is a Covered Person under the Plan.
2. No benefits will be paid if any material statement made in an application for coverage, enrollment of any Dependent or in any claim for benefits is false. Upon identifying any such false statement, Company shall give the Covered Person at least 30 day notice that his or her benefits have been suspended and that his or her coverage is to be terminated. If the false statement is fraudulent or is an intentional misrepresentation of a material fact, such termination shall be retroactive to the date coverage was provided or continued based on such fraudulent statement or intentional misrepresentation of material fact. If the false statement was not a fraudulent statement or intentional misrepresentation of material fact, termination of coverage shall be effective no earlier than the date of the suspension. The Covered Person may dispute any termination of coverage by filing a claim under the PPACA Claims Procedure for internal or external appeals, set out in §6.7 of this Certificate. If an appeal under §6.7 is filed, the resolution of the matter shall be in accordance with the outcome of the appeal proceedings. If no appeal is filed for any retroactive termination and the Company paid benefits prior to learning of any such false statement, the Subscriber must reimburse the Company for such payment. Terminations of coverage shall be handled in accordance with the applicable claims procedure requirements of Section 2719 of the PHSA, as added by PPACA. Retroactive terminations of coverage shall not violate the applicable prohibitions on rescissions of Section 2712 of the PHSA, as added by PPACA, and rescissions shall be handled in compliance with PPACA's applicable claim denial requirements.
3. No benefits will be paid for confinement in a Hospital or in a Skilled Nursing Facility if such confinement is primarily for custodial or domiciliary care. (Custodial or domiciliary care includes that care which consists of training in personal hygiene, routine nursing services and other forms of self care. Custodial or domiciliary care also includes supervisory services by a Physician or Nurse for a person who is not under specific medical or surgical treatment to reduce his or her disability and to enable that person to live outside an institution providing such care.) Company and not Covered Person shall be liable if the Company approves the confinement, regardless of who orders the service.
4. No benefits will be paid for nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
5. No benefits will be paid for private Duty Nursing. This provision does not apply to Home Health Care.
6. No benefits will be paid for special medical reports, including those not directly related to treatment of the Member. (e.g., Employment or insurance physicals, and reports prepared in connection with litigation.)
7. No benefits will be paid for services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.
8. No benefits will be paid for court ordered services, or those required by court order as a condition of parole or probation.
9. No benefits will be paid for Services and supplies provided to a Covered Person for an Injury or Illness resulting from an attempted suicide by that Covered Person unless resulting from a medical condition (including physical or mental health conditions) or from domestic violence.
10. No benefits will be paid for Services and supplies provided in connection with intentionally self-induced or intentionally self-inflicted injuries or illnesses unless resulting from a medical condition (including physical or mental conditions) or from domestic violence.
11. No benefits will be paid for Services and supplies provided to a Covered Person for Injuries incurred while the person was committing a criminal act.

MEDICAL EXCLUSIONS

12. Unless otherwise specifically provided in the Agreement, no benefit will be paid for, or in connection with, airfare and the Company will not pay for the transportation from Guam to any off-island facility, nor for any other non-medical expenses such as taxes, taxis, hotel rooms, etc. In no event will the Company pay for air ambulance or for the transportation of the remains of any deceased person.
13. No benefits will be paid for living expenses for Covered Persons who require, or who of their own accord seek, treatment in locations removed from their home.
14. No benefits will be paid for Services and supplies provided to a dependent of a non-Spouse Dependent. Dependents of non-Spouse Dependents are not eligible for coverage. For example, when a Dependent, other than a Spouse of the Subscriber, has a child, that child is a dependent of a non-Spouse Dependent and is not eligible to become covered under the Plan, unless such child otherwise becomes eligible for enrollment.
15. No benefits will be paid for home uterine activity monitoring.
16. No benefits will be paid for services performed by an immediate family member for which, in the absence of any health benefits coverage, no charge would be made. Immediate family member is defined as parents, spouses, siblings, or children of the insured member.
17. No benefits will be paid for treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. If a Member is covered under a Workers' Compensation law or similar law, and submits proof that the Member is not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational" regardless of cause. The Covered Benefits under the Group Health Insurance Certificate for Members eligible for Workers' Compensation are not designed to duplicate any benefit to which they are entitled under Workers' Compensation Law. All sums payable for Workers' Compensation services provided under the Group Health Insurance Certificate shall be payable to, and retained by Company. Each Member shall complete and submit to Company such consents, releases, assignments and other documents reasonably requested by Company in order to obtain or assure reimbursement under the Workers' Compensation Law
18. No benefits will be paid for:
 - a. Drugs or substances not approved by the Food and Drug Administration (FDA), or
 - b. Drugs or substances not approved by the FDA for treatment of the illness or injury being treated unless empirical clinical studies have proven the benefits of such drug or substance in treating the illness or injury, or
 - c. Drugs or substances labeled "Caution: limited by federal law to investigational use." or
 - d. Any drug or substance which does not, by federal or state law, require a prescription order (i.e., an over-the-counter (OTC) drug).
19. No benefits will be paid for experimental or Investigational Procedures, or ineffective surgical, medical, psychiatric, or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes, unless deemed medically necessary by the patient's physician and pre-authorized by the Company.

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

MEDICAL EXCLUSIONS

An approved clinical trial is defined as:

- Phase I, Phase II, Phase III, or Phase IV clinical trial,
- Being conducted in relation to the prevention, detection or treatment for Cancer or other life threatening disease or condition, and
- Is one of the following:
 1. A federally funded or approved trial.
 2. A clinical trial conducted under an FDA investigational new drug application.
 3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

20. No benefits will be paid for services or supplies related to Genetic Testing except as may be required by PPACA.
21. No benefits will be paid for any item or substance that is available without a Physician's prescription even if prescribed by a Physician, except as otherwise provided herein and except for medicines and supplies Medically Necessary for inpatient care.
22. No benefits will be paid for Services and supplies provided to perform transsexual surgery or to evaluate the need for such surgery. Evaluations and subsequent medications and Services necessary to maintain transsexual status are also excluded from coverage, as are complications or medical sequela of such surgery or treatment.
23. No benefits will be paid for injuries incurred by the operator of a motorized vehicle while such operator is under the influence of intoxicating alcoholic beverage, controlled drugs, or substances. If a blood alcohol level or the DRAEGER ALCO TEST is available and shows levels that are equal to or exceed 0.08 grams percent (gms%) or that exceed the amount allowed by law as constituting legal intoxication, no benefits will be paid.
24. No benefits will be paid for any medical Service or supply which is available to the Covered Person on Guam and which is paid by or reimbursable through a governmental agency or institution that provides medical and healthcare services to low-income or indigent persons, provided, however, this exclusion shall not apply to the treatment of any communicable disease as defined in Article 3 of Chapter 3, Title 10, Guam Code Annotated, and for which the Company shall pay for medical services and supplies as is medically necessary for the treatment of Covered Person. However, notwithstanding the aforesaid, in no event will the Company consider the availability of benefits under Medicaid or Medically Indigent Program when paying benefits under this Agreement.
25. No benefits will be paid in connection with elective abortions unless Medically Necessary.
26. No benefits will be paid for vision care services, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision), lasik, keratoplasty, and radial keratotomy, including related procedures designed to surgically correct refractive errors except as provided in the Covered Benefits section of the Group Health Insurance Certificate.
27. No benefits will be paid for eyeglasses or contact lenses or for Services and supplies in connection with surgery for the purpose of diagnosing or correcting errors in refraction except as provided in the Schedule of Benefits.
28. No benefits will be paid in connection with any injuries sustained while the Covered Person is operating any wheeled vehicle during an organized, off-road, competitive sporting event.
29. No benefits will be paid for personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies.
30. No benefits will be paid for hypnotherapy.
31. No benefits will be paid for religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.
32. No benefits will be paid for cosmetic Surgery or other services intended primarily to improve the Member's appearance or treatment relating to the consequences of, or as a result of, Cosmetic Surgery. This exclusion does not apply to:

MEDICAL EXCLUSIONS

- a. Medically Necessary reconstructive surgery as described in the Covered Benefits sections Mastectomy and Reconstructive Breast Surgery or Reconstructive Surgery.
 - b. surgery to correct the results of injuries causing an impairment.
 - c. surgery as a continuation of a staged reconstruction procedure, including but not limited to post-mastectomy reconstruction;
 - d. surgery to correct congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.
33. No benefits will be paid for routine foot/hand care, including routine reduction of nails, calluses and corns.
34. Except as otherwise provided in this agreement, no benefit will be paid for specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
35. No benefits will be paid for Services and supplies associated with growth hormone treatment unless the Covered Person is proven to have growth hormone deficiency using accepted stimulated growth hormone analyses and also shows an accelerated growth response to growth hormone treatment. Under no circumstances will growth hormone treatment be covered to treat short stature in the absence of proven growth hormone deficiency.
36. No benefits will be paid for Services and supplies provided for liposuction.
37. No benefits will be paid for weight reduction programs, or dietary supplements, except as pre-authorized by Company for the Medically Necessary treatment of morbid obesity.
38. No benefits will be paid for any drug, food substitute or supplement or any other product, which is primarily for weight reduction even if it is prescribed by a Physician.
39. Except as provided in this Agreement, or unless medically necessary for the treatment of Morbid Obesity or other disease, no benefit will be paid for gastric bypass, stapling or reversal if for the purpose of weight reduction or aesthetic purposes.
40. No benefits will be paid for surgical operations, procedures or treatment of obesity, except when pre-authorized by Company.
41. No benefits will be paid for the treatment of male or female Infertility, including but not limited to:
- a. The purchase of donor sperm and any charges for the storage of sperm;
 - b. The purchase of donor eggs and any charge associated with care of the donor required for donor egg retrievals or transfers or gestational carriers;
 - c. Charges associated with cryopreservation or storage of cryopreserved embryos (e.g. office, hospital, ultrasounds, laboratory tests, etc.);
 - d. Home ovulation prediction kits;
 - e. Injectable Infertility medications, including but not limited to, menotropins, hCG, GnRH agonists, IVIG;
 - f. Artificial Insemination, including in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and intracytoplasmic sperm injection (ICSI), and any advanced reproductive technology ("ART") procedures or services related to such procedures;
 - g. Any charges associated with care required for ART (e.g., office, Hospital, ultrasounds, laboratory tests, etc.);
 - h. Donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
 - i. Any charge associated with a frozen embryo transfer including but not limited to thawing charges;

MEDICAL EXCLUSIONS

- j. Reversal of sterilization surgery; and
 - k. Any charges associated with obtaining sperm for ART procedures.
42. Except as provided in this Agreement, no benefits will be paid for the purchase or rental of durable or disposable medical equipment and supplies, other than for:
- a. Equipment and supplies used in a Hospital or Skilled Nursing Facility, or in conjunction with an approved Hospital or Skilled Nursing Facility confinement, or as otherwise noted in the Agreement or
 - b. Items covered as preventive care under well-women coverage such as breastfeeding supplies in accordance with reasonable medical management techniques.
43. No benefits will be paid for household equipment, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbed, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Member's house or place of business, and adjustments to vehicles.
44. No benefits will be paid for outpatient supplies (except diabetic supplies), including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, and elastic stockings.
45. No benefits will be paid for Services and supplies provided for penile implants of any type.
46. No benefits will be paid for Services and supplies to correct sexual dysfunction.
47. Except as specifically provided, if a benefit is excluded, all Hospital, surgical, medical treatments, prescription drugs, laboratory services, and x-rays in relation to the excluded benefits are also excluded as of the time it is determined that the benefit is excluded.
48. Except as specifically provided in this Agreement, no benefits will be provided for Services and supplies not ordered by a Physician or not Medically Necessary.
49. No benefits will be paid for temporomandibular joint disorder treatment (TMJ) including treatment performed by prosthesis placed directly on the teeth except as covered in the Covered Benefits Section
50. Except as specifically provided in this Agreement, no benefits will be paid for corrective appliances, artificial aids and durable equipment.
51. No benefits will be paid for Services for which the Covered Person or Subscriber is not legally obligated to pay.
52. No benefit will be paid for ambulance services when used for routine and convenience transportation to receive outpatient or inpatient services, unless deemed medically necessary with prior authorization obtained from Company.
53. Elective or voluntary enhancement procedures, surgeries, services, supplies and medications including, but not limited to, hair growth, hair removal, hair analysis, sexual performance, athletic performance, anti-aging, and mental performance, even if prescribed by a Physician.
54. No benefits will be paid for hospital take-home drugs.
55. No benefits will be paid for fees for any missed appointments or voluntary transfer of records as requested by the Covered Person.
56. No benefits will be paid for educational services. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, are not covered.
57. No benefits will be paid for Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition.

MEDICAL EXCLUSIONS

58. No benefits will be paid for Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms or whether providing or receiving the Service.
59. No benefits will be paid for non-medically necessary services, including but not limited to, those services and supplies:
 - a. Which are not Medically Necessary, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;
 - b. That do not require the technical skills of a medical or mental health professional;
 - c. Furnished mainly for the personal comfort or convenience of the Member, or any person who cares for the Member, or any person who is part of the Member's family, or any Provider;
 - d. Furnished solely because the Member is an inpatient on any day in which the Member's disease or injury could safely and adequately be diagnosed or treated while not confined;
 - e. Furnished solely because of the setting if the service or supply could safely and adequately be furnished in a Physician's or a dentist's office or other less costly setting.
60. As required by HIPAA, no source-of-injury exclusion, such as exclusion 4.29 for off-road sporting events, will apply if the accident resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions).
61. No benefits will be paid for any continued services if you do not substantially follow your treatment plan or do not follow medical advice.

NOTES



Group Health Certificate

GOVERNMENT OF GUAM and TAKECARE INSURANCE COMPANY, INC.

GROUP HEALTH INSURANCE CERTIFICATE
FOR THE PERIOD OF:
OCTOBER 1, 2022 - SEPTEMBER 30, 2023



Health Plan Accredited by



A TanHoldings Company

takecareasia.com

Customer Service 671.647.3526 | Toll Free 1.877.484.2411 | customerservice@takecareasia.com

Our Island, Your Health Plan™

Connect with us     

How your plan works

How your medical plan works while you are covered in-network

You're in-network/participating coverage:

- Helps you get and pay for a lot of – but not all – health care services. Your cost share is lower when you use a network provider.

Providers

Our provider network is there to give you the care you need. You can find network providers and see important information about them most easily on our online provider directory. Just log in to the TakeCare's website www.takecareasia.com

Service area

Your plan generally pays for covered services only within a specific geographic area, called a service area, (e.g. Primary Care, Preventive Care, Chiropractic Care, Maternity Care, Hospice Services, Vision/Optical Hardware). There are some exceptions, such as for emergency services, urgent care, and transplant services. Your service area under this plan is Guam, CNMI and Palau

See the Who provides the care section below.

How your medical plan works while you are covered out-of-network

With your out of network/non-participating coverage:

- You can get care from providers who are not part of the TakeCare's network without a PCP referral
- You may have to pay the full cost for your care, and then submit a claim to be reimbursed
- You are responsible to get any required prior authorization/pre-certification
- Your cost share will be higher

Keeping a provider you go to now (continuity of care)

You may have to find a new provider when:

- You join the plan and the provider you have now is not in the network
- You are already a TakeCare's member and your provider stops being in our network

However, in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

If this situation applies to you, contact us for details. If we approve your request to keep going to your current provider, we will tell you how long you can continue to see the provider. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery.

We will authorize coverage only if the provider agrees to our usual terms and conditions for contracting providers.

Who provides the care?

Network providers

We have contracted with providers in the service area to provide covered services to you. These providers make up the network for your plan.

A select number of network providers are considered "preferred" with a lower copay/visit for you. These providers have entered into a written agreement with TakeCare to provide care or treatment at preferential or better rates compared to other network providers and have demonstrated better outcomes based on a standard measurement set (HEDIS) by the National Committee for Quality Assurance ("NCQA"). The network providers identified in our directory as preferred in-network providers are subject to change. Please check with us to confirm the preferential status of network providers.

To get network benefits, you must use network providers. There are some exceptions:

- **Emergency services** – see the description of emergency services in the Coverage and exclusions section.
- **Urgent care** – see the description of urgent care in the Coverage and exclusions section.
- **Transplants** – see the description of transplant services in the Coverage and exclusions section.

You may select a network provider from the online directory through the TakeCare's website.

You will not have to submit claims for services received from network providers. Your network provider will take care of that for you. And we will pay the network provider directly for what the plan owes.

Primary Care Provider (PCP)

We encourage you to get covered services through a PCP. They will provide you with primary care.

How you choose your PCP

You can choose a PCP from the list of PCPs in our directory.

Each covered family member is encouraged to select a PCP. You may each choose a different PCP. You should select a PCP for your covered dependent if they are a minor or cannot choose a PCP on their own.

What your PCP will do for you

Your PCP will coordinate your medical care or may provide treatment. They may send you to other network providers.

Changing your PCP

You may change your PCP at any time by contacting us.

Medical necessity, referral and Prior Authorization/ Prior Certification requirements

Your plan pays for its share of the expense for covered services only if the general requirements are met. They are:

- The service is medically necessary.
- For in-network benefits, you get the service from a network provider.

- You or your provider preauthorize the service when required.

Medically necessary/medical necessity

The Medically necessary/medical necessity requirements are in the Glossary section, where we define “medically necessary/medical necessity” That is where we also explain what our medical directors or a physician they assign consider when determining if a service is medically necessary.

Important note:

We cover medically necessary, sex-specific covered services regardless of identified gender.

Prior authorization/Pre-certification

You need pre-approval from us for some covered services. Pre-approval is also called preauthorization.

In-network/Participating

Your network physician is responsible for obtaining any necessary preauthorization before you get the care. Network providers cannot bill you if they fail to ask us for preauthorization. But if your physician requests preauthorization and we deny it, and you still choose to get the care, you will have to pay for it yourself.

Out of Network/Non-Participating

When you go to an out-of-network provider, you are responsible to get any required preauthorization from us. If you don't preauthorize:

- Your benefits may be reduced, or the plan may not pay. See your schedule of benefits for details.
- You will be responsible for the unpaid bills.
- Your additional out-of-pocket expenses will not count toward your deductible or maximum out-of-pocket limit.]

Notification is required to TakeCare within 48 hours after receiving emergency and urgent care services otherwise these services are not covered.

An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or injury.

We will tell you and your physician in writing of the preauthorization decision, where required by state law. An approval is valid for 2 months as long as you remain enrolled in the plan.

For an inpatient stay in a facility, we will tell you, your physician and the facility about your preauthorized length of stay. If your physician recommends that you stay longer, the extra days will need to be preauthorized. You, your physician, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. We will tell you and your physician in writing of an approval or denial of the extra days.

If you or your provider request preauthorization and we don't approve coverage, we will tell you why and explain how you or your provider may request review of our decision. See the Complaints, claim decisions and appeal procedures section.

Types of services that require Prior Authorization/ Prior Certification

Preauthorization is required for the following types of services and supplies:

- Inpatient services and supplies
 - o Stays in a hospital
 - o Stays in a skilled nursing facility
 - o Stays in a rehabilitation facility
 - o Stays in a hospice facility
 - o Stays in a residential treatment facility for treatment of mental disorders and substance related disorders
 - o Obesity surgery (bariatric)
- Outpatient services and supplies
 - o Cosmetic and reconstructive surgery

Contact us to get a list of the services that require preauthorization or see your schedule of benefits.

Sometimes you or your provider may want us to review a service that doesn't require precertification before you get care. This is called a predetermination, and it is different from precertification. Predetermination means that you or your provider requests the pre-service clinical review of a service that does not require precertification.

Certain prescription drugs are covered under the medical plan when they are given to you by your doctor or health care facility. The following precertification information applies to these prescription drugs:

For certain drugs, your provider needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are medically necessary.

Step therapy is a type of precertification where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

Contact us to get the most up-to-date preauthorization requirements and list of step therapy drugs.

Requesting a medical exception

Sometimes you or your provider may ask for a medical exception for drugs that are not covered or for which coverage was denied. You, someone who represents you or your provider can contact us. You will need to provide us with clinical documentation. Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members.

You, someone who represents you or your provider may seek a quicker medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a non-preferred drug.

MEMBER HANDBOOK

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your prescriber of our decision.

Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work with your other plan to decide how much each plan pays. This is called coordination of benefits (“COB”).

Key Terms

Here are some key terms we use in this section. These will help you understand this COB section.

Allowable expense means a health care expense that any of your health plans cover.

In this section when we talk about “plan” through which you may have other coverage for health care expenses we mean:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile insurance policy
- Medicare or other government benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

How Coordination of Benefits (COB) works

- When this is your primary plan, we pay your medical claims first as if there is no other coverage.
- When this is your secondary plan:
 - o We pay benefits after the primary plan and reduce our payment based on any amount the primary plan paid.
 - o Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.
 - o Each family member has a separate benefit reserve for each year. The benefit reserve balance is:
 - The amount that the secondary plan saved due to COB
 - Used to cover any unpaid allowable expenses
 - Erased at the end of the year

Determining who pays

The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. Contact us if you have questions or want more information.

A plan that does not contain a COB provision is always the primary plan.

COB rule	Primary Plan	Secondary Plan
Non-dependent or dependent	Plan covering you as an employee, retired employee or subscriber (not as a dependent)	Plan covering you as a dependent
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together	<ul style="list-style-type: none"> • Plan of parent responsible for health coverage in court order • Birthday rule applies if both parents are responsible or have joint custody in court order • Custodial parent’s plan if there is no court order 	<ul style="list-style-type: none"> • Plan of other parent • Birthday rule applies (later in the year) • Non-custodial parent’s plan
Child – covered by individuals who are not parents (i.e., stepparent or grandparent)	Same rule as parent	Same rule as parent
Active or inactive employee	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former)
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally	Plans share expenses equally

How COB works with Medicare

If your other coverage is under Medicare, federal laws explain whether Medicare will pay first or second. COB with Medicare will always follow federal requirements. Contact us if you have any questions about this.

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare or after an amount that Medicare would have paid if you had been covered. You are eligible for Medicare if you are covered under it.

For Medicare primary members, services are subject to prior approval and authorization by TakeCare for services outside the United States. Coverage is not guaranteed.

Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. See the schedule of benefits for more information.

Your current plan must be offered through the policyholder.

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

Our rights

We have the right to:

- Release or obtain any information we need for COB purposes, including information we need to recover any payments from your other health plans
- Reimburse another health plan that paid a benefit we should have paid
- Recover any excess payment from a person or another health plan, if we paid more than we should have paid

Benefit payments and claims

A claim is a request for payment that you or your health care provider submits to us when you want or get covered services. There are different types of claims. You or your provider may contact us at various times, to make a claim, to request approval, or payment, for your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit.

It is important that you carefully read the previous sections within How your plan works. When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. The amount of time we have to tell you about our decision on a claim depends on the type of claim.

Claim type and timeframes

Urgent care claim

An Urgent Care Claim means any claim for medical care or treatment that, if not quickly decided outside of standard time periods for making non-urgent care determinations, (1) could seriously jeopardize the life or health of the individual or the ability of the individual to regain maximum function; or (2) in the opinion of a physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-service claim

A Pre-service Claim means any claim for a benefit for which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care, or a determination of no coverage under the plan.

Post-service claim

A post-service claim is a claim that involves health care services you have already received.

Concurrent care claim extension

A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a hospital stay or adding a number of visits to a provider. You must let us know you need this extension 24 hours before the original approval ends.

Concurrent care claim reduction or termination

A concurrent care claim reduction or termination occur when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us.

During this continuation period, you are still responsible for your share of the costs, such as copayments, coinsurance and deductibles that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

Filing a claim

When you see a network provider, that office will usually send us a detailed bill for your services. If you see an out-of-network provider, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you should send it to within 90 days from the date of service with a claim form that you can either get online or contact us to provide. You should always keep your own record of the date, providers and cost of your services.

The benefit payment determination is made based on many things, such as your deductible or coinsurance, the necessity of the service you received, when or where you receive the services, or even what other insurance you may have. We may need to ask you or your provider for some more information

to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the Complaints, claim decisions and appeal procedures section for that information.

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

You may not be happy about a provider or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

Appeal

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

Claim decisions and appeal procedures

Your provider may contact us at various times to make a claim, or to request approval for payment based on your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit. You may not agree with our decision. As we said in Benefit payments and claims in the How your plan works section, we pay many claims at the full rate, except for your share of the costs. But sometimes we pay only some of the claim. Sometimes we deny payment entirely.

Any time we deny even part of the claim, it is an “adverse benefit determination” or “adverse decision.” For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don't agree, you can also appeal that decision.

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your provider may appeal for you without having to fill out an appeal form. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

Any other claim appeal

You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by contacting us. You need to include:

Your name

- The policyholder's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 30 calendar days for a post-service claim.

If you are still not like us answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Another person may submit an appeal for you, including a provider. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your provider). You should fill out an authorized representative form telling us you are allowing someone to appeal for you. You can get this form on our website or by contacting us. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

At your last available level of appeal, we will give you any new or additional information we may find and use to review your claim. There is no cost to you. We will give you the information before we give you our decision.

This decision is called the final adverse benefit determination. You can respond to the information before we tell you what our final decision is.

Exhaustion of appeal process

In most situations, you must complete the two levels of appeal with us before you can take these other actions:

- Contact the Guam Department of Revenue and Taxation to request an investigation of a complaint or appeal. File a complaint or appeal with the Guam Department of Revenue and Taxation.

- Pursue arbitration, litigation or other type of administrative proceeding

Sometimes you do not have to complete the two levels of appeal before you may take other actions. These situations are:

- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the external review process at the same time.
- We did not follow all of the claim determination and appeal requirements of the state. But you will not be able to proceed directly to external review if:
 - o The rule violation was minor and not likely to influence a decision or harm you
 - o The violation was for a good cause or beyond our control
 - o The violation was part of an ongoing, good faith exchange between you and us

Utilization review

Prescription drugs covered under this plan are subject to misuse, waste or abuse utilization review by us, your provider or your network pharmacy. The outcome of the review may include:

- Limiting coverage of a drug to one prescribing provider or one network pharmacy
- Quantity, dosage or day supply limits

Recordkeeping

We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

Eligibility, starting and stopping coverage

Eligibility

- * Government of Guam Employee, Retiree, or Survivor
- * Maintain Residency in Guam/CNMI
- * GovGuam employee working 30 hours or more per week
- * For RSP Plan, continuous enrollment in both Medicare Part A and B

Who is eligible

The policyholder decides and tells us who is eligible for health care coverage.

Residency requirement

For purposes of this requirement, Service Area is defined as Guam and CNMI and Covered Persons excludes covered dependent children. Enrollment in the Plan shall be limited to only those Covered Persons who are Domiciled in the Service Area and do not reside out of the Service Area for more than 182 consecutive days per plan year. TakeCare shall be entitled to prior notice from the Covered Person concerning his/her residency status and the failure of the Covered Person to provide this prior notice may result in a denial of benefits under this Agreement. TakeCare shall also be entitled to require substantiation from a Covered Person to determine the Covered Person's Domicile and may deny benefits under this Agreement for lack thereof. Covered Persons outside the Service Area must coordinate their care and obtain Prior Authorization from TakeCare for Services, excluding Emergency services. For a Covered Person who is Domiciled in the Service Area, time spent receiving continuous medical Services of the Service Area shall not count toward the 182-day maximum provided the receipt of such Services precludes returning to the Service Area. Further, time spent by a parent or spouse of such Covered Person shall not count toward the 182-day maximum, provided the parent or spouse is providing necessary assistance to the Covered Person and further provided that under no circumstance can there be more than one such caregiver hereunder for any incident out of the Service Area.

When can you join the plan

You can enroll:

- During an open enrollment period.
- After open enrollment period. Persons becoming eligible for enrollment after open enrollment may elect to enroll within (31) thirty days of the date of first becoming eligible.

Who can be a dependent on this plan

You can enroll the following given that you submit required documentations:

- The subscriber's legal spouse. A copy of official marriage certificate must be submitted.
- The subscriber's common law spouse. A notarized affidavit and proof of common law status.
- The subscriber's domestic partner. A notarized affidavit must be submitted. The subscriber's domestic partner who is (1) 18 years of age or older, (2) of the same or opposite sex as the Subscriber, (3) in an

exclusive mutually committed relationship with the Subscriber and intends to remain the Subscriber's sole domestic partner, (4) not married to any other person, (5) and not related to the Subscriber by blood to a degree that would prohibit marriage; and (6) has cohabitated with the Subscriber for the two (2) consecutive years immediately preceding the proposed Enrollment. A notarized affidavit and proof of domestic partner status.

- The subscriber's children up to age 26; unmarried:
 - o **Natural children.** A copy of an official certificate listing the subscriber as a parent must be submitted.
 - o **Adopted children** including those placed with you for adoption. A copy of the court document signed by a judge ordering legal adoption.
 - o **Stepchildren.** A copy of an official birth certificate and official marriage certificate listing the subscriber's legal spouse as a parent must be submitted.
 - o **Disabled children over age (26) twenty-six years** A copy of disability enrollment form signed by a licensed physician must be submitted.
 - o **Children under court order.** A copy of court document signed by a judge requiring such coverage must be submitted.
 - o **Children under legal guardianship.** A copy of the court document signed by a judge ordering legal guardianship and legal guardian enrollment form must be submitted.

Adding new dependents

You can add new dependents during the year. Coverage begins on the date of the event for new dependents that join your plan for the following reasons:

- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

TakeCare must receive completed enrollment form and required documentation not more than 31 days after the event date and premium must be paid.

Special times you and your dependents can join the plan

You can also enroll in these situations:

- Enrollment in both Medicare A & B, date of retirement, change in employment status (work hours increase - 30 hours or more)

- You didn't enroll before because you had other coverage and that coverage has ended.
- A court orders that you cover a dependent on your health plan.
- When your dependent moves outside the service area for your employee plan.

TakeCare must receive completed enrollment form and required documentation not more than 31 days after the event date and premium must be paid.

Notification of change in status

Tell us of any changes that may affect your benefits. Please contact us as soon as possible when you have a:

- Change of address
- Change in employment status (i.e. change in work hours, leave without pay, military leave)
- Dependent status change. Overage dependents: enrollment forms reflecting any class change would need to be submitted (ex. Class 3 to Class 1)
- Dependent who enrolls in Medicare or any other health plan

Starting Coverage

Your coverage under this plan has a start and end date. You start coverage after you complete the eligibility and enrollment process.

Stopping Coverage

Your coverage typically ends when you leave your job, but it can happen for other reasons. Ending coverage doesn't always mean you lose coverage with TakeCare. There will be circumstances that will still allow you to continue coverage.

TakeCare will send you notice if your coverage is ending. This notice will tell you the end date that your coverage ends.

When will your coverage end?

Your coverage under this plan will end if:

- This plan is no longer available.
- Reduction in work hours below 30 hours
- The policyholder asks to end coverage.
- You are no longer eligible for coverage, including when you move out of the service area.
- Your work ends.
- You stop making required premium contributions, if any apply.
- TakeCare end your coverage.

- Coverage should be for whole plan year regardless if you meet your maximum benefit.
- You have reached your overall maximum benefit under your plan.

When will the dependent's coverage end?

Dependent coverage will end if:

- A dependent is no longer eligible for coverage.
- You stop making required premium contributions, if any apply.
- Your coverage ends for any of the reasons listed above except:
 - o Exhaustion of your overall maximum benefit.
 - o You enroll under a group Medicare plan TakeCare offer. However, dependent coverage will end if your coverage under the Medicare plan.
- Your dependent has exhausted the maximum benefit under your medical plan.
- The date this plan no longer allows coverage for domestic partners or civil unions.
- The date the domestic partnership or civil union ends.

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the Special coverage options after your coverage ends section for more information.

Why would we end your coverage?

We may immediately end your coverage if you commit fraud or you intentionally misrepresented yourself when you applied for or obtained coverage. You can refer to the General provisions – other things you should know section for more information on rescissions.

On the date your coverage ends, we will refund to your employer any prepayment for periods after the date your coverage ended.

Special coverage options after your coverage ends

When coverage may continue under the plan

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have. Contact the policyholder to see what options apply to you.

In some cases, premium payment is required for coverage to continue. Your coverage will continue under the plan as long as the policyholder and we have agreed to do so. It is

the policyholder's responsibility to let us know when your work ends. If the policyholder and we agree in writing, we will extend the limits.

How can you extend coverage if you are totally disabled when coverage ends?

Your coverage may be extended if you are totally disabled when coverage ends.

Only the medical condition which caused the total disability is covered during your extension.

You are "totally disabled" if you cannot work at your occupation or any other occupation for pay or profit.

Your dependent is "totally disabled" if that person cannot engage in most normal activities of a healthy person of the same age and gender.

You may extend coverage only for services and supplies related to the disabling condition until the earliest of:

- When you or your dependents are no longer totally disabled
- When you become covered by another health benefits plan
- 12 months of coverage

How can you extend coverage for your disabled child beyond the plan age limits?

You have the right to extend coverage for your dependent child beyond plan age limits, if the child is not able to be self-supporting because of mental or physical disability and depends mainly (more than 50% of their income) on you for support.

The right to coverage will continue only as long as a physician certifies that your child still is disabled.

We may ask you to send us proof of the disability within 90 days of the date coverage would have ended.

We may ask you to send proof that your child is disabled after coverage is extended. We need this once every benefit period. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child. We will continue to provide coverage for disabled children over 26 years old provided they submit the requirements for enrollment.

How can you extend coverage when getting inpatient care when coverage ends?

Your coverage may be extended if you are getting inpatient care in a hospital or skilled nursing facility when coverage ends.

Benefits are extended for the condition that caused the hospital or skilled nursing facility stay or for complications from the condition. Benefits aren't extended for other medical conditions. You can continue to get care for this condition until the earliest of:

- When you are discharged
- When you no longer need inpatient care
- When you become covered by another health benefits plan
- 12 months of coverage

How can you extend coverage for hearing services and supplies when coverage ends?

If you are not totally disabled when your coverage ends, coverage for hearing services and supplies may be extended for 30 days after your coverage ends:

- If the prescription for the hearing aid is written during the 30 days before your coverage ends
- If the hearing aid is ordered during the 30 days before your coverage ends

How can you extend coverage for a child in college on medical leave?

You have the right to extend coverage for your dependent college student who takes a medically necessary leave of absence from school. The right to coverage will be extended until the earlier of:

- One year after the leave of absence begins, or
- The date coverage would otherwise end.
- GovGuam's plan covers dependent children up to age 26 regardless of student status.

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious illness or injury, and
- Be certified by the treating doctor as medically necessary due to a serious illness or injury.

The doctor treating your child will be asked to keep us informed of any changes.

Your health information

We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just contact us.

When you accept coverage under this plan, you agree to let your providers share information with us. We need information about your physical and mental condition and care.

To access the full GovGuam Health Insurance Certificate kindly visit TakeCare's GovGuam-dedicated web page at:

www.takecareasia.com/govguam2023

Live the Balanced Lifestyle with TakeCare

#BeActive

#Relax&Unwind

EatRight

#SociallyConnected



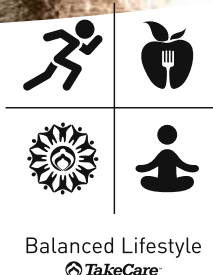
Ernest Aquino
Wellness Team Lead - TakeCare Wellness Center

Ernest is the Wellness Team Lead at TakeCare, specializing in the wellness, fitness and health education. He is also a certified lifestyle coach and facilitates the group prevention programs which includes the Prevent T2 Diabetes Prevention Program and the Balanced Lifestyle Kickstart Program.



Jennifer Artero, RN
Clinical Quality, Wellness and Contracting Manager; Diabetes Educator

Jennifer Artero, MSN, RN has served our local community as a nurse educator successfully in large part due to her leadership skills and ability to engage clients. This involves having clinical experience and advanced certifications in diabetes theories, and testing. She inspires others to align with and work toward their goals and provides them with the tools and guidance needed to realize that vision is sustainable.



Balanced Lifestyle
TakeCare

The only nationally recognized wellness program on island with a proven track record. TakeCare's Prevent T2 diabetes prevention program is fully recognized by the CDC.

"I used to be 254 lbs with a 44" waistline. Now I'm proud to say that I am 218 with a 40" waistline. I can keep going on about doing things I love while remaining healthy!"
- Richard Manley, 80 years old, Prevent T2 Participant

- Community Outreach
- Evolt 360 Body Analyzer
- Kids & Teen Workshops
- Group Fitness Classes
- Nicotine Cessation
- Disease Management Counseling
- Health & Wellness Workshops
- Nutrition Counseling
- Prevent T2 - Diabetes Prevention
- Worksite Wellness

For more information or to register for our programs, please contact our TakeCare Wellness Team at (671) 646-6956 ext. 7260, Monday through Friday from 8am - 5pm, or visit:

<https://takecarewellnesscenter.simplybook.me/> Or scan QR Code:



Connect with us

*All health education classes are FREE to TakeCare members unless otherwise specified.

Our Island, Your Health Plan™



Wellness & Fitness Incentives



Health Plan Accredited by



ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.



Wellness Incentives

WELLNESS, DISEASE MANAGEMENT, AND PREVENTIVE INCENTIVE PROGRAM

TakeCare provides wellness and disease management incentives up to \$250 per eligible individual or \$500 per eligible family per benefit period provided they met the following criteria stated under this incentive program. Virgin Pulse Health Check (formerly Health Risk Assessment), Health Education Workshops and Disease Management programs must be completed and done through TakeCare to be eligible for these incentives. Likewise, members must participate in the Plan for at least three (3) months of continuous coverage within the benefit period and are an active member by the end of the benefit period and must have paid all premiums due for the benefit period.

Wellness incentives are calculated 6 months after the end of the benefit period and payment will be made within thirty (30) business days. Incentives will only be paid under the member's primary insurance if the member is covered under multiple TakeCare plans. If the same member is covered under multiple TakeCare plans, this benefit is only extended under the member's primary insurance. Incentives are payable to the subscriber. The member is responsible to submit valid proof and documentation for incentives related to any reportable physical activities and/or sponsored TakeCare wellness and fitness events and payment of incentives is subject to TakeCare's review and approval.

CRITERIA/REQUIREMENT	If Completed at FHP Health Center	If Completed within TakeCare's Participating Network or Medication was filled by a Participating Pharmacy
Preventive		
Completion of Virgin Pulse's Online Health Check by eligible members 18 years and older once per benefit year paid by Virgin Pulse		\$5
Completion of a Biometric Screening through a TakeCare participating primary care provider or TakeCare's Wellness team or by eligible members 18 years and older once per benefit year.		\$5
Completion of an Annual Physical Exam through a TakeCare participating primary care provider once per benefit year	\$50	\$25
Completion of an Annual Physical Exam and Colorectal Cancer Screening for eligible members between 45 to 75 years of age with any of the following services: colonoscopy, sigmoidoscopy and fecal occult blood test once per benefit year as part of the annual physical exam through TakeCare's participating primary care provider	\$25	\$10
Completion of an Annual Physical Exam, Breast Cancer Screening and Screening Mammogram for eligible female members between 35 to 74 years of age as part of the annual physical exam through TakeCare's participating primary care provider	\$25	\$10
Completion of an Annual Physical Exam, Cervical Cancer Screening and Pap Smear for eligible female members between 21 to 65 years of age as part of the annual physical exam through TakeCare's participating primary care provider	\$25	\$10
Administration of flu vaccines for eligible members between 18 to 64 years old once per benefit year	\$10	\$5
Completion of an Annual Dental Exam through a TakeCare participating dentist	\$10	\$5
Completion of an Annual Vision Exam through a TakeCare participating primary care provider	\$10	\$5
Completion of a Pre-natal Visit with a TakeCare participating Obstetrician Gynecologist within the first trimester and member needs to provide documentation and proof of pre-natal visit and pregnancy test to TakeCare	Not Applicable	\$10
Completion of Postpartum visit on or between 7 and 84 days after delivery, member must provide documentation	Not Applicable	\$10
Achieve an HbA1c result of less than 8.0% at the end on the benefit period for members that are diagnosed with diabetes (Type 2).	\$10	Not Applicable
Achieving a 75% medication adherence to any one of the following – antidiabetic, antihypertensive, antihyperlipidemic or asthma medication in a benefit year for eligible patients/members diagnosed with diabetes, hypertension, dyslipidemia and asthma (respectively) as prescribed by a TakeCare participating primary care provider	\$10 at the pharmacy located at FHP	\$10
Completion of any TakeCare Disease Management Program or Wellness Workshop once per benefit year	\$25 per program up to \$50 maximum per member per benefit year	Not Applicable

Wellness and Preventive Incentives

- For eligible members 18 years old and older
- Virgin Pulse's Health Check, Wellness Workshops and Disease Management programs must be completed and done through TakeCare to be eligible for these incentives.
- Members needs to be enrolled under the plan for three (3) continuous months within the benefit period and is an active member at the end of the benefit period to be eligible.
- Incentives are covered under the member's primary plan for members enrolled under multiple TakeCare plans.
- The member is responsible to submit a valid proof and documentation for incentives related to any reportable criteria and payments for these incentives are subject to the review and approval of TakeCare.
- If TakeCare is not the member's primary insurance, the member is required to submit proof or documentation of completion of any preventive or screening related services.
- Please refer to TakeCare's related policy and procedures on incentives.

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Wellness Incentives

OUTCOME BASED INCENTIVE PROGRAM

TakeCare provides fitness and outcome based incentives up to \$350 per eligible individual and \$700 per eligible family per benefit period provided they met the following criteria stated under this incentive program. Virgin Pulse's Health Check must have been completed within three (3) months from the time of the incentive payout and should be done through TakeCare. Likewise, members must participate in the Plan for at least three (3) months of continuous coverage within the benefit period and are an active member by the end of the benefit period and must have paid all premiums due for the benefit period. Health Check must be completed within the same benefit year of the incentive payout.

Under the outcome based incentive program, Wellness incentives are calculated 6 months after the end of the benefit period and payment will be made within thirty (30) business days. This benefit is only extended to members with TakeCare as their primary insurance. Likewise, members must have paid all premiums due for the period.

CRITERIA/REQUIREMENT	MEMBER INCENTIVE
<p>Sustained blood pressure reading of lower than 140 over 90 if member completed Cardiac Risk Management (CRM) or Diabetes Management (DM) Program and was diagnosed with Hypertension prior to enrollment of the program. Initial screening and final screening must be at least (3) months apart within the benefit period. Screening must be performed by TakeCare's Wellness Team, primary care provider or chosen participating gym/fitness partner. Results must be submitted to TakeCare (tc.incentives@takecareasia.com).</p>	<p>Initial Screening - \$100 Final Screening - \$100</p>
<p>10% Improvement or sustained cholesterol screening results for LDL-C less than 100mg/dl or Triglycerides less than 150mg/dl if member completed Cardiac Risk Management (CRM) or Diabetes Management (DM) Program and was diagnosed with Hyperlipidemia prior to enrollment of the program.</p> <p>Initial screening and final screening must be at least (3) months apart within the benefit period. Screening must be performed by TakeCare's Wellness Team, primary care provider or chosen participating gym/fitness partner. Results must be submitted to TakeCare (tc.incentives@takecareasia.com).</p>	<p>Initial Screening - \$100 Final Screening - \$100</p>
<p>10% Improvement or sustained HBA1C result of 7% or lower if member completed Cardiac Risk Management (CRM) or Diabetes Management (DM) Program and was diagnosed with Diabetes prior to enrollment of the program.</p> <p>Initial screening and final screening must be at least (3) months apart within the benefit period. Screening must be performed by TakeCare's Wellness Team, primary care provider or chosen participating gym/fitness partner. Results must be submitted to TakeCare (tc.incentives@takecareasia.com).</p>	<p>Initial Screening - \$100 Final Screening - \$100</p>

■ Fitness and Outcome Based Incentives

- For eligible members 18 years old and older
- Members needs to be enrolled under the plan for three (3) continuous months within the benefit period and is an active member at the end of the benefit period to be eligible.
- Virgin Pulse's Health Check must be completed within the same benefit period of the fitness incentive payout.
- Incentives are covered under the member's primary plan for members enrolled under multiple TakeCare plans.
- All outcome based incentives are processed for payment within thirty days from the end of each quarter.
- Under the fitness incentives, incentives are calculated thirty (30) business days after the end of the benefit period for members that are manually submitting completed TakeCare fitness cards and payments are made within sixty (60) days after the end of the benefit period. For members using the TakeCare mobile application ("mobile app"), incentives will be calculated every time three (3) virtual cards were completed through the TakeCare mobile app and paid every quarter.
- To be eligible for the fitness incentives, HRA must be completed within the same benefit period.
- All initial/baseline and improvement result measurement for the outcome based incentives are evaluated and calculated at least (3) months prior to the member's current benefit year. These measurement may be completed by the member's primary care provider, TakeCare's Wellness Team or TakeCare fitness partners and will need to be submitted by the member to TakeCare.
- The member is responsible to submit a valid proof and documentation for incentives related to any reportable criteria and payments for these incentives are subject to the review and approval of TakeCare.

TC_WFINCENTIVES_JUDICIARY_REV0823022



Wellness Incentives

FITNESS/GYM INCENTIVE PROGRAM

Under the fitness incentives, incentives are calculated thirty (30) business days after the end of the benefit period for members that are manually submitting completed TakeCare fitness cards and payments are made within sixty (60) days after the end of the benefit period. For members using the TakeCare mobile application ("mobile app"), incentives will be calculated every time three (3) virtual cards were completed through the TakeCare mobile app and paid every quarter. If the same member is covered under multiple TakeCare plans, this benefit is only extended under the member's primary insurance. Incentives are payable to members 18 years old and older. You must be registered in MyTakeCare and complete a Health Check before redeeming your fitness rewards.

All initial/baseline and improvement result measurement for the outcome based incentives are evaluated and calculated every three (3) month within the member's current benefit year. These measurements may be completed by the member's primary care provider, TakeCare's Wellness Team or TakeCare fitness partners and will need to be submitted by the member to TakeCare.

All completed stamped cards must be submitted to TakeCare within thirty days from the end of the benefit period to be eligible for any incentives. Otherwise, no further incentive payment will be made to the eligible member after this deadline.

The member is responsible to submit a valid proof and documentation for incentives related to any reportable criteria and payments for these incentives are subject to the review and approval of TakeCare.



CRITERIA/REQUIREMENT	MEMBER INCENTIVE
<p>10% improvement or sustained normal or ideal body fat range (based on WHO/NIH guidelines); or 2-inch waist circumference improvement or sustained ideal range (Men less than 40 inches, Women less than 35 inches); or two (2) point improvement on body mass index ("BMI") or a sustained BMI of 18.5 to 24.9.</p> <p>For Males, Age 20-39 with Body Fat Percentage of 8-20.9, Age 40-59 with Body Fat Percentage of 11-22.9 and Age 60-79 with Body Fat Percentage of 13-24.9</p> <p>For Females, Age 20-39 with Body Fat Percentage of 21-32.9, Age 40-59 with Body Fat Percentage of 23-34.9 and Age 60-79 with Body Fat Percentage of 25-37.9</p> <p>Initial screening and final screening must be at least (3) months apart within the benefit period. Screening must be performed by TakeCare's Wellness Team, primary care provider or chosen participating gym/fitness partner. Results must be submitted to TakeCare (tc.incentives@takecareasia.com).</p>	<p>Initial Screening - \$100 Final Screening - \$100</p>
<p>Completion of ten (10) visits every month by eligible member to any TakeCare's participating gym/fitness partner, group fitness classes, and self-reported fitness activities.</p>	<p>\$10 per month for every month that member had ten (10) visits or more</p>

■ Fitness and Outcome Based Incentives

- For eligible members 18 years old and older
- Members needs to be enrolled under the plan for three (3) continuous months within the benefit period and is an active member at the end of the benefit period to be eligible.
- Virgin Pulse's Health Check must be completed within the same benefit period of the fitness incentive payout.
- Incentives are covered under the member's primary plan for members enrolled under multiple TakeCare plans.
- All outcome based incentives are processed for payment within thirty days from the end of each quarter.
- Under the fitness incentives, incentives are calculated thirty (30) business days after the end of the benefit period for members that are manually submitting completed TakeCare fitness cards and payments are made within sixty (60) days after the end of the benefit period. For members using the TakeCare mobile application ("mobile app"), incentives will be calculated every time three (3) virtual cards were completed through the TakeCare mobile app and paid every quarter.
- To be eligible for the fitness incentives, HRA must be completed within the same benefit period.
- All initial/baseline and improvement result measurement for the outcome based incentives are evaluated and calculated every three (3) month within the member's current benefit year. These measurement may be completed by the member's primary care provider, TakeCare's Wellness Team or TakeCare fitness partners and will need to be submitted by the member to TakeCare.
- The member is responsible to submit a valid proof and documentation for incentives related to any reportable criteria and payments for these incentives are subject to the review and approval of TakeCare.
- \$10 for every 10 visits or more to TakeCare's Wellness Center or member's fitness partner of choice.

For more information, call TakeCare Customer Service at 671.647.3526.

Our Island, Your Health Plan™



Guam Fitness Partners

1. **TakeCare Wellness Center**
 - Free, unlimited access to fitness classes
 - View calendar at www.takecareasia.com
 - Contact Information: (671) 646-6956 ext 7260
2. **Crossfit Hita**
 - Membership Includes:
 - ♦ Unlimited Access
 - Minimum Age: 5 years old
 - Contact Information: (671) 989-2448
3. **Crossfit Latte Stone**
 - Membership Includes:
 - ♦ Unlimited Access
 - Minimum Age: 16 years old
 - Contact Information: (671) 633-2357
4. **Custom Fitness**
 - Membership Includes:
 - ♦ Unlimited Access
 - Minimum Age: 3 years old
 - Contact Information: (671) 989-0436
5. **Guam Fitness Club***
 - Member Share: \$20 per month
 - Membership Includes:
 - ♦ Unlimited Access
 - Contact Information: (671) 487-7718
6. **Guam Muay Thai**
 - Membership Includes:
 - ♦ Unlimited Access
 - Minimum Age: 6 years old
 - Contact Information: (671) 487-7718
7. **Guam Taekwondo Center***
 - Annual registration Fee: \$40 per member
 - Membership Includes:
 - ♦ Unlimited Access
 - Minimum Age: 6 years old
 - Contact Information: (671) 788-9723
8. **Hilton Wellness Center***
 - Membership Includes:
 - ♦ Unlimited Access to Wellness Center and Group Classes
 - Minimum Age: 16 years old
 - Contact Information: (671) 646-1835 x5886
 - Upgrade Services:
 - ♦ Towel OR pool access: \$15.00/month
 - ♦ Towel AND pool access: \$25.00/month

9. **International Sports Center**
 - Membership Includes:
 - ♦ Unlimited Access
 - Minimum Age: 13 years old
 - Contact Information: (671) 477-9885
10. **Paradise Fitness Center**
 - Membership Includes:
 - ♦ Dual Club Access: Hagatna & Dededo Locations
 - Minimum Age: 13 years old
 - Contact Information: (671) 475-2100
11. **Rockit Ride***
 - Member Share: \$108 per month
 - Membership Includes:
 - ♦ Unlimited access
 - Contact information: (671) 482-1661
 - Limited monthly class memberships available
12. **Self Made Fitness***
 - Annual registration Fee: \$120 per member
 - Membership Includes:
 - ♦ SMF Group Program
 - Contact Information: (671) 727-8879
 - Upgrade Services:
 - ♦ SMF+ (1 private session per quadrimester): \$25.00/month
13. **SKIP Entertainment Company**
 - Membership Includes:
 - ♦ Access to One (1) Class Per Week
 - Minimum Age: 3 - 17 years old
 - Contact Information: (671) 472-4241
 - Upgrade Services:
 - ♦ Additional class access
 - ♦ \$55.00 off regular rates
14. **Synergy Studios**
 - Membership Includes:
 - ♦ Unlimited Access
 - Minimum Age: 7 years old
 - Contact Information: (671) 472-9642
15. **The Bridge Fitness Guam***
 - Member Share: \$50 per month
 - Membership Includes:
 - ♦ Unlimited Access
 - Minimum Age: 6 years old
 - Contact Information: (671) 969-3786

16. **The Pound Academy**
 - Membership Includes:
 - ♦ Access to One (1) Program:
 - ♦ Brazilian Jiu-Jitsu, Muay Thai, Group Fitness Classes, or Open Gym
 - Minimum Age: BJJ: 6 years old; Other Services: 13 years old
 - Contact Information: (671) 687-4229
17. **Tribe Guam**
 - Membership Includes:
 - ♦ Unlimited Access
 - Minimum Age: 4 years old
 - Contact Information: (671) 788-5719
18. **Unified**
 - Membership Includes:
 - ♦ Unlimited Access to Select Programs
 - ♦ GPP Lifestyle & Performance,
 - ♦ BURN(HER) & BUILD(HER)
 - Minimum Age: 15 years old
 - Contact Information: (671) 969-8641
19. **University of Guam: Triton Fitness Center**
 - Membership Includes:
 - ♦ Unlimited Access
 - Minimum Age: 16 years old
 - Contact Information: (671) 735-2861
20. **Urban Fitness**
 - Membership Includes:
 - ♦ Unlimited Access
 - Minimum Age: 10 years old
 - Contact Information: (671) 969-7308

Saipan Fitness Partners

21. **Gold's Gym**
 - Membership Includes:
 - ♦ Unlimited Access
 - Minimum Age: 16 years old
 - Contact Information: (670) 233-4000
22. **Latte Built Fitness**
 - Membership Includes:
 - ♦ Unlimited Access
 - Minimum Age: 15 years old
 - Contact Information: (670) 235-2265



A TanHoldings Company

takecareasia.com

Connect with us     

GG_Updated on 08/31/2022



Important: Please call TakeCare Customer Service at 647-3526 for more information or if your preferred fitness partner is not listed.

Note: Age restrictions may apply. **Additional fees apply for upgraded services, registration, uniform, etc. Members should contact the facility for more information. Fees and partner listing are subject to changes.

**Fitness Partner located on Saipan. TC Fitness Partner Rate Sheet_GovGuam_rev08292022



TakeCare Self-Report Fitness Activity

To earn fitness stamps through self-reported fitness activities, TakeCare Members must:

1. Be eligible for fitness incentives through TakeCare's Wellness and Fitness Incentives Program OR have a gym benefit through TakeCare.
2. Complete at least 30-minutes of an approved activity:
 - Walk | Jog | Run
 - Bike
 - Swim
 - Row (ocean)

3. Track your activity using one of the approved fitness apps:



Apple Fitness



Strava



Nike Run Club



Garmin



Peloton

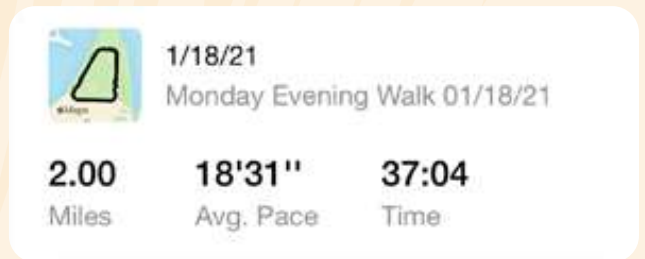


Map My Run by Under Armour

4. Upload a screenshot of your activity to <http://tiny.cc/TCActivityReport> and complete the validation form. *Program Restriction Apply

Screenshots should include:

- Clearly show exact date and time. Date listed as "TODAY", "YESTERDAY", etc will not be accepted.
- Show type of activity.
- Display duration of activity.
- Include GPS mapping/tracing of activity



Our Island, Your Health Plan™



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takecareasia.com

Connect with us

YOUR EXCUSE TO HAVE FUN

Sign up for Virgin Pulse to join fun health challenges, get the friendly competition going, and to complete your health check.

Complete an
online Health Check
and earn \$5!*

Effective February 8, 2021, TakeCare Insurance Company, Inc., switched to Virgin Pulse to help you improve your health and help you earn exciting incentives to keep you on track.

YOUR NEW WELL-BEING PROGRAM STARTS NOW!

What this switch means for you:

- Your **Health Risk Assessment** is now called **Health Check**. Complete your health check once per benefit year to unlock additional fitness incentives (must be eligible through **Wellness and Fitness Incentive program**).
- Whether you want to lose weight, feel energized, or live healthier than ever — TakeCare is offering a free, easy-to-use well-being program to help you accomplish your goals.
- Join TakeCare's free program to get active and live healthier. The best part? It's rewarding and you can participate with friends ... a great excuse to join and have fun!

*Paid by Virgin Pulse

Sign up today.

Visit <https://join.virginpulse.com/takecare>
or scan QR Code to register.



SCAN ME

TWO WAYS TO SIGN UP.

1. Visit <https://join.virginpulse.com/takecare> to register. As a TakeCare member, you can contact Member Services with any questions about registering or navigating the platform.

Phone: **888-671-9395** – representatives available 8am-9pm ET Monday – Friday

Email: support@virginpulse.com

2. Visit the App Store or Google Play and download the mobile app depending on your mobile device.



Virgin Pulse will provide you health tips, help you live them, and help you accomplish your goals so you can be the best you possible!





Register Today!

MyTakeCareSM is a convenient and secure online portal allowing you to access your personal medical and health plan information **24 hours a day, 7 days a week.**

With MyTakeCareSM, you will be able to access valuable health and wellness resources through TakeCare's Healthwise Knowledgebase, as well as manage your own personal health within MyTakeCareSM health calendar.

- **Reprint your member card**
- **See your claims information**
- **Track your wellness goals**
- **Complete a Health Check questionnaire**

Convenient Online Member Portal

Access to your personal medical and health plan information.

Account creation instructions

- 1 Visit my.takecareasia.com to register.
- 2 For New User Registration, click the "I'm a Member" link.
- 3 **Note** - you will need your TakeCare Insurance member ID number to create your account. You can find this on your TakeCare insurance card.
- 4 Follow the account creation wizard from here and save, write down, or remember your account credentials.

FHP Urgent Care

WALK-IN MEDICAL SERVICES

The **only** true-dedicated urgent care facility on island with no appointments necessary and a **complete medical team, diagnostic imaging services, lab, and pharmacy** to care for you and your family.



Choose FHP Urgent Care

For illness or injuries that are not life-threatening but still needs immediate medical care, consider the FHP Urgent Care Center for individuals of all ages.

- **One Stop Convenience:** Radiology, Lab & Pharmacy
- **Full complementary medical and support staff** to service you
- **Convenient Hours:** Open Mon-Sat* 8am to 8pm Closed Sun
- **Convenient Location:** Central part of the island-Lots of parking

ER wait times and out-of-pocket expenses are at an all-time high. Unless it is a true emergency, you will likely get quicker, quality medical care somewhere else. That is why it is important to know the difference between an Urgent Care and an Emergency Room visit in order for you to maximize your current health care benefit.

ER EMERGENCY ROOM			URGENT CARE UC		
Severe Abdominal or Chest Pain	Babies Needing Immediate Care	Serious Eye or Head Injuries	Allergic Reactions	Broken Bones	Sprains & Strains
Severe Burns	Stroke Symptoms (Numbness, Paralysis, Slurred Speech, etc.)	Significantly Difficultly Breathing	Cuts Requiring Stitches	Mild Fevers	Minor Burns
Heart Attack Symptoms	High Fevers	Suspected Drug Overdose or Poisoning	Pink Eye	Animal or Insect Bite	Cold & Flu Symptoms

When in Doubt, Dial 911

Call 911 immediately if someone is unconscious, having trouble breathing, has suffered a serious injury or may be having a heart attack.

COMPARE THE DIFFERENCE

Average urgent care visit cost: **\$300⁺**

Average emergency room visit cost: **\$1,000⁺**

No Appointments Necessary. Just Walk In.

Most major insurance companies accepted.

Call (671) 646-5825

LOCATED AT 548 SOUTH MARINE CORPS DRIVE
TAMUNING, GUAM 96913 (AT THE ITC-INTERSECTION)



Urgent Care
A Tan Holdings Company

Connect with us fhpguam.com

*Urgent Care/Pharmacy: Closed - Christmas Day and New Year's Day. Open 8am-5pm - Thanksgiving, day after Thanksgiving, Christmas Eve, and New Year's Eve.
†Based on average standard visit to treat minor cuts, bruises, sprains, flu symptoms, etc. with no insurance benefit or coinsurance.



The Island's Best One-Stop Clinic

Conveniently located in Tamuning and open longer than most clinics.

FHP Health Center features a roster of highly trained, credentialed, well-known and respected community-based physicians and professional staff. In addition, the center's modern technology and equipment supports medical services and expertise provided to its patients at its exceptional Centers of Care. These centers include **Urgent Care**, **Full Service Radiology** (MRI*, CT Scan*, Digital Mammography*, Ultrasound, and X-Ray)

-Accredited by the American College of Radiology*, **Primary Care** (Pediatrics, Adult Medicine, and Women's Health), **Occupational Health**, **Home Health** and **Hospice**, a **Cancer Center** (Hematology/Oncology), as well as **Dental** and **Vision centers**. In addition, FHP offers a convenient **in-house full-service pharmacy**, owned and operated by MegaDrug, and **full service laboratory** owned and operated by Diagnostic Laboratory Services (DLS).

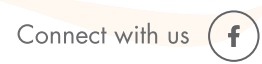
Hours of operation:
MONDAYS to SATURDAYS 8:00am – 8:00pm
SUNDAYS ALL CLOSED

DLS laboratory at FHP Health Center will mirror FHP's hours of operation.
Mega Drug III at FHP is open from **8:00am – 6:00pm, Monday thru Friday. 8:00am – 2:00pm, Saturdays. Closed on Sundays.**

For a detailed schedule for each department, please visit our website at takecareasia.com



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fhpguam.com



Call (671) 646-5825 Press 1 for appointments or scan QR Code above with your mobile device to request an appointment via email or visit <http://tiny.cc/FHPAppointments>.

Now accepting new patients.

We accept most insurances including TakeCare, StayWell, NetCare, Aetna, Tricare, Medicare, Medicaid, and self-pay patients are welcome.




A Tan Holdings Company



Wendy
FRICKEL, MD



Dawn
Ostberg, FNP



William "Ed"
STANLEY, PA-C



Mo-Ping
THAM, DO



Ashley
ARTERO, NP-C




Vincent "Vinnie"
DUENAS, DO (M)



Julie
NAMM, MD



Katrina
OSTERMANN, MD




Walter
STRATTON, PA-C



Helene
TUNCAP, PA-C



Marylou
DULAY, MD (M)



Edwin J.
SUPIT, MD




Vera
BECKA, MD



Edna
SANTOS, MD



Dennis
SARMIENTO, MD



James
ANGLIM, OD



Marlene
SAN NICOLAS, OD (M)




Lena
LEISHMAN, NP-C




Nancy
LENTZ, MD



Trenton J.
SCHEIBE, MD



Andrew
GRAVES, MD (M)



Aftab
CHAUDHRY, MD



Paul
CHUN, DMD



Collette
SUPIT, DDS



Jurga
MARTINI, DMD

-  **MEDICAL-Urgent Care**
-  **MEDICAL-Family Practice**
-  **MEDICAL-Internal Medicine**
-  **MEDICAL-Specialty**
-  **MEDICAL-Pediatrics**
-  **MEDICAL-Radiology**
-  **DENTAL**
-  **OPTOMETRY**
-  **DIETARY Services**
-  **MEDICAL-Locum Tenens**

M Medicare Healthcare Provider*

rev_08232022



Health Plan Accredited by
AAAHC
ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

GOVGUAM

Customer-Focused
Services

Customer Service Department

Office Hours
8:00am - 5:00pm
Monday - Friday

P.O. Box 6578
Tamuning, Guam 96931

671.647.3526
877.484.2411 (Toll Free)
671.647.3542 (Fax)
customerservice@takecareasia.com
www.takecareasia.com

- Information Hotline:
(671) 649-0468 (OGOV)
- Onsite Licensed Service Representative at DOA
- Concierge Assistance at FHP Health Center
- Online Enrollment Portal
- Dedicated Webpage
- Medical Referral Service ("MRS")



Chat with Us!
Scan QR Code or visit link to get started.
<https://takecareasia.com/tiva>



Travel Allowance Benefit

TakeCare will reimburse up to \$500 US dollars for the purchase of an airline ticket and/or payment for lodging while accessing medical care in the Philippines. *Subject to deductible on HSA plan.

This benefit applies to eligible members who are being referred to the Philippines for approved off island care and services meeting qualifying criteria of medical necessity for the travel benefit and approved as well as coordinated by TakeCare's Medical Management Department.

*Non-compliance with required treatment guidelines as defined by TakeCare's provider and Medical Management will result to non-eligibility under the travel benefit. TakeCare will cover one adult companion per patient, up to a maximum of two adult companions, for an approved travel benefit to accompany minors or disabled members. Approved companions are limited to eligible legal parents or legal guardians. Other limitations may also apply.

Services are limited to approved referrals for specialty care visits and consultations, diagnostic testing and imaging, out patient surgery, rehabilitation therapy, out patient chemotherapy and radiotherapy that are not available on Guam. **Executive Check Ups, Primary Care and Preventive Care are not eligible for the travel allowance benefit.**

This benefit is in addition to the airfare benefit which is available for hospital-to-hospital transfer.



Receive special offers or discounts when you present your TakeCare member ID card at any of our Affinity Partners.

The Affinity Rewards program is TakeCare's loyalty program that rewards members and member companies for supporting partner program members. As a TakeCare member, you have the benefit of receiving discounts and special offers from our Affinity Partners. In addition, you can receive rewards from TakeCare for actively participating in the program.

RESTAURANTS



Ajisen Ramen
Free Iced Tea with any entree purchase⁵



Fizz & Co.
Purchase one handmade soda, soda jerk favorites and get one free



Sagano Restaurant (at Onward)
Affinity members and four (4) guests receive 10% off dinner²



Caffé Cino
15% off cardholder's purchase⁵



Fountain Lobby Lounge (at Hotel Nikko Guam)
10% off card holder's over \$15 purchase¹



TGI Friday's **UPDATED**
15% off member's meal



Cappricciosa
\$3 OFF on any purchase of \$20 or more¹



Gabriel's Restaurant
10% off card holder's entree⁵



Tony Roma's
FREE side salad with every entrée¹



Caravel (at Onward Hotel)
Affinity members and four² (4) guests receive 10% off dinner



Magellan Restaurant (at Hotel Nikko Guam)
15% off card holder's meal and beverage¹



Tumon Bay Lobster & Grill
10% off on your entire bill

ENTERTAINMENT/SERVICES



Blakes
10% off any car rental or detail servicing



H2O Spa Guam **NEW**
10% OFF
*Conditions apply



MegaDrug III Pharmacy
5% off when purchased \$10 or more on over the counter items.



Car Audio Image **UPDATED**
10% OFF Selected Items: JBL/Skor Audio/PG / SS/Chemical Gys/Power Acoustik/DS 18⁵



Gemkell Corporation
Exclusive offer with the following locations:
Tumon Sands Plaza: BALENCIAGA, CHLOE, GIVENCHY, LESPORTSAC
The Plaza: BALENCIAGA, MARC JACOBS, LESPORTSAC, LONGCHAMP and Micronesia Mall: LACOSTE. Please ask sales associates for details



MGKM Kooling Services
10% off ALL BASIC CLEAN & SERVICES



Carrier
15% off regular list priced hi-wall, duct free air conditioning systems. Discount only applicable on 9K - 36K BTU models in stock. Free brackets with installation for 9K - 24K BTU units.



Guam Serenity Massage
10% OFF
*Conditions apply



Natural Ginger Spa
10% OFF
*Conditions apply



East Island Tinting
10% off all services including special promotions.



Ina Wellness Collective
\$100 OFF Holistic Health Coaching - Private & Group Programs
To redeem, mention you have TakeCare when booking a complimentary consultation. Check out www.inawellnesscollective.com or email hello@inawellnesscollective.com for more details



Spa Ayualam
35% Spa Treatments⁵



FHP Dental
10% off Teeth Whitening
(Conditions apply. Please call FHP Dental for more information).



Island Eye
Receive up to \$600.00 OFF LASIK Surgery.
*Please note: LASIK surgery is a cosmetic procedure and is not a covered benefit under your TakeCare medical plan



Tango Theatres
46 oz. popcorn and a 32 oz. drink for \$8.00 (actual price is at \$9.00)⁴



FHP Vision
10% off all frames and over the counter items.⁵



Island Skin Spa
10% off all regular priced facials, massages and waxes



The Laundry Time
5% off ALL PREMIUM ORDERS FOR LAUNDRY PICK UP & DELIVERY.
Use Code: [TAKECARE22] to avail discount.



KM Universal
15% off Sundries 5% off STIHL Bushcutters, Chainsaws, and Outdoor Power Equipment



Zephyr Cooling
10% discount off all basic AC cleaning



Furniture Kathy Style
20% discount on any regular priced items



Lotus Surf Shop
20% off All Apparel & Accessories⁴

For more information about the program or how to become an Affinity Rewards Partner, please contact us at affinityrewards@takecareasia.com. Conditions apply.

¹ RESTRICTIONS APPLY: Excludes alcohol. May not be combined with any other offer, promotion, or discount. Dine in only. Valid only on Guam. ² RESTRICTIONS APPLY: Excludes Special Events. May not be combined with any other offer, promotion, or discount. Valid only on Guam. ³ RESTRICTIONS APPLY: Limit one per table. May not be combined with any other offer, promotion, or discount. Valid only on Guam. ⁴ RESTRICTIONS APPLY: Please see Affinity Rewards partner for details. ⁵ RESTRICTIONS APPLY: Cannot be combined with any other offer, promotions, or discount. ⁶ Not valid on following promotional days: Dec. 24, 25, Dec. 31, Jan 1 and Feb. 14. Cannot be used in conjunction with any other promotions or discounts.



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DOWNLOAD THE TAKECARE MOBILE APP!



Attention TakeCare Members!

We understand that your needs have evolved and so has technology, which is why we have developed an app for your convenience. You now have the ability to access TakeCare at the convenience of your mobile device! Our mobile app gives you access to you and your family's member ID card, our network of providers, TakeCare wellness programs, fitness schedule, Affinity Rewards, and wellness partners. It also helps you manage your wellness and fitness incentives and track your fitness progress through biometrics!

Features Include:

- Access to Affinity Rewards Partner listing and discounts
- Submit and Access your biometric data to track your fitness progress*
- Digital TakeCare Member ID card
- Find a provider or clinic nearby or search by location
- Access to Fitness Stamp cards
- Automatic Submission of Completed Fitness Card
- Alerts for TakeCare sponsored events and promotions
- Incentives paid quarterly

*Available for select plans

Download the TakeCare mobile app today.



Getting started is simple.

1. Search by typing **'TakeCare app'** in the Apple iOS App Store (iPhone) or the Google Play App Store (Android)
2. Download the App for your Apple or Android phone
3. Open app and select "I AM A TAKECARE MEMBER, BUT IT'S MY FIRST TIME HERE"
4. Enter your information and TakeCare member ID number
(note: Use 11-digit Member ID number on your TakeCare insurance card)

Our Island, Your Health Plan™



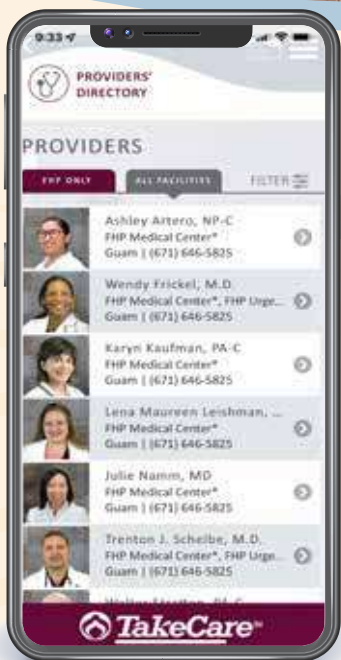
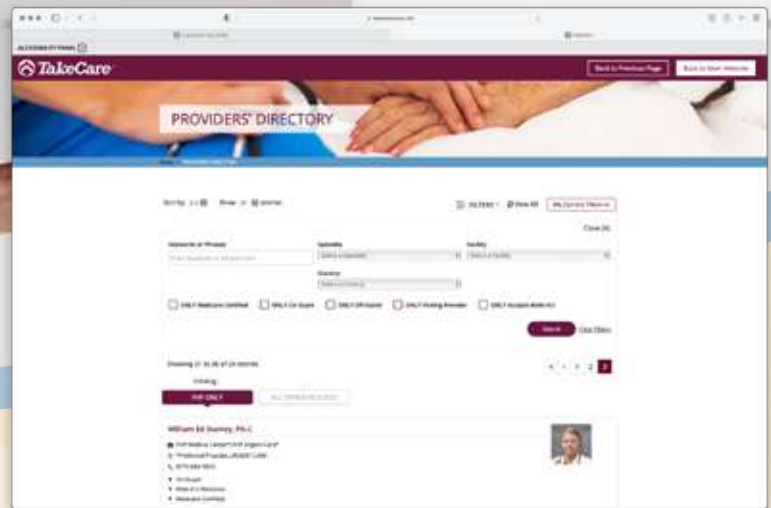
takecareasia.com

Connect with us

Attention TakeCare Members!

Are you looking for a specific doctor or specialist?

Visit <http://tiny.cc/TakeCareProviders> or scan the QR Code below for the latest TakeCare network provider listings. You can also download our mobile app so you can access on the go!



DOWNLOAD THE TAKECARE MOBILE APP!

Getting started is simple.

1. Search by typing 'TakeCare app' in the Apple iOS App Store (iPhone) or the Google Play App Store (Android)
2. Download the App for your Apple or Android phone
3. Open app and select "I AM A TAKECARE MEMBER, BUT IT'S MY FIRST TIME HERE"
4. Enter your information and TakeCare member ID number
(note: Use 11-digit Member ID number on your TakeCare insurance card-**do not include dash "-"*)

***Note:** TakeCare will discontinue hardcopy booklets. All provider listings subject to change. Please check TakeCare Mobile App for the latest updates on network provider listings and contracted services.

Download the TakeCare mobile app today.



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Our Island, Your Health Plan™

This booklet is designed to provide general information about the TakeCare plans offered to Government of Guam employees, retirees and survivors. In the event of a discrepancy between this booklet and the contract, the terms of the contract will prevail.

NOTES







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Our Island, Your Health Plan™

