TakeCare
A TanHoldings Company
Fiscal Year 2024
Updated 09.06.2023
Judiciary of Guam
Open Enrollment
Booklet
GUAM
Our Island, Your Health Plan

Member Benefits Handbook

JUDICIARY OF GUAM

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P.O. Box 6578 | Tamuning, Guam 96931
T (671) 647-3526 F (671) 647-3542

Hafa Adai Judiciary of Guam Employees!

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 programs and offerings that were made available to you.

TakeCare encourages you to access electronic versions of our Judiciary of Guam materials or enroll virtually/online through TakeCare's 2024 Judiciary of Guam page at www.takecareasia.com/judiciary2024 or scan the QR code below.

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.

JUDICIARY
SCAN ME

Elevating the member/patient

experience

TakeCare Insurance Company, Inc.
The First accredited Health Plan on Guam.

Health Plan Accredited by

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

TakeCare Insurance Company, Inc. has achieved another three year health plan accreditation by the Accreditation Association for Ambulatory Health Care (AAAHC). Through AAAHC accreditation, health plans demonstrate their commitment to providing high quality services and patient care for their members.

Health plans seeking accreditation by AAAHC undergo an extensive self-assessment and a rigorous on-site survey by AAAHC expert surveyors – physicians, nurses, and administrators who are actively involved in health care organizations. Below are the characteristics that are indicative of an accreditable health plan.

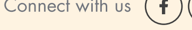
Quality and Standards of Care

- Member Rights, Responsibilities, Protections
- Network Adequacy
- Governance
- Case Management/Care Coordination
- Administration
- Health Education and Wellness Promotion
- Provider Network Credentialing
- Quality Improvement and Risk Management

takecareasia.com

Customer Service (671) 647.3526

Our Island, Your Health Plan℠



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Fiscal Year **2024**
PLAN RATES

Employee Rate Shares (biweekly)

CLASS	PPO1000	HSA2000	DENTAL 1000	DENTAL 2000
CLASS 1: EE (Employee)	$ 62.06	$ 0.00	$ 0.47	$ 5.28
CLASS 2: EE & Spouse	$ 129.33	$ 0.00	$ 1.05	$ 21.56
CLASS 3: EE & Child(ren)	$ 100.78	$ 0.00	$ 0.87	$ 17.63
CLASS 4: EE & Family	$ 179.50	$ 0.00	$ 1.45	$ 28.95

Medical/Dental Classes
Class 1 - Employee Only
Class 2 - Employee + Spouse/Cohabiting Partner
Class 3 - Employee + Dependent Child(ren)
Class 4 - Employee + Family

FY2024 JUDICIARY PPO 1000 SCHEDULE OF BENEFITS

Your Benefits: What TakeCare covers	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Deductible Per Individual Member (Class 1)	$1,000	$2,000**
Deductible Per Family (Class 2, 3, & 4) If a member meets their $1,000, the plan begins to pay for covered services for the individual	$2,000	$6,000**
Coverage Maximums Individual member annual maximum	Unlimited	
Medical Out of Pocket Maximums (includes deductibles and copayment) Per Individual member per policy year Per Family per policy year	$3,000 $9,000	No Maximum No Maximum
Prescription Out of Pocket Maximums (includes deductibles and copayment) Per Individual member per policy year Per Family per policy year	$2,000 $3,500	No Maximum No Maximum
Off-island services (Any services in the Philippines, Asia, Hawaii, U.S. Mainland and any other foreign participating providers)	Prior authorization from your doctor and approval from the Plan is required prior to services rendered at off-island facilities. Covered benefits at Participating Philippines Providers are payable 100% after deductible is met.	

Deductible and Co-Pay do not apply to these Benefits when you go to a Participating Provider	PARTICIPATING PROVIDERS Deductible does not apply	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. • **Includes Annual Exams and Lab Services (Guam and Philippines only)**	Plan Pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Outpatient Laboratory (Preventive & Diagnostic)	Plan Pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Immunizations/Vaccinations In accordance with the guidelines established by the CDC Advisory Committee on Immunization Practices	Plan Pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Pre-Natal Care Including Routine Labs and First Ultrasound	Plan Pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Sterilization Procedures (Prior Authorization Required) 1. Vasectomy (Outpatient Only) 2. Tubal Ligation (Traditional and with Fulguration)	Plan pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Well-Child Care In accordance with the Bright Futures/American Academy of Pediatrics recommendations for Preventive Pediatric Health Care • Infancy (Newborn to nine months) Maximum seven visits • Early Childhood (One to four years old) Maximum seven visits • Middle Childhood / Adolescence (from five, up to the attainment of eighteen years old) Maximum one per plan year	Plan Pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Well-Woman Care In accordance with the guidelines supported by the Health Resource and Service Administration (HRSA) and the Women's Health and Cancer Act • Contraceptive including Sterilization and Tubal Ligation if prescribed. • Includes coverage for Breast Pumps	Plan Pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Annual Eye Exam (once per member per plan year)	$15 Member Co-payment at FHP Clinic; $20 Member Co-payment outside FHP;	Plan Pays 70% of Eligible Charges, Member pays 30%*
Annual Eye Refraction (once per member per plan year)		

*Plan pays 70% of eligible charges, Member pays 30% coinsurance of eligible charges plus any difference between eligible charges and billed charges. Eligible charges for Non-Participating Providers are limited to the lesser of actual charges or Medicare's participating provider fee schedule in the geographic location where the service was rendered unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible charges except for an Out-Of-Service Area emergency. (Certificate §3.2.3, Contract §2.1.26)
**A separate deductible applies for services rendered by Non-Participating Providers. (Certificate §1.9.4, §3.2.3, Contract §2.1.26)

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Deductible does not apply to these Benefits when you go to a Participating Provider	PARTICIPATING PROVIDERS Deductible does not apply	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. Urgent Care Visits	$50 Member Co-Payment	Plan Pays 70% of Eligible Charges, Member pays 30%*
5. Mental Health Care and Substance Abuse 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%*
6. Home Health Care Visit **(Prior Authorization Required)**	Plan Pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%*
7. Hospice Care in Guam only, maximum $100 per day **(Prior Authorization Required)**	Plan Pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%*
8. Routine Diagnostic Tests (X-ray, ultrasound, ECG, EEG, EMG & non-routine mammogram)	$15 Member Co-Payment at FHP Clinic $20 Member Co-Payment outside FHP	Plan Pays 70% of Eligible Charges, Member pays 30%*
9. Injections (Does not include those on the Specialty Drugs Lists)	$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%*
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	$75 Member Co-Payment	$75 Member Co-payment, No balance bill in US per NSA
Ambulance Services (Ground Transportation only)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*

*Plan pays 70% of eligible charges, Member pays 30% coinsurance of eligible charges plus any difference between eligible charges and billed charges. Eligible charges for Non-Participating Providers are limited to the lesser of actual charges or Medicare's participating provider fee schedule in the geographic location where the service was rendered unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible charges except for an Out-Of-Service Area emergency. (Certificate §3.2.3, Contract §2.1.26)
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Deductible does not apply to these Benefits when you go to a Participating Provider	PARTICIPATING PROVIDERS Deductible does not apply	NON-PARTICIPATING PROVIDERS After deductible is met
Prescription Drugs		
1. Formulary generic drugs per prescription unit	**5% Member Coinsurance at Preferred Pharmacies; 10% Member Coinsurance at Non-Preferred Pharmacies** (90-day supply allowed at all SuperDrug locations including Kmart. Otherwise, 30-day supply allowed) **$0 Member Co-Payment** (90 day mail order)	**Member pays 30% of Average Wholesale Price (AWP) plus any difference between any eligible and billed charges**
2. Formulary brand name drugs per prescription unit	**10% Member Coinsurance at Preferred Pharmacies; 20% Member Coinsurance at Non-Preferred Pharmacies** (90-day supply allowed at all SuperDrug locations including Kmart. Otherwise, 30-day supply allowed) **$0 Member Co-Payment** (90 day mail order)	**Member pays 30% of Average Wholesale Price (AWP) plus any difference between any eligible and billed charges**
3. Non-Formulary **(Medically Necessary Only and Prior Authorization Required)**	**Plan Pays 70% Member pays 30%** (90-day supply allowed at all SuperDrug locations including Kmart. Otherwise, 30-day supply allowed and 90 day mail order)	**Member pays 30% of Average Wholesale Price (AWP) plus any difference between any eligible and billed charges**
4. Specialty Drugs **(Medically Necessary Only and Prior Authorization Required)**	**Plan Pays 70% Member pays 30%** (90-day supply allowed at all SuperDrug locations including Kmart. Otherwise, 30-day supply allowed) **Not Covered** (90 day mail order)	**Member pays 30% of Average Wholesale Price (AWP) plus any difference between any eligible and billed charges**
Travel Benefit - 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 primary care services, non-completion and/or non-compliance to contracted/participating physician determined treatment and dental care DO NOT QUALIFY for this benefit - Conditions and limitations apply as specified in the Member Handbook	**Member pays all costs above $500 per occurrence. No annual occurance limit as long as medical management requirements are met.**	**Not Covered**

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Deductible must be met for the following services	PARTICIPATING PROVIDERS After deductible is met	NON-PARTICIPATING PROVIDERS After deductible is met
Acupuncture	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Allergy Testing/Treatment $500 maximum benefit per member per plan year	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Airfare Benefit to Preferred Providers only For members who meet qualifying conditions, TakeCare provides emergency hospital to hospital transportation coverage (Prior Authorization Required)	Plan Pays 100%	Not Covered
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 Referral from Primary Care Physician and Prior Authorization from Plan is required Coverage is limited to the following maximums per member per plan year: • $25,000 per plan year for ages 16-21 years old • $75,000 per plan year for ages 0-15 years old **Services are subject to Plans benefit coverage guidelines and medical necessity**	$50 Member Co-Payment	Not Covered
Blood & Blood Derivatives	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Breast Reconstructive Surgery (In accordance with 1998 W.H.C.R.A) Includes medically necessary anesthesia	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Cardiac Surgery Includes medically necessary anesthesia	Play Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Cardiac Rehabilitation (inpatient) Up to 30 days following bypass surgery or myocardial infarction	Play Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Cataract Surgery Outpatient only. Includes lens implant and medically necessary anesthesia	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Chemotherapy Benefit	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Chiropractic Care	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Clinical Trials Includes phases I-IV outpatient or inpatient clinic trials that are conducted in relation to treatment of cancer of other life-threatening diseases or conditions as approved by the National Institute of Health or the National Cancer Institute	$40 Member Co-Payment	Plan Pays 70% of Eligible Charges, Member pays 30%*
Complex 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, CPAP machines, BPAP machines, insulin pumps, blood glucose monitors, oxygen and accessories when prescribed by a Physician **(Prior Authorization Required)**	Plan pays 80%, Member pays 20% of the total rental cost or purchase	Plan Pays 70% of Eligible Charges, Member pays 30%*
Elective Surgery (Prior Authorization Required) Includes medically necessary anesthesia	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
End Stage Renal Disease / Hemodialysis	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*

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Foot Care (subject to benefit limitations) Foot Care and Podiatry services	At Primary Care: $5 Member Co-Payment at FHP Clinic, $10 Member Co-Payment at Preferred Provider, $20 Member Co-Payment at Non-Preferred Provider At Specialist Care: $40 Member Co-Payment	Plan Pays 70% of Eligible Charges, Member pays 30%*
Growth Hormone Therapy	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Hearing Aids Maximum $1,000 benefit per member per 24 months. Limited to 1 device every 3 years.	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Hearing Services	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Hospitalization & Inpatient Benefits 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. Mental Health and Substance Abuse Admission	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Hyperbaric Oxygen Therapy & Wound Care Medically necessary **(Prior Authorization Required)**	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Implants, Orthotics & Prosthetic Devices Cardiac pacemakers, intraocular lenses, artificial eyes, heart valves, orthopedic internal prosthetic devices, stents, stump hose, cochlear implants, corrective orthopedic appliances and braces **(Limitations apply, please refer to contract)**	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%*
Infertility Services Diagnosis of Infertility	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 (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Oral and Maxillofacial Surgery Oral surgical procedures, limited to: - Reduction of fractures of the jaws or facial bones - Surgical correction of cleft lip, cleft palate or severe functional malocclusion - Removal of stones from salivary ducts - Excision of leukoplakia or malignancies - Excision of cysts and incision of abscesses when done as independent procedures	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
- Other surgical procedures that do not involve teeth or their supporting structures		
Physical Therapy (Prior Authorization Required)	Plan pays 80% for the first 20 visits and 50% thereafter	Plan Pays 70% of Eligible Charges, Member pays 30%*

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**A separate deductible applies for services rendered by Non-Participating Providers. (Certificate §1.9.4, §3.2.3, Contract §2.1.26)

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Radiation Therapy (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Reconstructive Surgery - Surgery to correct a functional defect - Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes	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%*
Speech Therapy (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Diagnostic Sleep Study (Prior Authorization Required)	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		
• Wellness Benefits at TakeCare Wellness Center	Plan Pays 100%	Not Covered
• TakeCare's health education and wellness classes	Plan Pays 100%	
• TakeCare's Wellness and Disease Management Programs and Incentives. (TakeCare's wellness incentive program pays members up to $250/individual, $500/family for qualifying wellness incentives; up to $350/individual, $700/family for qualifying outcome based and fitness incentives.)	Plan Pays 100%	
Vision Benefit Coverage for pair of contact lenses or eyeglasses lens/frames – maximum of $200 per member per 12 months	Plan pays 100% up to $200 per member per 12 months	Plan pays 100% up to $200 per member per 12 months through reimbursement, which needs to be submitted to Plan within 90 days from date of service

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FY2024 JUDICIARY HSA 2000 SCHEDULE OF BENEFITS

Your Benefits: What TakeCare covers	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Deductible Per Individual Member (Class 1)	$2,000	$4,000**
Deductible Per Family (Class 2, 3, & 4) If a member meets their $3,200, the plan begins to pay for covered services for the individual	$4,000	$12,000**
Coverage Maximums Individual member annual maximum	Unlimited	
Out of Pocket Maximums (includes deductible and copayment) Per Individual member per policy year Per Family per policy year **Medical and Prescription Out of Pocket Maximums are combined**	$4,000 $11,900	No Maximum
Off-island services (Any services in the Philippines, Asia, Hawaii, U.S. Mainland and any other foreign participating providers)	Prior authorization from your doctor and approval from the Plan is required prior to services rendered at off-island facilities. Covered benefits at Participating Philippines Providers are payable 100% after deductible is met.	
Deductible and Co-Pay do not apply to these Benefits when you go to a Participating Provider	PARTICIPATING PROVIDERS Deductible does not apply	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. • **Includes Annual Exams and Lab Services (Guam and Philippines only)**	Plan Pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Outpatient Laboratory (Preventive & Diagnostic)	Plan Pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Immunizations/Vaccinations In accordance with the guidelines established by the CDC Advisory Committee on Immunization Practices	Plan Pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Pre-Natal Care Including Routine Labs and First Ultrasound	Plan Pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Well-Child Care In accordance with the Bright Futures/American Academy of Pediatrics recommendations for Preventive Pediatric Health Care • Infancy (Newborn to nine months) Maximum seven visits • Early Childhood (One to four years old) Maximum seven visits • Middle Childhood / Adolescence (from five, up to the attainment of eighteen years old) Maximum one per plan year	Plan Pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Well-Woman Care In accordance with the guidelines supported by the Health Resource and Service Administration (HRSA) and the Women's Health and Cancer Act • Contraceptive including Sterilization and Tubal Ligation if prescribed. • Includes coverage for Breast Pumps	Plan Pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Annual Eye Exam (once per member per plan year) **Annual Eye Refraction** (once per member per plan year)	$15 Member Co-payment at FHP Clinic; $20 Member Co-payment outside FHP	Plan Pays 70% of Eligible Charges, Member pays 30%*

*Plan pays 70% of eligible charges, Member pays 30% coinsurance of eligible charges plus any difference between eligible charges and billed charges. Eligible charges for Non-Participating Providers are limited to the lesser of actual charges or Medicare's participating provider fee schedule in the geographic location where the service was rendered unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible charges except for an Out-Of-Service Area emergency. (Certificate §3.2.3, Contract §2.1.26)
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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		
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. Urgent Care Visits	$50 Member Co-Payment	Plan Pays 70% of Eligible Charges, Member pays 30%*
5. Mental Health Care and Substance Abuse 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%*
6. Home Health Care Visit **(Prior Authorization Required)**	Plan Pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%*
7. Hospice Care in Guam only, maximum $100 per day **(Prior Authorization Required)**	Plan Pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%*
8. Routine Diagnostic Tests (X-ray, ultrasound, ECG, EEG, EMG & non-routine mammogram)	$15 Member Co-Payment at FHP Clinic $20 Member Co-Payment outside FHP	Plan Pays 70% of Eligible Charges, Member pays 30%*
9. Injections (Does not include those on the Specialty Drugs Lists)	$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%*
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	$75 Member Co-Payment	$75 Member Co-payment, No balance bill in US per NSA
Ambulance Services (Ground Transportation only)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*

*Plan pays 70% of eligible charges, Member pays 30% coinsurance of eligible charges plus any difference between eligible charges and billed charges. Eligible charges for Non-Participating Providers are limited to the lesser of actual charges or Medicare's participating provider fee schedule in the geographic location where the service was rendered unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible charges except for an Out-Of-Service Area emergency. (Certificate §3.2.3, Contract §2.1.26)
**A separate deductible applies for services rendered by Non-Participating Providers. (Certificate §1.9.4, §3.2.3, Contract §2.1.26)

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Deductible must be met for the following services	PARTICIPATING PROVIDERS After deductible is met	NON-PARTICIPATING PROVIDERS After deductible is met
Acupuncture	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Airfare Benefit to Preferred Providers only For members who meet qualifying conditions, TakeCare provides emergency hospital to hospital transportation coverage (Prior Authorization Required)	Plan Pays 100%	Not Covered
Allergy Testing/Treatment $500 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) Includes medically necessary anesthesia	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Autism Spectrum Disorder Referral from Primary Care Physician and Prior Authorization from Plan is required Coverage is limited to the following maximums per member per plan year: • $25,000 per plan year for ages 16-21 years old • $75,000 per plan year for ages 0-15 years old **Services are subject to Plans benefit coverage guidelines and medical necessity**	$50 Member Co-Payment	Not Covered
Blood & Blood Derivatives	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Breast Reconstructive Surgery (In accordance with 1998 W.H.C.R.A) Includes medically necessary anesthesia	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Cardiac Surgery Includes medically necessary anesthesia	Play Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Cardiac Rehabilitation (inpatient) Up to 30 days following bypass surgery or myocardial infarction	Play Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Cataract Surgery Outpatient only. Includes lens implant and medically necessary anesthesia	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Chemotherapy Benefit	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Chiropractic Care	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Clinical Trials Includes phases I-IV outpatient or inpatient clinic trials that are conducted in relation to treatment of cancer of other life-threatening diseases or conditions as approved by the National Institute of Health or the National Cancer Institute	$40 Member Co-Payment	Plan Pays 70% of Eligible Charges, Member pays 30%*
Complex 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, CPAP machines, BPAP machines, insulin pumps, blood glucose monitors, oxygen and accessories when prescribed by a Physician (Prior Authorization Required)	Plan pays 80%, Member pays 20% of the total rental cost or purchase	Plan Pays 70% of Eligible Charges, Member pays 30%*
Elective Surgery (Prior Authorization Required) Includes medically necessary anesthesia	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
End Stage Renal Disease / Hemodialysis	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*

*Plan pays 70% of eligible charges, Member pays 30% coinsurance of eligible charges plus any difference between eligible charges and billed charges. Eligible charges for Non-Participating Providers are limited to the lesser of actual charges or Medicare's participating provider fee schedule in the geographic location where the service was rendered unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible charges except for an Out-Of-Service Area emergency. (Certificate §3.2.3, Contract §2.1.26)

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Deductible must be met for the following services	PARTICIPATING PROVIDERS After deductible is met	NON-PARTICIPATING PROVIDERS After deductible is met
Foot Care (subject to benefit limitations) Foot Care and Podiatry services	At Primary Care: $5 Member Co-Payment at FHP Clinic, $10 Member Co-Payment at Preferred Provider, $20 Member Co-Payment at Non-Preferred Provider At Specialist Care: $40 Member Co-Payment	Plan Pays 70% of Eligible Charges, Member pays 30%*
Growth Hormone Therapy	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Hearing Aids Maximum $1,000 benefit per member per 24 months. Limited to 1 device every 3 years.	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Hearing Services	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Hospitalization & Inpatient Benefits 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. Mental Health and Substance Abuse Admission	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Hyperbaric Oxygen Therapy & Wound Care Medically necessary **(Prior Authorization Required)**	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Implants, Orthotics & Prosthetic Devices Cardiac pacemakers, intraocular lenses, artificial eyes, heart valves, orthopedic internal prosthetic devices, stents, stump hose, cochlear implants, corrective orthopedic appliances and braces **(Limitations apply, please refer to contract)**	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%*
Infertility Services Diagnosis of Infertility	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 **(Prior Authorization Required)**	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Oral and Maxillofacial Surgery Oral surgical procedures, limited to: - Reduction of fractures of the jaws or facial bones - Surgical correction of cleft lip, cleft palate or severe functional malocclusion - Removal of stones from salivary ducts - Excision of leukoplakia or malignancies - Excision of cysts and incision of abscesses when done as independent procedures - Other surgical procedures that do not involve teeth or their supporting structures	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Physical Therapy (Prior Authorization Required)	Plan pays 80% for the first 20 visits and 50% thereafter	Plan Pays 70% of Eligible Charges, Member pays 30%*

*Plan pays 70% of eligible charges, Member pays 30% coinsurance of eligible charges plus any difference between eligible charges and billed charges. Eligible charges for Non-Participating Providers are limited to the lesser of actual charges or Medicare's participating provider fee schedule in the geographic location where the service was rendered unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible charges except for an Out-Of-Service Area emergency. (Certificate §3.2.3, Contract §2.1.26)
**A separate deductible applies for services rendered by Non-Participating Providers. (Certificate §1.9.4, §3.2.3, Contract §2.1.26)

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Deductible must be met for the following services	PARTICIPATING PROVIDERS After deductible is met	NON-PARTICIPATING PROVIDERS After deductible is met
Prescription Drugs		
1. Formulary generic drugs per prescription unit	5% Member Coinsurance at Preferred Pharmacies; 10% Member Coinsurance at Non-Preferred Pharmacies (90-day supply allowed at all SuperDrug locations including Kmart. Otherwise,30-day supply allowed) $0 Member Co-Payment (90 day mail order)	Member pays 30% of Average Wholesale Price (AWP) plus any difference between any eligible and billed charges
2. Formulary brand name drugs per prescription unit	10% Member Coinsurance at Preferred Pharmacies; 20% Member Coinsurance at Non-Preferred Pharmacies (90-day supply allowed at all SuperDrug locations including Kmart. Otherwise, 30-day supply allowed) $0 Member Co-Payment (90 day mail order)	Member pays 30% of Average Wholesale Price (AWP) plus any difference between any eligible and billed charges
3. Non-Formulary **(Medically Necessary Only and Prior Authorization Required)**	Plan Pays 70% Member pays 30% (90-day supply allowed at all SuperDrug locations including Kmart. Otherwise, 30-day supply and 90-day mail order allowed)	Member pays 30% of Average Wholesale Price (AWP) plus any difference between any eligible and billed charges
4. Specialty Drugs **(Medically Necessary Only and Prior Authorization Required)**	Plan Pays 70% Member pays 30% (90-day supply allowed at all SuperDrug locations including Kmart. Otherwise, 30-day supply allowed) Not Covered (90-day mail order)	Member pays 30% of Average Wholesale Price (AWP) plus any difference between any eligible and billed charges
Radiation Therapy **(Prior Authorization Required)**	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Reconstructive Surgery - Surgery to correct a functional defect - Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes	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%*
Speech Therapy **(Prior Authorization Required)**	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Sterilization Procedures **(Prior Authorization Required)** 1. Vasectomy (Outpatient Only) 2. Tubal Ligation (Traditional and with Fulguration)	Plan pays 100%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Diagnostic Sleep Study **(Prior Authorization Required)**	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%*
Travel Benefit - 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 primary care services, non-completion and/or non-compliance to contracted/participating physician determined treatment and dental care DO NOT QUALIFY for this benefit - Conditions and limitations apply as specified in the Member Handbook	Member pays all costs above $500 per occurrence. No annual occurrence limit as long as medical management requirements are met.	Not Covered

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Additional Benefits: What TakeCare covers	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Wellness & Fitness Benefit		
• Wellness Benefits at TakeCare Wellness Center	Plan Pays 100%	Not Covered
• TakeCare's health education and wellness classes	Plan Pays 100%	
• TakeCare's Wellness and Disease Management Programs and Incentives (TakeCare's wellness incentive program pays members up to $250/individual, $500/family for qualifying wellness incentives; up to $350/individual, $700/family for qualifying outcome based and fitness incentives.)	Plan Pays 100%	
Vision Benefit Coverage for pair of contact lenses or eyeglasses lens/frames – maximum of $200 per member per 12 months. Subject to deductible.	Plan pays 100% up to $200 per member per 12 months	Plan pays 100% up to $200 per member per 12 months through reimbursement, which needs to be submitted to Plan within 90 days from date of service

*Plan pays 70% of eligible charges, Member pays 30% coinsurance of eligible charges plus any difference between eligible charges and billed charges. Eligible charges for Non-Participating Providers are limited to the lesser of actual charges or Medicare's participating provider fee schedule in the geographic location where the service was rendered unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible charges except for an Out-Of-Service Area emergency. (Certificate §3.2.3, Contract §2.1.26)
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MEDICAL EXCLUSIONS

The following services are not covered by TakeCare:

1. No benefits will be paid for Injury or Illness when: (a) 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) 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 days' 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 grievance procedure provided for in this Certificate at §5.31. If a grievance is filed, the resolution of the matter shall be in accordance with the outcome of the grievance proceedings. If no grievance 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 recessions 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 Covered Person. (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 Injuries incurred while the person was committing a criminal act.

10. Unless otherwise specifically provided in this Certificate, 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.

11. 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.

12. 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.

13. No benefits will be paid for home uterine activity monitoring.

14. 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 Covered Person.

15. If a member is covered under a Worker's 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 this Certificate for members eligible for Worker's Compensation are not designed to duplicate any benefit to which they are entitled under Worker's Compensation Law. All sums payable for Worker's Compensation services provided under this Certificate shall be payable to, and retained by Company. A Covered Person 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 Worker's Compensation Law.

16. Except for clinical trials and a Covered Person exercising his or her "Right to Try" as set forth in Public Law 115-176 (May 30, 2018), 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."
   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).

17. Except for a Covered Person exercising his or her "Right to Try" as set forth in Public Law 115-176 (May 30, 2018), no benefits will be paid for experimental or investigational procedures, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes as determined by Company, unless prior authorization is obtained from the Company. Experimental and investigational treatments and procedures are those medical treatments and procedures that have not successfully completed a Phase III trial, have not been approved by the FDA and are not generally recognized as the accepted standard treatment for the disease or condition from which the patient suffers.

18. No benefits will be paid for services or supplies related to genetic testing, with the exception of BRAC1 Testing.

19. No benefits will be paid for services or supplies related to paternity testing.

20. 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 medication and supplies provided as part of Medically Necessary inpatient care.

21. No benefits will be paid in relation to the Robotic Suite or for Robotic Surgery.

22. No benefits will be paid for Services and supplies provided to perform surgery or to evaluate the need for surgery related to or arising from gender dysphoria or disorder, gender reassignment, or gender confirmation. Evaluations and subsequent medications and Services related to or arising from gender transition treatment are also excluded from coverage, as are complications or medical sequelae 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, or 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 Guam 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. 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 Certificate.

25. No benefits will be paid for audiograms, regardless of the reason for such tests.

26. Except under the optional Dental Plan, no benefits will be paid for dental services including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, orthodontics, dental splint and other dental appliances, root canal treatment, soft tissue impactions, alveolectomy, augmentation, and vestibuloplasty, treatment of periodontal disease, false teeth, prosthetic restoration of dental

implants, maxillary and mandible implants (Osseo integration) and all related services, removal of impacted teeth, bite plates, orthognathic surgery to correct a bite defect. This exclusion does not apply to:

a. Removal of bony impacted teeth, bone fractures, removal of tumors, and biopsy or excision of oral cysts.
b. Emergency Services stabilize an acute Injury to sound natural teeth, the jawbone or surrounding structures, if provided within 48 hours of the Injury or as required by PPACA to stabilize and treat a PPACA Emergency.
c. Surgical treatment of Temporomandibular Joint (TMJ) disorder.
d. Dental anesthesia when Medically Necessary.

27. To the extent permitted by PPACA and except as provided in the §4.51, no benefits will be paid for Services and supplies provided for the purpose of organ transplantation. Unless PPACA requires otherwise, all organ transplants are excluded from coverage, including but not limited to: heart, lung, liver, kidney, pancreas, bone marrow and cornea. Autologous bone marrow transplant (where the donor is also the recipient) is also excluded. Services and supplies directly related to the transplant, such as tissue typing and other pre-operative procedures are excluded as are Services and supplies provided post-operatively which are a consequence of the transplant surgery or the presence of the transplanted organ. This exclusion for post-operative supplies, to include anti-rejection or immunosuppressant medications, and Services continues for the life of the patient. Benefits directly related to the transplant will cease as of the time when it is determine that a transplant will be performed.

28. No benefits will be paid for Services and supplies provided in the course of organ donation whether for a Covered Person who is donating an organ or for someone who is donating an organ for transplantation into a Covered Person.

29. No benefits will be paid in connection with elective abortions unless Medically Necessary.

30. Except as provided in this Certificate, no benefits will be paid for vision care services and supplies, 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.

31. Except as provided in this Certificate, 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.

32. 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.

33. 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.

34. No benefits will be paid in connection with dialysis treatments which would not have been charged in the absence of the Plan.

35. No benefits will be paid for hypnotherapy.

36. 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.

37. No benefits will be paid for cosmetic surgery, defined as any surgical procedure directed at improving appearance; or for treatment or Services relating to the consequences of, or as a result of, cosmetic surgery, or except when required for as soon medically feasible repair of accidental injury or for the improvement of the functioning of a malformed body member. This exclusion does not apply to:

a. Breast Reconstruction. In accordance with the Women's Health and Cancer Rights Act, reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all states of mastectomy, including lymphedemas, are covered. Such re-constructive procedures are not limited to reconstructive procedures necessitated by mastectomies performed while covered under this Plan.
b. Surgery required for the prompt (i.e., as soon as medically feasible) repair of accidental Injury;
c. Surgery as a continuation of a staged reconstruction procedure, including but not limited to post-mastectomy reconstruction;
d. Surgery for the improvement of the functioning of a malformed body member, including but not limited to correcting congenital defects necessary to restore normal bodily functions (e.g., cleft lip and cleft palate).

38. No benefits will be paid for routine foot/hand care, including routine reduction of nails, calluses and corns.

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39. 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 auto injections.

40. 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.

41. No benefits will be paid for Services and supplies provided for liposuction.

42. 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.

43. 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.

44. If for aesthetic purposes, no benefits will be paid in connection with gastric bypass, stapling or reversal.

45. No benefits will be paid for surgical operations, procedures or treatment of obesity, except when Company has provided prior authorization.

46. 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;
    j. Reversal of sterilization surgery; and
    k. Any charges associated with obtaining sperm for ART procedures.

47. 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 Covered Person'shouse or place of business, and adjustments to vehicles.

48. 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.

49. No benefits will be paid for Services and supplies provided for penile implants of any type.

50. No benefits will be paid in connection with any implants or organ transplants. This exception shall not apply to orthopedic, cardiac, and ear and eye surgeries including but not limited to: Single and dual pacemakers; intraocular lens implants; artificial eyes; heart valves, orthopedic internal prosthetic devices; cardiac stents; stump hose; cochlear implants; corrective orthopedic appliances; and braces.

51. No benefits will be paid for Services and supplies to correct sexual dysfunction.

52. 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.

53. Except as specifically provided in this Certificate, no benefits will be provided for Services and supplies not ordered by a Physician or not Medically Necessary.

54. Except as specifically provided in this Certificate, no benefits will be provided for:

    a. Orthopedic footwear: Orthopedic footwear unless attached to an artificial foot or unless attached as a permanent part of a leg brace.
    b. Motorized limbs: Motorized artificial limbs.

55. No benefits will be paid for Temporomandibular Joint (TMJ) disorder treatment, including treatment performed by prosthesis placed directly on the teeth, except as provided for in § 4.26 of this Certificate.

56. No benefits will be paid for Services for which the Covered Person is not legally obligated to pay.

57. No benefits will be paid for recreational or educational therapy.

58. 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.

59. 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.

60. No benefits will be paid for hospital take-home drugs.

61. No benefits will be paid for fees for any missed appointments or voluntary transfer of records as requested by the Covered Person.

62. No benefits will be paid for educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders including developmental and learning disorders associated with mental retardation, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a Covered Person, whose ability to speak has been lost or impaired, to function without that ability, are not covered.

63. 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.

64. 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.

65. 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, as determined by Company, 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, mental health or a dental 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.

66. §4.67 As required by HIPAA, no source-of-injury exclusion will apply if: a) the Injury resulted from an act of domestic violence, or b) the Injury resulted from a medical condition (including both physical and mental health conditions). There is no source-of-injury exclusion for intentionally self-induced or intentionally self-inflicted injuries resulting from a medical condition (including physical and mental health conditions).

This booklet is designed to provide general information about the **TakeCare plans** offered to Judiciary 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.

Judiciary of Guam Dental $1,000

Your Benefits (subject to the specific limitations which are contained in the Group Health Cerificate):	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Diagnostic & Preventive Care 1. Caries Susceptibility Test 2. Exams • Includes Treatment plan • Once every 6 months 3. Fluoride Treatment • Annually for children up to age 19 years 4. Prophylaxis • Cleaning and polishing of teeth • Once every 6 months 5. Sealants • For permanent molars & pre-molars for children up to age 16 years 6. Space maintainers • For children up to age 16 years • Includes adjustments within 6 months of installation 7. Study Models 8. X-rays • Bite wing; maximum of 4 per plan year • Full mouth x-ray is limited to one every 3 years	100% of Eligible Expenses	70% of Eligible Expenses (Covered Member pays excess above Eligible Expenses)
Basic & Restorative Care **General Services** 1. Emergency Care (During office hours) 2. Pulp Treatment 3. Routine Fillings • Amalgam & Composite Resin • Synthetic & Plastic (Other than Gold & Porcelain) **Oral Surgery** 1. Simple Extractions 2. Complicated Extractions 3. Tooth Impactions **Periodontal Care** 1. Periodontal prophylaxis • Cleaning and polishing once every 6 months 2. Periodontal Treatment **General Anesthesia** • Includes Conscious Sedation and Nitrous Oxide • Covered when recommended by attending physician **Pulpotomy & Root Canals/Endodontic Surgery & Care**	80% of Eligible Expenses	70% of Eligible Expenses (Covered Member pays excess above Eligible Expenses)
Major & Replacement Care **Fixed Prosthetics** 1. Crowns & Bridges 2. Gold Inlays & Onlays 3. Replacement of Crown Restoration • Limited once every 5 years **Removable Prosthetics** 1. Full Dentures • Limited once every 5 years 2. Partial Dentures • Limited once every 5 years 3. Each Additional Tooth 4. Relines 5. Denture Repair	50% of Eligible Expenses	35% of Eligible Expenses (Covered Member pays excess above Eligible Expenses)
Deductible	None	None
Registration Fee Per Visit To Dentists	None	None
Coverage Maximums Per Member per Plan Year	$1,000	

Terms:

1. Unused balance are not transferrable to the following year
2. Charges for Non-participating Providers are limited to the lesser of actual charges or the usual, customary and reasonable charges in the geographic location where the service was rendered, unless otherwise provided in the agreement
3. The covered member pays any excess above Eligible Charges
4. Plan has no deductible
5. There are no registration fees for visits to participating providers

100121-DGNPGJH

Judiciary of Guam Dental $2,000

Your Benefits (subject to the specific limitations which are contained in the Group Health Cerificate):	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Diagnostic & Preventive Care 1. Caries Susceptibility Test 2. Exams • Includes Treatment plan • Once every 6 months 3. Fluoride Treatment • Annually for children up to age 19 years 4. Prophylaxis • Cleaning and polishing of teeth • Once every 6 months 5. Sealants • For permanent molars & pre-molars for children up to age 16 years 6. Space maintainers • For children up to age 16 years • Includes adjustments within 6 months of installation 7. Study Models 8. X-rays • Bite wing; maximum of 4 per plan year • Full mouth x-ray is limited to one every 3 years	100% of Eligible Expenses	70% of Eligible Expenses (Covered Member pays excess above Eligible Expenses)
Basic & Restorative Care **General Services** 1. Emergency Care (During office hours) 2. Pulp Treatment 3. Routine Fillings • Amalgam & Composite Resin • Synthetic & Plastic (Other than Gold & Porcelain) **Oral Surgery** 1. Simple Extractions 2. Complicated Extractions 3. Tooth Impactions **Periodontal Care** 1. Periodontal prophylaxis • Cleaning and polishing once every 6 months 2. Periodontal Treatment **General Anesthesia** • Includes Conscious Sedation and Nitrous Oxide • Covered when recommended by attending physician **Pulpotomy & Root Canals/Endodontic Surgery & Care**	80% of Eligible Expenses	70% of Eligible Expenses (Covered Member pays excess above Eligible Expenses)
Major & Replacement Care **Fixed Prosthetics** 1. Crowns & Bridges 2. Gold Inlays & Onlays 3. Replacement of Crown Restoration • Limited once every 5 years **Removable Prosthetics** 1. Full Dentures • Limited once every 5 years 2. Partial Dentures • Limited once every 5 years 3. Each Additional Tooth 4. Relines 5. Denture Repair	50% of Eligible Expenses	35% of Eligible Expenses (Covered Member pays excess above Eligible Expenses)

100121-DGNPGJU

This booklet is designed to provide general information about the **TakeCare plans** offered to Judiciary 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.

Judiciary of Guam Dental $2,000

Your Benefits (subject to the specific limitations which are contained in the Group Health Cerificate):	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
ORTHODONTIA	50% of Eligible Expenses	35% of Eligible Expenses (Covered Member pays excess above Eligible Expenses)
Deductible	None	None
Registration Fee Per Visit To Dentists	None	None
Coverage Maximums Per Member per Plan Year	$2,000	

Terms:

1. Unused balance are not transferrable to the following year
2. Charges for Non-participating Providers are limited to the lesser of actual charges or the usual, customary and reasonable charges in the geographic location where the service was rendered, unless otherwise provided in the agreement
3. The covered member pays any excess above Eligible Charges
4. Plan has no deductible
5. There are no registration fees for visits to participating providers

100121-DGNPGJU

DENTAL EXCLUSIONS

The following services are not covered by TakeCare:

1. Work in progress on the effective date of coverage. Work in progress is defines as:
    a. A prosthetic or other appliance, or modification of one, where an impression was made before the patient was covered, or
    b. A crown, bridge, or cast restoration for which the tooth was prepared before the patient was covered, or
    c. Root canal therapy, if the pulp chamber was opened before the patient was covered

2. Services not specifically listed in the agreement, services not prescribed, performed or supervised by a dentist; services which are not medically or dentally necessary or customarily performed; services that are not indicated because they have a limited of poor prognosis; or services for which there is a less expensive, professionally acceptable alternative.
3. Any services unless required and rendered in accordance with accepted standards or dental practice.
4. A crown, cast restoration, denture or fixed bridge or addition of teeth to one, if work involves a replacement of modification of a crown, a cast restoration, denture or bridge installed less than 5 years ago, or one that replaces a tooth that was missing before the date the enrollee became eligible for services under the plan (including previously extracted or missing teeth).
5. Replacement of existing dentures, crowns or fixed bridgework if the existing dentures, crowns or fixed bridgework can be made serviceable.
6. Precision attachments, interlocking device, one component of which is fixed to an abutment or abutments the other is integrated into a fixed or removable prosthesis in order to stabilize and/or retain it; or stress breakers, part of a tooth-borne and/or tissue borne prosthesis designed to relieve the abutment teeth and their supporting tissues from harmful stresses.
7. Replacement of lost or stolen appliance, or replacement of any appliance damaged while not in the mouth.
8. Any service for which the enrollee received benefits under any other coverage offered by the company.
9. Spare or duplicate prosthetic device.
10. Services included, related to or required for:
    a. Implants;
    b. Cosmetic Purposes
    c. Services or appliances to change the vertical dimension or to restore or maintain the occlusion, including but not limited to equilibrium, full mouth rehabilitation and restoration for malalignment of teeth;
    d. Temporomandibular joint (TMJ) or craniomandibular disorders, myofunctional therapy or the correction or harmful habits;
    e. Experimental procedures; and

11. Any over the counted drugs or medicine.

12. Fluoride varnish.

13. Charges for finance charge, broken appointments, completion of insurance forms, or reports, providing records, oral hygiene instruction, pit and fissure sealants and dietary instruction, or lack of cooperation on the part of the patient.

14. Charges in excess of the amount allowed by the plan for a covered service.

15. Any treatment, material, or supplies which are for orthodontic treatment, including extractions for orthodontics, unless otherwise specified as covered in your benefit summary.

16. Services for which no charge would have been made had the agreement not been in effect.

17. All treatments not specifically stated as being covered.

18. Surgical grafting procedures.

19. Conscious sedation, and other forms of relative analgesia, except as otherwise specifically provided herein.

20. Services paid for by Worker's Compensation.

21. Charges incurred while confined as an inpatient in hospital unless such charges would have been covered unless such charges would have been covered had treatment been rendered in dental office.

22. Treatment and/or removal of oral tumors. All surgical procedures except for surgical extractions of teeth and periodontal surgeries Performed by a Dentist. Surgical procedure is defined as the surgical and adjunctive treatment of diseases, injuries, and deformities of the oral and maxillofacial region

23. Panoramic x-ray if provided less than three (3) years from the Covered Person's last full mouth x-rays; and full mouth x-rays if provided less than three (3) years from the Covered Person's last panoramic x-ray.

100121-DGNPGJH

Group Health Certificate

JUDICIARY OF GUAM
and
TAKECARE INSURANCE COMPANY, INC.

GROUP HEALTH INSURANCE CERTIFICATE
JUDICIARY OF GUAM PPO 1000 / HSA 2000 / DENTAL 1000/2000
FOR THE PERIOD OF:
OCTOBER 1, 2023 - SEPTEMBER 30, 2024

takecareasia.com

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

Connect with us

Our Island, Your Health Plan℠

This booklet is designed to provide general information about the **TakeCare plans** offered to Judiciary 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.

General Terms and Conditions

Eligibility. An individual is eligible for Enrollment and benefits only if he or she satisfies the definition of Covered Person and has not previously had coverage under the Plan which was terminated for cause.

Dependent. A Dependent is a Spouse, Cohabiting Partner, or Child as defined herein.

Spouse, Cohabiting Partner, and Children. A Subscriber's legally married Spouse or Cohabiting Partner continuously residing within the Service Area, a Subscriber's Children under twenty-six (26) years of age or Children of a Subscriber's legally married Spouse under twenty-six (26) years of age may enroll as Eligible Dependents of the Subscriber if they meet each of the applicable eligibility requirements set forth in this Policy. For purposes of eligibility, "Children" means persons from birth up to but not including their twenty-sixth (26th) birthday, who are a Subscriber's or a Subscriber's legally married Spouse's natural or adopted Children, Children placed for adoption by an adoption agency with the Subscriber, Children under the legal guardianship and custody of the Subscriber by a court order, or Children for whom the Subscriber is required to provide health coverage pursuant to a Qualified Medical Child Support Order. Children of Cohabiting Partners are eligible for coverage so long as the Cohabiting Partner is a Covered Person. The Spouses and children of Children are not eligible for coverage. For purposes of this paragraph, if a Subscriber's Spouse is absent from the Service Area for ninety (90) consecutive days within the Plan Year, then the Spouse does not continuously reside in the Service Area.

Cohabiting Partner Eligibility. This Certificate includes coverage for a Cohabiting Partner provided that the Subscriber and Cohabiting Partner have complied with the following provisions:

A Cohabiting Partner becomes eligible for coverage only during the Judiciary's open enrollment period.

The Subscriber and a Cohabiting Partner are eighteen (18) years of age or older; are not related to each other by blood to a degree that would bar marriage; are not legally married or the Cohabiting Partner of any other person; have cohabited for two (2) consecutive years immediately preceding enrollment; and a notarized affidavit in a form acceptable to the Company attesting to these facts is submitted to the Company during the Judiciary's open enrollment period for each year that the Cohabiting Partner is to be enrolled.

For purposes of this paragraph, if a Cohabiting Partner is absent from the Company's Service Area for ninety (90) consecutive days within the Plan Year, then the Cohabiting Partner does not continuously reside in the Service Area.

Coverage for Children Outside the Service Area. Eligible Dependent Children residing outside the Service Area are eligible for coverage up to but not including their twenty-sixth (26th) birthday, provided proof of eligibility such as but not limited to a legal birth certificate being submitted to the Company. The Eligible Dependent Children must select a Participating Provider as provided in § 2.1.1 of this Certificate. To obtain coverage, all care must be provided or coordinated with the Participating Primary Care Provider and prior authorization must be obtained from the Company for Specialty and Hospital Services excluding Emergency and covered Primary Care Services.

Commencement of Coverage for Eligible Dependents.

To add Eligible Dependents, unless enrollment is pursuant to a Qualified Medical Child Support Order or other Special Enrollment Period as specified herein, a Subscriber shall complete an application for enrollment to add an Eligible Dependent within thirty (30) days of the date the Eligible Dependent becomes eligible or during open enrollment. After the thirty (30) days limit has passed, the Subscriber will not be allowed to add an Eligible Dependent until the next open enrollment period.

Coverage for newborn Children of a Subscriber begins at birth, provided an application for enrollment form for the newborn is received by the Company within thirty (30) days of their birth. An Application for enrollment received after this period will result in no coverage for the newborn until the next open enrollment period at which time the Subscriber has another opportunity to enroll Eligible Dependents.

Coverage for Children for whom a Subscriber or the Subscriber's legally married Spouse or Cohabiting Partner has been appointed legal guardian by a court begins from the date that guardianship was ordered, provided an enrollment form for the Child is received by the Company within thirty (30) days of that date and the applicable premium is paid. The Company may require the Subscriber to present evidence that guardianship has been ordered, including court orders. Eligibility for a Child for whom a Subscriber or the Subscriber's legally married Spouse has been appointed legal guardian ends when the guardianship ends or the Child reaches the age of majority.

Coverage for adopted Children of a Subscriber can be applied for on the date of placement for adoption, which is the date the Subscriber assumes and retains a legal obligation for full or partial support of the Child in anticipation of the adoption of the Child, provided an enrollment form for the Child is received by the Company within thirty (30) days of the date of placement for adoption. The Company may require the Subscriber to present evidence that placement has been obtained, including adoption agency documentation. Eligibility for coverage for an adopted Child ends if the placement is interrupted before legal adoption or the Child is removed from the Subscriber's custody.

Commencement of Coverage for New Spouse. Eligibility for coverage of a new legally married Spouse of Subscriber begins on the date of marriage as indicated on the marriage certificate, provided an enrollment form is submitted to the Company within thirty (30) days of the date of marriage. Official documentation of proof of marriage will be required.

Commencement of Coverage for Cohabiting Partner. Coverage for a Cohabiting Partner can be applied for only during the Judiciary's open enrollment period. Coverage begins on the Judiciary's effective date following the open enrollment period, provided an enrollment form, affidavit, and other documentation as requested by the Company, is submitted to the Company during the Judiciary's open enrollment period.

Documentary Evidence. Company reserves the right to require a Subscriber to provide documentary evidence of eligibility of an Eligible Dependent, including but not limited to, copies of tax returns, birth certificates, marriage certificates and court orders, to supplement an application for enrollment.

Other Eligibility Requirements. Additionally, the following requirements must be met to ensure eligibility:

Subscriber through whom the Eligible Dependent is eligible must be enrolled in the Plan;

The Eligible Dependent must continuously reside in the Service Area, except as provided herein for Children in §5.3.2 above. For purposes of this Certificate, if an Eligible Dependent is absent from the Service Area for more than ninety (90) consecutive days in any one hundred eighty (180) day period, that Eligible Dependent does not continuously reside in the Service Area; and the Eligible De-

pendent Children must select a Participating Provider as provided in §2.1.1 of this Certificate.

Biological or adopted children or children placed for adoption, and children under legal guardianship. Eligible children include the Subscriber's biological or adopted children or children placed with the Subscriber for adoption by the Subscriber, and children under legal guardianship of the Subscriber or the Subscriber's legally married Spouse or Cohabiting Partner; and children of the Subscriber's legally married Spouse or Cohabiting Partner. Except for children under legal guardianship, the Plan may not deny enrollment of a child on the grounds that the child is not claimed as a Dependent on the Subscriber's Guam tax return or on the grounds that the child does not reside with the Subscriber or in the Plan's Service Area. If a Subscriber is required, by a court or administrative order, to provide health care for a child, as defined above, the Plan shall permit the Subscriber to enroll, under family coverage, the child and himself/herself, provided the child is otherwise eligible, without regard to any open enrollment season or open enrollment restriction.

Incapacitated Child. An unmarried, dependent biological child, adopted child, or child placed for adoption with the Subscriber or the Subscriber's legally married Spouse or Cohabiting Partner, which child is over the age of twenty-six (26) years, and incapable of self-sustaining employment by reason of mental retardation or physical handicap, and is therefore primarily dependent on the Subscriber for support and maintenance and has been continuously dependent since reaching age twenty-six (26).

Child Not Denied Coverage. In accordance with Title 10 GCA § 95101, and notwithstanding any other provision of this Certificate, no child whose parent is a Subscriber or Spouse shall be denied coverage solely for any of the following reasons:

The child was born out of wedlock.
The child is not claimed as a dependent on the parent's Guam tax return.
The child does not reside with the parent or in the Service Area.

The child has a pre-existing or excluded medical condition.
The child is adopted or the subject of adoption proceedings.

Residency Requirement. Except as otherwise specifically stated in this Certificate, 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 ninety (90) consecutive days per Plan Year. Company shall be entitled to require substantiation from a Covered Person to determine the Covered Person's Domicile and may deny benefits under this Certificate for lack thereof. For a Covered Person who is Domiciled in the Service Area, time spent receiving continuous medical services out of the Service Area shall not count toward the ninety (90) 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 ninety (90) 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.

Enrollment Documentation. The following documents are required prior to enrolling the following Dependents:

Incapacitated child. For a child with a continuing dependency resulting from incapacity, as described in §5.7 of this Certificate, satisfactory proof of such continuing incapacity and dependency, within thirty-one (31) days of such child attaining the limiting age and annually thereafter.

Child under court order. For a Dependent child under court order requiring the Subscriber to provide health coverage for such child, a certified copy of the court order requiring such coverage.

Child under guardianship. For a Dependent child under guardianship, a certified copy of the court order granting the guardianship of such child to the Subscriber or the Subscriber's legally married Spouse or Cohabiting Partner. The Subscriber shall also be required to provide such evidence as to the qualification of the Dependent for legal guardianship as Company may require.

Cohabiting Partner. For a Cohabiting Partner of the Subscriber.

Affidavit. A notarized affidavit executed by both the Subscriber and the Cohabiting Partner verifying the parties' cohabitation for the two (2) consecutive years immediately preceding the proposed Enrollment of such Cohabiting Partner.

Proof of eligibility. Satisfactory proof that the Cohabiting Partner is over age 18 years.

Inpatient Confined Applicant. Any individual shall be entitled to the full benefits of this Plan beginning on his or her effective date regardless of any pre-existing medical condition and regardless of whether he or she is confined as an inpatient. In the event the individual is confined in an inpatient facility covered under this Certificate and incurring costs covered under this Plan, Company will make best efforts to coordinate with the individual's prior carrier, if any, to minimize disruption in the individual's medical care and to minimize cost to the Plan.

Enrollment.

Enrollment During an Open Enrollment Period. An eligible individual may enroll in the Plan and may cause his or her Dependents to become Enrolled, during an open Enrollment period.

Enrollment after Open Enrollment period. Persons becoming eligible for Enrollment after completion of the open Enrollment period under this Certificate may elect to enroll within thirty (30) days of the date of first becoming eligible.

After Thirty (30) Day Enrollment.

Subscriber. Subject to §5.12.3.3, an individual eligible to enroll as a Subscriber who does not make written election for Enrollment within thirty (30) days after first becoming eligible shall not be permitted to enroll hereunder until the next open Enrollment period unless entitled to special enrollment rights under HIPAA or PPACA.

Dependents. Subject to § 5.12.3.2 , a Subscriber with Dependents eligible for Enrollment who does not make written election for Enrollment of such Dependents within thirty (30) days after their first becoming eligible shall not be permitted to enroll such Dependents hereunder until the next open Enrollment period unless entitled to special enrollment rights under HIPAA or PPACA.

HIPAA and PPACA Enrollment requirements. If an individual eligible to Enroll as a Subscriber loses other employer coverage or acquires a Dependent through marriage, birth, adoption of a child under nineteen (19) years of age, or placement for adoption of a child under nineteen 19) years of age, then the special Enrollment requirements of HIPAA may be applicable. If a Subscriber becomes eligible for a HIPAA special enrollment, such Subscriber and Spouse/Cohabiting Partner and children, if applicable, shall be entitled to change from Class I or Class II to Class III or Class IV during such special Enrollment. A child previously excluded, or whose coverage ceased, because of age, shall have special enrollment rights to enter or reenter the Plan upon receipt of notice of the right to do so, to the extent required by Section 2714 of the PHSA, as added by PPACA, and the regulations thereunder.

Commencement of coverage. After fulfilling all conditions of Enrollment as set out in this Certificate, coverage under the Plan shall commence:

Previously Enrolled. As of the Effective Date of this Certificate, for a Subscriber and his or her Covered Dependents who are Enrolled on such Effective Date.

Not yet Enrolled. As of the first day following the pay period in which the individual satisfies the Enrollment requirements set forth in this Certificate and Company becomes entitled to receive the appropriate Premium for a Subscriber and his or her Covered Dependents who become Enrolled subsequent to the Effective Date of this Certificate.

Afterborn children. Except as provided in Continuing Enrollment, coverage of a Dependent of a Subscriber who becomes eligible after such Subscriber has been Enrolled hereunder shall commence as of the first day of the pay period following the timely filing of an application for Enrollment and liability for the appropriate Premium accrues, except that coverage for a child born, adopted (if under nineteen (19) years), placed for adoption (if under nineteen (19) years), or for whom legal guardianship has taken place after the Subscriber has been enrolled hereunder, shall commence from the date of birth, date of adoption, date of placement for adoption or from the date that guardianship was ordered, whichever is applicable; provided that the Subscriber applies to Enroll the child within the first thirty (30) days of that date and the applicable Premium is paid.

Open Enrollment Period. For any eligible individual and his or her eligible Dependents who apply for Enrollment or re-Enrollment during the Judiciary's open Enrollment period, coverage shall commence as of the Plan effective date first following the open enrollment period.

Continuing Enrollment. Subscribers and Covered Dependents enrolled under this Plan on the last day of a Plan Year shall be automatically enrolled for the following Plan Year unless they change to some other plan during open enrollment or unless this Plan is not renewed.

Medical term. Covered Persons must continue medical coverage under this Agreement for a minimum of twelve (12) months or for the balance of the Plan Year, except when terminating the Judiciary employment, or when termination of enrollment is approved by the Judiciary and by Company. A rate increase during the Plan Year is not grounds for disenrollment.

Dental eligibility and term. Covered Persons may enroll in the Company's dental plan only if they are enrolled in Company's medical plan. Covered Persons in the medical and dental Plan must continue their medical and dental coverage under this Certificate for a minimum of twelve (12) months or for the balance of the Plan Year, except when terminating Judiciary employment, or when termination of Enrollment is approved by Judiciary and by Company. A rate increase during the Plan Year is not grounds for disenrollment.

Leave without pay, reduction in force, sabbatical and related status. A Subscriber, who enters the status with the Judiciary of leave without pay, or sabbatical leave as approved by the Judiciary, or is laid off due to a reduction in the workforce by the Judiciary, and all enrolled Dependents of such Subscriber, can remain covered under this Certificate if such Subscriber self-pays both the Subscriber's and the Judiciary's share of the Premium for such coverage directly to the Company. Within 10 business days following commencement of the leave without pay, reduction in force, sabbatical or related status, the Subscriber must provide Company: (i) proof, in a form satisfactory to Company, that he or she has been approved by the Judiciary for such status and (ii) written notice of his or her intention to continue coverage during the leave. Such notice must be accompanied by the first month's Premium. Subsequent Premium payments must be made by the 15th day of the month preceding the month for which coverage is being paid. Subscribers who do not make their Premium payments when due shall have their coverage terminated as of the last day for which payment was made and shall not be allowed to reenroll in the Plan until the next enrollment period following the return to work. In no case, however, can such continued membership in the Plan extend for a period in excess of 12 months. If Company does not receive the full amount of Premium due at least 15 days in advance, it shall make a good faith effort to notify the Subscriber that coverage shall terminate on the last day of the month for which Premium was paid. Notwithstanding the aforesaid, laid off Subscribers may not remain in the Plan beyond the end of the current Plan Year.

-Notwithstanding the aforesaid, if the leave is taken pursuant to the Family and Medical Leave Act of 1993, Company shall fully cooperate in assisting the Judiciary in complying with this Act.
-Active employees required to live out of the Service Area pursuant to their employment by the Judiciary or Judiciary-sponsored training status and their eligible Dependents shall be eligible for coverage under the Plan.

Military leave. Company shall be given prior written notice if a Subscriber shall take a military leave of absence ("Military Leave"). Coverage for such Subscriber shall continue for the shorter of eighteen (18) months or the duration of the Military Leave up to a cumulative length of no longer than five (5) years unless otherwise agreed upon with Company, provided Premiums are paid. Even if the Subscriber elects not to continue coverage for himself or herself or any Dependent during the Subscriber's Military Service, the Subscriber and all Dependents shall be eligible to re-enroll immediately after such Military Leave terminates, without a waiting period or health statement, upon the Subscriber's return to employment by the Judiciary if the Subscriber satisfies applicable requirements that were in the Plan prior to such Military Leave and no discharge from Military Service is less than fully honorable. Company shall not provide coverage for any Injury or Illness determined by the Secretary of Veterans' Affairs to have been incurred or aggravated during Military Service. The provisions of this paragraph are notwithstanding any other section of this Certificate.

Reduction in hours. If a Subscriber's work hours are reduced below 20 per week, such Subscriber and his/her enrolled Dependents shall be eligible to remain in the Plan in accordance with all other terms of the Plan. Alternatively, such Subscriber shall have the option to disenroll within 30 days of the effective date on which the reduction in hours occurs provided that, within 10 business days following such effective date, the Subscriber shall have provided notice to Company of his/her intent to disenroll. Further, he/she shall not be eligible to reenroll until a future open Enrollment or until his/her work hours are increased to at least 20 hours per week.

Coordination of Benefits. If a Covered Person receives any medical, Surgical, Hospital or other Services entitling that Covered Person to the payment of benefits under this Certificate and such Services are also covered or payable under any other plan, which, for purposes of this section, shall include Medicare Parts A and B and any motor vehicle insurance policy or contract, then the benefits of this Plan and each other plan shall be appropriately coordinated and adjusted so that such benefits shall not exceed one hundred percent (100%) of Eligible Charges. Integration or coordination of benefits with Medicare shall be done on a "Carve Out" or "Benefit Offset" basis. When any other plan provides benefits in the form of Services rather than cash payments, the reasonable cash value of such Services rendered shall be deemed to be both an allowable expense and a benefit paid. The coordination and adjustment of benefits shall be determined as follows:

The plan under which the Covered Person is a Subscriber is primary.
In the case of a Dependent child, the plan of the parent whose birthday occurs earlier in the calendar year is the primary carrier. If both parents have the same birthday, then the plan in which the Covered Person has been enrolled for the longest continuous time pays first. However, other rules apply if a claim is made for an insured dependent child whose parents are separated or di-

This booklet is designed to provide general information about the **TakeCare plans** offered to Judiciary 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.

vorced. If the parent with custody of the child has not remarried, the plans shall pay in this order: first, any plan in which the child is insured as a Dependent of the parent who has custody; and second, any plan in which the child is insured as a Dependent of the parent who does not have custody.

If the parent with custody of the child has remarried, the plans shall pay in this order: first, any plan in which the child is insured as a dependent of the parent who has custody; second, any plan in which the child is insured as the dependent of the stepparent; and third, any plan in which the child is insured as the dependent of the parent who does not have custody.

These rules do not apply when a court decree fixes the responsibility for the health Services costs of a child whose parents have separated or divorced. Any plan in which the child is insured as the dependent of a parent with this legal responsibility shall always pay first.

If the order of payment is unclear, the National Association of Insurance Commissioners' (NAIC) Coordination of Benefits model shall apply.

In no event shall coordination of benefits require Company to: (i) make any payment which would exceed the amount for which it would be liable under this Plan if a Covered Person were not eligible to receive benefits from any other plan; or (ii) pay the excessive, unnecessary or unreasonable portion of any charge or expense. A Covered Person who is also enrolled in one or more of Company's other plans shall be entitled to receive benefits from all of such plans not to exceed one hundred percent (100%) of Eligible Charges.

Preferred Provider: Shall be defined as a Participating Provider that is either an Out-patient Clinic or Individual Physician/Provider Practice within the Service Area or Hospital or Ambulatory Surgical Center located outside the Service Area. The Out-patient Clinic or Individual Physician/Provider Practice shall be a Participating Provider at the time of services and have entered into a written agreement with the Company to provide care and treatment to Covered Person at preferential or better member share (copayment and/or co-insurance) and have demonstrated better outcomes based on a standard clinical measurement set by the National Committee for Quality Assurance ("NCQA"). The Hospital or Ambulatory Surgical Center shall be a Participating Provider at the time of services are rendered to the Covered Person. These providers shall be specifically designated by name as a Preferred Provider in the more recent of Company's most current member brochure or Company's most current updated listing of participating providers.

The following sections refer to charges incurred by a Covered Person for Covered Services provided at Preferred Providers:

The Covered Person has obtained written Prior Authorization from Company to receive services from a Preferred Provider and has agreed to receive services from such Preferred Provider. No Prior Authorization shall be required for Emergency or PPACA Emergency cases and the Covered Person may select the Preferred Provider where Emergency or PPACA Emergency Services shall be rendered.

Company shall only provide airfare for the Covered Person for the most direct route to and from the location of the Covered Person and the Preferred Provider as determined by Company. Regardless of the location of the Covered Person, or if it is Medically Necessary to provide for a break in the trip, Company shall provide the lesser of the lowest applicable economy airfare or the lowest economy, round-trip airfare on a commercial direct flight between Guam and the Preferred Provider. In no event shall Company provide an air ambulance.

If the Service is one of the following specific procedures or conditions: open heart surgery, oncology surgery to include but not limited to the following cancers: brain, lung, liver, kidney, adrenal, nasopharyngeal, tongue, prostate, colon, genito-urinary, breast and gynecological oncology, aneurysmectomy, pneumonectomy, intra cranial surgery, acute leukemia, gamma knife or if the level of care required is NICU Level III, or if the expected cost to the Company for off-island Covered Services exceeds $50,000.00, Company shall pay the air fare of one companion of the Covered Person to the Preferred Provider

If it is Medically Necessary for a licensed medical attendant to be with the Covered Person, Company shall provide for one airline seat for such attendant.

If the Covered Person is unable to self-care, Company shall provide for one airline seat for a qualified assistant

Company may, at its option, make the travel arrangements for the Covered Person and his or her companion, attendant or assistant (if any) and purchase the airline tickets. In the event the covered person/attendant purchases the seat(s), the Company will reimburse for actual expenses incurred in purchasing Medically Necessary seat(s), but not more than the Company would have paid had it purchased the seat(s) for the companion in advance. In no event will Company reimburse for any seat(s) purchased with frequent flyer miles.

Company may provide access to Preferred Outpatient Clinics whereby members will pay a reduced co-payment. Company shall identify such Outpatient Clinics on its most recently updated provider directory for the Judiciary of Guam members.

If no Participating Provider available. If there is no Participating Provider available to provide Medically Necessary Covered Services to a Covered Person, the Non-Participating Provider is treated as a Single Source Provider, defined as a Provider who is the only Provider in Guam for a Covered Service. A Covered Person using a Non-Participating Provider as a Single Source Provider shall not be responsible for charges in excess of Eligible Charges. Company will cover those Services at a Non-Participating Provider unless otherwise agreed by the Covered Person, such that the Covered Person will have no greater out-of-pocket cost than he or she would have had, had the Services been rendered by a Participating Provider.

In case Emergency medical care is needed off-island, and it is medically imprudent for the Covered Person to be transported to a Participating Provider, Company will cover Services rendered to the Covered Person at a Non-Participating Provider, such that the Covered Person shall not be liable for Co-Payments or Co-Insurance in excess of Co-Payments and Co-Insurance that would have been charged if Participating Providers had been used, and shall have no greater out of pocket cost than he or she would have had, had the Services been rendered by a Participating Provider. The Company shall pay an amount for PPACA Emergency Services computed as provided in this Certificate.

Subrogation, Right of Reimbursement and Right of Recovery. The Company reserves the "right of subrogation," the "right of reimbursement," and the "right of recovery," in the event of an Illness, Injury, or condition caused by a third party or with respect to which a "first party payor" has liability, for which the Company has paid or is being requested to pay benefits under this Plan or for which the Company chooses to advance benefits as provided in this Section.

Definitions.

As used throughout this provision, the term "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to or for the benefit of a Covered Person due to a Covered Person's Injury, Illness or condition. The term "Responsible Party" includes (without limitation) the liability insurer of such party or any insurance coverage.

For purposes of this provision, the term

"Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured or underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

For purposes of this provision, a "Covered Person" includes anyone on whose behalf the Company pays or provides any benefit including, but not limited to, the participating employee or former employee and any minor child or other dependent of any such employee, and any person who acts or holds funds on behalf of such an employee, former employee or dependent. For example, if an injured Covered Person is a minor child, and the child's parents receive a recovery for the child, "Covered Person" for purposes of the Company's right to repayment shall include a right for the Company to recover from the parents or other party receiving or holding such recovery on behalf of the child.

For the purposes of this section, a first party payor is a person or company with whom a Covered Person has either a contractual relationship, is in privity with a non-responsible party through whom benefits are available that are related to the Illness or Injury, or for whom benefits are otherwise available, regarding the Illness or Injury but regardless of fault, such as workers' compensation coverage, uninsured motorist coverage and no-fault motorist coverage.

Subrogation. Immediately upon paying or providing any benefit under the Judiciary of Guam Health Insurance Plan, and as permitted by Guam's laws, the Company shall be subrogated to all rights of recovery that a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's Injury, Illness, or condition to the full extent of benefits provided or to be provided by the Company.

Reimbursement. In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an Injury, Illness, or condition, the Company has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Company has paid and will pay as a result of that Injury, Illness, or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

Right of Recovery. The Company also has a "right of recovery," in that it may choose to take action to recover the amount of all claims paid to or on behalf of a Covered Person from the third party, or from any insurer or other party that is or may be liable for damages related to the third party's actions.

Constructive Trust. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Company, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an Injury, Illness, or condition, he or she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Company and the Plan, and will give the Company rights to recover equitable and money damages from the Covered Person.

Lien Rights. The Company shall automatically have a lien to the extent of benefits paid by the Company for treatment of the Illness, Injury, or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise related to treatment for any Illness, Injury, or condition for which the Company paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Company including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Company. The Company may file this lien with the third party, third party's agent, any insurance company, first party payor or the court in which any action is filed, to assure that the lien is satisfied from any such recovery. Further, the Plan reserves the right to notify the Responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

First-Priority Claim. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Company, the Covered Person acknowledges that the Company's recovery rights are the first priority claim against all Responsible Parties and are to be paid to the Company before any other claim for the Covered Person's damages. The Company shall be entitled to full reimbursement on a first-dollar basis from any and all payments from each and every Responsible Party, even if such payment to the Company will result in a recovery to the Covered Person that is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Company is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments. The terms of this entire subrogation, reimbursement and right of recovery provision shall apply to each and every settlement or judgment related to the Injury, Illness or condition of the Covered Person, and the Company is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies any medical benefit the Company provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Company is entitled to recover from any and all settlements or judgments, including (without limitation) those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation. The Covered Person shall fully cooperate with the Company's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Company within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to Injury, Illness, or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the Company or the Plan, or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Company may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person. The Covered Person shall do nothing to prejudice the Company's subrogation or recovery interest or to prejudice the Company's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

Right of Investigation. The Company has the right to conduct an investigation regarding the Injury, Illness, or condition of any Covered Person to or for the benefit of whom the Company pays benefits under the Plan to identify any Responsible Party. Each Covered Person receiving benefits under the Plan acknowledges or is deemed to acknowledge that the Company has such right of investigation.

Interpretation. In the event that any claim is made that any part of this subrogation, reimbursement and right of recovery

provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Company shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Company, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Company may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

After expenses incurred by the Company in obtaining any recovery from, on behalf of or related to such third party, the net amount recovered must be divided proportionately with the Covered Person to allow the Covered Person to recover a proportionate share of any deductible for which the insured was responsible.

Benefit Exclusion or Delay. In cases where third party or first party payor liability is being pursued, and upon the execution and delivery to Company of all documents required by it, to secure its rights of subrogation, reimbursement and right of recovery entitlements, as provided in this Section 5.25, the Company may pay benefits in connection with such Injury or Illness if it is satisfied that its subrogation, reimbursement and recovery rights are being upheld and shall be repaid only from the proceeds (beginning with the first proceeds) of any and all recoveries, if any, from or on behalf of such third party or from any first party payor. As security for such repayment, the Company shall have a lien, as provided in this § 5.25, against any and all such recoveries to the extent of the amount advanced to the Covered Person by Company.

PPACA Compliance. In the event that any applicable provision of PPACA prohibits the application of any provision of this §5.16, the section shall be deemed modified to the extent necessary to comply with PPACA.

Covered Person eligible for Medicare. The Plan shall pay its benefits pursuant to this Certificate before Medicare if (i) the Subscriber is an active, full-time employee of Judiciary or his or her Spouse is a Covered Person and the Subscriber or Spouse who is a Covered Person is sixty-five (65) or older; or (ii) the Subscriber or Spouse who is a Covered Person is under age sixty-five (65) and is in the Medicare waiting period during which he or she or his or her Spouse is receiving treatment for end-stage renal disease (ESRD).

If any Covered Person, including disabled active individuals as defined in the Omnibus Budget Reconciliation Act of 1993, incurs expense for benefits covered under the Plan and for which the Covered Person is eligible for and entitled to benefits under Medicare, then the Plan, where primary carrier, shall pay to the full limit of its coverage before Medicare assumes coverage. The Covered Person shall have covered benefits equal to the greater of the two plans' benefits (shall reduce benefits by the amount Medicare would pay, and the Plan shall not provide any benefit if the amount Medicare would pay equals or exceeds its benefit.)

If any Covered Person, for whom Medicare is or would be primary, is eligible for but not enrolled in the entire Medicare program but is receiving income benefits from Social Security, the Plan shall provide no benefits on behalf of that person. However, under no circumstances shall anyone be required to enroll in Medicare in order to receive benefits under the Plan, unless the Medicare programs are available at no cost. Eligible Persons receiving Social Security may be required to enroll in Medicare Part A in order to receive benefits under the Plan, unless Medicare Part A is available to her or him at no cost but shall be required to enroll in Part B, subject to the Judiciary o or some other entity paying the Part B premium. For a Covered Person enrolled in Medicare Parts A and B and where Medicare is primary, Company shall pay the co-payments, Deductibles, and co-insurance required by Medicare and treat Covered Person as having met the Out-of-Pocket maximum under the Plan for purpose of receiving benefits under this Certificate.

Incarcerated Benefits. The Plan is secondary payor for services furnished to individuals in the custody of penal authorities. The state or territory (or other government component which operates the prison) in which the beneficiary resides is responsible for all medical costs incurred.

Release of medical information. As a condition to the receipt of Plan benefits, each Covered Person authorizes Company to use and obtain information about his or her medical history, medical condition and the Services provided to him or her as may be necessary in connection with the administration of this Certificate. Information from medical records of Covered Persons and information received from Physicians or Hospitals arising from the Physician-patient relationship shall be kept confidential and shall only be disclosed with the consent of the Covered Person and in accordance with applicable law.

No warranty of Service.

Company is not an insurer against, nor liable for, the negligence or other wrongful act or omission of any Physician, Hospital, Hospital employee or other Provider, or for any act or omission of any Covered Person.

Company does not guarantee the availability of or undertake to provide any Services of any third party.

Termination for cause. Company may terminate a Covered Person from the Plan for:

Misuse of card. A Covered Person knowingly allowing his or her Plan identity card to be used by another person or falsely representing the relation between himself or herself and another in order that the other person can obtain Services hereunder; or

Non-payment. A Covered Person's failure to pay or arrange to pay applicable Deductibles, Co-Payments, or Co-Insurance as soon as practicable, and in no case later than the next Enrollment period.

To the extent required by PPACA, terminations for cause (other than for non-payment of premiums) shall be handled as required by the applicable PPACA Claims Procedure Requirements provided in §6.7 and as reflected in the Company's Appeal Procedures attached hereto.

Termination other than for cause. Other terminations of benefits, not for cause, are as follows:

Termination by a Covered Person. Except as otherwise provided in this Agreement or applicable law, if the Covered Person terminates his or her rights under this Certificate then all rights to benefits shall cease as of the effective date of such termination. If a Subscriber's coverage so terminates, his or her Covered Dependents' coverage shall terminate on the same date. However, Company shall pay Eligible Charges for all Covered Services incurred prior to the date of termination.

Marriage terminated or spouse no longer eligible. If the spouse of a Subscriber ceases to be a Spouse as defined herein, coverage for such person under this Certificate shall terminate on the first (1st) day of the pay period following termination of eligibility.

Children no longer eligible as Dependents. Coverage shall terminate as to a Dependent child who attains age twenty-six (26), or who enters the Military Service, on the date of such occurrence. However, a Dependent

child who has attained the limiting age (26), and who is incapable of self-sustaining employment by reason of developmental disability or physical handicap, and who is primarily dependent upon the Subscriber for support and maintenance, may continue to be covered under this Plan as an enrolled Dependent during the continued disability or handicap, provided that proof of such incapacity and dependency is furnished to Company within thirty (30) days of the child's attainment of the limiting age and annually thereafter.

Rebate of Premium. In the event of termination of coverage, the Judiciary or the Subscriber, as applicable, shall receive a pro rata rebate of the Premium paid to Company for such Covered Person.

Effective date of termination. Except as otherwise provided herein, termination of coverage shall take effect on the first (1st) day of the pay period following the event causing termination.

To the extent required by PPACA, disputed terminations (other than for non-payment of premiums) shall be handled as required by the applicable PPACA Claims Procedure Requirements provided in §6.7 of this Certificate.

HIPAA compliance. Company shall provide the certifications required by HIPAA for terminated Subscribers and their Covered Dependents, upon notification by the Judiciary of the Subscriber's termination. Company shall also provide certifications for all other terminated Covered Persons, such as Dependent children reaching the limiting age, divorce of a Spouse, or no longer cohabiting, without notification by the Judiciary, but after receipt of actual notice of the triggering event.

Grievance Procedures. The Grievance Procedure is not applicable to medical malpractice. Adverse benefit determinations, including rescission of coverage, and their appeals which are subject to PPACA Claims Procedure Requirements provided in §6.7 and reflected in the Company's Appeal Procedures attached. A grievance is a formal complaint or dissatisfaction with the service received by a Covered Person. Grievance includes complaints about the quality of care or non-quality of care services at any of the Company's contracted network facilities, providers or with any administration provider/behavioral services and access to care. Non-quality of care services includes complaints about administrative services, sales processes or other marketing issues. A Covered Person and/or his or her representative may file a written grievance claim, including all relevant documentation, with the Company. The Covered Person and Company shall provide additional information or documentation, as applicable, if requested in writing.

Within sixty (60) days after a grievance is received by the Company, the Covered Person shall be notified in writing of the denial, partial denial or approval of the grievance.

If a Covered Person does not agree with the decision, then the Covered Person or the Covered Person's authorized representative may file a grievance appeal as follows:

A written grievance appeal request must be directed to the Grievance Coordinator. The request shall state all bases for the grievance appeal and be supported by all relevant information and documentation.

The Grievance Coordinator may refer grievance appeals to the medical society, the utilization department, peer review committee, or a medical specialty organization for an opinion to assist in the resolution of the grievance appeal.

Within ten (10) working days of the receipt of a grievance appeal, the Grievance Coordinator shall be available to meet with the Covered Person to discuss possible resolution of the matter and establish the time frame for review of the grievance appeal, which shall not exceed thirty (30) days.

If, after receipt of the written decision on disposition of the grievance appeal, the Covered Person is not satisfied, then the Covered Person may proceed with mediation or arbitration

For issues that are not subject to the Company's Appeals Procedures (in the attached appeals exhibit), and for matters that are not required by law to be submitted to arbitration, the parties agree that disputes will first be submitted to some form of Alternative Dispute Resolution ("ADR") through mediation or arbitration before a lawsuit may be filed. The form of ADR used shall be in the discretion of the appellant, and shall be governed by the Rules and Procedures promulgated by JAMS found at www.jamsadr.com, including: (i) Mediation; or (ii) Arbitration including those conducted pursuant to JAMS' Streamlined Arbitration Rules and Procedures. Judgment on either the Mediation or Arbitration award may be entered in any court having jurisdiction. This clause shall not preclude parties from seeking provisional remedies in aid of Mediation or Arbitration from a court of appropriate jurisdiction.

Notice. For purposes of service of any notice or other document under this Certificate, a Covered Person's address shall be that stated in the enrollment materials, unless the Covered Person designates a new address by providing written notice to the Company. The address of the Company is: 415 Chalan San Antonio Street, Tamuning, Guam 96913, unless the Company designates a new address in writing served on the Covered Person.

Cooperation Regarding Federal Law. Company and the Judiciary shall fully cooperate in implementing any Qualified Medical Child Support Order as defined and required by federal law. This shall include enrolling the employee, if eligible, and the relevant child, if eligible, outside a regularly scheduled open enrollment period.

Claims and Payment for Service

Submission of claims. When Services are provided to a Covered Person, the Covered Person shall inform the Provider that he or she is a Covered Person of Company. In the case of a Participating Provider, the Covered Person is not responsible for filing the claim. In the case of a Non-Participating Provider, the Covered Person must file a claim for reimbursement unless the Provider agrees to file a claim on the Covered Person's behalf. Company shall not be obligated to make any payment until it receives, reviews, and approves a claim for payment.

Payment for Covered Services. Company shall make payment of claims for Covered Services directly to Participating Providers. In the case of Non-Participating Providers, the Covered Person is responsible for payment to the Provider, and payment of claims shall be made by Company directly to the Covered Person.

Reimbursement for Services. If the Covered Person has paid for Covered Services, Company, upon submission of a complete claim by the Covered Person shall reimburse the Covered Person to the same extent that it would have directly paid the Provider of the Covered Services.

Payment of late claims. In no event shall any payment be owed or made on any claim submitted to Company more than ninety (90) days after which the Covered Services were rendered, unless:

-The claim is subject to coordination of benefits, Company is not the primary carrier, and the claim was submitted to the primary carrier during the twelve (12) month period; or
-Required by law, including applicable PPACA Claims Procedure requirements.

Proof of Payment of Deductible. Company shall require participating providers to report all payments made by members for Covered Services within 120 days of the date when the Covered Services were rendered. Company shall not credit any eligible amounts paid towards any Deductible unless proof of such payment is submitted within one hundred twenty (120) days of the date on which the Covered Services were rendered.

Utilization review.

Company shall not be required to pay any claim until it determines that Services provided to a Covered Person are Covered Services.

Company has the right to conduct utilization review on a prospective concurrent and/or retrospective basis, subject to compliance with PPACA applicable Claims Procedure Requirements.

PPACA Claims Procedure Requirements. Adverse benefit determinations, including rescissions of coverage, and their appeals are subject to the requirements of Section 2719 of the PHSA, as added by PPACA, and applicable regulations to include 45 CFR 147.136 and 29 CFR 2560.503-1. The Company's PPACA Claims Procedure is reflected in the attached Exhibit.

As required by PPACA, the Company shall comply with U.S. Department of Labor claims regulations applicable to health plans under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), as set forth at Section 2560.503-1 of Title 29, Code of Federal Regulations, as such regulations may be updated from time to time by the Secretary of Labor (the "ERISA Claims Regulations"). These ERISA Claims Regulations shall apply notwithstanding that the Plan is a government plan, previously not subject to ERISA's requirements, but shall be modified as follows:

An adverse benefit decision, to which the ERISA Claims Regulations shall apply, shall include a rescission, whether or not the rescission has an adverse effect on any particular benefit at that time.

In the case of a claim determination (whether adverse or not) involving urgent care, the claimant shall be notified as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

On appeal, the claimant must be allowed to review the claim file and to present evidence and testimony.

Other aspects of the PPACA Claims Procedure regulations must be followed.

Specific Limitations on Benefits

Limitations. The medical benefits available under this Certificate are subject to the following specific limitations per Covered Person, in addition to all other exclusions and limitations set forth in the Contract and this Certificate:

Maximum Annual Benefit. The total benefits payable to or on behalf of a Covered Person per Plan Year shall be as stated in the Exhibits attached hereto.

Non-Spouse Dependent. Maternity benefits for a non-Spouse Dependent are covered, except that newborn care shall not be covered for a child born to a non-Spouse Dependent. A child born to a non-Spouse Dependent shall not be covered unless such child specifically meets the requirements for coverage as a Dependent of an employee (such as the employee becoming the guardian of such child).

Allergy Testing and Treatment. A maximum benefit of Five Hundred Dollars ($500) per Plan Year for charges for allergy testing, treatment, and allergy injections, including allergy serum, that are not considered essential benefits under PPACA. Benefits for Allergy testing and treatment that constitute essential benefits under PPACA are subject only to the PPACA Annual Limit.

Annual Refraction Eye Examination. Coverage is limited to one visit per member per Plan Year. There is no dollar limit for an annual eye examination.

Hearing Aids. Coverage for hearing aids is limited to One Thousand Dollars ($1,000) per Covered Person per 24-month period. Replacements for hearing aids are allowed once every three years.

Preventive Physical Exam. Coverage for the routine preventive physical exam is limited as follows: (a) one exam per plan year; and (b) at least 9 months have passed following the last covered preventive physical exam.

Other Benefit Limitations. The medical benefits available under this Certificate are subject to the following other benefit limitations, in addition to all other exclusions and limitations set forth in the Contract and this Certificate, per Covered Person:

Emergency Services. Coverage for Emergency Services is generally limited to those Services required for diagnosis and treatment of an Emergency immediately after onset. PPACA Emergency Services shall be provided as necessary to stabilize the Covered Person, without regard to such time limit.

Prior Authorization. Prior authorization must be obtained from the Company before a Covered Person is admitted to a Hospital or has one of the Surgeries or Medical Procedures listed in §3.2.2.3. The prior authorization process will be handled in accordance to the Milliman Healthcare Guidelines.

Responsibility for prior authorization. The Participating Provider ordering the hospitalization or Surgery for a Covered Person shall obtain prior authorization. The Covered Person shall not be responsible for obtaining prior authorization and shall not be liable for any penalty.

The Non-Participating Provider or the Covered Person shall be responsible for obtaining prior authorization required by the Company prior to the hospitalization or Surgery. In the event a Covered Person is admitted to a Hospital for an Emergency, required authorization consists of: notifying Company (i) within forty eight (48) hours of the admission if it occurs on a day other than a Saturday, Sunday or holiday; or (ii) within seventy-two (72) hours if it occurs on a Saturday, Sunday or holiday, and, in either case, receiving Company's authorization for the admission. PPACA Emergency Services shall not require prior authorization, and such services provided by Non-Participating Providers shall not require any notification or other administrative requirement other than what is required when provided by Participating Providers.

Prior authorization denials shall be handled pursuant to the PPACA Claims Procedure Requirements provided in §6.7 and as reflected in the Company's Appeal Procedures.

List of outpatient and inpatient procedures requiring prior authorization (unless a PPACA Emergency):

- All elective outpatient surgical procedures requiring use of surgical facilities including treatment under §2.9.3.1
- All out of service area services and procedures
- Any and all diagnostics in excess of $300.00 including specialty laboratory
- Any back or disc surgery
- Any knee surgery
- Any varicose veins surgery
- All hospital surgical procedures
- Any procedure requiring implants
- Any procedure requiring orthopedic devices and/or prosthetics
- Any services related to Autism Spectrum Disorder
- Any elective surgery
- Breast reconstruction surgery
- Biopsies
- Carpal Tunnel Release
- Cardiac Surgery
- Cardiac Care (Rehabilitation and Therapy)
- Clinical Trials
- Chemotherapy
- Congenital Treatment
- CT Scan
- Durable Medical Equipment: Standard hospital bed, wheelchairs, walkers, crutches, oxygen, suction machine, CPAP machine
- End Stage Renal Disease treatment/Hemodialysis

- EMG/NCT (upper extremities)
- Gall bladder surgery
- Heart bypass surgery
- Heart catheterization
- Hernia surgery
- Hysterectomy
- Hyperbaric Oxygen treatment
- Mastectomy
- MIBI Scan, Thallium Stress Test, Exercise Stress Test MRI
- Endoscopies and colonoscopies
- Occupational Therapy
- Oncology Care Services (Chemotherapy/Radiation)
- Ophthalmology procedures
- Pain management studies
- Physical Therapy requiring more than five (5) out-patient visits
- Prostatectomy
- Radiological and nuclear diagnostic procedures performed or ordered by the same provider on any one patient two or more time
- Sleep Study
- Speech Therapy
- Sterilization (Traditional Tubal Ligation, Tubal Ligation with Fulguration and Vasectomy)
- Upper GI Endoscopy

Excess Non-Participating Provider Charges. The Covered Person shall be responsible for charges by a Non-Participating Provider in excess of Eligible Charges, except: (a) for an Out-Of-Service Area emergency; or (b) when the Non-Participating Provider is a Single Source Provider, defined as a Provider who is the only Provider in Guam for a Covered Service. A Covered Person using a Non-Participating Provider for a PPACA Emergency shall not be liable for Co-Payments or Co-Insurance in excess of Co-Payments and Co-Insurance that would have been charged if Participating Providers had been used. The Company shall pay an amount for PPACA Emergency Services computed as provided in this Certificate.

Excessive Participating Provider Charges. Neither the Covered Person nor the Company shall be liable for charges by a Participating Provider in excess of the Eligible Charges. These charges shall be the responsibility of the Participating Provider.

Skilled Nursing Facility Care. Coverage for Skilled Nursing Facility Services is limited to sixty (60) days maximum per Plan Year.

Well Baby Care. Well Baby Care is covered only as required by PPACA (as a PPACA Preventive Care Services or otherwise). Payment, for such Services shall be limited to no more than seven (7) visits per Plan Year, commencing at birth; and 1 visit per year for ages 5 to 18 years of age. Well Baby Care will not be subject to the Deductible, and shall be covered at 100% by the Company. Any such care that is PPACA Preventive Care Services shall be covered without Deductibles, Co-Payments or Co-Insurance if received from a Participating Provider. Charges for treatment of Illness or Injury shall be covered as regular benefits. If the care is PPACA Preventive Care Services, requirements of this Certificate and PPACA regulations shall be followed in determining the portion of any combined visit or service that is to be provided without Deductibles, Co-Payments or Co-Insurance.

Case Management. Company may, in its discretion, assign Nurses or other qualified health professionals for the purpose of Case Management. Payment for alternative Services in one instance does not obligate the Company to provide the same or similar benefits for the same or any other Covered Person in any other instance. Payment of these alternative benefits is made as an exception and in no way changes or voids the benefits, terms or conditions of this Agreement.

Vision Hardware Benefit. The Plan will pay up to a maximum of Two Hundred Dollars ($200) per Covered Person per 12-month period, toward the purchase of prescription eyeglasses, contact lenses, frames, eyeglass lenses, single vision lenses, bifocal lenses, trifocal lenses, or lenticular/aphakic lenses, regardless of whether services are rendered by a Participating or Non-Participating Provider.

Appeals Exhibit

I. APPEAL

As a Covered Person you have the right to appeal an Adverse Benefit Determination. There are two methods of appeal: Internal and External. The Internal Appeal is to TakeCare itself; the External Appeal is to the federal Office of Personnel Management.

The Internal Appeal is the first step of the appeal process. During the Internal Appeal you may request additional information about the Adverse Benefit Determination made by TakeCare and may ask TakeCare to reconsider its determination. Adverse Benefit Determinations arising under Medical and Dental Health Plans are subject to the Internal Appeal Process.

The External Appeal is the second step of the appeal process. An External Appeal is filed after an Internal Appeal is exhausted and TakeCare has decided not to reconsider its determination. Adverse Benefit Determinations arising under Medical Health Plans only are subject to the External Appeal Process. Adverse Benefit Determinations arising under Dental Health Plans are not subject to the External Appeal Process.

Covered Persons appealing an Adverse Benefit Determination must follow the procedures set forth in these Appeal Procedures.

II. DEFINITIONS

For the purposes of these Appeal Procedures, the following definitions shall apply:

Adverse Benefit Determination. An Adverse Benefit Determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan (e.g., a rescission of coverage), and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Appeal. An appeal means a request by a Covered Person for review and reconsideration of an Adverse Benefit Determination. For the purposes of these Appeal Procedures, the terms "appeal" and "claim" may be used interchangeably.

Authorized Representative. An Authorized Representative means an individual authorized in writing by a Covered Person to represent the Covered Person under the Internal Appeal Process and/or External Appeal Process. Such representation includes the right to receive and review information and documents on behalf of the Covered Person, including a Covered Person's confidential information.

Claim. A claim means a Covered Person's assertion that a particular service, benefit or payment is covered under a plan. For the purposes of these Appeal Procedures, the terms "appeal" and "claim" may be used interchangeably.

Claimant. A Claimant means a Covered Person who makes a claim for benefits under the Internal Appeal Process or the External Appeal Process. For purposes of Appeals, references to a Covered Person or Claimant may also include a Claimant's Authorized Representative.

Concurrent Care Claim. A Concurrent Care Claim means a claim involving care that TakeCare has previously approved or an ongoing course of treatment to be given over a period of time or a number of treatments, and any reduction or termination by TakeCare of that care before the end of such period of time or number of treatments.

Concurrent Care Extension Claim. A Concurrent Care Extension Claim means a claim whereby a Covered Person has

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received approval from TakeCare for concurrent care and wishes to extend the course of treatment beyond the period of time or number of treatments previously approved by TakeCare.

Expedited External Appeal. An Expedited External Appeal means a request for resolution of an appeal outside the normal time frame for appeal when (1) the time frame for completing an Internal Appeal would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function; or (2) following receipt of an Internal Appeal Determination that denied benefits, the timeframe for conducting a standard external appeal would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function.

External Appeal. An External Appeal means a Covered Person's written request (unless it is an Expedited External Appeal) for an independent review and reconsideration of an Adverse Benefit Determination (including an Internal Appeal Determination) once the Internal Appeal Process has been exhausted and which is conducted pursuant to the External **Appeal Process.** Adverse Benefit Determinations arising under Medical Health Plans only are subject to the External Appeal Process. Adverse Benefit Determinations arising under Dental Health Plans are not subject to the External Appeal Process.

The only Adverse Benefit Determinations subject to External Appeal include claims that involve (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment); or (2) a Rescission of coverage, other than Rescissions based on a failure to pay premiums.

External Appeal Decision. An External Appeal Decision means a decision by an independent review organization at the conclusion of an External Appeal.

Internal Appeal. An Internal Appeal means a Covered Person's written request (unless it is an Urgent Care Claim) for review and reconsideration of an Adverse Benefit Determination in the first instance pursuant to the Internal Appeal Process. Adverse Benefit Determinations arising under Medical and Dental Health Plans are subject to the Internal Appeal Process.

Internal Appeal Determination. An Internal Appeal Determination means a determination by TakeCare at the conclusion of an Internal Appeal.

Non-urgent Care Claim. A Non-urgent Care Claim means any claim for a benefit which is not an Urgent Care Claim.

Notice of Denial of Internal Appeal. A Notice of Denial of Internal Appeal means notification to a Covered Person that their Internal Appeal of an Adverse Benefit Determination has been upheld by TakeCare at the completion of the Internal Appeal Process.

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 means any claim for a benefit that is not a Pre-service Claim.

Rescission. A Rescission means termination of a Covered Person's coverage back to the initial date of coverage based on a Covered Person committing an act that constitutes fraud or intentionally misrepresenting a material fact prohibited by the terms of the plan.

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.

III. INTERNAL APPEAL PROCESS

A. PROCEDURES FOR INTERNAL APPEAL

1. When to Request an Internal Appeal.

a. Time Limit. You or your Authorized Representative may file an Internal Appeal within one hundred eighty (180) calendar days of receipt of an Adverse Benefit Determination. If you choose to have someone act on your behalf during the appeal, you must appoint an Authorized Representative in writing and complete TakeCare's Authorization to Release and Disclose Protected Health Information prior to TakeCare releasing any confidential or protected health information to your representative. During an Internal Appeal, you or your Authorized Representative may also be referred to as "Claimant."

b. Urgent Care Claim. If your appeal is an Urgent Care Claim or Concurrent Care Claim involving urgent care, your request may be filed immediately with the TakeCare Customer Service Department. In the event an appeal of an Urgent Care Claim needs to be made outside of normal business hours (including weekends and holidays), you may contact TakeCare's Health Plan Administrator at (671) 300-7147. TakeCare will appoint an individual at TakeCare to provide you with an Internal Appeal Determination (whether adverse or not), taking into account the medical exigencies, not later than seventy-two (72) hours after receipt of your appeal by TakeCare. The individual who decides your Urgent Care Claim will not be someone involved in the initial Adverse Benefit Determination. The Individual who decides your Urgent Care Claim will be a health professional with training relevant to the claim if the Adverse Benefit Determination is based in whole or in part on medical judgment, including whether a given treatment is experimental, investigational, or not medically necessary or appropriate. If you fail to provide TakeCare with sufficient information to determine whether, or to what extent, benefits may be covered or payable under TakeCare's Plan, TakeCare shall notify you not later than twenty-four (24) hours after receipt of the appeal, of the specific information required. You will be provided reasonable time, but not less than forty-eight (48) hours, to provide TakeCare with the information. Thereafter, TakeCare will notify you of its Internal Appeal Determination no later than forty-eight (48) hours after the earlier of TakeCare's receipt of the requested information or the end of the time given to the Claimant to provide the information. TakeCare shall accept and acknowledge Urgent Care Claims orally and may also provide its determination in these situations orally to the Claimant. Written notification of the Internal Appeal Determination shall be provided to Claimant within three (3) calendar days of any oral determination made by TakeCare.

c. Expedited External Appeal. Under certain circumstances, a Claimant with an Urgent Care Claim or a Concurrent Care Extension Claim may be allowed to proceed with an Expedited External Appeal at the same time as the Internal Appeal Process. The procedure to initiate a simultaneous Expedited External Appeal is further described below in TakeCare's External Appeal Process.

d. Dental Health Plans Excepted. Adverse Benefit Determinations arising under Medical Health Plans only are subject to the Internal and External Appeal Processes. Adverse Benefit Determinations arising under Dental Health Plans are not subject to the External Appeal Process.

2. Procedure to Request Internal Appeal.

a. Request for Appeal Form. You may file an Internal Appeal by sending a Request for Appeal Form to the Appeals Coordinator, TakeCare Customer Service Department by faxing the request to (671) 647-3542; sending it by mail to P.O. Box 6578, Tamuning, Guam 96931; or by hand delivery at Century Plaza, 219 S. Marine Corp Drive, Ste. 200,

Tamuning, Guam 96913 . A Request for Appeal Form is attached to the Notice of Claim of Denial or Adverse Benefit Determination form or is available from TakeCare's Customer Service Department. If you have any questions or concerns about or during the Internal Appeal process, you may contact the TakeCare Customer Service Department at (671) 647-3526 or 1-877-484-2411.

b. Additional Information. You are not required to submit additional information to support the appeal. However, it may be helpful to include any additional information you have to clarify or support the request. For example, you may want to include medical records or physician opinions in support of the request. TakeCare shall provide you, upon request and free of charge, access to and copies of all information and documentation in its possession relevant to the appeal. You will be provided, free of charge, any new or additional evidence considered, relied upon, or generated by TakeCare in connection with the appeal, or any new or additional rationale for a denial during the Internal Appeal process. In such an event, TakeCare shall provide a reasonable opportunity for you to respond to such new evidence or rationale.

c. Urgent Care Claim. If the appeal is an Urgent Care Claim, please see Section A(1)(b) above of this Internal Appeal Process.

3. Review by Appeals Committee for Non-Urgent Care Claims.

a. If a timely non-urgent care appeal is filed with TakeCare within one hundred eighty (180) calendar days of receiving an Adverse Benefit Determination, the appeal will be reviewed by an Appeals Committee consisting of no less than three (3) individuals at TakeCare who were not involved in the initial Adverse Benefit Determination and who are not direct subordinates of those individuals. If the appeal of any Adverse Benefit Determination is based in whole or in part on medical judgment, including whether a given treatment is experimental, investigational, or not medically necessary or appropriate, the Appeals Committee will have as a member a health care professional or in the alternative will consult with a health care professional with training relevant to the claim.

b. For non-urgent care appeals, you will have the option of appeal without a hearing or an appeal with a hearing during which you may appear in person and present evidence or testimony before the Appeals Committee. When filing the Request for Appeal Form, you must indicate whether or not a hearing is being requested. If you fail to indicate whether or not you want a hearing, TakeCare will proceed as if you have opted not to have a hearing. Even if you do not request a hearing, you may still submit relevant facts and additional evidence in support of the appeal to the TakeCare Customer Service Department.

c. TakeCare shall acknowledge receipt of the appeal in writing within five (5) calendar days of its filing. If the appeal is to be presented in a hearing before the Appeals Committee, the acknowledgement letter will also notify the Claimant of the date and time of the hearing. If the date and time of the hearing are not convenient for you, you may contact the Appeals Coordinator, TakeCare Customer Service Department prior to the designated hearing date, waive the time frame for TakeCare's appeal determination and reschedule the hearing date.

d. If the appeal is a Concurrent Care Claim due to a reduction or termination of services, TakeCare shall acknowledge receipt either orally or in writing, as the case may permit. In such a case, TakeCare shall give the Claimant notice and sufficient time in advance of the reduction or termination of services to appeal and time to receive a decision of the appeal before any interruption of care occurs.

e. Provided that all necessary information is provided when the appeal is made, TakeCare will notify you in writing of the Appeals Committee's determination within fifteen (15) calendar days of receipt of an appeal for a Pre-service Claim or within thirty (30) calendar days of receipt of an appeal for a Post-service Claim.

f. If additional information is needed before the appeal can be determined, a delay in the Appeals Committee making a determination may occur. If the delay is due to circumstances beyond TakeCare's control, in the case of a Pre-service Claim, TakeCare shall notify you prior to the expiration of the original fifteen (15) calendar-day period that it intends to extend the time to make a decision for an additional fifteen (15) calendar days. Likewise, in the case of a Post-service Claim, TakeCare shall notify you prior to the expiration of the original thirty (30) calendar-day period that it intends to extend the time to make a decision for an additional fifteen (15) calendar days. If the Claimant fails to submit necessary information to decide the claim, TakeCare shall notify the Claimant of the specific information that is needed within five (5) calendar days for a Pre-service Claim and within thirty (30) calendar days for a Post-service Claim. For a Pre-service Claim, the notification may be oral, unless the Claimant requests written notification. If the extension is due to the failure of the Claimant to submit necessary information, the Claimant shall have sixty (60) calendar days to submit the requested information. As a result, a Pre-service Claim may be considered within ninety (90) calendar days, and a Post-service Claim may be considered within one hundred and five (105) calendar days.

g. If the appeal is denied, TakeCare shall issue a Notice of Denial of Internal Appeal advising the Claimant of the Internal Appeal Determination. The Notice will state the reasons for the denial including reference to specific plan provisions, guidelines and protocols as a basis for the decision, or an explanation of the scientific or clinical judgment used in confirming the initial Adverse Benefit Determination. If the advice of a health care professional was relied upon during the deliberation of the appeal, the Notice will identify the professional.

h. If the appeal is denied, the Claimant shall be deemed to have exhausted the remedies available under TakeCare's Internal Appeal Process and may file an External Appeal of the Internal Appeal Determination as provided in Section IV below. If TakeCare fails to strictly adhere to its Internal Appeal Process, the Claimant shall be deemed to have exhausted the remedies available under the Internal Appeal Process, and the Claimant may initiate the External Appeal Process in Section IV below or court action, as applicable, unless the violation was: (1) de minimis; (2) non-prejudicial; (3) attributable to good cause or matters beyond the plan's or issuer's control; (4) in the context of an ongoing good-faith exchange of information; and (5) not reflective of a pattern or practice of non-compliance. The Claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under local law, as applicable, on the basis that TakeCare has failed to provide a reasonable Internal Appeal Process.

1. Notice.
TakeCare shall deliver written notice of the Internal Appeal Determination to the Claimant by its deposit in the United States Mail via certified mail return receipt requested, or by personal delivery to the Claimant within the time frames provided in Section III(A)(3) above. If sent by mail, the notice shall be deemed to be delivered on its deposit in the United States mail. Such notice shall be addressed to the Claimant at his or her address as shown in TakeCare's records. Upon written request by a Claimant, TakeCare will deliver written notice of the Internal Appeal Determination to the Claimant electronically or by facsimile.

IV. EXTERNAL APPEAL PROCESS

A. PROCEDURES FOR EXTERNAL APPEAL

1. When to Request an External Appeal.

a. Time Limit. You or your Authorized Representative may file a written External Appeal with the External Appeal Examiner

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("Examiner") within four (4) months after the date of receipt of a Notice of Denial of Internal Appeal from TakeCare. If there is no corresponding date four (4) months after the date of receipt of such a Notice, then your request must be filed by the first day of the fifth month following the receipt of the Notice. For example, if the date of receipt of the Notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
b. Dental Health Plans Excepted. Adverse Benefit Determinations arising under Medical Health Plans only are subject to the External Appeal Process. Adverse Benefit Determinations arising under Dental Health Plans are not subject to the

External Appeal Process.

2. Examiner; Independent Reviewer.

a. The Examiner during the External Appeal Process shall be the federal Office of Personnel Management ("the OPM"). The OPM shall designate individuals to conduct the External Appeal that are independent third parties with clinical and legal expertise and with no financial or personal conflicts with TakeCare as determined by the OPM.

3. Procedure to Request External Appeal.

a. Request for External Appeal Form. The External Appeal of an Adverse Benefit Determination or an Internal Appeal Determination may be initiated by sending the Request for External Appeal form which is attached to the Notice of Denial of Internal Appeal. The forms are also available at the TakeCare Customer Service Department. The Request for External Appeal may be sent electronically to DisputedClaim@opm.gov; by faxing the request to (202) 606-0036; or by sending it by mail to P.O. Box 791, Washington, DC 20044. If a Claimant has any questions or concerns during the External Appeal Process, the Claimant can call the OPM at the toll free number, (877) 549-8152; the Employee Benefits Security Administration (EBSA) at (866) 444-EBSA (3272); or the Guam Department of Revenue and Taxation, 1240 Army Drive, Barrigada, Guam 96921, (671) 635-1843~46.

b. Additional Information. In addition to the Request for External Appeal form, the Claimant may submit additional information concerning a denied claim to the OPM at the mailing address listed above. If the Claimant chooses to submit additional information to the OPM, the additional information will be shared with TakeCare in order to give TakeCare an opportunity to reconsider its denial of a claim. Information concerning the Claimant's right to privacy during the External Appeal Process shall be provided in the Notice of Privacy Act Rights statement attached to the Notice of Denial of Claim or Adverse Benefit Determination, or Notice of Denial of Internal Appeal received from TakeCare.

4. Procedure for Preliminary Review.

When the Examiner receives an External Appeal, the Examiner will contact TakeCare to request information.

a. Within five (5) business days of receipt of an External Appeal by the Examiner, TakeCare must provide the Examiner with all of the documents and any information it considered in making the Denial of Claim or Adverse Benefit Determination, or Internal Appeal Determination including:

(1) Claimant's certificate of coverage or benefit;

(2) A copy of the Adverse Benefit Determination;

(3) A copy of the Internal Appeal Determination;

(4) A summary of the claim;
(5) An explanation of TakeCare's Adverse Benefit Determination and Internal Appeal Determination; and

(6) All documents and information considered in making the Adverse Benefit Determination or Internal Appeal Determination including any additional information that may have been provided to TakeCare or relied upon by TakeCare during the Internal Appeal Process.

TakeCare shall provide this information electronically at DisputedClaim@opm.gov; by fax at (202) 606-0036; or by priority mail at P.O. Box 791, Washington, DC 20044.

b. The Examiner will review the information from TakeCare and may request additional information that it deems necessary to the External Appeal. If the Examiner requests additional information, TakeCare shall supply the information as expeditiously as possible and within five (5) business days.

c. If the Examiner determines that a Claimant is not eligible for External Appeal, the Examiner will notify the Claimant and TakeCare in writing.

5. Review Process.

a. The Examiner will review all of the information and documents timely received. In reaching a decision, the Examiner will review the claim de novo and not be bound by any decisions or conclusions reached during TakeCare's claims and Internal Appeal Process.

b. The Examiner will forward all documents submitted directly to the Examiner by the Claimant. Upon receipt of any information submitted by the Claimant, the Examiner must within one (1) business day forward the information to TakeCare. Upon receipt of any such information, TakeCare may reconsider its Adverse Benefit Determination or Internal Appeal Determination that is the subject of the External Appeal. Reconsideration by TakeCare will not delay the External Appeal. The External Appeal may be terminated as a result of the reconsideration only if TakeCare decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Internal Appeal Determination and provide coverage or payment. Within one (1) business day after making a decision to reverse, TakeCare will provide written notice of its decision to the Claimant and the Examiner. The Examiner must terminate the External Appeal upon receipt of the notice from TakeCare.

c. The Examiner must provide written notice of the External Appeal Decision as expeditiously as possible and within forty-five (45) days after the Examiner receives the request for the External Appeal. The Examiner must deliver the notice of External Appeal Decision to the Claimant and to TakeCare.

d. The Examiner's External Appeal Decision notice will contain the following:

(1) A general description of the reason for the request for External Appeal, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial, including denial codes);

(2) The date the Examiner received the assignment to conduct the External Appeal and the date of the Examiner's decision;

(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(5) A statement that the determination is binding except to the extent that other remedies may be available under Guam or Federal law to either TakeCare or to the Claimant;

(6) A statement that judicial review may be available to the Claimant; and
(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

e. After an External Appeal Decision, the Examiner will maintain records of all

claims and notices associated with the External Appeal Process for six (6) years. The Examiner must make such records available for examination by the Claimant or TakeCare upon request.

6. Reversal of TakeCare's Determination.

Upon receipt of notice of an External Appeal Decision reversing the Adverse Benefit Determination or Internal Appeal Determination, TakeCare immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim, regardless of whether TakeCare intends to seek judicial review of the External Review Decision and unless or until there is a judicial decision otherwise.

B. EXPEDITED EXTERNAL APPEAL

1. Request for Expedited External Appeal. A Claimant may make a written or oral request for an Expedited External Appeal at the time the Claimant receives:

a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the time frame for completion of an Internal Appeal would seriously jeopardize the Claimant's life or health or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an Urgent Care Claim as part of the Internal Appeal Process, or an Adverse Benefit Determination if the Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received services, but has not been discharged from a facility, and the Claimant has filed a request for a or Concurrent Care Claim involving Urgent Care; or

b. An Internal Appeal Determination if the Claimant has a medical condition where the normal time frame for completion of a standard External Appeal would seriously jeopardize the Claimant's life or health or would jeopardize the Claimant's ability to regain maximum function, or if the Internal Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received services, but has not been discharged from a facility.

2. Procedure to Request Expedited External Appeal.

a. The Expedited External Appeal process shall be administered by the OPM. The Claimant's request for expedited review can be initiated in the same way as a standard External Appeal by calling the toll free number, (877) 549-8152. In addition, a Claimant may request an Expedited External Appeal of an Adverse Benefit Determination or a final internal Adverse Benefit Determination by sending the Request for External Appeal Form which is attached to the Notice of Denial of Claim or Adverse Benefit Determination or which is also available at the TakeCare Customer Service Department electronically to DisputedClaim@opm.gov; by faxing the request to (202) 606-0036; or by sending it by mail to P.O. Box 791, Washington, DC 20044.

b. If a Claimant has any questions or concerns during the Expedited External Appeal Process, the Claimant can call the OPM at the toll free number, (877) 549-8152; the EBSA at (866) 444-EBSA (3272); or the Guam Department of Revenue and Taxation, 1240 Army Drive, Barrigada Guam, (671) 635-1843~46. The Claimant may submit additional information concerning the denied claim to the OPM at the mailing address listed above. If the Claimant does submit additional information to the OPM, the information will be shared with TakeCare in order to give TakeCare an opportunity to reconsider the denial. Information concerning the Claimant's right to privacy during the External Appeal Process was provided in the Notice of Privacy Act Rights statement attached to the Notice of Denial of Claim or Adverse Benefit Determination or Notice of Denial of Internal Appeal from TakeCare.

3. Examiner; Independent Reviewer.

The Examiner during the Expedited External Appeal Process shall be the OPM. The OPM shall designate individuals to conduct the External Appeal that are independent third parties with clinical and legal expertise and with no financial or personal conflicts with TakeCare as determined by the OPM.

4. Procedure for Preliminary Review.

When the Examiner receives a request for an Expedited External Appeal, the Examiner will contact TakeCare to request information.

a. Immediately upon receipt of request by the Examiner, TakeCare must provide to the Examiner all of the documents and any information required under paragraph IV(A)(4).

b. The Examiner will review the information from TakeCare and may request additional information that it deems necessary to the External Appeal.

c. If the Examiner determines that your claim is not eligible for Expedited External Appeal, the Examiner will notify you and TakeCare as expeditiously as possible.

5. Review Process.

a. The Examiner must comply with the requirements set forth in paragraph IV(A)(5)(a).

b. The Examiner will forward all documents submitted directly to the Examiner by the Claimant. Upon receipt of any information submitted by the Claimant, the Examiner must immediately forward the information to TakeCare. Upon receipt of any such information, TakeCare may reconsider its Adverse Benefit Determination or Internal Appeal Determination that is the subject of the External Appeal. Reconsideration by TakeCare will not delay the External Appeal. The External Appeal may be terminated as a result of the reconsideration only if TakeCare decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Internal Appeal Determination and provide coverage or payment. Immediately after reversing the decision, TakeCare must provide notice of its decision to the Claimant and the assigned Examiner. This notice can be provided orally but must be followed up with written notice within forty-eight (48) hours. The Examiner must terminate the External Appeal upon receipt of the initial notice from TakeCare.

c. The Examiner must provide notice of the External Appeal Decision as expeditiously as the medical circumstances require and within seventy-two (72) hours or less (depending on the medical circumstances of the case) once the Examiner receives the request for the External Appeal. The Examiner must deliver the notice of External Appeal Decision to the Claimant and TakeCare. This notice can be initially provided orally but must be followed up in writing within forty-eight (48) hours.

d. The Examiner's External Appeal Decision notice must comply with the requirements set forth in paragraph IV(A)(5)(d).

e. After an External Appeal Decision, the Examiner must maintain records as required in paragraph IV(A)(5)(e).

6. Reversal of TakeCare's Determination.

Upon receipt of notice of an Expedited External Appeal Decision reversing the Adverse Benefit Determination or Internal Appeal Determination, TakeCare immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim regardless of whether TakeCare intends to seek judicial review of the External Review Decision and unless or until there is a judicial decision otherwise.

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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		
Preventive	If Completed at **FHP Health Center**	If Completed within TakeCare's Participating Network or Medication was filled by a Participating Pharmacy
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	$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, antihypertentsive, antihyperlipidemic or asthma medication in a benefit year for eligible patients/members diagnosed with diabetes, hypertention, 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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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
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).	Initial Screening - $100 Final Screening - $100
10% Improvement or sustained cholesterol screening results for LDL-C less than 100md/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. 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).	Initial Screening - $100 Final Screening - $100
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. 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	Initial Screening - $100 Final Screening - $100

▪ **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.

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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'sprimary 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
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. **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** **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** **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).**	Initial Screening - $100 Final Screening - $100
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.	$10 per month for every month that member had ten (10) visits or more

▪ **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℠

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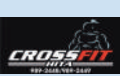
TakeCare Fitness Partners*



Guam Fitness Partners

TakeCare Wellness Center
- Free, unlimited access to fitness classes
- View calendar at www.TakeCareAsia.com
- Contact Information: (671) 646-6956 ext 7260

Carlson Gracie MAFA
- Call for membership rates
- Minimum Age: 5 years old
- Contact Information: (671) 788-0440

Crossfit Hita
- Discount
  - Unlimited Access: $89 per month
  - Open Gym: $35 per month
- Minimum Age: 5 years old
- Contact Information: (671) 989-2448

Crossfit Latte Stone
- Discount
  - Unlimited Access: $65 per month
- Minimum Age: 16 years old
- Contact Information: (671) 633-2357

Custom Fitness
- Discount
  - Unlimited Access: $77 per month
- Minimum Age: 3 years old
- Contact Information: (671) 989-0436

Guam Fitness Club
- Contact for membership rates
- Contact Information: https://www.guamfitnessclub.com/

Guam Muay Thai
- Discount
  - Unlimited Access: $10 off youth and adult rates
- Minimum Age: 6 years old
- Contact Information: (671) 487-7718

Guam Taekwondo Center
- Discount
  - Unlimited Access: $75 per month
  - Registration Fee: $40 per member
- Minimum Age: 6 years old
- Contact Information: (671) 788-9623

Hilton Wellness Center
- Discount
  - Unlimited Access to Wellness Center and Group Fitness Classes: $65 per month
- Additional Hilton discounts included
- Minimum Age: 16 years old
- Contact Information: (671) 646-1835 x5886

International Sports Center
- Discount
  - Unlimited Access: $65 per month
  - Registration Fee: $59 per member
- Minimum Age: 13 years old
- Contact Information: (671) 477-9885

Paradise Fitness Center
- Call for membership rates
- Membership Includes:
  - Dual Club Access: Hagatna & Dededo Locations
- Minimum Age: 13 years old
- Contact Information: (671) 475-2100

Rockit Ride
- Contact for membership rates
- Contact Information: (671) 482-1661 (WhatsApp)

Self Made Fitness
- Contact for membership rates
- Contact Information: (671)727-8879

SKIP Entertainment Company
- Discount
  - $5.00 off all membership rates
- Minimum Age: 3 - 17 years old
- Contact Information: (671) 472-4241

Synergy Studios
- Discount
  - 10% off infrared sauna
- Minimum Age: 7 years old
- Contact Information: (671) 472-9642

The Bridge Fitness Guam
- Call for membership rates
- Minimum Age: years old
- Contact Information: (671) 969-3786

The Pound Academy
- Discount
  - Unlimited Access: $80 per month
  - Registration Fee: $50 per member
- Minimum Age: BJJ: 6 years old; Other Services: 13 years old
- Contact Information: (671) 687-4229

Tribe Guam
- Discount
  - 10% off membership rates
- Minimum Age: 4 years old
- Contact Information: (671) 788-5719

Unified
- Discount
  - Unlimited Access: $105 per month
- Minimum Age: 15 years old
- Contact Information: (671) 969-8641

University of Guam: Triton Fitness Center
- Discount
  - Unlimited Access: $50.00/semester or $100.00/year
- Minimum Age: 16 years old
- Contact Information: (671) 735-2861

Urban Fitness
- Discount
  - Unlimited Access: $45
- Minimum Age: 10 years old
- Contact Information: (671) 969-7308

Saipan Fitness Partners

Golds Gym
- Call for membership rates
- Minimum Age: 16 years old
- Contact Information: (670) 233-4000

Latte Built Fitness
- Call for membership rates
- Minimum Age: 15 years old
- Contact Information: (670) 235-2265

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.

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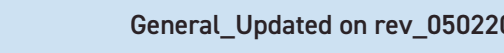

General_Updated on rev_05022023

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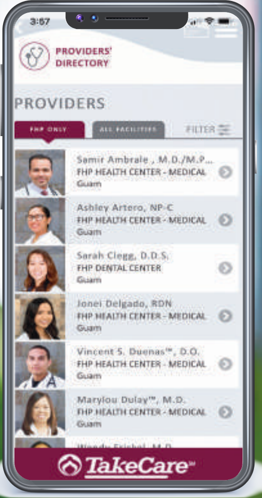

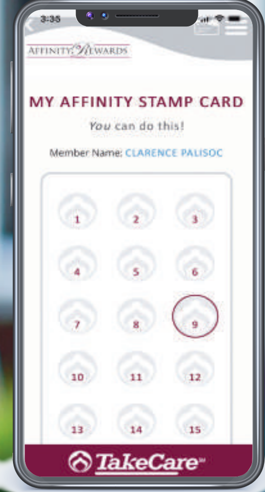

Attention TakeCare Members!

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

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**)

Download the TakeCare mobile app today.

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NEW APPS & FITNESS ACTIVITIES ADDED

TakeCare Self-Report Fitness Activity

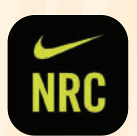
Self-Reporting
Fitness Activity

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 Insurance.

2. Complete at least 30-minutes of an approved activities such as:
   - Walking/Jogging/Running ▪ Strength Training*
   - Biking ▪ Court/Field Sports* ▪ Swimming
   - Rowing ▪ Boxing/Combat Sports* ★New activities

3. Track your activity using one of your favorite fitness apps such as these below, plus others:



GARMIN

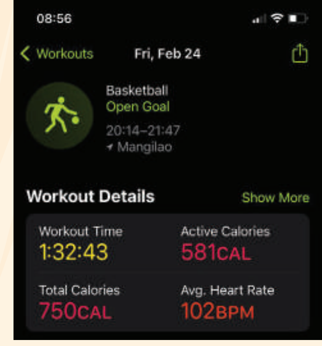
Apple Fitness | FitBit (NEW) | Garmin | Nike Run Club

Peloton | Samsung (NEW) | Strava | Under Armour (NEW)

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

Screenshots <u>must</u> include:

- Exact Date and Time (Dates listed as "Today"," Yesterday", etc will not be accepted)
- Type of activity
- Duration (time) of activity
- Optional: GPS mapping, heart rate, calories, steps, distance



Scan QR Code to upload via mobile device.

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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 for supporting partner program members. As a TakeCare member, you have the benefit of receiving discounts and special offers from our Affinity Partners.

RESTAURANTS/FOOD

Ajisen Ramen
Free Iced Tea with any entree purchase5

Fountain Lobby Lounge (at Hotel Nikko Guam)
10% off card holder's over $15 purchase[1]

Asiga
5% off on food and drinks[4]

Ignite Juice Bar
10% off on one item on menu[2]
15% Discount on Cleanse Program, 5 days or more[2]

Caffe Cino
15% off cardholder's purchase[5]

Islander Terrace (at Hilton Guam Resort)
15% off. (Sunday-Thursday, up to 6 pax)[5]

Cappricciosa
$3 off on any purchase of $20 or more[1]

Magellan Restaurant (at Hotel Nikko Guam)
Free Iced Tea with any entree purchase[5]

Fisherman's Cove (at Hilton Guam Resort)
15% off on Total Purchase[5]

TGI Friday's
15% Off member's meal

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

Tony Roma's
FREE side salad with every entrée[1]

ENTERTAINMENT/SERVICES

Blake's Car Rental
10% off any car rental or detail servicing

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

Car Audio Image
10% off Selected Items: JBL/Skor Audio/ PG / SS/Chemical Gys/Power Acoustik/DS 18 5

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

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.

Lagoon Spa
5% off (Conditions apply)*

Drip Served Daily
10% off of all active wear and apparel

Lotus Surf Shop
20% off All Apparel & Accessories[4]

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

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

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

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

Moka's Paddleboarding
10% off select services. Includes Rental, Tag-Alongs, and Expeditions.

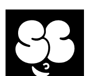
Fewture
15-25% off of all selected merchandise.
(Including Pop-ups, events and online purchases.)
Use Code: [**TKCR**] for online orders only.

Natural Ginger Spa
5% off (Conditions apply)*

Furniture Kathy Style
20% discount on any regular priced items

Pat's Tinting & Detailing
Tinting - $30 off, Detailing - $35 off
*Restriction - complete auto detailing

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



Smile Child
10% OFF (In-store and online)
Use Code: [**TAKECARE10**] for online orders only.

Guam Serenity Massage
10% off (Conditions apply)*

H20 Spa Guam
5% off (Conditions apply)*

Spa Ayualam
35% Spa Treatment[5]

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

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

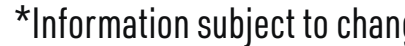
Island Eye Specialists
Receive up to $600.00 OFF LASIK Surgery.
*Please note: LASIK surgery is a cosmetic procedure and is not a covered benefit under your TakeCare medical plan

Wanderlust Paddleboards
10% off all boards[2]
Must Contact Wanderlust Paddleboards to avail discount.

Zephyr Cooling
10% discount off all basic AC cleaning

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

*Information subject to change

Connect with us 

RSVD 07012023

Convenient Online Member Portal

Access to your personal medical and health plan information.

MyTakeCare℠

Register Today!

MyTakeCare℠ 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 MyTakeCare℠, 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 MyTakeCare℠ health calendar.

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

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.

This booklet is designed to provide general information about the **TakeCare plans** offered to Judiciary 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.

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.

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 radio-therapy 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.

*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.

PIKA'S BEST OF GUAM
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Best Medical Clinic on Guam | Best Dental Clinic on Guam | Best Eye Clinic on Guam | Best Pediatrician on Guam

Doctors who care. Experience you can trust.

The FHP Health Center is your convenient, one-stop health care facility for your family, medical, dental, vision needs. In addition to our highly-trained and well known physicians, FHP also offers a full-service pharmacy, laboratory, radiology and specialty care center in one location.

We accept most insurances including TakeCare, NetCare, Staywell, Tricare, Medicaid, Medicare, and self-pay patients are welcomed. Come experience the FHP difference. Now accepting new patients. Call for an appointment.

Pictured above L-R:
Paul Chun, DMD-Dental; **Marlene San Nicolas**, OD-Optometry; **Mo-Ping Tham**, DO-Urgent Care; **Marylou Dulay**, MD-Internal Medicine; **Samir Ambrale**, MD, MPH-Oncology; **Edna Santos**, MD-Pediactrics; **Andrew Graves**, MD-Radiology

▪ Medical Care
- Adult Medicine
- Occupational Health Services
- Laboratory
- Pediatrics
- Radiology
- Urgent Care

▪ Cancer Care
▪ Dental Care
▪ Home Health
▪ Hospice Care
▪ Vision Care

Primary Care
Adult Medicine
Business Hours: **Mon–Fri 8am–6pm**
Pediatrics
Business Hours: **Mon–Fri 8am–5pm**

Specialty Care
Cancer Center
Business Hours: **Mon–Fri 8am–5pm**

Urgent Care
Business Hours: **Every day* 8am–8pm**

*Urgent Care: Closed-Christmas Day and New Year's Day, Thanksgiving

Home Health
Business Hours: **Mon – Fri 8am-5pm**
Occupational Health Services
Business Hours: **Mon – Fri 9am-4pm**
Imaging Center
Business Hours: X-Ray **Monday-Saturday 8am-5pm**
MRI, CT Scan, Digital Mammogram, Ultrasound, Echocardiogram, and BMD **by appointment**

Other Services
Dental Center
Vision Center
Business Hours: **Mon – Sat 8am – 6pm**

DLS laboratory at FHP Health Center will mirror FHP's hours of operation. **Mega Drug III at FHP** is open from 8:00am – 6:30pm Monday thru Friday. 8:00am – 4:00pm Saturdays. Closed on Sundays.

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

On-Island Network

Non-FHP providers

- Adult Health Care Clinic
- American Medical Centers*
- American Pediatric Clinic
- Dededo Polymedic Clinic
- Dr. Chang's Clinic
- Dr. Shieh's Clinic*
- Evergreen Health Center
- FHP Health Center*
- Guam Adult/Pediatric Clinic
- Guam Med Health Care Center
- Guam Medical Imaging Center
- Guam Radiology Consultants
- Guam SDA Clinic
- Hagatna Med Clinic
- Harmon Pediatrics
- Health Partners, LLC
- IHP Medical Group*
- Isla Pediatrics
- Micronesia Medical & Anesthesia Associates
- MPG Pediatrics*
- Marianas Physicians Group*
- Pacific Cardiology Consultants
- Pacific Health Center
- Pacific Medical Group
- Pediatric & Adolescent Clinic
- Polymedic Clinic
- Sagua Managu*
- St. Anthony's Clinic
- Premise Health
- Tumon Medical Office
- Tumon Pediatric Clinic

MEDICAL SERVICES

- Acupuncture
- Birthing Centers
- Chiropractic
- Dialysis
- DME
- Hearing Services
- Home Health
- Hospice
- Occupational Therapy
- Optometrists
- Physical Therapy
- Massage Therapy

SPECIALISTS

- Anesthesiology
- Applied Behavior Analysis
- Behavioral Health
- Cardiology
- Dermatology
- Endocrinology
- Geriatrics
- Nephrology
- Neurology
- Surgery
- Urology
- Oncology (medical)
- Oncology (radiation)
- Ophthalmology
- Oral/Maxillofacial Surgery
- Orthopedics
- Otolaryngology (ENT)
- Perinatology
- Podiatry
- Pulmonology

PHARMACIES

- Community
- Express Med
- Guam Rexall
- ITC Pharmacy
- Minutes Rx Pharmacy
- Oka Pharmacy
- Perezville
- Super Drugs*
- Mega Drug I, II, III*

HOSPITALS

- Guam Memorial Hospital Authority
- Guam Regional Medical City

* *Preferred In-Network Providers*

Revised 08/16/2023

Philippine Network
Medical

- St. Luke's Medical Center
  - Global City
  - Quezon City
- The Medical City
  - Pasig City
  - Iloilo
  - Clark
- Makati Medical Center
- Cebu Doctor's University Hospital, Inc.
- Cardinal Santos Medical Center

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Philippine Network
Pharmacy / Dental

PHARMACY

- Available to TakeCare members accessing care in the Philippines
- 100% coverage for prescription drugs listed on the TakeCare formulary listing
- Approved prescription drugs can be obtained from approved pharmacy locations
- Approval from TakeCare MRO is required

Locations ▪**San Juan City** ▪**Makati** ▪**Pasig City** ▪**Quezon City** ▪**Taguig City**

Locations ▪**The Medical City** ▪**St. Luke's Quezon City** ▪**Makati Medical Center**

DENTAL

Preferred Locations

- Alabang
- Bonafacio Global City
- Bacolod
- Cebu
- Makati

Services Available

- Diagnostic
- Basic Treatment
- Endodontics
- Periodontics
- Crowns, Bridges
- Dentures
- Oral Surgery

US & Asia Network

PIH HEALTH

CONTINENTAL US

- Cedars Sinai Hospital*
- Children's Hospital of Los Angeles*
- PIH Health Downey Hospital
- PIH Health Good Samaritan Hospital
- PIH Whittier Hospital
- Long Beach Memorial Medical Center
- Mayo Clinic Health System*
- MD Anderson Cancer Centers*
- Miller Children's Hospital
- Pacific Cardiovascular Associates
- UCLA Medical Center
- Western Medical Center Santa Ana
- Plus 1.2 million providers nationwide*

HAWAII

- Adventist Health Castle*
- Shriners Hospital for Children
- The Queen's Medical Center*
- Wahiawa General Hospital*
- 180 PCPs, 9 Urgent Care, 112 specialists*

US PHARMACY BENEFIT MANAGER (PBM)

- Elixir Solutions

1,000s of pharmacies nationwide

NEW ZEALAND

- 5 Hospitals, 7 PCPs, 350 Specialists

ASIA

- Kameda Medical Center, Japan
- Samsung Medical Center, Korea
- Sime Darby Healthcare, Malaysia
- Raffles Hospital, Singapore
- Taiwan Adventist Hospital, Taiwan
- Bumrungrad Hospital, Thailand

THE QUEEN'S MEDICAL CENTER

Bumrungrad International

Sime Darby Healthcare

RafflesHospital Singapore

Kameda Medical Center

*

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 lastest TakeCare network provider listings. You can also download our mobile app so you can access on the go!

DOWNLOAD THE TAKECARE MOBILE APP!

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

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 "-"**)

Download the TakeCare mobile app today.

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takecareasia.com

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NCQA
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AAAHC
ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.
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