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

FISCAL YEAR 2018
Updated 09.01.2018

GOVGUAM
Open Enrollment Booklet
TakeCare was voted four years consecutively for the island’s Best Insurance Company!

We are humbled and proud our members put their trust and confidence in our abilities to meet their healthcare and medical needs today, and for generations to come.
You can count on us to deliver comprehensive insurance coverage and quality health care when and where you need it.

What does accreditation mean to you?

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

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

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

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

---

**The first accredited health plan on Guam by the Accreditation Association for Ambulatory Health Care (AAAHC).**

- 15% Co-Payment at FHP Health Center for Primary Care for HSA plan.
- Inclusion of preferred primary care network at 10% copayment.
- 100% Coverage for Routine & Preventive Laboratory Services.
- Gym Membership covered at 100% at preferred Fitness Partners on island.
- 100% Coverage for Disease Management and Wellness Programs.
- Wellness and Fitness incentives up to $700 per individual, $1,400 per family to reward and encourage you to live a healthy, balanced lifestyle.
- Preferred access to FHP Health Center and Urgent Care - Open 7am to 11pm / 7 days week, 363 days a year.*
- 100% Coverage for approved Prescription Drugs in the Philippines available at preferred Mercury Drug & MedExpress Pharmacy locations.
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A sound mind and body give you optimum control over debilitating sickness and disease. Discover the path to wellness with TakeCare and FHP Health Center’s Wellness Programs. Health Education Classes and Fitness Program Classes arm you with healthy lifestyle practices and a dose of prevention so you can do more.

- Balanced Lifestyle Workshop
- Cardiac Risk Management
- Children’s Health Improvement Program
- Diabetes Management
- Nicotine Cessation Program
- Nurse Care Management
- Nutrition Counseling
- Takecare Fitness Program
- TakeCare Wellness Workshop
- Teen Talk Workshop
- Well Mommy Well Baby Program
- Worksite Wellness

For more information or to register for our health education classes, please contact our TakeCare Wellness Team at 300-7161 or 300-7224, Monday through Friday from 8am-5pm or email wellness@takecareasia.com.

* All health education classes are FREE to TakeCare members unless otherwise specified. Referral is required from your primary care physician. Please fax referral to (671) 647-3541 or email to wellness@takecareasia.com.
**Wellness, Disease Management, and Preventive Incentive Program**

**CRITERIA/REQUIREMENT - MEMBER INCENTIVE**

<table>
<thead>
<tr>
<th>Wellness and Preventive Incentives</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of TakeCare’s Online Health Risk Assessment by eligible members 18 years and older once per benefit year.</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>Completion of a Biometric Screening through a TakeCare participating primary care provider, TakeCare’s Wellness Team or member’s chosen fitness partner once per benefit year.</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>Completion of an Annual Physical Exam through a TakeCare participating primary care provider once per benefit year.</td>
<td>$50 or $75</td>
<td></td>
</tr>
<tr>
<td>Completion of an Annual Physical Exam and Colorectal/Cancer Screening for eligible members ages 50 and older with any of the following services: colonoscopy, sigmoidoscopy and fecal occult blood test once per benefit year as part of the annual physical exam through TakeCare’s participating primary care provider.</td>
<td>$25 or $10</td>
<td></td>
</tr>
<tr>
<td>Completion of an Annual Physical Exam, Breast Cancer Screening and Screening Mammograms for eligible female members between 40 to 69 years of age as part of the annual physical exam through TakeCare’s participating primary care provider.</td>
<td>$25 or $10</td>
<td></td>
</tr>
<tr>
<td>Completion of an Annual Physical Exam, Cervical Cancer Screen and Pap Smear for eligible female members between 21 to 64 years of age as part of the annual physical exam through TakeCare’s participating primary care provider.</td>
<td>$25 or $10</td>
<td></td>
</tr>
<tr>
<td>Administration of flu vaccines for eligible members between 18 to 64 years old once per benefit year.</td>
<td>$10 or $15</td>
<td></td>
</tr>
<tr>
<td>Completion of an Annual Dental Exam through a TakeCare participating dentist.</td>
<td>$10 or $15</td>
<td></td>
</tr>
<tr>
<td>Completion of an Annual Vision Exam through a TakeCare participating primary care provider.</td>
<td>$10 or $15</td>
<td></td>
</tr>
<tr>
<td>Completion of a Pre-natal Visit with a TakeCare participating Obstetrician Gynecologist within the first trimester and member needs to provide documentation and proof of pre-natal visit and pregnancy test to TakeCare.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achieving a 75% medication adherence to asthmatic medication in a benefit year for eligible patients/members diagnosed with diabetes as prescribed by a TakeCare participating primary care provider.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achieving a 75% medication adherence to asthmatic medication in a benefit year for eligible patients/members diagnosed with asthma as prescribed by a TakeCare participating primary care provider.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Based Incentive Program</th>
<th>CRITERIA/REQUIREMENT</th>
<th>MEMBER INCENTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% improvement or sustained blood pressure reading of lower than 140 over 90 among eligible members that completed a TakeCare Disease Management program, was part of TakeCare’s Wellness team identified Hypertensive managed group and was diagnosed with hypertension at the beginning of the program.</td>
<td>50% per quarter</td>
<td></td>
</tr>
<tr>
<td>10% improvement or sustained cholesterol screening results for LDL-C less than 100 or Triglycerides less than 150 if eligible member completed a TakeCare Disease Management program, was part of TakeCare’s Wellness team identified High cholesterol managed group diagnosed, and was diagnosed with hyperlipidemia at the beginning of the program.</td>
<td>50% per quarter</td>
<td></td>
</tr>
<tr>
<td>10% improvement or sustained HbA1c result of 7% or below if eligible member completed a TakeCare Disease Management program, was part of TakeCare’s Wellness team identified diabetic managed group diagnosed, and was diagnosed with diabetes at the beginning of the program.</td>
<td>50% per quarter</td>
<td></td>
</tr>
</tbody>
</table>

**Wellness Incentives**

**CRITERIA/REQUIREMENT**

- Completion of TakeCare’s Online Health Risk Assessment by eligible members 18 years and older once per benefit year.
- Completion of a Biometric Screening through a TakeCare participating primary care provider, TakeCare’s Wellness Team or member’s chosen fitness partner once per benefit year.
- Completion of an Annual Physical Exam through a TakeCare participating primary care provider once per benefit year.
- Completion of an Annual Physical Exam and Colorectal/Cancer Screening for eligible members ages 50 and older with any of the following services: colonoscopy, sigmoidoscopy and fecal occult blood test once per benefit year as part of the annual physical exam through TakeCare's participating primary care provider.
- Completion of an Annual Physical Exam, Breast Cancer Screening and Screening Mammograms for eligible female members between 40 to 69 years of age as part of the annual physical exam through TakeCare’s participating primary care provider.
- Completion of an Annual Physical Exam, Cervical Cancer Screen and Pap Smear for eligible female members between 21 to 64 years of age as part of the annual physical exam through TakeCare’s participating primary care provider.
- Administration of flu vaccines for eligible members between 18 to 64 years old once per benefit year.
- Completion of an Annual Dental Exam through a TakeCare participating dentist.
- Completion of an Annual Vision Exam through a TakeCare participating primary care provider.
- Completion of a Pre-natal Visit with a TakeCare participating Obstetrician Gynecologist within the first trimester and member needs to provide documentation and proof of pre-natal visit and pregnancy test to TakeCare.
- Achieving a 75% medication adherence to asthmatic medication in a benefit year for eligible patients/members diagnosed with diabetes as prescribed by a TakeCare participating primary care provider.
- Achieving a 75% medication adherence to asthmatic medication in a benefit year for eligible patients/members diagnosed with asthma as prescribed by a TakeCare participating primary care provider.
- Completion of any TakeCare Disease Management Program or Wellness Workshop once per benefit year.
- Please refer to TakeCare’s related policy and procedures on incentives.

**Health and Outcome Based Incentives**

- The member is responsible to submit a valid proof and documentation for incentives related to any reportable criteria and payments for these incentives are subject to the review and approval of TakeCare.
- Incentives are covered under the member’s primary plan for members enrolled under multiple TakeCare plans.
- Members need to be enrolled under the plan for three (3) continuous months within the benefit period and is an active member at the end of the benefit period to be eligible.
- Health Risk Assessment (HRA) must be completed within the same benefit period of the fitness incentive payment.
- Incentives are covered under the member’s primary plan for members enrolled under multiple TakeCare plans.
- All outcome based incentives are processed for payment within thirty (30) days from the end of each quarter.
- All initial/baseline and improvement outcome measurement for the outcome based incentives are evaluated and calculated every three (3) months within the member’s current benefit year. These measurements may be completed by the member’s primary care provider, TakeCare’s Wellness Team or TakeCare’s fitness partner and will need to be submitted by the member to TakeCare.
- $5 per program to a maximum of $50 per member per benefit year.
- The member is responsible to submit a valid proof and documentation for incentives related to any reportable criteria and payments for these incentives are subject to the review and approval of TakeCare.

**Eye**

- Members enrolled under multiple TakeCare plans will be eligible for eye membership benefit under the primary TakeCare plan.
- Members need to select their eye choice during open enrollment regardless whether they are an existing or new TakeCare eligible member.
- $115 for every 10 extra frames to TakeCare’s Wellness Center or member’s fitness partner of choice.
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**FITNESS/GYM INCENTIVE PROGRAM**

<table>
<thead>
<tr>
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<th>MEMBER INCENTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% improvement or sustained normal or ideal body fat range, or 1-2 inch waist circumference improvement or sustained ideal range for waist circumference depending on the member's age and gender, or two (2) point improvement on eligible member's body mass index (&quot;BMI&quot;) score or a sustained BMI score between 18.5 to less than 25 if eligible member is part of TakeCare’s Wellness or Fitness partner identified weight or physical activity managed group and eligible member has chosen and enrolled under a TakeCare participating gym/fitness partner.</td>
<td>$50 per quarter</td>
</tr>
<tr>
<td>Completion of ten (10) visits every month by eligible member to any TakeCare’s participating gym/fitness partner.</td>
<td>$10 per month for every month that member had ten (10) visits or more</td>
</tr>
</tbody>
</table>
| • Fitness and Outcome Based Incentives  
  - Full access to fitness classes  
  - Members need to select their gym choice during open enrollment regardless whether they are an existing or new TakeCare eligible member.  
  - Members enrolled under multiple TakeCare plans will only be eligible for gym membership benefit under the primary TakeCare plan.  
  - The member is responsible to submit a valid proof and documentation for incentives related to any reportable criteria and payments for these incentives are subject to the review and approval of TakeCare. |

**Health Risk Assessment (“HRA”)**

Health Risk Assessment (“HRA”) must be completed within the same benefit period of the fitness incentive payout. For eligible members 18 years old and older, Gyms may have age limitations.

**Additional fees may apply: enrollment, uniform, etc.,**

**Membership upgrade options available. Please contact facility for more information.**

**Important:** Please call TakeCare Customer Service at 647-3526 prior to accessing your gym enrollment. Gym hours may vary. Gym hours will be updated after the end of the benefit period. For members using the TakeCare mobile application (“mobile app”), incentives will be calculated every time three (3) virtual cards were completed through the TakeCare mobile app and paid every quarter.

**TakeCare Wellness Center**

Membership includes:

- Full access to fitness classes
- CrossFit HiTa Membership Includes:
  - Unlimited access
  - Contact Information: Tel: 999-2448
- CrossFit Latte Stone
  - One-time registration fee $10
  - Membership Includes:
    - 18 visits per month
  - Contact Information: Tel: 633-2397
- Hilton Wellness Center
  - Membership Includes:
    - Unlimited access to TakeCare classes
    - Contact Information: Tel: 637-7880

**Guam Muay Thai**

Membership Includes:

- Unlimited access
- Contact Information: Tel: 487-7718

**Guam Taekwondo Center**

- Membership Includes:
  - Unlimited access to TakeCare classes
  - Contact Information: Tel: 437-7800

**International Sports Center**

Membership Includes:

- Unlimited access
- Contact Information: Tel: 477-9945

**Mantrasana Fitness Studio**

- Membership Includes:
  - Unlimited access to Mantrasana and Jambu classes
  - Contact Information: Tel: 499-2399

**PFC Agana/Dededo**

- Membership Includes:
  - Unlimited access
  - Contact Information: Tel: 487-7718

**TakeCare Customer Service**

For more information, call TakeCare Customer Service at 671 647-3526.

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Register Today!

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

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

- Reprint your member card
- See your claims information
- Track your wellness goals
- Complete a health risk assessment questionnaire

Account creation instructions

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

Convenient Online Member Portal

Access to your personal medical and health plan information.

Complete an online HRA and earn $5!

A completed “Health Risk Assessment” questionnaire can only be submitted once per benefit year.

Completing your Online Health Risk Assessment:

Before beginning the questionnaire, please have your medical information at hand with approximate dates of most recent preventive services, health screenings, and measurements, including your height, weight, waist measurement, blood pressure, cholesterol, and glucose test results, if known. While none of this information is required, it will make your HRA profile more accurate and complete.

5 Easy Steps

Step 1: Log in to your “MyTakecare account.” If you do not have an account, you can create an account at my.takecareasia.com. Click the “I’m a member” link and follow the instructions. Note: You will need your TakeCare Member ID number which can be found on your TakeCare insurance card.

Step 2: Once you have successfully logged into your “MyTakecare account,” navigate down to “My Health Tools” located in the middle of the screen, then click on “Health Risk Assessment.”

Step 3: Click “Accept” then “Enter.” This will prompt you to start the Health Risk Assessment Questionnaire.

Step 4: Answer the questionnaire and don’t forget to click “Submit.”

Step 5: A Health Risk Assessment report will be generated. You can print a copy or revisit the site to obtain your results at any time.

Additional information:

- Health Risk Assessment Online Questionnaire
- Step 1: Log in to your “MyTakecare account.”
- Step 2: Once you have successfully logged into your “MyTakecare account,”
- Step 3: Click “Accept” then “Enter.”
- Step 4: Answer the questionnaire and don’t forget to click “Submit.”
- Step 5: A Health Risk Assessment report will be generated.

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DO YOU HAVE AN EMERGENCY?

If you or a family member become ill or injured and your condition does not pose an immediate, serious threat to your health or life or is not a bonafide emergency, then you may want to consider an Urgent Care Center.

URGENT CARE vs. EMERGENCY ROOM

<table>
<thead>
<tr>
<th>URGENT CARE</th>
<th>EMERGENCY ROOM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor injuries and illnesses</td>
<td>Severe injuries and illnesses</td>
</tr>
<tr>
<td>In general: If the illness is something you would normally see your family doctor for – but you cannot get an appointment right away or it is after hours, urgent care is the right choice. Bring your insurance card &amp; a photo ID.</td>
<td>In general: If the illness of injury seems more critical than something you would see your family doctor for or if you feel the emergency is life threatening, go to the nearest emergency room.</td>
</tr>
<tr>
<td>Sprains, strains, or possible broken bones</td>
<td>Complex fractures or bones protruding through the skin</td>
</tr>
<tr>
<td>Headache</td>
<td>Head injuries or a sudden, very severe headache or loss of vision could be the sign of a stroke</td>
</tr>
<tr>
<td>Sore throat, cough, ear infections, fever, flu symptoms</td>
<td>Chest pain or other heart attack symptoms – call 911</td>
</tr>
<tr>
<td>Minor burns, lacerations requiring a few stitches, animal bite</td>
<td>Serious lacerations, severe bleeding, poisoning</td>
</tr>
<tr>
<td>Worker’s compensation injuries</td>
<td>Intoxication, overdose or attempted suicide</td>
</tr>
</tbody>
</table>

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

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

(After an ER visit, TakeCare must be notified within 48 hours for benefits to apply.)

Experience the FHP Difference

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

We accept most insurances including NetCare, Aetna, Tricare, and self-pay patients are welcomed. Now accept new patients. Call for an appointment.

Medical Care
- Adult Medicine
- OB/GYN
- Occupational Health Services
- Laboratory
- Pediatrics
- Radiology
- Urgent Care

Dental Care
- Home Health/Hospice Care
- Pharmacy
- Specialty Care
- Vision Care

Primary Care
- Adult Medicine
- OB/GYN
- Pediatrics
- Business Hours: Mon–Fri 8am–5pm

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

Urgent Care
- Business Hours: Monday–Friday 8am–5pm
- Business Hours: USA 1st and 2nd Saturday of the month

*Medical Services
- Home Health
- Business Hours: Mon–Fri 8am–5pm
- Occupational Health Services
- Business Hours: Mon–Fri 7am–4pm
- Pharmacy
- Business Hours: Mon–Fri 8am–5pm
- Sat 8am–12pm, and Sundays and Holidays Closed
- Imaging Center
- Business Hours: Monday–Friday 8am–5pm
- CT Scan, Digital Mammogram, Ultrasound, Cardiodynamics, and BMI by appointment

Other Services
- Dental Center
- Vision Center
- Business Hours: Mon–Sat 8am–4pm

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Call the FHP Health Center at 664-5825 and Press 2 to schedule an appointment today.

Our Island, Your Clinic

TakeCare is designed to provide general information about the TakeCare plans offered to Government of Guam employees, retirees and survivors. In the event of a discrepancy between this booklet and the contract, the terms of the contract will prevail.
Andrew Graves, M.D.
Andrew Graves is an award-winning board certified diagnostic radiologist. Dr. Graves received his BS in Biology from Cal Poly Pomona University and his M.D. from Loma Linda University School of Medicine.

Comprehensive Diagnostic Medical Imaging

- MRI (3Tesla-Higher Resolution)
- CT Scan
- Digital Mammogram
- Full Digital X-Ray
- Ultrasound (with 4D Technology)
- Interventional exams such as ultrasound guided biopsy and aspirations
- Echocardiogram
- Bone Mineral Density/Dexa Scan

Accredited by the American College of Radiology.

Call the FHP Health Center at 646-5825 and Press 2 to schedule an appointment today.

Our Island, Your Clinic™

Customer-Focused Services

24/7 Customer Service

A live customer service representative is available to answer your calls 24 hours a day, 7 days a week.

Customer Service Department

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

Call Center
24 hours/7 days a week

P.O. Box 6578
Tamuning, Guam 96931

671.647.3526
877.484.2411 [Toll Free]
671.647.3542 [Fax]
customerservice@takecareasia.com
www.takecareasia.com
Simply present your TakeCare member ID card at any of our Affinity Partners to receive a special offer or discount.

Receive a stamp from our Affinity Partners for each visit. Submit 3 completed Affinity Rewards cards to TakeCare Customer Service to receive a prize. For TakeCare Customer Service office when you complete 1 digital Affinity Rewards Card to receive a prize. All submitted Affinity Rewards Card will be entered into a quarterly raffle drawing. Prizes can be redeemed from TakeCare Customer Service.

RESTAURANTS
- **Alien Ramen**
  - FREE soda with any entree purchase
- **Capricciosa**
  - 10% OFF on any purchase of $20 or more
- **Gambit (at Onward Hotel)**
  - Affinity members and up to 4 guests receive 10% off dinner
- **Dolce Frutta**
  - 10% off of coffee & & drinks
- **Frost Bite**
  - First small ice cream or small snow ice with any $10 purchase
- **Fitz & Co.**
  - Buy one sandwich and get one FREE
- **Gabriel’s Restaurant**
  - 15% off of the bill at Gabriel’s

ENTERTAINMENT
- **Adventures with Wookie**
  - 15% OFF the purchase of Adventures with Wookie “Unique Like Me!”
- **The Brad Nive**
  - 15% OFF the purchase of Singer Shoes & Footwear
- **Insomnia**
  - 15% off of any item in the mall

SERVICES
- **FHP Dental**
  - 15% of all new customers
  - 10% of all returns
  - 10% off of all future appointments

**RESTRICTIONS APPLY:**
- Cannot be combined with any other offers, promotions, or discounts.
- Valid on Guam.
- Cannot be used in conjunction with any other promotions or discounts.

**More Information:**
- For more information about the Affinity Rewards Program, please contact us at affinityrewards@takecareasia.com.
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**PARTICIPATING PROVIDERS**

The true measure of any health care organization is the quality of the care you receive. And at the heart of this is your relationship with your participating provider. Your participating provider is essential in providing your day to day health care needs as well as providing the avenue for health care alternatives such as specialty care. That’s why, at TakeCare, you have the freedom to make the most important health care decision of all — the choice of your participating provider.

This provider directory serves as a helpful tool to select a participating provider.

**HOW TO SELECT A PARTICIPATING PROVIDER**

Choose a Participating Provider (Medical Group or Individual Physician) from this directory. You and your enrolled dependents may choose a different Participating Provider. You may switch Participating Providers as often as needed by simply calling TakeCare Customer Service at (671) 647-3526 or toll free at 1-(877) 484-2411 and (680) 488-4715 in Palau. Your new selection will be effective immediately. Services received through providers not listed in this Provider Directory may be covered at a lesser coverage level. Please refer to your Schedule of Benefits for specific Out-of-Network Benefits.

**HELPFUL INFORMATION**

Who is a Participating Provider?

A Participating Provider is any individual practice association, individual physician, hospital or group of licensed providers who have entered into a written agreement with TakeCare to provide medical or dental services to you and your enrolled dependents.

What is a Primary Care Provider and a Specialty Care Provider and how many of each do you have in your network of providers?

A Primary Care Provider is responsible for providing or authorizing your medical care services. A Primary Care Provider may be physicians of Internal Medicine, Pediatrics, Family Practice or General Practice. A Specialty Care Provider is a duly licensed physician, osteopath, psychologist or other practitioner that your Primary Care Provider may refer you to. TakeCare has the largest on-island contracted provider network with over 100 Primary Care and Specialty Care Providers.

When am I able to access a Specialty Care Provider?

When you or your Primary Care Provider feel you need more specialized treatment, you may request a referral to seek a specialist for an office consultation. However, before any treatment begins, you may need to have prior authorization from TakeCare’s Medical Management Department. Once the request is reviewed and approved, treatment can commence.

**WHO TO CALL FOR HELP**

If you have any questions, please feel free to call the Take Care Customer Service Department, Monday-Friday, 8am-5pm in Guam (671) 647-3526 or 24/7, toll free 1-(877) 484-2411 or Palau (680) 488-4715.

**Medicare Healthcare Provider**

*List of Providers, in the TakeCare Network, accepting Medicare. A Medicare provider is a participating/contracted provider who accepts Medicare fee schedules as a basis of payment for their services. This provider only bills you for any deductible and copayment/coinsurance amounts under your Medicare coverage. TakeCare Network Providers, identified herein as Providers who accept Medicare, are subject to changes depending on whether the provider continues to accept Medicare covered members.

**Preferred Provider**

*In a participating or directly contracted provider that has entered into a written agreement with TakeCare to provide care or treatment at preferential or better rates compared to other contracted or participating providers and have demonstrated better outcomes based on standard set by the National Committee for Quality Assurance (“NCQA”). The participating providers who are listed herein are preferred providers who are subject to change. Please check with TakeCare to confirm the preferential status of contracted/participating providers.

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

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

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

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

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

*Non-compliance with required treatment guidelines as defined by TakeCare’s provider and Medical Management will result to non-eligibility under the travel benefit. TakeCare will cover one adult companion per patient, up to a maximum of two adult companions, for an approved travel benefit to accompany minors or disabled members. Approved companions are limited to legal parents or legal guardians. Other limitations may also apply.
GOVGUAM PPO 1500

SCHEDULE OF BENEFITS

Your Benefits: What TakeCare covers

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Per Individual Member (Class 1)</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
<tr>
<td>Deductible Per Family (Classes 2, 3, &amp; 4)</td>
<td>$3,000</td>
<td>$9,000</td>
</tr>
</tbody>
</table>

Coverage Maximums

<table>
<thead>
<tr>
<th>Maximum</th>
<th>Individual member maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage Maximum</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

Out of Pocket Maximum (Including accumulated deductible, copay, and coinsurance)

<table>
<thead>
<tr>
<th>Maximum</th>
<th>Unlimited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per individual member per policy year</td>
<td>$3,000</td>
</tr>
<tr>
<td>Per Family per policy year</td>
<td>$9,000</td>
</tr>
</tbody>
</table>

Any services in the Philippines, Hong Kong, Japan, Taiwan, and Foreign Participating Provider (Prior Authorization Required)

| Requires a referral from your doctor and approval in advance from TakeCare. |

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

<table>
<thead>
<tr>
<th>Preventive Services (Out Patient Only)</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Physical Exam</td>
<td>Plan Pays 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>- Members may choose to receive age appropriate annual physical in the Philippines with no dollar limit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Pumps</td>
<td>Plan Pays 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>- In accordance with Women's Preventive Health guidelines.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes preventive lab tests</td>
<td>Plan Pays 100%</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Immunizations/Vaccinations

| In accordance with the guidelines established by the Advisory Committee on Immunization Practices of the CDC. |
|------------------------------------------------|------------------------------------------------|
| Plan Pays 100%                                | Not Covered                     |

Pre-Natal Care including Routine Labs and First Ultrasound

| Plan Pays 100%                                | Not covered                    |

Well-Child Care

| Plan Pays 100%                                | Not covered                    |
| - Infant to four months old: 7 visits per plan year |
| - Early childhood (one to four years old): 7 visits per plan year |
| - Middle Childhood/Adolescence (five to seventeen years old): up to one visit per plan year |
| - In accordance with the Bright Futures/American Academy of Pediatrics recommendations for Preventive Pediatric Health Care. |

Well-Woman Care (In accordance with the guidelines supported by the Health Resource and Services Administration (HRSA))

| Plan Pays 100%                                | Not Covered                    |
| - Contraceptive including sterilization and tubal ligation if prescribed. |

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

<table>
<thead>
<tr>
<th>Annual Eye Exam (once per member per plan year)</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Pays 100%</td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>

Outpatient Physician Care & Services

<table>
<thead>
<tr>
<th>$5 Member Co-Payment at FP CHP, $10 Member Co-Payment at Preferred Provider, $20 Member Co-Payment at Non-Preferred Provider</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Pays 70% of Eligible Charges, Member pays 30%</td>
<td>After deductible is met</td>
<td></td>
</tr>
</tbody>
</table>

GOVGUAM PPO 1500

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

1. Specialist Care Visits
2. Volunteer Second Surgical Opinion
3. Home Health Care Visit
4. Hospice Care in Guam only, maximum 180 days at a maximum of $150 per day (Prior Authorization Required)
5. Routine and Preventive Laboratory
6. Specialty Laboratory
7. X-ray Services
8. Injection (Does not include those on the Specialty Drugs List and Orthopedic Prostheses)

Outpatient Mental Health Care

<table>
<thead>
<tr>
<th>Outpatient Mental Health Care</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Pays All Charges above $150 per benefit year</td>
<td>Plan Pays 70% of Eligible Charges, Member pays 30%</td>
<td></td>
</tr>
</tbody>
</table>

Outpatient Services Check-up Services are covered at Participating Providers in the Philippines up to the cost but not exceeding Php1,250 per member per plan year. Benefits is not applicable to cash if unused during a plan year and cannot be applied towards any other services.

<table>
<thead>
<tr>
<th>Urgent Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Visit the Service (Available at Participating Urgent Care Providers.)</td>
</tr>
<tr>
<td>2. Outside the Service Area</td>
</tr>
</tbody>
</table>

Prescription Drugs

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10 Member Co-Payment at FP CHP Pharmacy</td>
<td>After deductible is met</td>
<td></td>
</tr>
<tr>
<td>$15 Member Co-Payment outside FP Pharmacy (30 day supply)</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>$30 Member Co-Payment (30 day supply)</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>$50 Member Co-Payment</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>$100 Member Co-Payment (30 day supply)</td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture (limited to 30 visits per member per benefit year)</td>
<td>Paid 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>AIDS Treatment (Prior Authorization Required)</td>
<td>Plan Pays 80%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Allergy Benefit to Preferred Providers only</td>
<td>Paid 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Ambulatory Surgery/Center Care (Prior Authorization Required)</td>
<td>Paid 80%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Blood &amp; Blood Derivatives</td>
<td>Paid 80%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Breast Reconstructive Surgery (Prior Authorization Required)</td>
<td>Paid 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>Cardiac Surgery (Prior Authorization Required)</td>
<td>Paid 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>Cataract Surgery (Prior Authorization Required)</td>
<td>Plan Pays 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>Chemical Dependency</td>
<td>Paid 80%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Chemotherapy Benefit (Prior Authorization Required)</td>
<td>Paid 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>Chiropractic Care (limited to 30 visits per member per benefit year)</td>
<td>Paid 80%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Congestive Anomaly Disease Coverage (Prior Authorization Required)</td>
<td>Paid 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>Paid 80%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>Paid 80%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Emergency Care (For on and off island emergencies, Plan must be contacted and advised within 48 hours)</td>
<td>Paid 80%</td>
<td>Paid 80% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>End Stage Renal Disease / Hemodialysis (Prior Authorization Required)</td>
<td>Paid 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>Hearing Aids (For on and off island emergencies)</td>
<td>Paid 80%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Hospitalization &amp; Inpatient Benefits (Prior Authorization Required)</td>
<td>Paid 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>Inpatient (Prior Authorization Required)</td>
<td>Member Pays 20%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Infertility (Prior Authorization Required)</td>
<td>Paid 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>Inhalation Therapy</td>
<td>Paid 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>Paid 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>Paid 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>Occupational Therapy limited to 30 visits per member per benefit year</td>
<td>Paid 80%</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Additional Benefits: What TakeCare covers

#### Wellness & Fitness Benefit
1. Wellness Benefits at TakeCare Wellness Center
2. TakeCare at Wellness and Disease Management Programs and Incentives
3. Gym Benefit
   - For list of gym partners, please contact TakeCare’s Customer Service Department.

#### Participating Provider Benefits in the Philippines (Prior Authorization Required)
- Appropriate equipment and co-insurance are arranged for eligible services covered in-patient and out-patient services after meeting the deductible
- Not Covered

#### Deductible must be met for the following services

<table>
<thead>
<tr>
<th>Service</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organ Transplant - coverage based on Medicare including but not limited to the following organs. Includes coverage for donor expenses.</td>
<td>Plan Pays 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>1. Heart</td>
<td>Plan Pays 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>2. Lung</td>
<td>Plan Pays 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>3. Liver</td>
<td>Plan Pays 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>4. Kidney</td>
<td>Plan Pays 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>5. Pancreas</td>
<td>Plan Pays 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>6. Intestinal</td>
<td>Plan Pays 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>7. Bone Marrow</td>
<td>Plan Pays 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>8. Cornea</td>
<td>Plan Pays 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Plan Pays 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>Robotic Surgery/Robotic Suite (Prior Authorization Required)</td>
<td>Plan Pays 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Maximum 60 days per member per plan year (Prior Authorization Required)</td>
<td>Paid 80% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>Visional Procedures (Prior Authorization Required)</td>
<td>Plan Pays 80%</td>
<td>Paid 70% of Eligible Charges, Member Pays 30%</td>
</tr>
<tr>
<td>Lasik an Eye Procedure (Outpatient Only)</td>
<td>Paid 80%</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

#### Deductible must be met after the deductible is met

<table>
<thead>
<tr>
<th>Service</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOVGUAM PPO 1500</td>
<td>Paid 100%</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

This booklet is designed to provide general information about the TakeCare PPO offered to Government of Guam employees, retirees and survivors. It is the intent of the insurer to provide the most current information possible. It is to be used as a guide only. The terms of the contract will prevail.
<table>
<thead>
<tr>
<th>Your Benefits</th>
<th>What TakeCare covers</th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Per Individual Member (Class 1)</td>
<td>$2,000</td>
<td>$4,000</td>
<td></td>
</tr>
<tr>
<td>Deductible Per Family (Class 2, 3 &amp; 4)</td>
<td>$4,000</td>
<td>$12,000</td>
<td></td>
</tr>
<tr>
<td><strong>Coverage Maximums</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual member annual maximum</td>
<td>Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out of Pocket Maximums (including accumulated deductible, copayment, and coinsurance)</td>
<td>$4,000</td>
<td>No Maximum</td>
<td></td>
</tr>
<tr>
<td>Per Individual member per policy year</td>
<td>$12,000</td>
<td>No Maximum</td>
<td></td>
</tr>
<tr>
<td>Per Family per policy year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any Services in the Philippines, Hawaii &amp; the U.S. Mainland, Japan, Taiwan and Foreign Participating Providers (Prior Authorization Required)</td>
<td>Requires a referral from your Doctor and approval in advance from TakeCare</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**Preventive Services (Out Patient Only)**
- In accordance with the guidelines established by the U.S. Preventive Services Task Force (USPSTF) Grades A and B recommendations.
  - Annual Physical Exam
    - Members may choose to receive age appropriate annual physical in the Philippines with no dollar cap.
    - Breast Pumps (in accordance with Women’s Preventive Health guidelines)
    - Includes preventative lab tests
- Immunizations/Vaccinations
  - In accordance with the guidelines established by the Advisory Committee on Immunization Practices of the CDC

**Pre-Natal Care**
- Including Routine Labs and First Ultrasound
  - Plan Pays 100% | Not covered |

**Well-Child Care**
- Infant (newborn to nine months) up to 7 visits per plan year
- Early childhood (one to four years) up to 7 visits per plan year
- Middle Childhood/Adolescence (five to seventeen years) up to one visit per plan year
- In accordance with the Bright Futures/American Academy of Pediatrics recommendations for Preventive Pediatric Health Care
  - Plan Pays 100% | Not covered |

**Well-Woman Care**
- In accordance with the guidelines supported by the Health Resources and Service Administration (HRSA)
  - Contraception including sterilization and Tubal Ligation if prescribed.
  - Plan Pays 100% | Not covered |

<table>
<thead>
<tr>
<th>Deductible must be met for the following services</th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Laboratory</td>
<td>Plan pays 100%</td>
<td>Plan pays 50% of Eligible Charges, Member pays 50%</td>
</tr>
<tr>
<td>Specialty Laboratory</td>
<td>$20 Member Co-Payment</td>
<td>Plan pays 50% of Eligible Charges, Member pays 50%</td>
</tr>
</tbody>
</table>

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

**Preventive Services (Out Patient Only)**
- In accordance with the guidelines established by the U.S. Preventive Services Task Force (USPSTF) Grades A and B recommendations.
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    - Breast Pumps (in accordance with Women’s Preventive Health guidelines)
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- Immunizations/Vaccinations
  - In accordance with the guidelines established by the Advisory Committee on Immunization Practices of the CDC

**Pre-Natal Care**
- Including Routine Labs and First Ultrasound
  - Plan Pays 100% | Not covered |

**Well-Child Care**
- Infant (newborn to nine months) up to 7 visits per plan year
- Early childhood (one to four years) up to 7 visits per plan year
- Middle Childhood/Adolescence (five to seventeen years) up to one visit per plan year
- In accordance with the Bright Futures/American Academy of Pediatrics recommendations for Preventive Pediatric Health Care
  - Plan Pays 100% | Not covered |

**Well-Woman Care**
- In accordance with the guidelines supported by the Health Resources and Service Administration (HRSA)
  - Contraception including sterilization and Tubal Ligation if prescribed.
  - Plan Pays 100% | Not covered |

**Deductible must be met for the following services**

**Outpatient Laboratory**
- Plan pays 100% | Plan pays 50% of Eligible Charges, Member pays 50% |
- Specialty Laboratory | $20 Member Co-Payment | Plan pays 50% of Eligible Charges, Member pays 50% |
### Deductible must be met for the following services

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>After deductible is met</td>
<td>After deductible is met</td>
<td></td>
</tr>
</tbody>
</table>

#### Hospitalization & Inpatient Benefits (Prior Authorization Required)
- Room & Board for a semi-private room, intensive care, coronary care and surgery
- All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia and medication
- Physician’s hospital services
- Mental Health Care services

#### Implants (Prior Authorization Required)
- Limited to cardiac pacemakers, heart valves, stents, intracranial lenses, orthopedic internal prosthetic devices; please refer to contract and certificate of insurance.

#### Inhalation Therapy

#### Maternity Care
- Labor and Delivery

#### Outpatient Executive Check-up
- Services are covered at Participating Providers in the Philippines up to the cost but not exceeding Php13,250 per member per plan year.
- Benefit is not convertible to cash if unused during a plan year and cannot be applied to any other services.

#### Outpatient Mental Health Care

#### Nuclear Medicine (Prior Authorization Required)

#### Occupational Therapy (Limited to 20 visits per member per benefit year)

#### Organ Transplant - coverage based on Medicare including but not limited to the following organs. Includes coverage for donor expenses.
- Heart
- Lung
- Liver
- Kidney
- Pancreas
- Intestine
- Bone Marrow
- Bone

#### Orthopedic Conditions (Prior Authorization Required)
- Internal and External Prostheses such as but not limited to artificial joints, limbs and spinal segments.

#### Outpatient Physician Care & Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>After deductible is met</td>
<td>After deductible is met</td>
<td></td>
</tr>
</tbody>
</table>

| 1. Primary Care Visits | $5 Member Co-Payment at PHP Clinic, $10 Member Co-Payment at Preferred Provider, $20 Member Co-Payment at Non-Preferred Provider |
| 2. Specialized Care Visits | $40 Member Co-Payment |
| 3. Voluntary Second Surgical Opinion | $40 Member Co-Payment |

### Deductible must be met for the following services

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>After deductible is met</td>
<td>After deductible is met</td>
<td></td>
</tr>
</tbody>
</table>

#### 4. Home Health Care Visit

#### 5. Hospice Care in Guam only, maximum 180 days at a maximum of $150 per day (Prior Authorization Required)
- $40 Member Co-Payment
- $10 Member Co-payment at PHP Clinic, $20 Member Co-payment outside PHP

#### 6. X-ray Services

#### 7. Injections (Does not include those on the Specialty Drugs List and Orthopedic injectables)

#### Optical Benefit
- Coverage for pair of contact lenses or eyeglasses ($50 deductibles / maximum of $150 per member per benefit year).

#### Physical Therapy (Prior Authorization Required)

#### Prescription Drugs

<table>
<thead>
<tr>
<th>Formulary</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formulary generic drugs per prescription unit</td>
<td>$10 Member Co-Payment at PHP Pharmacy, $15 Member Co-Payment outside PHP Pharmacy (30 day supply)</td>
</tr>
</tbody>
</table>

### Additional Benefits: What TakeCare Covers

#### Wellness & Fitness Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Covered By TakeCare Wellness Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Wellness benefit at TakeCare Wellness Center</td>
<td>Plan Pays 100%</td>
</tr>
<tr>
<td>2. TakeCare’s Wellness and Disease Management Programs and Initiatives</td>
<td>Plan Pays 100%</td>
</tr>
<tr>
<td>3. Gym benefit</td>
<td>Plan Pays 100% for gym access per member per plan year</td>
</tr>
</tbody>
</table>
MEDICAL EXCLUSIONS

The following services are not covered by TakeCare:

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

2. No benefits will be paid if any material statement made in an application for coverage, enrollment of any Dependent or in any claim for benefits is false. Upon identifying any such false statement, Company shall give the Covered Person at least 30 days notice that his or her benefits have been suspended and that his or her coverage is to be terminated. If the false statement is fraudulent or is an intentional misrepresentation of a material fact, such termination shall be retroactive to the date coverage was provided or continued based on such fraudulent statement or intentional misrepresentation of material fact. If the false statement was not a fraudulent statement or intentional misrepresentation of material fact, termination of coverage shall be effective no earlier than the date of the suspension. The Covered Person may dispute any termination of coverage under the provisions of Section 2711 of the PHSA, as added by PPACA. Retroactive terminations of coverage shall not be effective prior to the date specified in the provisions on rescission of Section 2711 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 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 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. (Custodial or domiciliary care includes 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.)

4. No benefits will be paid for nursing and home 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 including 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 condition or from domestic violence.

10. No benefits will be paid for Services and supplies provided in connection with intentionally self-inflicted injuries or illnesses unless resulting from a medical condition including physical or mental condition 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 taxis, hotel rooms, etc. In no event will the Company pay for an 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 enrolment.

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, siblings, spouse, or children of the insured member.

17. No benefits will be paid for treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. If a Member is covered under a Workers’ Compensation Law or similar law, and submits proof that the Member is not covered for a particular disease or injury under such law, that disease or injury will be considered “non-occupational” regardless of cause. The Covered Benefits under the Group Health Insurance Certificate for Members eligible for Workers’ Compensation are not designed to duplicate any benefits to which they are entitled under Workers’ Compensation Law. All sums payable for Workers’ Compensation services provided under the Group Health Insurance Certificate shall be payable to, and retained by Company. Each Member shall, and 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.
   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 clinical treatment or procedures, research studies, or other experimental or investigational health care procedures or pharmaceutical regimes, unless deemed medically necessary by the patient’s physician and preauthorized by the Company.

   Experimental and investigational treatments and procedures are those medical treatments and procedures that have not successfully completed a Phase III trial, have not been approved by the FDA and are generally recognized as the accepted standard therapy for the disease or condition for which they are being administered.

   Experimental and investigational treatments includes off label therapies. Off-label therapies are those medical therapies that use an FDA approved drug or procedure for a non-indicated use. Also, these experimental or investigational medical and surgical procedures, equipment, items, and medications, are otherwise not covered by Medicare or covered under qualifying clinical trials.

20. No benefits will be paid for services or supplies related to Genetic Testing.

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.
MEDICAL EXCLUSIONS cont.

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

23. No benefits will be paid for injuries incurred by the operator of a motorized vehicle while such operator is under the influence of intoxicating alcoholic beverage, controlled drugs, or substances. If a blood alcohol level or the DRAGER 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. 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 for dental services including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, dental splint and other dental appliances, root canal treatment, soft tissue impactions, alveectomy, augmentation, and vestibuloplasty, treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, maxillary and mandible implants (Osseo integration) and all related services, removal of impacted teeth, bite plates, orthognathic surgery to correct a bit defect. This exclusion does not apply to:
   a. Emergency Services to stabilize an acute injury to sound natural teeth, the jawbone or surrounding structures, if provided within 48 hours of the injury or as required by PPACA to stabilize and treat a PPACA Emergency.
   b. Surgical treatment of TMJ as described in the Covered Benefits Section “Temporomandibular Joint Syndrome [TMJ] Services”.
   c. Dental anesthesia when provided according to the conditions described in the Covered Benefits Section, “Limited General Anesthesia for Dental Procedures”.
   d. Procedures deemed medically necessary by patient’s physician and pre-authorized by Company.

26. No benefits will be paid in connection with elective surgery unless Medically Necessary.

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

28. No benefits will be paid for Services in connection with surgery for the purpose of diagnosing or correcting errors in refraction.

29. 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.

30. 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.

31. No benefits will be paid for hypnotherapy.

32. 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.

33. 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.

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

35. 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 stimulation (wrinkle method), cytotoxicity testing (Bryan’s Test), treatment of non-specific candida sensitivity, and urine autotjesions.

36. 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.

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

38. 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.

39. No benefits will be paid for any drug, food substitute or supplement or any other product, which is primarily for weight reduction unless medically necessary.

40. 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.

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

42. 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, ultrasonoids, laboratory tests, etc.)
   d. Home ovulation prediction kits
   e. Injectable infertility medications, including but not limited to, metopron, hCG, GnRH agonists, MIG.
   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, ultrasonoids, laboratory tests, etc.)
This booklet is designed to provide general information about the benefits offered to Government of Guam employees, retirees and survivors. In the event of a discrepancy between this booklet and the contract, the terms of the contract will prevail.

43. 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.

44. 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.

45. 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.

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

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

48. 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.

49. 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.

50. 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

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

52. No benefits will be paid for Services for which the Covered Person or Subscriber is not legally obligated to pay.
### GOVGUAM Dental $1,000

#### SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>Diagnostic &amp; Preventive Care</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Caries Susceptibility Test</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
<tr>
<td>2. Exams (Once every 6 months)</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
<tr>
<td>3. Fluoride Treatment (Annually for children age 19 &amp; under)</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
<tr>
<td>4. Prophylaxis (Cleaning of teeth once every 4 months)</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
<tr>
<td>5. Sealants (For permanent molars and children age 15 &amp; under)</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
<tr>
<td>6. Space maintainers (For children age 15 &amp; under) includes adjustments within 6 months of installation</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
<tr>
<td>7. Study Models</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
<tr>
<td>8. Treatment Plan</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
<tr>
<td>9. X-rays (Bitewing Maximum of 4 per Plan Year)</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
<tr>
<td>10. X-rays (Full mouth, once every 3 years)</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
</tbody>
</table>

#### Basic & Restorative Care

<table>
<thead>
<tr>
<th>General Services</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Emergency Care (During office hours)</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
<tr>
<td>2. Pulses Treatment</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
<tr>
<td>3. Routine Fillings (Silver &amp; composite resin)</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Oral Surgery</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Simple Extractions</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
<tr>
<td>2. Complicated Extractions</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
<tr>
<td>3. Extraction of impacted teeth</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
</tbody>
</table>

#### Periodontal Care

<table>
<thead>
<tr>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Periodontal Prophylaxis (Cleaning once every 6 months)</td>
<td>100% of Eligible Expenses</td>
</tr>
<tr>
<td>2. Periodontal Treatment</td>
<td>100% of Eligible Expenses</td>
</tr>
<tr>
<td>Conscious Sedation and Nitrous Oxide for children under the age of 13.</td>
<td>100% of Eligible Expenses</td>
</tr>
</tbody>
</table>

#### Pulpotomy & Root Canal/Radicular Surgery Care

<table>
<thead>
<tr>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Crowns</td>
<td>100% of Eligible Expenses</td>
</tr>
<tr>
<td>2. Gold Inlays &amp; Onlays</td>
<td>100% of Eligible Expenses</td>
</tr>
<tr>
<td>3. Bridges (Fixed)</td>
<td>100% of Eligible Expenses</td>
</tr>
<tr>
<td>4. Replacement of Crown Restoration (Once every 5 years)</td>
<td>100% of Eligible Expenses</td>
</tr>
</tbody>
</table>

#### Major & Replacement Care

<table>
<thead>
<tr>
<th>Removable Prosthetics</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Full Dentures (Once every 5 years)</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
<tr>
<td>2. Partial Dentures (Once every 5 years)</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
<tr>
<td>3. Each anesthetics, but only if medically or dentally necessary</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
<tr>
<td>4. Relines</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
<tr>
<td>5. Denture Repair</td>
<td>100% of Eligible Expenses</td>
<td>70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)</td>
</tr>
</tbody>
</table>

#### Prosthetics

<table>
<thead>
<tr>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Work in progress on the effective date of coverage. Work in progress is defined as:</td>
<td>None</td>
</tr>
<tr>
<td>a) A prosthetic or other appliance, or modification of one, where an impression was made before the patient was covered.</td>
<td>None</td>
</tr>
<tr>
<td>b) A crown, bridge, or cast restoration for which the tooth was prepared before the patient was covered.</td>
<td>None</td>
</tr>
<tr>
<td>c) Root canal therapy, if the pulp chamber was opened before the patient was covered.</td>
<td>None</td>
</tr>
<tr>
<td>2. Services not specifically listed in the Agreement, Services not prescribed, performed or supervised by a Dentist, Services which are not medically or dentally necessary or customarily performed, Services that are not indicated because they have a limited or poor prognosis, or Services for which there is a less expensive, professionally acceptable alternative.</td>
<td>None</td>
</tr>
<tr>
<td>3. Any Service unless required and rendered in accordance with accepted standards of dental practice.</td>
<td>None</td>
</tr>
<tr>
<td>4. A crown, cast restoration, denture or fixed bridge or addition of teeth to one, if work involves a replacement or modification of a crown, cast restoration, denture or bridge installed less than five years ago or one that replaces a tooth that was missing before the date of the Covered Person became eligible for Services under the plan (including previously extracted missing teeth).</td>
<td>None</td>
</tr>
<tr>
<td>5. Replacement of existing dentures, crowns or fixed bridgework if the existing dentures, crowns or fixed bridgework can be made serviceable.</td>
<td>None</td>
</tr>
<tr>
<td>6. Precision attachments, Interlocking device, one component of which is fixed to an abutment or abutments the other is integrated into a fixed or removable prosthesis in order to stabilize and/or retain it; or stress breakers, part of a tooth borne and/or tissue-borne prosthesis designed to relieve the abutment teeth and their supporting tissues from harmful stresses.</td>
<td>None</td>
</tr>
<tr>
<td>7. Replacement of any lost or stolen appliance, or replacement of any appliance damaged while not in the mouth.</td>
<td>None</td>
</tr>
<tr>
<td>8. Any Service for which the Covered Person received benefits under any other coverage offered by the Company.</td>
<td>None</td>
</tr>
<tr>
<td>9. Spare or duplicate prosthetic devices.</td>
<td>None</td>
</tr>
<tr>
<td>10. Services included, related to, or required for:</td>
<td>None</td>
</tr>
<tr>
<td>a) Implants;</td>
<td>None</td>
</tr>
<tr>
<td>b) Cosmetic purposes;</td>
<td>None</td>
</tr>
<tr>
<td>c) Services or appliances to change the vertical dimension or to restore or maintain the occlusion, including but not limited to, equilibration, full mouth rehabilitation and restoration for malalignment of teeth;</td>
<td>None</td>
</tr>
<tr>
<td>d) Temporomandibular joint (TMJ) or craniomandibular disorders, myofunctional therapy or the correction of harmful habits;</td>
<td>None</td>
</tr>
<tr>
<td>e) Experimental procedures; and</td>
<td>None</td>
</tr>
<tr>
<td>f) Intentionally self-inflicted injury unless resulting from a medical condition including physical or mental conditions; or from domestic violence.</td>
<td>None</td>
</tr>
</tbody>
</table>

#### Limits

1. Unused balances are not transferable to the following year.
2. Charges for Non-participating Providers are limited to the lesser actual charges of the Company’s determination of the usual, customary and reasonable charge in geographic location where the service was rendered, unless otherwise provided in the agreement.
3. The Covered member pays any excess above the Eligible Charges.

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**GOVGUAM Dental $1,000**

**SCHEDULE OF BENEFITS**

<table>
<thead>
<tr>
<th>Your Benefits: What TakeCare covers</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Pays</td>
<td>Plan Pays</td>
<td>Plan Pays</td>
</tr>
</tbody>
</table>

**DENTAL EXCLUSIONS**

No benefits will be paid for:

1. Work in progress on the effective date of coverage. Work in progress is defined as:
   a) A prosthetic or other appliance, or modification of one, where an impression was made before the patient was covered.
   b) A crown, bridge, or cast restoration for which the tooth was prepared before the patient was covered.
   c) Root canal therapy, if the pulp chamber was opened before the patient was covered.
2. Services not specifically listed in the Agreement, Services not prescribed, performed or supervised by a Dentist, Services which are not medically or dentally necessary or customarily performed, Services that are not indicated because they have a limited or poor prognosis, or Services for which there is a less expensive, professionally acceptable alternative.
3. Any Service unless required and rendered in accordance with accepted standards of dental practice.
4. A crown, cast restoration, denture or fixed bridge or addition of teeth to one, if work involves a replacement or modification of a crown, cast restoration, denture or bridge installed less than five years ago or one that replaces a tooth that was missing before the date of the Covered Person became eligible for Services under the plan (including previously extracted missing teeth).
5. Replacement of existing dentures, crowns or fixed bridgework if the existing dentures, crowns or fixed bridgework can be made serviceable.
6. Precision attachments, Interlocking device, one component of which is fixed to an abutment or abutments the other is integrated into a fixed or removable prosthesis in order to stabilize and/or retain it; or stress breakers, part of a tooth borne and/or tissue-borne prosthesis designed to relieve the abutment teeth and their supporting tissues from harmful stresses.
7. Replacement of any lost or stolen appliance, or replacement of any appliance damaged while not in the mouth.
8. Any Service for which the Covered Person received benefits under any other coverage offered by the Company.
9. Spare or duplicate prosthetic devices.
10. Services included, related to, or required for:
    a) Implants;
    b) Cosmetic purposes;
    c) Services or appliances to change the vertical dimension or to restore or maintain the occlusion, including but not limited to, equilibration, full mouth rehabilitation and restoration for malalignment of teeth;
    d) Temporomandibular joint (TMJ) or craniomandibular disorders, myofunctional therapy or the correction of harmful habits;
    e) Experimental procedures; and
    f) Intentionally self-inflicted injury unless resulting from a medical condition including physical or mental conditions; or from domestic violence.

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**100117-DGNPGGO**
11. Any over the counter drugs or medicine.

12. Fluoride varnish.

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

14. Charges in excess of the amount allowed by the Plan for a Covered Service.

15. Any treatment, material, or supplies which are for orthodontic treatment, including extractions for orthodontics.

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

17. All treatments not specifically stated as being covered.

18. Surgical grafting procedures.

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

20. Services paid for by Workers’ Compensation.

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

22. Treatment and/or removal of oral tumors.

23. All surgical procedures except for surgical extractions of teeth and periodontal surgeries performed by a Dentist. Surgical procedure is defined as the surgical and adjunctive treatment of diseases, injuries, and deformities of the oral and maxillofacial region.

24. Panoramic x-ray if provided less than three (3) years from the Covered Person’s last full mouth x-rays; and full mouth x-rays if provided less than three (3) years from the Covered Person’s last panoramic x-ray.
Eligibility. An individual is eligible for Enrollment and benefits only if he or she satisfies the definition of Covered Person and has not previously had coverage under the Plan which was terminated for cause.

- Dependent. A Dependent is either a:
  - Spouse. The Spouse of the Subscriber includes: (i) a lawful wedded spouse; or (ii) a divorced spouse where there is an order issued by a court having jurisdiction over the parties that the Subscriber continue to provide such spouse coverage under the Plan, provided that no Subscriber can enroll more than one (1) person as a spouse at a time unless one spouse is covered pursuant to a court order.
  - Domestic Partner. The Domestic Partner of the Subscriber shall be defined as a person who: (1) is 18 years of age or older; (2) is of the same or opposite sex as the Subscriber; (3) is in an exclusive mutually commuted relationship with the Subscriber and intends to remain the Subscriber’s sole domestic partner; (4) is not married to any other person; (5) is 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.
  - Children. The following are eligible for coverage as children under the Plan.
    - Subscriber’s biological or adopted children or children placed for adoption. Eligible children include the Subscriber’s biological or adopted children or children placed for adoption by the Subscriber and children under legal guardianship of the Subscriber, and children of the Subscriber’s lawfully married Spouse. The Plan may not deny enrollment of a child on the basis that the child is not a blood relative to the Subscriber or the Subscriber’s lawfully married Spouse as defined for purposes of benefit eligibility. The adult child up to age 26 as required by PPACA, a child having a relationship to the Subscriber or the Subscriber’s covered Dependent Children as provided in section 5.2.1 and 5.2.3.1 shall be eligible until the child’s 26th birthday, regardless of whether the child is married, dependent on the Subscriber, or a student. The spouse of a married adult child shall not be eligible and the child of an adult child shall not be eligible for coverage under this section 5.2.3.6. The adult child shall receive coverage on the same terms as other children except for any special rights designed for individuals below the age of 19 and any other differences permitted by HIPAA. For an adult child who was previously covered by the plan and excluded due to age, marital status, or cessation of dependency or student status, and any dependent children who were previously covered up to but not including their twenty-sixth (26th) birthday, provided proof of eligibility such as not limited to a legal birth certificate being submitted to the Company to show the Dependent Child’s relationship by blood to the Subscriber. Any individual who is18 and over and has not previously had coverage under the Plan which was terminated for cause. Application of material fact, the Domestic Partner shall be a covered Dependent Children residing outside the Service Area who intend to remain the Domestic Partner’s eligibility as a Domestic Partner. If the affidavit contains any material fact which later proves to be untrue as a result of fraud or intentional misrepresentation of material fact, the Domestic Partner shall be required to provide such evidence as to the qualification of the Domestic Partner’s eligibility as a Domestic Partner. If the affidavit contains any material fact which later proves to be untrue as a result of fraud or intentional misrepresentation of material fact, the Domestic Partner shall be required to provide such evidence as to the qualification of the Domestic Partner’s eligibility as a Domestic Partner. The Plan may not deny enrollment of a child on the basis that the child is not a blood relative to the Subscriber or the Subscriber’s lawfully married Spouse as defined for purposes of benefit eligibility. The adult child up to age 26 as required by PPACA, a child having a relationship to the Subscriber or the Subscriber’s covered Dependent Children as provided in section 5.2.1 and 5.2.3.1 shall be eligible until the child’s 26th birthday, regardless of whether the child is married, dependent on the Subscriber, or a student. The spouse of a married adult child shall not be eligible and the child of an adult child shall not be eligible for coverage under this section 5.2.3.6. The adult child shall receive coverage on the same terms as other children except for any special rights designed for individuals below the age of 19 and any other differences permitted by HIPAA. For an adult child who was previously covered by the plan and excluded due to age, marital status, or cessation of dependency or student status, and any dependent children who were previously covered up to but not including their twenty-sixth (26th) birthday, provided proof of eligibility such as not limited to a legal birth certificate being submitted to the Company to show the Dependent Child’s relationship by blood to the Subscriber. Any individual who is18 and over and has not previously had coverage under the Plan which was terminated for cause.
This booklet is designed to provide general information about the special enrollment rights under HIPAA or PPACA.

To enroll such Dependents hereunder until the first becoming eligible shall not be permitted of such Dependents within thirty (30) days after first becoming eligible, or to minimize disruption in the individual's medical care and to minimize cost to the Plan.

Enrollment.

- **Enrollment during an open Enrollment period.** An individual may become eligible in the Plan and may cause his or her Dependents to become Enrolled, during an open Enrollment period.

- **Enrollment after open Enrollment period.** Persons be enrolled for the following Plan Year unless

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

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

- **Not yet Enrolled.** As of the first day following the pay period in which the individual enters the status with GovGuam of leave without pay, reduction in hours, or for the balance of the Plan Year, except when terminating GovGuam sponsored training status and their eligible Dependents shall be eligible for coverage under the Plan.

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

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

Dental eligibility and term

- **Covered Persons may enroll in the Company's dental plan only if they are enrolled in the Company's medical plan.**

- **医疗 leave.** Coverage for such Subscriber shall continue for the shorter of eighteen (18) months or the duration of the Medical Leave up to a cumulative length of no longer than five (5) years unless otherwise agreed upon with Company, provided premiums are paid. Even if the Subscriber elects not to continue coverage for himself or herself or any Dependent during the Subscriber’s Military Service, the Subscriber and all Dependents shall be eligible for enrollment in the Plan and may elect to enroll in the Plan beginning the month following his or her separation of active employment by GovGuam, if the Subscriber’s status change from active to retired employee is pursuant to the Family and Medical Leave Act of 1993, Company shall fully cooperate in assisting GovGuam in complying with this Act.

- **Active employees required to live out of the Service Area** to their employment by GovGuam or GovGuam sponsored training status and their eligible Dependents shall be eligible for coverage under the Plan.

Military leave. Company shall be given prior written notice if a Subscriber shall take leave of absence (“Military Leave”). Coverage for such Subscriber shall continue for the shorter of eighteen (18) months or the duration of the Medical Leave up to a cumulative length of no longer than five (5) years unless otherwise agreed upon with Company, provided premiums are paid. If a Subscriber becomes eligible for coverage under the Plan prior to such Military Leave and no discharge from Military Service is less than fully honorable. Company shall not provide coverage for any injury or illness determined by the Subscribers entitled to care, if any, during his or her Military Service. The provisions of this paragraph are notwithstanding any other section of this Agreement.

Reduction in hours. If a Subscriber’s work hours are reduced below 30 per week due to a GovGuam cost-saving program, such Subscriber and his/her enrolled Dependents shall be eligible for coverage under the Plan and may elect to enroll in the Plan beginning the month following his or her separation of active employment by GovGuam, or is laid off due to a reduction in the workplace size of 20% or more. If a Subscriber is laid off due to a reduction in workplace size of 20% or more, the Subscribers shall have provided notice to Company of his/her intent to discontinue. Further, he/she shall not be eligible to reenroll until a future open Enrollment or until his/her work hours increase to at least 30 hours per week.

Procedure upon retirement. A newly retired Subscriber, and all of his/her enrolled Dependents, may remain in the Plan by paying the full amount of the Premium due to Company, in accordance with the time frames applicable to GovGuam, until such Subscriber’s status change from active to retired employee is pursuant to the Family and Medical Leave Act of 1993, Company shall fully cooperate in assisting GovGuam in complying with this Act. Further, he/she shall not be eligible to reenroll until a future open Enrollment or until his/her work hours increase to at least 30 hours per week.
another person or falsely representing the relation between himself or herself and another in order that the other person can obtain Services hereunder; or

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

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

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

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

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

o Domestic Partnership terminated. If the domestic partnership of a subscriber ceases to be a Domestic Partner as defined herein, coverage for such person under this Agreement shall terminate on the first (1st) day of the pay period following termination of eligibility.

o Children no longer eligible as Dependents. Coverage shall terminate and no longer be available for any child who attains age twenty-six (26), or who enters the Military Service, on the date of such occurrence. However, a Dependent child who has attained the limiting age (26), and who is incapable of self-sustaining employment by reason of developmental disability or physical handicap, and who is primarily dependent upon the Subscriber for support and maintenance, may continue to be covered under this Plan as an Enrolled Dependent during the continued disability or handicap provided of such incapacity is expected to continue for a period of one year or longer. However, a child who attains age twenty-six (26), or who enters the Military Service, on the date of such occurrence. However, a Dependent child who has attained the limiting age (26), and who is incapable of self-sustaining employment by reason of developmental disability or physical handicap, and who is primarily dependent upon the Subscriber for support and maintenance, may continue to be covered under this Plan as an Enrolled Dependent during the continued disability or handicap provided of such incapacity is expected to continue for a period of one year or longer.

DEDUCTIBLE, CO-Payment, Co-INSURANCE AND OUT OF POCKET MAXIMUM

Deductible: Shall be defined as the amount paid by a Covered Person or Family for Covered Services during a Plan Year before Covered Services shall be paid by the Company under this Agreement. No deductible shall apply to preventive services as defined by PPACA, annual examination, primary physician care, prescription drugs, routine lab, urgent care, out-patient executive check-up and routine x-ray under the PPO plan and preventive services as defined by PPACA, routine laboratory and out-patient executive check-up under the HSA plan.

Under this Plan, there is no Deductible for Dental Benefits as defined by this Agreement and Certificate and there is a Deductible when Participating Providers are utilized for PPACA Preventive Care Services, but there is a Deductible for other Medical Benefits (as defined in Article 2 of this Certificate). Payments by a Covered Person for Dental Benefits shall not be applied to the Deductible for Medical Benefits. Any costs paid towards the Deductible applicable to Participating Providers do not accumulate towards the Deductible applicable to Non-Participating Providers.

The Deductible shall be accumulated by each Covered Person during the Plan Year.

The Deductible for the PPO plan is $1,500 for Covered Services received through Participating Providers per Covered Person, with a Family maximum of $3,000 for Covered Services received through Participating Providers. There is a separate Deductible of $3,000 per Covered Person, with a Family maximum of $9,000 for Covered Services received through Non-Participating Providers. The Deductible for Class I is $1,500, and $3,000 for Class II through IV. If a Covered Person meets their $1,500 deductible, the Plan begins to pay for Covered Services.

The Deductible for the HSA plan is $2,000 for Covered Services received through Participating Providers, with a Family maximum of $4,000 for Covered Services received through Participating Providers. There is a separate Deductible of $4,000 per Covered Person, with a Family maximum of $12,000 for Covered Services received through Non-Participating Providers. The Deductible for Class I is $2,000, and $4,000 for Class II through IV. If an individual member enrolled in Classes II, III, or IV of a family plan meets $2,000 in covered expenses, the Plan begins to pay for covered expenses for that individual.

Co-Payment: Shall be defined as the predetermined (flat) dollar amount that a Covered Person must pay for certain Covered Services as stated in this Agreement and Certificate and after the Deductible, when applicable, has been met.

Co-Insurance: Shall be defined as the percentage of Eligible Charges that a Covered Person must pay for certain Covered Services as stated in this Agreement, and after the Deductible has been met and before the Out of Pocket Maximum has been met. A Covered Person can be responsible for Co-Payments and Co-Insurance for PPACA Preventive Care Services only.

Co-Insurance shall be in addition to the Deductible.

The Co-Insurance shall be paid by each Covered Person, if applicable, during each calendar year, according to the maximum amounts provided in the Plan as indicated in the charts in Exhibits A and B. No Co-Insurance shall be imposed when Participating Providers are utilized for preventive care as required by PPACA.

Exceptions to Out of Pocket Maximums. The following payments do not accumulate towards the Out of Pocket Maximums:

(a) payments for Services which are not covered; (b) payments for otherwise Covered Services that exceed the Plan’s maximums; (c) payments for Services of Non-Participating Providers; and (d) payments for Dental Benefits under the optional dental plan. All other out-of-pocket expenses for covered benefits shall count towards the deductible and out-of-pocket maximum.

Deductibles, Co-Payments and Co-Insurance for Participating and Non-Participating Provider Charges.

The Deductible, Co-Payments and Co-Insurance for Participating Providers shall be paid by the Company and the Subscriber, as applicable, to Non-Participating Providers. Subject to the terms of this Agreement, a Covered Person shall be required to pay, as Co-Insurance, the amounts shown on the Schedule of Benefits.

The Co-Insurance shall not apply to Non-Participating Providers. The Co-Insurance for Class I is $2,000 and $4,000 for Class II through IV.

The Co-Insurance shall not apply to the Co-Insurance for Covered Services received through Participating Providers. The Co-Insurance for Covered Services as stated in this Agreement and Certificate and after the Deductible, when applicable, has been met.

The Co-Insurance shall be paid by each Covered Person for certain Covered Services as stated in this Agreement and Certificate and after the Deductible has been met and before the Out of Pocket Maximum has been met. A Covered Person can be responsible for Co-Payments and Co-Insurance for PPACA Preventive Care Services only.

The Co-Insurance shall be paid by each Covered Person, if applicable, during each calendar year, according to the maximum amounts provided in the Plan as indicated in the charts in Exhibits A and B. No Co-Insurance shall be imposed when Participating Providers are utilized for preventive care as required by PPACA.

Exceptions to Out of Pocket Maximums. The following payments do not accumulate towards the Out of Pocket Maximums:

(a) payments for Services which are not covered; (b) payments for otherwise Covered Services that exceed the Plan’s maximums; (c) payments for Services of Non-Participating Providers; and (d) payments for Dental Benefits under the optional dental plan. All other out-of-pocket expenses for covered benefits shall count towards the deductible and out-of-pocket maximum.
Non-Spouse Dependent. Maternity benefits for a non-Spouse Dependent are covered. Except that Newborn care shall not be covered for a child born to a non-Spouse Dependent. A child born to a non-Spouse Dependent shall not be covered unless such child specifically meets the requirements for coverage as a Dependent of an employee (such as the employee becoming the guardian of such child).

Nuclear medicine. Coverage for nuclear medicine and all Covered Services related thereto shall be included.

Orthopedic conditions. Coverage for orthopedic conditions and related internal and external prosthetic devices, are included:
  - Except as specifically limited under this Agreement, Services, supplies and devices related to the treatment of chronic or acute orthopedic conditions are included. This includes, but is not limited to:
    - Prosthetic devices. Devices, including artificial joints, limbs and spinal segments
    - Orthotic devices. Orthotic devices, which are defined as apparatus or apparatus that support or align movable parts of the body, correct deformities or improve the functioning of movable parts of the body.

Radiation therapy. Coverage for radiation therapy and all Services related thereto shall be included.

Allergy testing. A maximum benefit of One Thousand Dollars ($1000) per Plan Year for charges for allergy testing that are not consistent with standard benefits under PPACA. Benefits for Allergy testing and treatment that constitute essential benefits under PPACA are subject only to the limitations set forth in §3.2.2. Prior Authorization will be handled in accordance to the Milliman Healthcare Guidelines.

Responsibility for Prior Authorization. The Participating Provider entering the hospitalization or Surgery for a Covered Person shall obtain Prior Authorization. The Covered Person shall not be responsible for obtaining Prior Authorization and shall not be liable for any penalty. The Non-Participating Provider or the Covered Person shall be responsible for obtaining Prior Authorization required by the Company prior to the hospitalization or Surgery. In the event a Covered Person is admitted to a Hospital for an Emergency, required authorization cannot be approved by Company within forty-eight (48) hours of the admission if it occurs on a day other than Saturday, Sunday or Holiday, or within twenty-four (24) hours if it occurs on a Saturday, Sunday or Holiday, and, in either case, receiving Company’s authorization for the admission. PPACA Emergency Services shall not constitute Prior Authorization and such services provided by Non-Participating Providers shall not require any notification or other administrative requirement other than what is required when heard by participating Providers.

Prior Authorization. Prior Authorization denials shall be handled pursuant to the PPACA Claims Procedure Requirements provided in §6.7, to the extent required by PPACA.

Reduced benefit without Prior Authorization. If a required Prior Authorization is not obtained in accordance with this §3.2.2, Company shall pay fifty percent (50%) of the Eligible Charges incurred in connection with the confinement or Surgery. If the Participating Provider is the person required to obtain the Prior Authorization, the reduced benefits will be charged to the Non-Participating Provider. No penalty for failure to obtain Prior Authorization shall be imposed for a PPACA Emergency, whether Participating or Non-Participating Providers are utilized.

List of outpatient and inpatient procedures requiring authorization (unless a PPACA Emergency). If the following procedures are not pre-certified by plan, payment may be denied.

  - AIDS treatment
  - All elective outpatient surgical procedures requiring use of surgical facilities
  - 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 procedure requiring implants
  - Any procedure requiring orthopedic devices and/or prosthetics
  - Any varicose veins surgery
  - Breast reconstruction surgery
  - Carpal Tunnel Release
  - Durable Medical Equipment: Standard hospital bed, wheelchairs, walkers, crutches, oxygen, suction machine, CPAP machine
  - EMG/NCT (upper extremities)
  - End Stage Renal Disease treatment / Hemodialysis
  - Gall Bladder Surgery
  - Heart By-Pass Surgery
  - Cardiac surgery
  - Chemotherapy
  - Heart catheterization
  - Hernia surgery
  - Hysterectomy
  - Mastectomy
  - MIBI Scan, Thallium Stress Test, Exercise Stress Test
  - MRI (All)
  - Non-Routine Endoscopies and Colonoscopies
  - Pain Management Studies
  - Physical Therapy requiring more than five (5) out-patient visits
  - Prostalectomy
  - Radiological and nuclear diagnostic procedures performed or ordered by the same provider on any one patient two or more time
  - Ultrasounds [All with the exception of the first OB ultrasound & first FNST]
  - Upper GI Endoscopy
  - Robotic Suite and Robotic Surgery
  - Clinical trials
  - Congenital treatment
  - Hyperbaric Oxygen treatment

Excess Non-Participating Provider charges. The Covered Person shall be responsible for charges by a Non-Participating Provider in excess of Eligible Charges, except [ ] Non-Participating Service Area emergency, or [ ] when the Non-Participating Provider is a

  - Safe Source Provider as defined in §7.9 of the Agreement. A Covered Person using a Non-Participating Provider for a PPACA Emergency shall not be liable for Co-Payments or Co-Insurance in excess of Co-Payments and Co-Insurance that would have been charged if Participating Providers had been used. The Company shall pay an amount for PPACA Emergency Services computed as provided in this Agreement.

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

Physical therapy. Charges for the first twenty (20) visits to a licensed physical therapist for physical therapy, including neuromuscular re-education. After twenty (20) visits in a Plan Year, Company shall pay fifty percent (50%) of Eligible Charges.

Pregnancy termination. Charges for the termination of Pregnancy is covered only when Medically Necessary.

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

Well Child Care. Well Child Care is covered only as set forth in §2.7 and as required by PPACA (as a PPACA Preventive Care Services or otherwise).

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

TakeCare Mobile App!

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GovGuam Open Enrollment

Fiscal Year 2018

PLAN RATES

ACTIVE EMPLOYEE SHARE (Bi-Weekly)

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RETIREE EMPLOYEE SHARE (Semi-Monthly)

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