EXHIBIT D

TakeCare Insurance Company, Inc.

Preferred Provider Organization ("PPO") and Health Saving Account ("HSA") Medical Plan

Certificate of Coverage

Government of Guam

October 1, 2021 – September 30, 2022

Welcome

Hafa Adai and welcome to TakeCare Insurance Company, Inc.

Thank you for considering the TakeCare health plan for your needs. At TakeCare, we are committed to deliver quality and affordable health care benefits and services that focuses on you and your family needs. We collaboratively work with your health care providers to ensure you receive the island's best health care.

Introduction

This is your certificate of coverage or "certificate." It describes your covered services – what service your plan pays for and how to access these services. The schedule of benefits ("SOBs") included as Exhibit A of this certificate, provides information on how much TakeCare will pay for covered services and your payment responsibility under your chosen TakeCare plan. This certificate along with the group policy, and SOB describes and provides information on your TakeCare Health Plan.

It's important that you read and understands this certificate and your SOB. You can return them to us, within 30 days, if you have any questions on your coverage, please contact us TakeCare's Customer Service department at 1-671-647-3526 or 1-877-484-2411 (toll free) or through electronic mail at CustomerService@takecareasia.com.

If your coverage under any part of this plan replaces coverage under another plan, your coverage for benefits provided under the other coverage may reduce benefits paid by this plan. See the General coverage provisions section of this certificate.

How we use words

When we use:

- "You" and "your" we mean you and any covered dependents (if you included dependent coverage under your chosen plan)
- "Us," "we," and "our" mean TakeCare Insurance Company, Inc. or TakeCare
- Words that are in bold, we define them in the Glossary section.

Contact us

- For questions about your plan, you can contact us through phone at at 1-671-647-3526 or 1-877-484-2411 (toll free) or through electronic mail at CustomerService@takecareasia.com
- Calling the Customer Services and/or Medical Referral Services number on your ID card
- Logging in to the TakeCare's website at https://www.takecareasia.com
- Writing us at P.O. Box 6578 Tamuning, Guam 96931

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Your member website is available 24/7. With your member website, you can:

- See your Schedule of Benefits, collaterals and other coverage forms
- Online enrollment link
- Benefit highlights
- Provider directory

Your ID card

Show your member ID card each time you seek covered services from a provider. Only members on your plan can use your ID card. We will mail you your ID card. You may also access your ID card through TakeCare's Mobile App.

Wellness and related rewards/incentives

You may be eligible to earn rewards for completing certain activities that improve your health, coverage, and experience with us. We may encourage you to access certain health services, participate in programs, including but not limited to wellness & disease management programs; utilize tools, improve your health metrics or continue participating on TakeCare preventive, wellness, fitness and disease management programs and earn incentives. Talk with TakeCare's Wellness team about these programs and refer to the Wellness Incentive Program section of this booklet for more information.

Gym Membership benefit

- TakeCare provides coverage for gym membership to eligible members at contracted/participating gym facilities in Guam and the CNMI
- A list of contracted/participating gym facilities may be found in the benefit booklet and is subject to change. This benefit only provides coverage for the monthly membership fee based on the agreement between TakeCare and the Gym.
- Members are only allowed to select and enroll at one gym facility at a time under the covered gym membership benefit.
- Age restrictions may apply based on the policies of each contracted/participating gym facilities.
- Gym facilities are limited to TakeCare's contracted Fitness Partners.
- Members can change their gym facilities once gym membership is activated provided the member inform TakeCare about the change in gym facility. TakeCare will approve the change and changes will be effective the first of the following month after TakeCare's approval.
- Members are responsible for all and any additional charges not covered by TakeCare. This includes but is not limited to registration fees, uniform fees, promotion fees, termination fees, etc.
- No utilization requirement to keep gym membership.

Enrollment:

- Eligible members must inform TakeCare Insurance and complete a gym enrollment form and necessary documents prior to enrolling at a gym facility. Failure to submit required documents to TakeCare each plan year may result in your gym membership not being covered by the Plan.

Gym Reward:

- Members are eligible to receive a USD $10 monetary value when they have completed the Health Risk Assessment and attended their registered gym at least 10 days per month, for three consecutive months. See the Wellness Incentive Program of this booklet for more information.

Discount arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called "third-party service providers". These third-party service providers may pay us so that they can offer you their services.

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Third-party service providers are independent contractors. The third-party service provider is responsible for the goods and services they deliver. We have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don't pay the third-party service providers for the services they offer. You are responsible for paying for their services and discounted goods.

Coverage and exclusions

Your plan provides covered services. These are:

- Described in this section.
- Not listed as an exclusion in this section or the General plan exclusions section.
- Not beyond any limits in the schedule of benefits.
- Medically necessary. See the How your plan works – Medical necessity and precertification requirements section and the Glossary for more information.

For covered services under the outpatient prescription drug plan:

- You need a prescription from the prescribing provider
- You need to show your ID card to the network pharmacy when you get a prescription filled

This plan provides insurance coverage for many kinds of covered services, such as a doctor's care and hospital stays, but some services aren't covered at all or are limited. For other services, the plan pays more of the expense.

For example:

- Physician care generally is covered but physician care for cosmetic surgery is never covered. This is an exclusion.
- Home healthcare is generally covered but it is a covered service only up to a set number of visits a year.
- This is a limitation.
- Your provider may recommend services that are considered experimental or investigational services.
- But an experimental or investigational service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a terminal illness. See Clinical trials in the list of services below.

Some services require precertification from us. For more information see the How your plan works – Medical necessity and precertification requirements section.

The covered services and exclusions below appear alphabetically to make it easier to find what you're looking for. You can find out about limitations for covered services in the schedule of benefits. If you have questions, contact us.

Acupuncture

Covered services include acupuncture services provided by a physician if the service is provided as a form of anesthesia in connection with a covered surgical procedure up to 30 visits per eligible member per benefit year .

The following are not covered services:

- Acupuncture, other than for anesthesia
- Acupressure
- Any services after the 30th visit per eligible member per year

Airfare reimbursement benefit

For qualifying conditions where care is not be available on Guam; the Airfare Benefit may provide an economy round trip airfare for the insured member, a companion if medically required and a medical escort if medically required to one of

our designated preferred facilities in the Philippines or other in-network/participating providers as determined by TakeCare. TakeCare must be your primary insurer or if Medicare is your primary insurer, TakeCare will cover secondary to Medicare. A TakeCare participating provider must provide your medical referral. TakeCare's approval is required in advance of travel. This benefit does not cover Diagnostic Procedures, Second Opinions or Air Ambulance. To learn more about your eligibility for this benefit, please contact Customer Service or Medical Referral Department.

Qualifying conditions when care is not available on Guam:

Acute leukemia treatment, Ambulatory Surgical Center Services, Aneurysmectomy, Gamma knife surgery, Inpatient services expected to exceed USD $25,000, Intracranial surgery, Oncology surgery performed by a surgical oncologist, Open heart surgery, Neurosurgery, NICU Level III services, Pneumonectomy and Transplants. Transplants must be obtained at an approved facility in the USA, or Joint Commission International (JCI) facility Outside the USA.

Care Facilities

Preferred Facilities are specific facilities outside of Guam selected by the Plan and is the destination of travel for which a member is scheduled to receive care for any of the qualifying conditions noted above. Please refer to your plan summary brochure for a list of preferred facilities, which is subject to change.

Reimbursement Policy:

- Members being referred for consultation, preventive services and/or for services for non-qualifying conditions do not qualify for the Airfare Benefit
- If an off-island consultation results in one of the above procedures, that cost of the airfare maybe reviewed for reimbursement.
- Member, who subsequently underwent surgery or treatment procedures that meet TakeCare's criteria for the airfare benefit, may request reimbursement for airfare.

Request for reimbursement requirements:

- Submit a TakeCare Request for Reimbursement Form, properly completed and signed within 90 days of the date of service for those services that qualify for reimbursement
- Include a copy of the airfare receipt (proof of payment), airline ticket, boarding pass, and itinerary.
- Include medical records, including but not limited to the operative report indicating the date of service, name of procedure performed, detailed description of the procedure performed, name and address of the facility where service was performed.
- Requests will be reviewed and processed within 45 days of receipt of required documents.
- Tickets will only be reimbursed in monetary value. We are not able to reimburse tickets purchased using frequent flyer miles
- This benefit does not cover charges for meals or lodging

Ambulance services

An ambulance is a vehicle staffed by medical personnel and equipped to provide ground transportation an ill or injured person.

Emergency

- Covered services include emergency transport to a hospital by a licensed ambulance:
    - To the first hospital to provide emergency services
    - From one hospital to another if the first hospital can't provide the emergency services you need
    - When your condition is unstable and requires medical supervision and rapid transport

Non-emergency

Covered services also include preauthorized transportation to a hospital by a licensed ambulance:

- From a hospital to your home or to another facility if an ambulance is the only safe way to transport you
- From your home to a hospital if an ambulance is the only safe way to transport you; limited to 100 miles

- When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient treatment

The following are not covered services:

- Non-emergency airplane transportation by an out-of-network provider
- Ambulance services for routine transportation to receive outpatient or inpatient services

Applied behavior analysis

Covered services include certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions that:

- Systematically change behavior
- Are responsible for observable improvements in behavior

Autism spectrum disorder

Autism spectrum disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association subject to the benefit limitation on the summary of benefits.

Covered services include services and supplies provided by a physician or behavioral health provider for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a provider in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

The following are not covered services:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)

Experimental or investigational therapies

Covered services include drugs, devices, treatments, or procedures from a provider under an “approved clinical trial” only when you have cancer or a terminal illness. All of the following conditions must be met:

- Standard therapies have not been effective or are not appropriate
- We determine you may benefit from the treatment

An approved clinical trial is one that meets all of these requirements:

- The Food and Drug Administration (FDA) has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status, when this is required
- The clinical trial has been approved by an institutional review board that will oversee it
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and:
    - It conforms to standards of the NCI or other applicable federal organization
    - It takes place at an NCI-designated cancer center or at more than one institution
- You are treated in accordance with the procedures of that study

Routine patient costs

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Covered services include routine patient costs you have from a provider in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

The following are not covered services:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)

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- The clinical trial has been approved by an institutional review board that will oversee it
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and:
    - It conforms to standards of the NCI or other applicable federal organization
    - It takes place at an NCI-designated cancer center or at more than one institution
- You are treated in accordance with the procedures of that study

Diabetic services, supplies, equipment, and self-care programs

Covered services include:

- Services
    - Foot care to minimize the risk of infection
- Supplies
    - Injection devices including syringes, needles and pens
    - Test strips - blood glucose, ketone and urine
    - Blood glucose calibration liquid
    - Lancet devices and kits
    - Alcohol swabs
- Equipment
    - External insulin pumps and pump supplies
    - Blood glucose monitors without special features, unless required due to blindness
- Prescribed self-care programs with a health care provider certified in diabetes self-care training

Durable medical equipment (DME)

DME and the accessories needed to operate it are:

- Made to withstand prolonged use
- Mainly used in the treatment of illness or injury
- Suited for use in the home
- Not normally used by people who do not have an illness or injury
- Not for altering air quality or temperature
- Not for exercise or training

Your plan only covers the same type of DME that Medicare covers but, there are some DME items Medicare covers that your plan does not.

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Covered services include the expense of renting or buying DME and accessories you need to operate the item from a DME supplier. If you purchase DME, that purchase is only covered if you need it for long-term use.

Covered services also include:

- One item of DME for the same or similar purpose
- Repairing DME due to normal wear and tear
- A new DME item you need because your physical condition has changed
- Buying a new DME item to replace one that was damaged due to normal wear, if it would be cheaper than repairing it or renting a similar item

The following are not covered services:

- Communication aid
- Elevator
- Maintenance and repairs that result from misuse or abuse
- Massage table
- Message device (personal voice recorder)
- Over bed table
- Portable whirlpool pump
- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

Emergency services

When you experience an emergency medical condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

Covered services include only outpatient services to evaluate and stabilize an emergency medical condition in a hospital emergency room. You can get emergency services from network providers or out-of-network providers.

If your physician decides you need to stay in the hospital (emergency admission) or receive follow-up care, these are not emergency services. Different benefits and requirements apply. Please refer to the How your plan works – Medical necessity and precertification requirements section and the Coverage and exclusions section that fits your situation (for example, Hospital care or Physician services). You can also contact us or your network physician or primary care physician (PCP).

Non-emergency services

If you go to an emergency room for what is not an emergency medical condition, the plan may not cover your expenses. See the schedule of benefits for this information.

Habilitation therapy services

Habilitation therapy services help you keep, learn or improve skills and functioning for daily living (e.g., therapy for a child who isn't walking or talking at the expected age). The services must follow a specific treatment plan, ordered by your physician. The services must be performed by a:

- Licensed or certified physical, occupational or speech therapist
- Hospital, skilled nursing facility or hospice facility
- Home health care agency
- Physician

Outpatient physical, occupational, and speech therapy

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Covered services include:

- Physical therapy if it is expected to develop any impaired function
- Occupational therapy if it is expected to develop any impaired function
- Speech therapy if it is expected to develop speech function that resulted from delayed development (speech function is the ability to express thoughts, speak words and form sentences)

The following are not covered services:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Hearing aids

Hearing aid means:

- Any wearable, non-disposable instrument or device designed to aid or make up for impaired hearing
- Parts, attachments or accessories

Covered services include prescribed hearing aids and the following hearing aid services:

- Audiometric hearing visit and evaluation for a hearing aid prescription performed by:
    - A physician certified as an otolaryngologist or otologist
    - An audiologist who:
        - Is legally qualified in audiology
        - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
        - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a prescription written during a covered hearing exam
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The following are not covered services:

- Replacement of:
    - A hearing aid that is lost, stolen or broken
    - A hearing aid installed within a 36-month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any services exceeding the benefit limitation as stated on the summary of benefits

Hearing exams

Covered services include hearing exams for evaluation and treatment of illness, injury or hearing loss when performed by a hearing specialist.

The following are not covered services:

- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay

Home health care

Covered services include home health care provided by a home health care agency in the home, but only when all of the following criteria are met:

- You are homebound
- Your physician orders them

- The services take the place of a stay in a hospital or a skilled nursing facility, or you are unable to receive the same services outside your home
- The services are a part of a home health care plan
- The services are skilled nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse

Medical social services are provided by or supervised by a physician or social worker.

If you are discharged from a hospital or skilled nursing facility after a stay, the intermittent requirement may be waived to allow coverage for continuous skilled nursing services. See the schedule of benefits for more information on the intermittent requirement.

Short-term physical, speech, and occupational therapy provided in the home are subject to the same conditions and limitations imposed on therapy provided outside the home. See Rehabilitation services and Habilitation therapy services in this section and the schedule of benefits.

The following are not covered services:

- Custodial care
- Services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
- Any services exceeding the benefit limitation as stated on the summary of benefits

Hospice care

Covered services include inpatient and outpatient hospice care when given as part of a hospice care program. The types of hospice care services that are eligible for coverage include:

- Room and board
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a hospice care agency or hospice care provided in a hospital
- Psychological and dietary counseling
- Pain management and symptom control

Hospice care services provided by the providers below will be covered, even if the providers are not an employee of the hospice care agency responsible for your care:

- A physician for consultation or case management
- A physical or occupational therapist
- A home health care agency for:
    - Physical and occupational therapy
    - Medical supplies
    - Outpatient prescription drugs
    - Psychological counseling
    - Dietary counseling

The following are not covered services:

- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling including estate planning and the drafting of a will
- Homemaker services, caretaker services, or any other services not solely related to your care, which may include:
    - Sitter or companion services for you or other family members

  - Transportation
  - Maintenance of the house
- Any services exceeding the benefit limitation as stated on the summary of benefits

Hospital care

Covered services include inpatient and outpatient hospital care. This includes:

- Semi-private room and board. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services and supplies provided by the outpatient department of a hospital, including the facility charge.
- Services of physicians employed by the hospital.
- Administration of blood and blood derivatives.

The following are not covered services:

- All services and supplies provided in:
  - Rest homes
  - Any place considered a person's main residence or providing mainly custodial or rest care
  - Health resorts
  - Spas
  - Schools or camps

Infertility services

Basic infertility

Covered services include seeing a provider:

- To diagnose and evaluate the underlying medical cause of infertility.
- To do surgery to treat the underlying medical cause of infertility. Examples are endometriosis surgery
- or, for men, varicocele surgery.

The following are not covered services:

- All infertility services associated with or in support of an ovulation induction cycle while on injectable medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Artificial insemination services.

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services. After your child is born, covered services include:

- No less than 48 hours of inpatient care in a hospital after a vaginal delivery
- No less than 96 hours of inpatient care in a hospital after a cesarean delivery
- A shorter stay, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier

Covered services also include services and supplies needed for circumcision by a provider.

The following are not covered services:

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

Mental health treatment

Covered services include the treatment of mental disorders provided by a hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider including:

- Inpatient room and board at the semi-private room rate (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your stay in a hospital, psychiatric hospital, or residential treatment facility
- Outpatient treatment received while not confined as an inpatient in a hospital, psychiatric hospital, or residential treatment facility, including:
    - Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes telemedicine consultation)
    - Individual, group, and family therapies for the treatment of mental disorders
    - Other outpatient mental health treatment such as:
        - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician
        - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician
        - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
            - You are homebound
            - Your physician orders them
            - The services take the place of a stay in a hospital or a residential treatment facility, or you are unable to receive the same services outside your home
            - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease to avoid placing you at risk for serious complications
        - Electro-convulsive therapy (ECT)
        - Transcranial magnetic stimulation (TMS)
        - Psychological testing
        - Neuropsychological testing
        - 23-hour observation
        - Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

Obesity surgery and services

Obesity surgery is a type of procedure performed on people who are morbidly obese for the purpose of losing weight. Your physician will determine whether you qualify for obesity surgery.

Covered services include:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Outpatient prescription drugs included under the Outpatient prescription drugs section
- One obesity surgical procedure
- A multi-stage procedure when planned and approved by us
- Adjustments after an approved lap band procedure, including approved adjustments in an office or outpatient setting

The following are not covered services:

- Weight management treatment
- Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate.
- Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:

- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
- Hypnosis, or other forms of therapy

- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Oral and maxillofacial surgery (treatment of mouth, jaws and teeth)

Covered services include the following when provided by a physician, a dentist and hospital:

- Surgery needed to:
  - Cut out cysts, tumors, or other diseased tissues.
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
- Related dental services are limited to:
  - The first placement of a permanent crown or cap to repair a broken tooth
  - The first placement of dentures or bridgework to replace lost teeth
  - Orthodontic therapy to pre-position teeth

The following are not covered services:

- Services normally covered under a dental plan
- Dental implants

Outpatient surgery

Covered services include services provided and supplies used in connection with outpatient surgery performed in a surgery center or a hospital's outpatient department.

The following are not covered services:

- A stay in a hospital (see Hospital care in this section)
- A separate facility charges for surgery performed in a physician's office
- Services of another physician for the administration of a local anesthetic

Physician services

Covered services include services by your physician to treat an illness or injury. You can get services:

- At the physician's office
- In your home
- In a hospital
- From any other inpatient or outpatient facility
- By way of telemedicine

Other services and supplies that your physician may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

Prescription drugs - outpatient

Read this section carefully. This plan does not cover all prescription drugs and some coverage may be limited. This doesn't mean you can't get prescription drugs that aren't covered; you can, but you have to pay for them yourself. For more information about prescription drug benefits, including limits, see the schedule of benefits.

Covered services are based on the drugs in the drug guide. Your cost may be higher if you're prescribed a prescription drug that is not listed in the drug guide. You can find out if a prescription drug is covered; see the Contact us section. All

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Drugs listed in the formulary at the beginning of the Plan Year shall continue to be offered during the Plan Year. Drugs may be added to the formulary during the Plan Year. No drug can be reclassified from Generic to Brand Name or Specialty Drug during the Plan Year.

Your provider can give you a prescription in different ways including:

- A written prescription that you take to a network pharmacy
- Calling or e-mailing a prescription to a network pharmacy
- Submitting the prescription to a network pharmacy electronically

Prescription drug synchronization

If you are prescribed multiple maintenance medications and would like to have them each dispensed on the same fill date for your convenience, your network pharmacy can coordinate that for you. This is called synchronization. We will apply a prorated daily cost share rate, to a partial fill of a maintenance drug, if needed, to synchronize your prescription drugs.

How to access network pharmacies

You can find a network pharmacy either online or by phone. See the Contacts section for how.

You may go to any of our network pharmacies. If you don't get your prescriptions at a selected pharmacy, your prescriptions will not be a covered service under the plan. Pharmacies include network retail, mail order and specialty pharmacies.

Some prescription drugs are subject to quantity limits. This helps your provider and pharmacy ensure your prescription drug is being used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these limits.

Any prescription drug made to work beyond one month shall require the copayment amount that equals the expected duration of the medication.

The pharmacy may substitute a generic prescription drug for a brand-name prescription drug. Your cost share may be less if you use a generic drug when it is available.

Pharmacy types

Retail pharmacy

A retail pharmacy may be used and provided for a 30-day supply up to a maximum of 365-day supply of prescription drugs per benefit year. A network retail pharmacy will submit your claim. You will pay your cost share directly to the pharmacy. There are no claim forms to complete or submit.

Mail order pharmacy

The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. Each prescription and refill is limited to a maximum 365-day supply per benefit year.

Specialty pharmacy

We cover specialty prescription drugs when filled through a network retail or specialty pharmacy.
Each prescription is limited to a 30-day supply up to a maximum of 365-day supply per benefit year. You can view the list of specialty prescription drugs. See the Contact us section for how.

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

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

- Requiring a partial fill or denial of coverage

What if the pharmacy you use leaves the network?
Sometimes a pharmacy might leave the network. If this happens, you will have to get your prescriptions filled at another network pharmacy. You can use your provider directory or call us to find another network pharmacy in your area.

Other covered services

Anti-cancer drugs taken by mouth, including chemotherapy drugs
Covered services include any drug prescribed for cancer treatment. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment.

Contraceptives (birth control)
For females who are able to become pregnant, covered services include certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a prescription from your provider and must fill it at a network pharmacy. At least one form of each FDA-approved contraception method is a covered service. You can access a list of covered drugs and devices. See the Contact us section for how.

We also cover over-the-counter (OTC) and generic prescription drugs and devices for each method of birth control approved by the FDA at no cost to you. If a generic drug or device is not available for a certain method, we will cover the brand-name prescription drug or device at no cost share.

A medical exception can be made if your provider determines that the contraceptives covered under the plan is not medically appropriate for you. Your provider may request a medical exception and submit it to TakeCare for review.

Diabetic supplies
Covered services include but are not limited to the following:

- Alcohol swabs
- Blood glucose calibration liquid Diabetic syringes, needles and pens
- Lancet devices and kits
- Test strips for blood glucose, ketones, urine

See the Diabetic services, supplies, equipment, and self-care programs section for medical covered services.

Immunizations
Covered services include preventive immunizations as required by the ACA when given by a network pharmacy.
You can find a participating network pharmacy by contacting us. Check with the pharmacy before you go to make sure the vaccine you need is in stock. Not all pharmacies carryall vaccines.

OTC drugs
Covered services include certain OTC medications when you have a prescription from your provider. You can see a list of covered OTC drugs by logging on to the COMPANY website.

Preventive care drugs and supplements
Covered services include preventive care drugs and supplements, including OTC ones, as required by the ACA.
Tobacco cessation prescription and OTC drugs
Covered services include FDA approved prescription and OTC drugs to help stop the use of tobacco products. You must receive a prescription from your provider and submit the prescription to the pharmacy for processing.

Risk reducing breast cancer prescription drugs
Covered services include prescription drugs used to treat people who are at:

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- Increased risk for breast cancer
- Low risk for medication side effects

The following are not covered services:

- Abortion drugs
- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a covered service
- Dietary supplements including medical food
- Drugs or medications
    - Administered or entirely consumed at the time and place it is prescribed or provided
    - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception
    - That include the same active ingredient or a modified version of an active ingredient as a covered
    - prescription drug unless we approve a medical exception
    - That is therapeutically the same or an alternative toa covered prescription drug, unless we approve a medical exception
    - That is therapeutically the same or an alternative to an OTC drug unless we have approved a medical exception
    - Not approved by the FDA or not proven safe or effective
    - Provided under your medical plan while inpatient at a healthcare facility
    - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
    - That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
    - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a covered service
    - That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
    - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our precertification and clinical policies
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
    - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate
- Infertility:
    - Prescription drugs used primarily for the treatment of infertility
- Injectables including:
    - Any charges for the administration or injection of prescription drugs
    - Needles and syringes except for those used for insulin administration

  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
- Insulin pumps, tubing or other ancillary equipment and supplies for insulin pumps
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment to a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which is illegal, unethical, imprudent, abusive, not medically necessary or otherwise improper and drugs obtained for use by anyone other than the member as identified on the ID card
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents
- Treatment, drug, service or supply to stop or reduce smoking or the use of tobacco products or to treat or reduce nicotine addition, dependence or craving including medications, nicotine patches and gum unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's drug guide
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's drug guide

Preventive care

Preventive covered services are designed to help keep you healthy, supporting you in achieving your best health through early detection. If you need further services or testing such as diagnostic testing, you may pay more as

these services aren't preventive. If a covered service isn't listed here under preventive care, it still may be covered under other covered services in this section. For more information, see your schedule of benefits.

The following agencies set forth the preventive care guidelines in this section:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC)
- United States Preventive Services Task Force (USPSTF)
- Health Resources and Services Administration
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

These recommendations and guidelines may be updated periodically. When updated, they will apply to this plan. The updates are effective on the first day of the year, one year after the updated recommendation or guideline is issued.

For frequencies and limits, contact your physician or us. This information is also available at https://www.healthcare.gov/.

Breast-feeding support and counseling services

Covered services include assistance and training in breast-feeding and counseling services during pregnancy or after delivery. Your plan will cover this counseling only when you get it from a certified breast-feeding support provider.

Breast pump, accessories and supplies

Covered services include renting or buying equipment you need to pump and store breast milk.

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Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Counseling services
Covered services include preventive screening and counseling by your health professional for:

- Alcohol or drug misuse
    - Preventive counseling and risk factor reduction intervention
    - Structured assessment
- Genetic risk for breast and ovarian cancer
- Obesity and healthy diet
    - Preventive counseling and risk factor reduction intervention
    - Nutritional counseling
    - Healthy diet counseling provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease
- Sexually transmitted infection
- Tobacco cessation
    - Preventive counseling to help stop using tobacco products
    - Treatment visits
    - Class visits

Family planning services – female contraceptives
Covered services include family planning services as follows:

- Counseling services provided by a physician on contraceptive methods. These will be covered when you get them in either a group or individual setting.
- Contraceptive devices (including any related services or supplies) when they are provided, administered, or removed by a physician during an office visit.
- Voluntary sterilization including charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

The following are not preventive covered services:

- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA
- Male contraceptive methods, sterilization procedures or devices

Immunizations
Covered services include preventive immunizations for infectious diseases.

The following are not preventive covered services:

- Immunizations that are not considered preventive care, such as those required due to your employment or travel

Prenatal care
Covered services include your routine pregnancy physical exams at the physician, PCP, OB, GYN or OB/GYN office. The exams include initial and subsequent visits for:

- Anemia screening
- Blood pressure
- Chlamydia infection screening
- Fetal heart rate check

- Fundal height
- Gestational diabetes screening
- Gonorrhea screening
- Hepatitis B screening
- Maternal weight
- Rh incompatibility screening

Preventive care drugs

Contraceptives (birth control)
For females who are able to become pregnant, covered services include certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a prescription from you provider and must fill it at a network pharmacy. At least one form of each FDA-approved contraception methods is a covered service. You can access a list of covered drugs and devices. See the Contact us section for how.

We also cover over-the-counter (OTC) and generic prescription drugs and devices for each of the methods identified by the FDA at no cost to you. If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drugs or devices for that method at no cost.

A medical exception can be made if your provider determines that the contraceptives covered under the plan is not medically appropriate for you. Your provider may request a medical exception and submit it to TakeCare for review.

Preventive care drugs and supplements
Covered services include preventive care drugs and supplements, including OTC ones, as required by the ACA, when you have a prescription and it is filled at a network pharmacy.

Risk reducing breast cancer prescription drugs
Covered services include prescription drugs used to treat people who are at an increased risk for breast cancer and a low risk for adverse medication side effects. You will need a prescription from your provider and have it filled at a network pharmacy.

Tobacco cessation prescription and OTC drugs
Covered services include FDA approved prescription and OTC drugs to help stop the use of tobacco products. You must receive a prescription from your provider and submit the prescription to the pharmacy for processing.

Routine cancer screenings
Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure specialist consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

Routine physical exams

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A routine preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
    - Screening and counseling services on topics such as:
        - Interpersonal and domestic violence
        - Sexually transmitted diseases
        - Human immune deficiency virus (HIV) infections
    - High risk human papillomavirus (HPV) DNA testing for women

Covered services include:

- Annual routine office visit to a physician
- Hearing screening
- Vision screening
- Radiological services, lab and other tests
- For covered newborns, an initial hospital checkup

Well woman preventive visits

A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Office visit to a physician, PCP, OB, GYN or OB/GYN for services including Pap smears
- Preventive care breast cancer (BRCA) gene blood testing
- Screening for diabetes after pregnancy for women with a history of diabetes during pr e gn a nc y
- Screening for urinary incontinence

Private duty nursing - outpatient

Covered services include private duty nursing care, ordered by a physician and provided by an R.N. or L.P.N. when:

- You are homebound
- Your physician orders services as part of written treatment plan
- Services take the place of a hospital or skilled nursing facility stay
- Your condition is serious, unstable, and requires continuous skilled 1-on-1 nursing care
- Periodic skilled nursing visits are not adequate

The following are not covered services:

- Inpatient private duty nursing care
- Care provided outside the home
- Maintenance or custodial care
- Care for your convenience or the convenience of the family caregiver

Prosthetic device

A prosthetic device is a device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness, injury or congenital defects.

Covered services include the initial provision and subsequent replacement of a prosthetic device that your physician orders and administers.

Coverage includes:

- Instruction and other services (such as attachment or insertion) so you can properly use the device
- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage

You may receive a prosthetic device as part of another covered service and therefore it will not be covered under this benefit.

The following are not covered services:

- Orthopedic shoes and therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Reconstructive breast surgery and supplies

Covered services include all stages of reconstructive surgery by your provider and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your surgery reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
    - Surgery on healthy breast to make it symmetrical with the reconstructed breast
    - Treatment of physical complications of all stages of the mastectomy, including lymphedema
    - Prostheses

Reconstructive surgery and supplies

Covered services include all stages of reconstructive surgery by your provider and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your surgery is to implant or attach a covered prosthetic device.
- Your surgery corrects a gross anatomical defect present at birth. The surgery will be covered if:
    - The defect results in severe facial disfigurement or major functional impairment of a body part
    - The purpose of the surgery is to improve function
- Your surgery is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your surgery will improve function.

Covered services also include surgery, as soon as medically feasible, to fix teeth injured due to an accident when:

- Teeth are sound natural teeth. This means the teeth were stable, functional and free from decay or disease at the time of the injury.
- The surgery returns the injured teeth to how they functioned before the accident.

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

Covered services include cardiac rehabilitation services you receive at a hospital, skilled nursing facility or physician's office, but only if those services are part of a treatment plan determined by your risk level and ordered by your physician.

Pulmonary rehabilitation

Covered services include pulmonary rehabilitation services as part of your inpatient hospital stay if they are part of a treatment plan ordered by your physician. A course of outpatient pulmonary rehabilitation may also be covered if it is performed at a hospital, skilled nursing facility, or physician's office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your physician.

Short-term rehabilitation services

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Short-term rehabilitation services help you restore or develop skills and functioning for daily living. The services must follow a specific treatment plan, ordered by your physician. The services have to be performed by a:

- Licensed or certified physical, occupational, or speech therapist
- Hospital, skilled nursing facility, or hospice facility
- Home health care agency
- Physician

Covered services include:

- Spinal manipulation to correct a muscular or skeletal problem. Your provider must establish or approve a treatment plan that details the treatment and specifies frequency and duration.

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury, or surgical procedure
- Occupational therapy, but only if it is expected to do one of the following:
    - Significantly improve, develop, or restore physical functions you lost as a result of an acute illness, injury, or surgical procedure
    - Help you relearn skills so you can significantly improve your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to do one of the following:
    - Significantly improve or restore lost speech function or correct a speech impairment resulting from an acute illness, injury, or surgical procedure
    - Improve delays in speech function development caused by a gross anatomical defect present at birth (speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.)
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
    - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
    - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function

Short-term physical, speech and occupational therapy services provided in an outpatient setting are subject to the same conditions and limitations for outpatient short-term rehabilitation services. See the Short-term rehabilitation services section in the schedule of benefits.

The following are not covered services:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling
- Any services exceeding the benefit limitation as stated on the summary of benefits

Skilled nursing facility

Covered services include recertified inpatient skilled nursing facility care. This includes:

- Room and board, up to the semi-private room rate
- Services and supplies provided during a stay in a skilled nursing facility

Substance related disorders treatment

Covered services include the treatment of substance related disorders provided by a hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider as follows:

- Inpatient room and board, at the semi-private room rate (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your stay in a hospital, psychiatric hospital, or residential treatment facility.
  Treatment of substance related disorders in a general medical hospital is only covered if you are admitted to the hospital's separate substance related disorders section or unit, unless you are admitted for the treatment of medical complications of substance related disorders.
  As used here, "medical complications" include, but are not limited to:
    - Electrolyte imbalances
    - Malnutrition
    - Cirrhosis of the liver
    - Delirium tremens
    - Hepatitis
- Outpatient treatment received while not confined as an inpatient in a hospital, psychiatric hospital, or residential treatment facility, including:
    - Office visits to a physician or behavioral health provider such as a psychologist, social worker, or licensed professional counselor (includes telemedicine consultation)
    - Individual, group, and family therapies for the treatment of substance related disorders
    - Other outpatient substance related disorders treatment such as:
        - Partial hospitalization treatment provided in a facility or program for treatment of substance related disorders provided under the direction of a physician
        - Intensive outpatient program provided in a facility or program for treatment of substance related disorders provided under the direction of a physician
        - Ambulatory or outpatient detoxification which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
        - 23-hour observation
        - Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

Tests, images and labs – outpatient

Diagnostic complex imaging services

Covered services include:

- Computed tomography (CT) scans, including for preoperative testing
- Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including positron emission tomography (PET) scans
- Other imaging service where the billed charge exceeds $500 Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Laboratory
- Pathology
- Other tests

These are covered only when you get them from a licensed radiology provider or lab.

Diagnostic x-ray and other radiological services

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Covered services include x-rays, scans and other services (but not complex imaging) only when you get them from a licensed radiology provider. See Diagnostic complex imaging services above for more information.

Therapies – Chemotherapy, infusion, radiation

Chemotherapy

Covered services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your hospital benefit covers the initial dose of chemotherapy after a cancer diagnosis during a hospital stay.

Infusion therapy

Infusion therapy is the intravenous (IV) administration of prescribed medications or solutions. Covered services include infusion therapy you receive in an outpatient setting including but not limited to:

- A freestanding outpatient facility
- The outpatient department of a hospital
- A physician's office
- Your home from a home care provider

You can access the list of preferred infusion locations by contacting us.

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable home health care maximums.

Certain infused medications may be covered under the outpatient prescription drug benefit. You can access the list of specialty prescription drugs by contacting us.

Radiation therapy

Covered services include the following radiology services provided by a health professional:

- Accelerated particles
- Gamma ray
- Mesons
- Neutrons
- Radioactive isotopes
- Radiological services
- Radium

Transplant services

Covered services include transplant services provided by a physician and hospital.

This includes the following transplant types:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T Cell receptor therapy for FDA-approved treatments

Covered services also include:

- Travel and lodging expenses
    - If you are working with a facility that is 100 or more miles away from where you live, travel and lodging expenses are covered services for you and a companion, to travel between home and the facility
    - Coach class air fare, train or bus travel are examples of covered services

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Network of transplant facilities

We designate facilities to provide specific services or procedures. They are listed as facilities in your provider directory.

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the IOE facility we designate to perform the transplant you need. You may also get transplant services at a non-IOE facility, but your cost share will be higher.

The following are not covered services:

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

Urgent care services

Covered services include services and supplies to treat an urgent condition at an urgent care center as described below:

- Urgent condition within the network (in-network)
    - If you need care for an urgent condition, you should first seek care through your physician, PCP. If your physician is not reasonably available, you may access urgent care from an urgent care center that is in-network.
- Urgent condition outside the network (out-of-network)
    - You are covered for urgent care obtained from a facility that is out-of-network if you are temporarily unable to get services in-network and getting the health care service cannot be delayed.

The following are not covered services:

- Non-urgent care in an urgent care center

Vision care

Covered services include:

- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing

The following are not covered services:

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes
- Any services exceeding the benefit limitation as stated on the summary of benefits

Walk-in clinic

Covered services include, but are not unlimited to, health care services provided at a walk-in clinic for:

- Scheduled and unscheduled visits for illnesses and injuries that are not emergency medical conditions
- Preventive care immunizations administered within the scope of the clinic's license

General plan exclusions

The following are not covered services under your plan:

1. No benefits will be paid for Injury or Illness, (a) when the Covered Person is entitled to receive disability benefits or compensation (or forfeits his or her right thereto) under Worker's Compensation or Employer's Liability Law for such Injury or Illness or (b) when Services for an Injury or Illness are rendered to the Covered Person by any federal, state, territorial, municipal or other governmental instrumentality or agency without charge, or (c) when such Services would have been rendered without charge but for the fact that the person is a Covered Person under the Plan.

2. No benefits will be paid if any material statement made in an application for coverage, enrollment of any Dependent or in any claim for benefits is false. Upon identifying any such false statement, Company shall give the Covered Person at least 30 day notice that his or her benefits have been suspended and that his or her coverage is to be terminated. If the false statement is fraudulent or is an intentional misrepresentation of a material fact, such termination shall be retroactive to the date coverage was provided or continued based on such fraudulent statement or intentional misrepresentation of material fact. If the false statement was not a fraudulent statement or intentional misrepresentation of material fact, termination of coverage shall be effective no earlier than the date of the suspension. The Covered Person may dispute any termination of coverage by filing a claim under the PPACA Claims Procedure for internal or external appeals, set out in §6.7 of this Certificate. If an appeal under §6.7 is filed, the resolution of the matter shall be in accordance with the outcome of the appeal proceedings. If no appeal is filed for any retroactive termination and the Company paid benefits prior to learning of any such false statement, the Subscriber must reimburse the Company for such payment. Terminations of coverage shall be handled in accordance with the applicable claims procedure requirements of Section 2719 of the PHSA, as added by PPACA. Retroactive terminations of coverage shall not violate the applicable prohibitions on rescissions of Section 2712 of the PHSA, as added by PPACA, and rescissions shall be handled in compliance with PPACA's applicable claim denial requirements.

3. No benefits will be paid for confinement in a Hospital or in a Skilled Nursing Facility if such confinement is primarily for custodial or domiciliary care. (Custodial or domiciliary care includes that care which consists of training in personal hygiene, routine nursing services and other forms of self care. Custodial or domiciliary care also includes supervisory services by a Physician or Nurse for a person who is not under specific medical or surgical treatment to reduce his or her disability and to enable that person to live outside an institution providing such care.) Company and not Covered Person shall be liable if the Company approves the confinement, regardless of who orders the service.

4. No benefits will be paid for nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)

5. No benefits will be paid for private Duty Nursing. This provision does not apply to Home Health Care.

6. No benefits will be paid for special medical reports, including those not directly related to treatment of the Member. (e.g., Employment or insurance physicals, and reports prepared in connection with litigation.)

7. No benefits will be paid for services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.

8. No benefits will be paid for court ordered services, or those required by court order as a condition of parole or probation.

9. No benefits will be paid for Services and supplies provided to a Covered Person for an Injury or Illness resulting from an attempted suicide by that Covered Person unless resulting from a medical condition (including physical or mental health conditions) or from domestic violence.

10. No benefits will be paid for Services and supplies provided in connection with intentionally self-induced or intentionally self-inflicted injuries or illnesses unless resulting from a medical condition (including physical or mental conditions) or from domestic violence.

11. No benefits will be paid for Services and supplies provided to a Covered Person for Injuries incurred while the person was committing a criminal act.

12. Unless otherwise specifically provided in the Agreement, no benefit will be paid for, or in connection with, airfare and the Company will not pay for the transportation from Guam to any off-island facility, nor for any other non-medical expenses such as taxes, taxis, hotel rooms, etc. In no event will the Company pay for air ambulance or for the transportation of the remains of any deceased person.

13. No benefits will be paid for living expenses for Covered Persons who require, or who of their own accord seek, treatment in locations removed from their home.

14. No benefits will be paid for Services and supplies provided to a dependent of a non-Spouse Dependent. Dependents of non-Spouse Dependents are not eligible for coverage. For example, when a Dependent, other than a Spouse of the Subscriber, has a child, that child is a dependent of a non-Spouse Dependent and is not eligible to become covered under the Plan, unless such child otherwise becomes eligible for enrollment.

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

16. No benefits will be paid for services performed by an immediate family member for which, in the absence of any health benefits coverage, no charge would be made. Immediate family member is defined as parents, spouses, siblings, or children of the insured member.

17. No benefits will be paid for treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. If a Member is covered under a Workers' Compensation law or similar law, and submits proof that the Member is not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational" regardless of cause. The Covered Benefits under the Group Health lnsurance Certificate for Members eligible for Workers' Compensation are not designed to duplicate any benefit to which they are entitled under Workers' Compensation Law. All sums payable for Workers' Compensation services provided under the Group Health lnsurance Certificate shall be payable to, and retained by Company. Each Member shall complete and submit to Company such consents, releases, assignments and other documents reasonably requested by Company in order to obtain or assure reimbursement under the Workers' Compensation Law

18. No benefits will be paid for:

    a. Drugs or substances not approved by the Food and Drug Administration (FDA), or

    b. Drugs or substances not approved by the FDA for treatment of the illness or injury being treated unless empirical clinical studies have proven the benefits of such drug or substance in treating the illness or injury, or

    c. Drugs or substances labeled ”Caution: limited by federal law to investigational use." or

    d. Any drug or substance which does not, by federal or state law, require a prescription order (i.e., an over-the-counter (OTC) drug).

19. No benefits will be paid for experimental or Investigational Procedures, or ineffective surgical, medical, psychiatric, or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes, unless deemed medically necessary by the patient’s physician and pre-authorized by the Company.

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

    An approved clinical trial is defined as:

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

20. No benefits will be paid for services or supplies related to Genetic Testing except as may be required by PPACA.

21. No benefits will be paid for any item or substance that is available without a Physician's prescription even if prescribed by a Physician, except as otherwise provided herein and except for medicines and supplies Medically Necessary for inpatient care.

22. No benefits will be paid for Services and supplies provided to perform transsexual surgery or to evaluate the need for such surgery. Evaluations and subsequent medications and Services necessary to maintain transsexual status are also excluded from coverage, as are complications or medical sequela of such surgery or treatment.

23. No benefits will be paid for injuries incurred by the operator of a motorized vehicle while such operator is under the influence of intoxicating alcoholic beverage, controlled drugs, or substances. If a blood alcohol level or the DRAEGER ALCO TEST is available and shows levels that are equal to or exceed 0.08 grams percent (gms%) or that exceed the amount allowed by law as constituting legal intoxication, no benefits will be paid.

24. No benefits will be paid for any medical Service or supply which is available to the Covered Person on Guam and which is paid by or reimbursable through a governmental agency or institution that provides medical and healthcare services to low-income or indigent persons, provided, however, this exclusion shall not apply to the treatment of any communicable disease as defined in Article 3 of Chapter 3, Title 10, Guam Code Annotated, and for which the Company shall pay for medical services and supplies as is medically

necessary for the treatment of Covered Person. However, notwithstanding the aforesaid, in no event will the Company consider the availability of benefits under Medicaid or Medically Indigent Program when paying benefits under this Agreement.

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

26. No benefits will be paid for vision care services, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision), lasik, keratoplasty, and radial keratotomy, including related procedures designed to surgically correct refractive errors except as provided in the Covered Benefits section of the Group Health lnsurance Certificate.

27. No benefits will be paid for eyeglasses or contact lenses or for Services and supplies in connection with surgery for the purpose of diagnosing or correcting errors in refraction except as provided in the Schedule of Benefits.

28. No benefits will be paid in connection with any injuries sustained while the Covered Person is operating any wheeled vehicle during an organized, off-road, competitive sporting event.

29. No benefits will be paid for personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies.

30. No benefits will be paid for hypnotherapy.

31. No benefits will be paid for religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.

32. No benefits will be paid for cosmetic Surgery or other services intended primarily to improve the Member's appearance or treatment relating to the consequences of, or as a result of, Cosmetic Surgery. This exclusion does not apply to:

    a. Medically Necessary reconstructive surgery as described in the Covered Benefits sections Mastectomy and Reconstructive Breast Surgery or Reconstructive Surgery.

    b. surgery to correct the results of injuries causing an impairment.

    c. surgery as a continuation of a staged reconstruction procedure, including but not limited to post-mastectomy reconstruction;

    d. surgery to correct congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.

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

34. Except as otherwise provided in this agreement, no benefit will be paid for specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.

35. No benefits will be paid for Services and supplies associated with growth hormone treatment unless the Covered Person is proven to have growth hormone deficiency using accepted stimulated growth hormone analyses and also shows an accelerated growth response to growth hormone treatment. Under no circumstances will growth hormone treatment be covered to treat short stature in the absence of proven growth hormone deficiency.

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

37. No benefits will be paid for weight reduction programs, or dietary supplements, except as pre-authorized by Company for the Medically Necessary treatment of morbid obesity.

38. No benefits will be paid for any drug, food substitute or supplement or any other product, which is primarily for weight reduction even if it is prescribed by a Physician.

39. Except as provided in this Agreement, or unless medically necessary for the treatment of Morbid Obesity or other disease, no benefit will be paid for gastric bypass, stapling or reversal if for the purpose of weight reduction or aesthetic purposes.

40. No benefits will be paid for surgical operations, procedures or treatment of obesity, except when pre-authorized by Company.

41. No benefits will be paid for the treatment of male or female Infertility, including but not limited to:

    a. The purchase of donor sperm and any charges for the storage of sperm;

    b. The purchase of donor eggs and any charge associated with care of the donor required for donor egg retrievals or transfers or gestational carriers;

    c. Charges associated with cryopreservation or storage of cryopreserved embryos (e.g. office, hospital, ultrasounds, laboratory tests, etc.);

    d. Home ovulation prediction kits;

    e. Injectable Infertility medications, including but not limited to, menotropins, hCG, GnRH agonists, IVIG;

    f. Artificial Insemination, including in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and intracytoplasmic sperm injection (ICSI), and any advanced reproductive technology ("ART") procedures or services related to such procedures;

    g. Any charges associated with care required for ART (e.g., office, Hospital, ultrasounds, laboratory tests, etc.);

    h. Donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;

    i. Any charge associated with a frozen embryo transfer including but not limited to thawing charges;

    j. Reversal of sterilization surgery; and

    k. Any charges associated with obtaining sperm for ART procedures.

42. Except as provided in this Agreement, no benefits will be paid for the purchase or rental of durable or disposable medical equipment and supplies, other than for:

    a. Equipment and supplies used in a Hospital or Skilled Nursing Facility, or in conjunction with an approved Hospital or Skilled Nursing Facility confinement, or as otherwise noted in the Agreement or

    b. Items covered as preventive care under well-women coverage such as breastfeeding supplies in accordance with reasonable medical management techniques.

43. No benefits will be paid for household equipment, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbed, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Member's house or place of business, and adjustments to vehicles.

44. No benefits will be paid for outpatient supplies (except diabetic supplies), including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, and elastic stockings.

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

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

47. Except as specifically provided, if a benefit is excluded, all Hospital, surgical, medical treatments, prescription drugs, laboratory services, and x-rays in relation to the excluded benefits are also excluded as of the time it is determined that the benefit is excluded.

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

49. No benefits will be paid for temporomandibular joint disorder treatment (TMJ) including treatment performed by prosthesis placed directly on the teeth except as covered in the Covered Benefits Section

50. Except as specifically provided in this Agreement, no benefits will be paid for corrective appliances, artificial aids and durable equipment.

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

52. No benefit will be paid for ambulance services when used for routine and convenience transportation to receive outpatient or inpatient services, unless deemed medically necessary with prior authorization obtained from Company.

53. Elective or voluntary enhancement procedures, surgeries, services, supplies and medications including, but not limited to, hair growth, hair removal, hair analysis, sexual performance, athletic performance, anti-aging, and mental performance, even if prescribed by a Physician.

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

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

56. No benefits will be paid for educational services. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, are not covered.

57. No benefits will be paid for Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition.

58. No benefits will be paid for Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms or whether providing or receiving the Service.

59. No benefits will be paid for non-medically necessary services, including but not limited to, those services and supplies:

    a. Which are not Medically Necessary, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;

    b. That do not require the technical skills of a medical or mental health professional;

    c. Furnished mainly for the personal comfort or convenience of the Member, or any person who cares for the Member, or any person who is part of the Member's family, or any Provider;

    d. Furnished solely because the Member is an inpatient on any day in which the Member's disease or injury could safely and adequately be diagnosed or treated while not confined;

    e. Furnished solely because of the setting if the service or supply could safely and adequately be furnished in a Physician's or a dentist's office or other less costly setting.

60. As required by HIPAA, no source-of-injury exclusion, such as exclusion 4.29 for off-road sporting events, will apply if the accident resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions).

Specific Exclusions:

Behavioral health treatment

Services for the following categories (or equivalent terms as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association):

- Stay in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

Blood, blood plasma, synthetic blood, or blood derivatives

Examples of these are:

- The service of blood donors, including yourself, apheresis or plasmapheresis
- The blood you donate for your own use, excluding administration and processing expenses and except where described in the Coverage and exclusions, Transplant services section

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Cosmetic services and plastic surgery

Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons, except where described in Coverage and exclusions under the Reconstructive breast surgery and supplies and Reconstructive surgery and supplies sections

Cost share waived

Any cost for a service when any out-of-network provider waives all or part of your copayment, coinsurance, deductible, or any other amount

Court-ordered services and supplies

This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are a covered service under your plan

Custodial care

Services and supplies meant to help you with activities of daily living or other personal needs. Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter, including emptying or changing containers and clamping tubing
- Watching or protecting you
- Respite care, adult or child day care, or convalescent care
- Institutional care, including room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating, or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform

Educational services

Examples of these are:

- Any service or supply for education, training or retraining services or testing. This includes:
    - Special education
    - Remedial education
    - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
    - Job training
    - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations

Any health or dental examinations needed:

- Because a third-party requires the exam. Examples include examinations to get or keep a job, and examinations required under a labor agreement or other contract.
- To buy insurance or to get or keep a license.
- To travel
- To go to a school, camp, sporting event, or to join in a sport or other recreational activity.

EXHIBIT D

Experimental or investigational

Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trials.

Foot care

Routine services and supplies for the following:

- Routine pedicure services, such as such as routine cutting of nails, when there is no illness or injury in the nails
- Supplies (including orthopedic shoes), ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
- Treatment of calluses, bunions, toenails, hammertoes or fallen arches
- Treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working, or wearing shoes

Foot orthotic devices

Foot orthotics or other devices to support the feet, such as arch supports and shoe inserts, unless required for the treatment of or to prevent complications of diabetes

Growth/height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- Surgical procedures, devices and growth hormones to stimulate growth

Maintenance care

Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services

Medical supplies – outpatient disposable

Any outpatient disposable supply or device. Examples of these include:

- Sheaths
- Bags
- Elastic garments
- Support hose
- Bandages
- Bedpans
- Home test kits not related to diabetic testing
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

Mental health and substance use disorders conditions

The following conditions/diagnoses (or equivalent terms as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association) are not covered by the behavioral health plan:

- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders and nicotine dependence except as described in the Coverage and exclusions- Preventive care section
- Pathological gambling, kleptomania, and pyromania
- Specific developmental disorders of scholastic skills (learning disorders/learning disabilities)
- Specific developmental disorder of motor functions
- Specific developmental disorders of speech and language

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- Other disorders of psychological development

Missed appointments

Any cost resulting from a canceled or missed appointment

Nutritional support

Any food item, including:

- Infant formulas
- Nutritional supplements
- Vitamins
- Prescription vitamins
- Medical foods
- Other nutritional items

Other non-covered services

- Services you have no legal obligation to pay
- Services that would not otherwise be charged if you did not have the coverage under the plan

Other primary payer

Payment for a portion of the charges that Medicare or another party is responsible for as the primary payer

Personal care, comfort or convenience items

Any service or supply primarily for your convenience and personal comfort or that of a third-party

Prescription or non-prescription drugs and medicines - outpatient

- Outpatient prescription or non-prescription drugs and medicines provided by the policyholder or through a third-party vendor contract with the policyholder
- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient

prescription drug plan

Routine exams

Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the Covered services and exclusions section

Services outside of Guam, the USA Mainland and Hawaii

Services outside of Guam, the USA Mainland and Hawaii, that are not approved through the prior authorization/pre-authorization process

Services provided by a family member

Services provided by a spouse, civil union partner, domestic partner, parent, child, stepchild, brother, sister, in- law, or any household member

Sexual dysfunction and enhancement

Any treatment, prescription drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape of a sex organ
- Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance

Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance

Telemedicine

- Services given by providers that are not contracted with TakeCare as a telemedicine provider; behavioral health services are covered when provided by either network or out- of-network providers
- Services given when you are not present at the same time as the provider
- Services including:
    - Telephone calls
    - Telemedicine kiosks
    - Electronic vital signs monitoring or exchanges, (e.g., Tele-ICU, Tele-stroke)

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

Tobacco cessation

Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:

- Counseling, except as specifically provided in the Covered services and exclusions section
- Hypnosis and other therapies
- Medications, except as specifically provided in the Covered services and exclusions section
- Nicotine patches
- Gum

Treatment in a federal, state, or governmental entity

Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity unless coverage is required by applicable laws

Voluntary sterilization

- Reversal of voluntary sterilization procedures, including related follow-up care

Wilderness treatment programs

See Educational services in this section

Work related illness or injuries

Coverage available to you under workers' compensation or a similar program under local, state or federal law for any illness or injury related to employment or self-employment

EXHIBIT D

How your plan works

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

You're in-network coverage:

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

Providers

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

Service area

Your plan generally pays for covered services only within a specific geographic area, called a service area. There are some exceptions, such as for emergency services, urgent care, and transplant services. Your service area under this plan is Guam, CNMI and Palau

See the Who provides the care section below.

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

With your out-of-network coverage:

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

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

You may have to find a new provider when:

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

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

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

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

Who provides the care?

Network providers

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

A select number of network providers are considered "preferred" with a lower copay/visit for you. These providers have entered into a written agreement with TakeCare to provide care or treatment at preferential or better rates compared to other network providers and have demonstrated better outcomes based on a standard measurement set (HEDIS)

by the National Committee for Quality Assurance ("NCQA"). The network providers identified in our directory as preferred in-network providers are subject to change. Please check with us to confirm the preferential status of network providers.

To get network benefits, you must use network providers. There are some exceptions:
Emergency services – see the description of emergency services in the Coverage and exclusions section.
Urgent care – see the description of urgent care in the Coverage and exclusions section.
Transplants – see the description of transplant services in the Coverage and exclusions section.

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

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

Primary Care Provider (PCP)
We encourage you to get covered services through a PCP. They will provide you with primary care.

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

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

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

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

Medical necessity, referral and prior authorization/prior certification requirements

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

- The service is medically necessary.
- For in-network benefits, you get the service from a network provider.
- You or your provider preauthorize the service when required.

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

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

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

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

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Out-of-network/Non-Participating

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

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

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

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

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

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

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

Types of services that require prior authorization/preauthorization

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

- Inpatient services and supplies
    - Stays in a hospital
    - Stays in a skilled nursing facility
    - Stays in a rehabilitation facility
    - Stays in a hospice facility
    - Stays in a residential treatment facility for treatment of mental disorders and substance related disorders
    - Obesity surgery (bariatric)
- Outpatient services and supplies
    - Cosmetic and reconstructive surgery
- All elective outpatient surgical procedures requiring use of surgical facilities including treatment
- 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

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- 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 outside the Service Area
- 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 outside the Service Area
- Sterilization (Traditional Tubal Ligation, Tubal Ligation with Fulguration and Vasectomy)
- Upper GI Endoscopy

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

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

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

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

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

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

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Requesting a medical exception

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

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

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

What the plan pays and what you pay

Who pays for your covered services – this plan, both of us, or just you? That depends.

The general rule

The schedule of benefits lists what you pay for each type of covered service. In general, this is how your benefit works:

- You pay the deductible, when it applies.
- Then the plan and you share the expense. Your share is called a copayment or.
- Then the plan pays the entire expense after you reach your maximum out-of-pocket limit.

When we say “expense” in this general rule, we mean the negotiated charge for a network provider, and allowable amount for an out-of-network provider.

Negotiated charge

For health coverage:

This is the amount a network provider has agreed to accept or that we have agreed to pay them or a third-party vendor (including any administrative fee in the amount paid).

Some providers are part of TakeCare’s network for some TakeCare plans but are not considered network providers for your plan. For those providers, the negotiated charge is the amount that provider has agreed to accept for rendering services or providing prescription drugs to members of your plan.

For prescription drug services:
When you get a prescription drug, we have agreed to this amount for the prescription or paid this amount to the network pharmacy or third-party vendor that provided it. The negotiated charge may include a rebate, additional service or risk charges and administrative fees. It may include additional amounts paid to or received from third parties under price guarantees.

Allowable amount

This is the amount of an out-of-network provider’s charge that is eligible for coverage. You are responsible for all charges above this amount. The allowable amount depends on the geographic area where you get the service or supply. Allowable amount doesn’t apply to involuntary services. These are services or supplies that are:

- Provided at a network facility by an out-of-network provider
- Not available from a network provider
- An emergency service

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Special terms used:

- Average wholesale price (AWP) is the current average wholesale price of a prescription drug as listed in the Facts & Comparisons®, Medi-Span daily price updates or any other similar publication we choose to use.
- Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility provider's estimated costs for the service and leave the provider with a reasonable profit. This means for:
    - Hospitals and other facilities that report costs or cost to charge ratios to The Centers for Medicare & Medicaid Services (CMS), the FCR rate is based on what the facilities report to CMS
    - Facilities that don't report costs or cost to charge ratios to CMS, the FCR rate is based on a statewide average of these facilities

We may adjust the formula as needed to maintain the reasonableness of the allowable amount. For example, we may make an adjustment if we determine that in a state the charges of a specific type of facility are much higher than charges of facilities that report to CMS.

- Geographic area is normally based using the first three digits of a zip code. If we believe we need more data for a particular service or supply, we may base rates on a wider geographic area such as the entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees without taking into account adjustments for specific provider performance. We update our system with these when revised within 180 days of receiving them from CMS. If Medicare doesn't have a rate, we use one or more of the items below to determine the rate for a service or supply:
    - The method CMS uses to set Medicare rates
    - How much other providers charge or accept as payment?
    - How much work it takes to perform a service?
    - Other things as needed to decide what rate is reasonable, we may make the following exceptions:
        - For inpatient services, our rate may exclude amounts CMS allows for operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) programs
        - Our rate may exclude other payments that CMS may make directly to hospitals or other providers and backdated adjustments
        - For anesthesia, our rate may be at least 105% of the rate CMS establishes
        - For lab, our rate may be 75% of the rate CMS establishes
        - For DME, our rate may be 75% of the rate CMS establishes
        - For medications that are paid as a medical benefit instead of a pharmacy benefit, our rate may be 100% of the rates CMS establishes.

When the allowable amount is based on a percentage of the Medicare allowed rate, it is not affected by adjustments or incentives given to providers under Medicare programs.

Our reimbursement policies

We have the right to apply our reimbursement policies to all out-of-network services including involuntary services. This may affect the allowable amount. When we do this, we consider:

- The length and difficulty of a service
- Whether additional expenses are needed, when multiple procedures are billed at the same time
- Whether an assistant surgeon is needed
- If follow up care is included
- Whether other conditions change or make a service unique
- Whether any of the services described by a claim line are part of or related to the primary service provided, when a charge includes more than one claim line
- The educational level, licensure or length of training of the provider

We base our reimbursement policies on our review of:

- CMS National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and aren't appropriate
- Generally accepted standards of medical and dental practice

- The views of physicians and dentists practicing in relevant clinical areas

Paying for covered services – the general requirements

There are several general requirements for the plan to pay any part of the expense for a covered service. For in-network coverage, they are:

- The service is medically necessary
- You get your care from a network provider
- You or your provider preauthorize the service when required

For out-of-network coverage:

- The service is medically necessary
- You get your care from an out-of-network provider
- You or your provider preauthorize the service when required

For outpatient prescription drugs, your costs are based on:

- The type of prescription you're prescribed
- Where you fill the prescription

The plan may make some brand-name prescription drugs available to you at the generic prescription drug cost share.

Generally, your plan and you share the cost for covered services when you meet the general requirements. But sometimes your plan will pay the entire expense, and sometimes you will. For details, see your schedule of benefits and the information below.

You pay the entire expense when:

- You get services or supplies that are not medically necessary or not covered.
- Your plan requires preauthorization, your physician requests it, we deny it and you get the services without preauthorization.
- You get care from an out of-network provider and the provider waives all or part of your cost share.

In all these cases, the provider may require you to pay the entire charge. Any amount you pay will not count towards your deductible or your maximum out-of-pocket limit.

Where your schedule of benefits fits in

The schedule of benefits shows any out-of-pocket costs you are responsible for when you receive covered services and any benefit limitations that apply to your plan. It also shows any maximum out-of-pocket limits that apply.

Limitations include things like maximum age, visits, days, hours, and admissions. Out-of-pocket costs include things like deductibles, copayments and coinsurance.

Keep in mind that you are responsible for paying your part of the cost sharing. You are also responsible for costs not covered under this plan.

Coordination of benefits

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

Key Terms

Here are some key terms we use in this section. These will help you understand this COB section.
Allowable expense means a health care expense that any of your health plans cover.

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

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

How Coordination of Benefits (COB) works

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

Determining who pays

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

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

COB rule	Primary Plan	Secondary Plan
Non-dependent or dependent	Plan covering you as an employee, retired employee or subscriber (not as a dependent)	Plan covering you as a dependent
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together	• Plan of parent responsible for health coverage in court order • Birthday rule applies if both parents are responsible or have joint custody in court order • Custodial parent's plan if there is no court order	• Plan of other parent • Birthday rule applies (later in the year) • Non-custodial parent's plan
Child – covered by individuals who are not parents (i.e., stepparent or grandparent)	Same rule as parent	Same rule as parent
Active or inactive employee	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former

		employee)
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally	Plans share expenses equally

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

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

You are eligible for Medicare if you are covered under it.

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

Your current plan must be offered through the policyholder.

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

Our rights
We have the right to:

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

Benefit payments and claims

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

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

Claim type and timeframes

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

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

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

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

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

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

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

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

The benefit payment determination is made based on many things, such as your deductible or coinsurance, the necessity of the service you received, when or where you receive the services, or even what other insurance you may have. We may need to ask you or your provider for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

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

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

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Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

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

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

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

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

Appeal of an adverse benefit determination

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

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

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

- The policyholder’s name
- A copy of the adverse benefit determination
- Your reasons for making the appeal

- Any other information you would like us to consider

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

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

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

At your last available level of appeal, we will give you any new or additional information we may find and use to review your claim. There is no cost to you. We will give you the information before we give you our decision.
This decision is called the final adverse benefit determination. You can respond to the information before we tell you what our final decision is.

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

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

File a complaint or appeal with the Guam Department of Revenue and Taxation.

- Pursue arbitration, litigation or other type of administrative proceeding

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

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

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

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

Requiring a partial fill or denial of coverage

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Recordkeeping

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

Fees and expenses

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

Appeals Process

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.

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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 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 Baltej Pavilion, Suite 108, 415 Chalan San Antonio, 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 ("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.

EXHIBIT D

Eligibility, starting and stopping coverage

Eligibility

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

Who is eligible

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

Residency requirement

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

When can you join the plan

You can enroll:

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

Who can be a dependent on this plan

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

- The subscriber's **legal spouse**. A copy of official marriage certificate must be submitted.
- The subscriber's **common law spouse**. A notarized affidavit and proof of common law status.
- The subscriber's **domestic partner** who is (1) 18 years of age or older, (2) of the same or opposite sex as the Subscriber, (3) in an exclusive mutually committed relationship with the Subscriber and intends to remain the Subscriber's sole domestic partner, (4) not married to any other person, (5) and not related to the Subscriber by blood to a degree that would prohibit marriage; and (6) has cohabitated with the Subscriber for the two (2) consecutive years immediately preceding the proposed Enrollment. A notarized affidavit and proof of domestic partner status.
- The subscriber's **children under 26 years of age**:
    - o **Natural children**. A copy of an official certificate listing the subscriber as a parent must be submitted.
    - o **Adopted children** including those placed with you for adoption. A copy of the court document signed by a judge ordering legal adoption.
    - o **Stepchildren**. A copy of an official birth certificate and official marriage certificate listing the subscriber's legal spouse as a parent must be submitted.

- **Disabled children over age the age of (26) twenty-six years**. A copy of disability enrollment form signed by a
- licensed physician must be submitted.
- **Children under court order**. A copy of court document signed by a judge requiring such coverage must be submitted.
- **Children under legal guardianship**. A copy of the court document signed by a judge ordering legal guardianship must be submitted.

Adding new dependents

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

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

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

Special times you and your dependents can join the plan

You can also enroll in these situations:

- Enrollment in both Medicare A & B, date of retirement, change in employment status (work hours increase – 30 hours or more)
- You didn't enroll before because you had other coverage and that coverage has ended.
- A court orders that you cover a dependent on your health plan.
- When your dependent moves outside the service area for your employee plan.

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

Notification of change in status

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

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

Starting Coverage

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

Stopping Coverage

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

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

When will your coverage end?

Your coverage under this plan will end if:

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- This plan is no longer available.
- You ask to end coverage.
- The policyholder asks to end coverage.
- You are no longer eligible for coverage, including when you move out of the service area.
- Your work ends.
- You stop making required premium contributions, if any apply.
- TakeCare end your coverage.
- Coverage should be for whole plan year regardless if you meet your maximum benefit.
- You have reached your overall maximum benefit under your plan.

When will the dependent's coverage end?

Dependent coverage will end if:

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

What happens to your dependents if you die?

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

Why would we end your coverage?

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

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

Special coverage options after your coverage ends

When coverage may continue under the plan

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

In some cases, premium payment is required for coverage to continue. Your coverage will continue under the plan as long as the policyholder and we have agreed to do so. It is the policyholder's responsibility to let us know when your work ends. If the policyholder and we agree in writing, we will extend the limits.

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

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

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

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

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

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

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

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

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

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

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

We may ask you to send proof that your child is disabled after coverage is extended. We need this once every benefit period. You must send it to us within 30 days of our request. If you don't, we can terminate coverage for your dependent child. We will continue to provide coverage for disabled children over 26 years old provided they submit the requirements for enrollment.

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

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

Benefits are extended for the condition that caused the hospital or skilled nursing facility stay or for complications from the condition. Benefits aren't extended for other medical conditions.

You can continue to get care for this condition until the earliest of:

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

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

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

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

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

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

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

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious illness or injury,
- Cause the dependent child to lose status as a full-time student under the plan, and

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- Be certified by the treating doctor as medically necessary due toa serious illness or injury.

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

EXHIBIT D

General provisions – other things you should know

Administrative provisions

How you and we will interpret this certificate

We prepared this certificate according to ERISA and other federal and Guam laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this certificate when we administer your coverage.

How we administer this plan

We apply policies and procedures we've developed to administer this plan.

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your providers. Even network providers are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the group policy. This document may have amendments and riders too. Under certain circumstances, we, the policyholder or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive precertification, prescription quantity limits or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the policyholder or provider, can do this.

If a service cannot be provided to you

Sometimes things happen outside of our control. These are things such as natural disasters, epidemics, fire, and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can't, we may refund any unearned premium.

Legal action

You must complete the internal appeal process before you take any legal action against us for any expense or bill. See the Complaints, claim decisions and appeal procedures section. You cannot take any action until 60 days after we receive written submission of a claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Physical examinations and evaluations

At our expense, we have the right to have a physician of our choice examine you. This will be done at reasonable times while certification or a claim for benefits is pending or under review.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim. Important things to keep are:

- Names of physicians and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception

Honest mistakes

You or the policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in premium contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

EXHIBIT D

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past
- Loss of coverage going forward
- Denial of benefits
- Recovery of amounts we already paid

We also may report fraud to criminal authorities.

Rescission means you lose coverage both going forward and going backward. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind your coverage:

- We will give you 30 days advance written notice of any rescission of coverage
- You have the right to a TakeCare appeal
- You have the right to a third-party review conducted by an independent ERO

Some other money issues

Assignment of benefits

When you see a network provider, they will usually bill us directly. When you see an out-of-network provider, we may choose to pay you or to pay the provider directly. To the extent allowed by law, we will not accept an assignment to an out-of-network provider.

Financial sanctions exclusions

If coverage provided under this certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for covered services if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC).

You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Premium contribution

Your plan requires that the policyholder make premium contribution payments. We will not pay for benefits if premium contributions are not made. Any decision to not pay benefits can be appealed.

Recovery of overpayments

We sometimes pay too much for covered services or pay for something that this plan doesn't cover. If we do, we can require the person we paid, you or your provider, to return what we paid. If we don't do that, we have the right to reduce any future benefit payments by the amount we paid by mistake.

When you are injured

If someone else caused you to need care – say, a careless driver who injured you in a car crash– you may have a right to get money. We are entitled to that money, up to the amount we pay for your care. We have that right no matter whom the money comes from – for example, the other driver, the policyholder, or another insurance company.

To help us get paid back, you are doing these things now:

- Agreeing to repay us from money you receive because of your injury.

- Giving us the right to seek money in your name, from any person who causes you injury and from your own insurance. We can seek money only up to the amount we paid for your care.
- Agreeing to cooperate with us so we can get paid back in full. For example, you'll tell us within 30 days of when you seek money for your injury or illness. You'll hold any money you receive until we are paid in full. And you'll give us the right to money you get, ahead of everyone else.
- Agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money.

We don't have to reduce the amount we're due for any reason, even to help pay your lawyer or pay other costs you incurred to get a recovery.

Your health information

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

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

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

Effect of benefits under other plans

EXHIBIT D

Glossary

Allowable amount
See How your plan works – What the plan pays and what you pay.

Behavioral health provider
A health professional who is properly licensed or certified to provide covered services for mental health and substance related disorders in the state where the person practices.

Brand-name prescription drug
An FDA-approved drug marketed with a specific name by the company that manufactures it; often the same company that developed and patents it.

Coinsurance
A percentage paid by a covered person for a covered service.

Copay/copayments
A dollar amount or percentage paid by a covered person for a covered service.

Covered service
The benefits, subject to varying cost shares, covered in this plan. These are:

- Described in the Providing covered services section
- Not listed as an exclusion in the Coverage and exclusions – Providing covered services section or the
- General plan exclusions section
- Not beyond any limits in the schedule of benefits
- Medically necessary. See the How your plan works – Medical necessity, referral and precertification requirements section and the Glossary for more information

Deductible
The amount a covered person pays for covered services per year before we start today.

Detoxification
The process of getting alcohol or other drugs out of an addicted person's system and getting them physically stable.

Drug guide
A list of prescription drugs and devices established by us or an affiliate. It does not include all prescription drugs and devices. This list can be reviewed and changed by us or an affiliate. A copy is available at your request.

Emergency medical condition
A severe medical condition that:

- Comes on suddenly
- Needs immediate medical care
- Leads a person with average knowledge of health and medicine to believe that, without immediate medical care, it could resultin:
    - Danger to life or health

- Loss of a bodily function
- Loss of function to a body part or organ
- Danger to the health of an unborn baby

Emergency services
Treatment given in a hospital's emergency room. This includes evaluation of and treatment to stabilize the emergency medical condition.

Experimental or investigational
Drugs, treatments or tests not yet accepted by physicians or by insurance plans as standard treatment. They may not be proven as effective or safe for most people.

A drug, device, procedure, or treatment is experimental or investigational if:

- There is not enough outcome data available from controlled clinical trials published in the peer- reviewed literature to validate its safety and effectiveness for the illness or injury involved.
- The needed approval by the FDA has not been given for marketing.
- A national medical or dental society or regulatory agency has stated in writing that it is experimental or investigational or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility provider state that it is experimental or investigational.

Formulary exclusions list
A list of **prescription** drugs not covered under the plan. This list is subject to change. Once the Plan Year has commenced, all additions to the Formulary Exclusions List must include a 60-day prior written notice to any subscriber who is taking the medication explaining the reason(s) for excluding the medication and suggesting alternative medications. The Company must receive an acknowledgment from the subscriber of having received and read the notice.

Generic prescription drug

- An FDA-approved drug with the same intended use as the brand-name product. It offers the same:
- Dosage
- Safety
- Strength
- Quality
- Performance

Health professional
A person who is authorized by law to provide health care services to the public; for example, physicians, nurses and physical therapists.

Home health care agency
An agency authorized by law to provide home health services, such as skilled nursing and other therapeutic services.

Hospital
An institution licensed as a hospital by applicable law and accredited by The Joint Commission (TJC). This is a place that offers medical care. Patients can stay overnight for care. Or they can be treated and leave the same day. All hospitals must meet set standards of care. They can offer general or acute care. They can also offer service in one area, like rehabilitation.

Infertile/infertility

EXHIBIT D

A disease defined by the failure to become pregnant:

- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
  - At least 2 abnormal semen analyses obtained at least 2 weeks apart

Jaw joint disorder

This is:

- A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

Lifetime maximum

The most this plan will pay for covered services incurred by a covered person during their lifetime.

Mail order pharmacy

A pharmacy where prescription drugs are legally dispensed by mail or another carrier.

Medically necessary/medical necessity

Healthcare services that we determine a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that we determine are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, physician or other health care provider
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
- Following the standards set forth in our clinical policies and applying clinical judgment

Mental disorder

A mental disorder is in general, a set of symptoms or behavior associated with distress and interference with personal function. A complete definition of mental disorder is in the most recent edition of The International Classification of Diseases, Tenth Edition (ICD-10).

Negotiated charge

See How your plan works – What the plan pays and what you pay.

Network provider

A provider listed in the directory for your plan. A NAP provider listed in the NAP directory is not a network provider. A network provider can also be referred to as an in-network provider.

Out-of-network provider

EXHIBIT D

A provider who is not a network provider.

Physician

A health professional trained and licensed to practice and prescribe medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy. Under some plans, a physician can also be a primary care physician (PCP).

Prior Authorization/Preauthorization, preauthorize

Pre-approval that you or your provider receives from us before you receive certain covered services. This may include a determination by us as to whether the service is medically necessary and eligible for coverage.

Preferred drug

A prescription drug or device that may have a lower out-of-pocket cost than a non-preferred drug.

Prescription drug

This is an instruction written by a physician that authorizes a patient to receive a service, supply, medicine or treatment.

Provider(s)

A physician, health professional, person, or facility, licensed or certified by law to provide health care services to you. If state law does not specifically provide for licensure or certification, they must meet all Medicare approval standards even if they don't participate in Medicare.

Psychiatric hospital

An institution licensed or certified as a psychiatric hospital by applicable laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse or mental disorders (including substance related disorders).

Residential treatment facility

An institution specifically licensed as a residential treatment facility by applicable laws to provide for mental health or substance related disorder residential treatment programs. It is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following: For residential treatment programs treating mental disorders:

- A behavioral health provider must be actively on duty 24 hours/day for 7 days/week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- It is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution) For substance related residential treatment programs:
- A behavioral health provider or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a physician
- It is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution)

For detoxification programs within a residential setting:

- An R.N. must be onsite 24 hours/day for 7 days/week within a residential setting
- Residential care must be provided under the direct supervision of a physician

EXHIBIT D

Retail pharmacy
A community pharmacy that dispenses outpatient prescription drugs at retail prices.

Room and board
A facility's charge for your overnight stay and other services and supplies expressed as a daily or weekly rate.

Semi-private room rate
An institution's room and board charge for most beds in rooms with 2 or more beds. If there are no such rooms, we will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled nursing facility
A facility specifically licensed as a skilled nursing facility by applicable laws to provide skilled nursing care.
Skilled nursing facilities also include:

- Rehabilitation hospitals
- Portions of a rehabilitation hospital
- A hospital designated for skilled or rehabilitation services

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- Custodial care
- Ambulatory care
- Part-time care

It does not include institutions that primarily provide for the care and treatment of mental disorders or substance related disorders.

Skilled nursing services
Services provided by a registered nurse or licensed practical nurse within the scope of their license.

Specialist
A physician who practices in any generally accepted medical or surgical sub-specialty.

Specialty prescription drugs
These are prescription drugs that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration. You can contact us to access the list of specialty drugs.
Specialty pharmacy
This is a pharmacy designated by us as a network pharmacy to fill prescriptions for specialty prescription drugs.

Stay
A full-time inpatient confinement for which a room and board charge is made.

Step therapy
A form of precertification under which certain prescription drugs are excluded from coverage, unless a first- line therapy drug is used first by you. The list of step therapy drugs is subject to change by us or an affiliate. An updated copy of the list of drugs subject to step therapy is available upon request or on our website.

Substance related disorder

This is a physical or psychological dependency, or both, on a drug or alcohol. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include an addiction to nicotine products, food or caffeine.

Surgery or surgical procedures

The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as:

- Cutting
- Abrading
- Suturing

- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution
- Otherwise physically changing body tissues and organs

Telemedicine

A consultation between you and a provider who is performing a clinical medical or behavioral health service that can be provided electronically by:

- Two-way audiovisual teleconferencing
- Telephone calls
- Any other method required by law

Terminal illness

A medical prognosis that you are not likely to live more than 12 months.

Urgent condition

An illness or injury that requires prompt medical attention but is not a life-threatening emergency medical condition.

Walk-in clinic

A health care facility that provides limited medical care on a scheduled and unscheduled basis. A walk-in clinic may be located in, near or within a:

- Drug store
- Pharmacy
- Retail store
- Supermarket

The following are not considered a walk-in clinic:

- Ambulatory surgical center
- Emergency room
- Hospital
- Outpatient department of a hospital
- Physician’s office
- Urgent care facility