Member Handbook

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Our Island, Your Health Plan™

TakeCare℠

takecareasia.com

Connect with us

Welcome to TakeCare's Health Plan

Hafa Adai and thank you for choosing a TakeCare Health Plan. We pledge to deliver quality and affordable health care by focusing on your needs and concerns.

We will work as a team with your primary care provider to ensure you receive the island's best health care.

Your Member Handbook

We encourage you to thoroughly read this member handbook to better understand your health plan. Please refer to your schedule of benefits for a summary listing of benefit coverage, copayments, co-insurance, deductible, exclusions and limitation specific to your health plan.

If you need some assistance, please contact our **Customer Service Department** at 1-877-484-2411 (toll free in the 50 states and territories), **Monday through Sunday, 24 hours a day** or by email at CustomerService@takecareasia.com.

NOTE: This member handbook constitutes only a summary of the TakeCare Health Plan. The TakeCare group policy (the "policy"), TakeCare's benefit policies, and schedule of benefits must also be consulted to determine the exact terms and conditions of coverage. A copy of the policy is available at your employer's personnel office. If there is a discrepancy between the member handbook and the schedule of benefits, the schedule of benefits shall control. No oral statement can modify or otherwise affect the benefits, limitations or exclusions stated in the TakeCare policy, the member handbook or the schedule of benefits.

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Getting Started

Joining

To join a TakeCare Health Plan, you will need to enroll during the annual open enrollment period designated by your employer. If you are a new employee, you may enroll within thirty-one (31) days of meeting your employer's waiting period.

Eligibility - Covering Your Family Members

Your enrolled spouse and eligible dependents receive the same coverage you do, provided they:

- meet your employer's eligibility requirements,
- reside within TakeCare's service area; and
- select a primary care physician located on the island of your residence.

Note: If you are absent from the service area for more than ninety (90) consecutive days within the benefit period, it is your responsibility to notify your employer and TakeCare. You will not be considered a resident of the service area and will be terminated from the plan, except in limited circumstances.

Eligible dependents include your spouse and children from birth up to but not including their twenty-sixth (26th) birthday.

Eligible dependents may include:

Children from birth up to but not including their twenty sixth (26th) birthday, who are your or your legally married spouse's natural, adopted or step children, children placed for adoption by an agency with you or your spouse, children under you or your legally married spouse's legal guardianship or custody by court order, or children for whom you or your legally married spouse are required to provide health coverage pursuant to a Qualified Medical Child Support Order. Children of common-law spouses or domestic partners are not eligible for coverage. The spouses and children of dependent Children are not eligible for coverage.

A **Common-law Spouse** may be eligible for coverage depending on your employer's group plan and subject to TakeCare underwriting guidelines. The subscriber and a common-law spouse shall be the same or opposite gender; eighteen (18) years of age or older; not related to each other by blood to a degree that would bar marriage; not legally married or the common-law spouse of any other person; and have cohabited for two (2) consecutive years immediately preceeding enrollment.

A common-law spouse becomes eligible for coverage only during the group's open enrollment period. A notarized affidavit in a form acceptable to TakeCare attesting to these facts must be submitted to TakeCare during the group's open enrollment period for each year that the common-law spouse is to be enrolled. The children of a common-law spouse are not eligible for coverage.

- A child through **legal guardianship** is eligible for coverage only during the group's open enrollment period.
- **Parents, other adult relatives, and unborn children** are not eligible for coverage.
- If there is a **divorce**, your spouse will become ineligible on the day in which your divorce is final unless your spouse qualifies for COBRA continuation coverage.

Note: You must report any changes affecting you or your dependent's eligibility within thirty-one (31) days of the eligibility period to TakeCare with the appropriate forms validated by your employer.

Enrollment

To join a TakeCare Health Plan, you will need to enroll during your employer's open enrollment period or other qualifying event. Qualifying events are defined as events when members who reside continuously in the service area first become eligible: (1) during open enrollment, or (2) when the employee becomes eligible for coverage, or (3) on their date of birth (for newborns), or (4) on the date of marriage (for legal spouse), or (5) on the date of placement for adoption or is ordered by a court, or (6) during any special enrollment period as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To add eligible dependents, a TakeCare Change Request Form (CRF) listing the names must be received by the TakeCare Membership Accounting Services (MAS) Department within thirty-one (31) days of the date they first become eligible or during open enrollment. After the thirty-one (31) day limit has passed, you will not be able to add these dependents until the next open enrollment.

Additions of a spouse or children may require additional official documentation for the purpose of verifying eligibility. These documents are as follows:

- **Newborn** - copy of an official birth certificate.

- **Natural children** - copy of an official birth certificate listing the subscriber as a parent.

- **Stepchildren** - copy of an official birth certificate and official marriage certificate listing the subscriber's legal spouse as a parent.

- **Other dependent children** - a copy of the court document signed by a judge ordering legal guardianship or legal adoption. In addition, a copy of the subscriber's current year's income tax filing under the laws of the applicable jurisdiction identifying the child(ren) as a dependent and a notarized TakeCare affidavit are required for children acquired through legal guardianship. A child through legal guardianship is eligible for coverage only during the employer group's open enrollment period.

- Spouse through **legal marriage** - copy of official marriage certificate.

- Spouse through **common-law** - notarized TakeCare affidavit and proof of common-law status.

Lock-in Provision

TakeCare's plans include a lock-in provision which means that once enrolled, a subscriber and eligible dependents must remain enrolled in the group medical and/or dental plan for the entire benefit period, and cannot voluntarily terminate enrollment until the group's next open enrollment period or upon termination of employment.

Updating your membership records

Your membership record contains information from your enrollment application including your address and the telephone number, as well as your specific health plan coverage and primary care physician you selected upon enrollment. These records are very important because they identify you as an eligible member and determine where you can receive services.

You are required to update any changes in name, address, contact number, or other health plan coverage information with the TakeCare Customer Service (CS) Department immediately.

When does coverage begin

Coverage for you and your eligible dependents is usually effective on the first of the month following receipt and approval of enrollment forms and all documentation required by the TakeCare Membership Accounting Services (MAS) Department.

Enrollment forms and supporting documents must be received by TakeCare on or before the 20th of the month to be effective the first of the following month.

You may be required to pay for services that are provided to your new dependent before a Change Request Form (CRF) is submitted to TakeCare. TakeCare will reimburse you for all covered and eligible services upon receipt and approval of your Change Request Form (CRF) and official supporting documents within the thirty-one (31) day eligibility period.

Off Island Dependent Children and Live and Work Member

Off island dependent child(ren) under their parent's insurance plan will be covered provided that they are a full time student with at least twelve (12) semester units or the equivalent as determined by TakeCare at an accredited grade school, high school or collegiate level or vocational institute of learning. The off island dependent child(ren) must be identified on TakeCare's enrollment form and documentations must be submitted to TakeCare to identify the subscriber as a parent whether the child(ren) has the same or different last name as the subscriber. Identification of member's primary care provider must be done within thirty (30) days from the member's effective date or open enrollment date. All eligible off island dependent child(ren) are required to complete and submit the Off Island Student Verification Form to TakeCare every school term along with a Certification of School Attendance. The Certification must be completed and signed by the appropriate school official after the enrollment/drop period and submitted to TakeCare within 30 days after the start of the term. Failure to provide this information within the 30-day deadline or non-attendance in the term will forfeit any out of service area benefits for the respective term.

Members covered under the live and work benefit needs to be identified prior to the group's effective date. Similarly, their primary care providers are required to be prior identified. If the member and primary care provider information are not prior identified, TakeCare will deny any off island coverage. All eligible members under live and work needs to complete and submit a Live and Work Enrollment form within thirty (30) days after Open Enrollment or qualifying events.

Accessing Care

HOW YOUR TAKECARE COVERAGE WORLS:

Your membership card

You will need to present your membership card to your health care provider to verify your coverage. Carry your membership card with you at all times. If you lose your membership card, please contact the TakeCare Customer Service Department. A fee will be charged for each replacement card.

The enrollment form will serve as a temporary member ID and proof of member's enrollment and eligibility until an official member ID card is issued by TakeCare.

Choosing your primary care physician

Generally, a primary care physician is a family practitioner, internist, pediatrician, or an obstetrician-gynecologist. A primary care physician may also be a medical group or clinic (such as the FHP clinic) providing medical care.

As a member of TakeCare, you and each family member must select a primary care physician for your medical needs. The primary care physician you select will provide and/or coordinate your healthcare needs.

Select your primary care physician by choosing from the TakeCare provider directory from within your service area.

When selecting your primary care physician, please keep in mind:

- **Each family member** may choose a different primary physician.
- **If you do not select** a primary care enrollment (by not listing one on your form), TakeCare may select a doctor for of your dependents.
- **You may change** your selected primary car by calling the TakeCare Customer Service Department.

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physician at enrollment
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e physician

TakeCare will not cover fees for copies and/or transfers of medical or dental records, including x-rays, films and slides.

Primary Care Services are limited to the member's service area.

Specialty Care

Your primary care physician in your service area may refer you to a specialist. You must return to your primary care physician in your service area after your consultation with the specialist. If your specialist recommends additional visits, tests, or services because of a chronic, complex, or serious medical condition, your primary care physician will use our criteria when creating your treatment plan and work with the TakeCare Medical Management Department for the appropriate authorizations and/or referrals. Please refer to your schedule of benefits for specific coverage levels for certain benefits.

If you are newly enrolled in our plan, you will need to see your primary care physician to obtain a new referral and receive authorization from the TakeCare Medical Management Department for continued specialty care.

Well-Woman Care

Well-Woman Care is included as part of the preventive health service benefit and is limited to the member's service area. This important preventive care benefit makes it easy for any woman to receive an annual gynecological exam by allowing direct access to an OB/GYN specialist, without a referral. The well-woman benefit provides a pelvic exam, clinical breast exam and other medically indicated services as recommended by the TakeCare Preventive Health Guidelines. Please refer to your schedule of benefits for specific coverage levels for certain benefits.

Maternity Care

Birthing centers and/or inpatient hospital benefits include normal delivery, delivery by cesarean section, any complications of pregnancy or childbirth and miscarriage are covered for the subscriber or dependent spouse. This benefit is limited to the member's service area. Please refer to your schedule of benefits for specific coverage levels for certain benefits.

Breast Reconstruction, following a Mastectomy

In the case of a subscriber or eligible dependent who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Please refer to your schedule of benefits for specific coverage levels for certain benefits.

Well Baby Care (from birth up to two (2) years old)

Well Baby Care is preventive health care services provided to a healthy newborn infant in the first two (2) years of life, including physical examinations developmental/behavioral assessment, screenings and age approriate immunizations, as determined to be medically necessary and recommended by the TakeCare Preventive Healthcare Guidelines, even though they are not provided as a result of illness, injury or congenital defect. Well Baby Care does not include complications of newborn or infancy care. Well Baby Care does not include care for congenital abnormalities. Complications of newborn or infancy care, as well as care for congenital abnormalities are subject to plan limitations. Services are limited to the member's service area. Please refer to your schedule of benefits for specific coverage levels for certain benefits.

Well Child Care (from two (2) up to eighteen (18) years old age)

Well Child Care is preventive health care services provided to a healthy child from two (2) years of age up to eighteen (18) years of age, including physical examinations, developmental/behavioral assessment, screenings and age appropriate immunizations, as determined to be medically necessary and recommended by the TakeCare Preventive Healthcare Guidelines, even though they are not provided as a result of illness, injury or congenital defect. Well Child Care does not include care for congenital abnormalities. Care for congenital abnormalities is subject to Plan Limitations. Services are limited to the member's service area. Please refer to your schedule of benefits for specific coverage levels for certain benefits.

Immunization

TakeCare guidelines on immunizations are based on Center for Desease Control and Prevention requirements. This ensures that you and/or your family receive the highest level for recommended immunizations against preventable diseases. Services are lmited to the member's service area. Please refer to the schedule of benefits for specific coverage levels for certain benefits.

Health Improvement Programs

Under TakeCare's Wellness and Disease management programs, members have access to a variety of fitness, educational, and health improvement classes. These programs are designed to help improve the health and the quality of life of TakeCare members through wellness promotion and disease prevention. Please refer to your schedule of benefits for specific coverage levels for certain benefits.

Wellness and Preventive Incentives

Eligible members 18 years old and older can earn up to $250 per individual or up to $500 per family per benefit year. Health Risk Assessments, Wellness Workshops must only be done through TakeCare to be eligible for these incentives. Members are also required to participate in the Plan for at least three (3) months of continuous coverage within the benefit period and are an active member by the end of the benefit period except for the fitness incentive. Wellness incentives are to be calculated six (6) months after the end of benefit period and payment will be made within thirty (30) business days. Incentives will only be paid under the member's primary insurance if the member is covered under multiple TakeCare plans.

All initial/baseline and improvement result measurements for outcome based incentives are evaluated and calculated every three (3) months wihtin the member's current benefit period. These measurements are done either through the member's primary care physician, TakeCare's Wellness team or Preferred Fitness partners and will be ubmitted to TakeCare by the member.

The member is responsible to submit valid proof and documentation for incentives related to any reportable criteria and payment for incentives is subject to TakeCare's review and approval.

If TakeCare is not the member's primary insurance, the member is required to submit proof or documentation of completion of any preventive or screening related services.

Please refer to TakeCare's related policy and procedures on incentives.

Fitness and Outcome Based Incentive Program

TakeCare provides outcome based incentives up to $300 per eligible individual per benefit period provided that the Health Risk ("HRA") and all Wellness Workshops and Disease Managemen Programs were done through TakeCare. Member's must also participate in the plan for at least three (3) months of continuous coverage within the benefit period and are an active member by the end of the benefit period. Health Risk Assessment (HRA) must be completed within the same benefit year of the incentive payout.

Under the outcome based inentive program, incentives are calculated six (6) months after the end of the benefit period and payment will be made within thirty (30) business days. This benefit is only extended to members with TakeCare as their primary insurance.

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

All initial/baseline and improvement result measurement for the outcome based incentives are evaluated and calculated every three (3) months within the member'scurrent benefit period. These measurements are done either through the member's primary care provider, TakeCare's Wellness team or TakeCare's fitness partners and will be submitted to TakeCare by the member.

All completed stamped cards must be submitted within thirty (30) days from the end of the member's benefit period, otherwise no further incentives will be paid out.

The member is responsible to submit valid proof and documentation for incentives and payments of incentives is subject to TakeCare's review and approval.

Members with multiple TakeCare coverage will only be allowed to enroll under a gym of their choice under their plan where TakeCare is the primary insurance.

For members with gym membership benefit under their plans who will not be able to complete ten (10) visits to TakeCare's gym partner of their choice for two (2) consecutive months, will have their gym benefit terminated.

Members with valid medical condition that are not able to meet the visit requirement may submit a medical note from a licensed participating provider to avoid termination of gym membership.

Home Health Care

Home Health Care services that are deemed medically necessary covered upon referral by a member's primary care. Wound care products, if medically necessary and ordered by your physician, are covered only when used as part of Home Health Care visit. Please refer to your schedule benefits for specific coverage levels for certain benefits.

Hospice Care

TakeCare has a end-of-life care program available at FHP Home Health.

Mail Order Pharmacy

TakeCare offers convenience of prescription drugs mail order. To learn more about mail order services, please contact Envision Pharmaceutical Services at 1-800-361-4542 or by email at customerservcie@envisionrx.com or talk to your pharmacist and/or primary care provider. Please refer to your schedule of benefits for specific levels for certain benefits.

Airfare Benefit to Off-Island Hospitals

TakeCare offers an airfare benefit through specific plans for hospital-to-hospital transfers from a service area hospital to an off-island hospital. TakeCare pay for the round-trip air transportation of a member who requires medical treatment at a facility. The following conditions and limitations apply to airfare benefit. Please refer to your schedule of benefits specific coverage levels for certain benefits.

All conditions must be met before you are eligible for benefit:

- Medical treatment you require is not available on-island.
  Member must have been enrolled in the plan for six (6) consecutive months prior to accessing this benefit.
  TakeCare must be the primary insurance carrier.

Limitation to airfare benefit:

- Choice of off-island hospital is the sole discretion of TakeCare.
- Airfare is for the patient only
- Aifare for the patient is in coach/economy class only.
- Airfare transfer is subject to airline seat availability. TakeCare will assist with airline reservations, but TakeCare makes no guarantee of availability.
- Air Transfer must be for hospital-to-hospital transfer only.
- Airfare benefit is only for transfers to Preferred Providers in the Philippines.

Authorization of health care services

TakeCare has processes in place to review requests by providers for authorization of health care services to members. A list of the health care services requiring prior authorization may be found at the end of this section. TakeCare may also use criteria or guidelines to determine whether to approve, modify, or deny, based on medical necessity and coverage, requests by providers of health services for members. The criteria used to modify or deny requested health care services may be provided free of charge to you the member, the providers, and the public upon request.

Decisions to deny or modify request for authorization of health care services, based on medical necessity, are made only licensed physicians or other appropriately licensed health care professionals.

TakeCare's Medical Management Department makes these decisions within the following timeframe:

- Pre-Service requests - decisions on requests for authorization of health care services will be made in a timely fashion within five (5) business days from TakeCare's receipt of the information reasonably necessary to make the decision.

- Urgent Care Service requests - decision on urgent care requests for authorization of health care services (where your condition poses an imminent, serious threat to your health) will be made in a timely fashion appropriate to the nature of your condition, within twenty-four (24) hours after TakeCare's receipt of the information reasonably necessary and requested by TakeCare to make the decision. Please note that prior authorization is not required for care that any prudent lay person would consider an emergency.

If the decision is not possible to be made within these timeframes, TakeCare will notify the provider making the request for service that a decision is not possible to be made within the required timeframe. The notification will specify what information is required to enable TakeCare to make a decision. Once the requested information is received, TakeCare will make a decision to approve, modify, or deny the request for authorization within the timeframe specified above.

Decision notifications are communicated to the provider making the request within twenty-four (24) hours from the decision either in writing, verbally or both. You are notified of decisions to modify or deny the requested health care services, in writing, within two (2) business days of the decision.

The written decision will include the specific reason or reasons for the decision, the clinical reason or reasons for modification or denials if the decision is based on medical necessity, and information on how to file an appeal of the decision with TakeCare. In addition, the internal criteria or benefit interpretation and/or administration policy, if any, relied upon in making the decision will be made available upon request (See Appeals and Grievance section of this handbook).

Prior Authorization - a formal process requiring provider to obtain approval with TakeCare's Medical Management department for the provision of covered services/procedures before they are done. Without such prior approval, the service, procedure, medication equipment is not covered. TakeCare's Medical Management Department reviews the physician's orders to ensure that service, procedure, medication, or equipment is medically necessary.

Prior Authorization is required for:

All off-island services:
Primary care, preventive services, specialty referrals, evaluation, hospitalizations, surgeries including maternity care and delivery, procedures, services, and/or treatments.

Inpatient/Hospitalization and related services:

- All scheduled inpatient admissions, including but not limited to surgeries, ceasarian sections, and admission resulting from an emergency.

Outpatient, in-office and related services
Outpatient surgical procedures, excluding maternity care.

Outpatient services/treatment:

- Cancer care (chemotherapy/radiation therapy)
- Self-injectables
- Sleep Studies
- Neuropsych testing

Radiological/nuclear/magnetic/resonance scans:

- MRI/MRA
- CT Scan
- Spiral CT Scan
- Bone density studies

Appliance/Prosthetics/Durable Medical Equipment (DME)

- These benefits are available with an additional corresponding cost.

Provider Access

TakeCare members have access to providers for primary and specialty care through a network of healthcare professionals both on-island and off-island. TakeCare members can seek primary care services through the FHP clinic or through TakeCare's independent provider network on island. Access to specialty care services are facilitated through a referral process from the member's primary care provider that are reviewed and prior authorized by TakeCare's Medical Management Department. Care coordination for off-island referrals are accomplished through TakeCare's network of participating providers and facilities. Members may coordinate services for their approved referrals with non-participating providers of their choice through their out-of-network benefit.

Please note that:

1. TakeCare's Medical Management Department must coordinate and prior authorize your care to specific qualified facilities to limit your out of pocket costs as well as to provide coverage under your participating network benefits.

If your prior authorized visit requires additional visits, tests, or services, you will need to work with the physician and/or facility together with TakeCare's Medical Management Department in advance for coordination and authorization for additional services to the same physician/facility or other physicians/facilities who are directly contracted with TakeCare for a new referral.

Requests from TakeCare's contracted provider for additional visits, tests, or services to physicians/facilities who are not directly contracted with TakeCare regardless of prior authorization from TakeCare's Medical Management Department will be covered under your plan's non-participating benefits as stated on your schedule of benefits.

2. All care or services requiring prior authorization will require you to obtain prior authorization from the TakeCare's Medical Management Department. If you self-refer to a provider and/or facility for visits, tests, or services which require a prior authorization from TakeCare's Medical Management Department, services will be denied and is not covered under your plan. Self-referrals for primary care and Requests from TakeCare's contracted provider for additional visits, tests, or services to physicians/facilities who are not directly contracted with TakeCare regardless of prior authorization from TakeCare's Medical Management Department will be covered as defined under your plan's non-participating benefits as stated on your schedule of benefits. Services that do not require prior authorization by TakeCare's Medical Management Department within or outside of the service area shall be covered under your non-participating/ out of network benefits.

Self- referrals are limited to primary care consultations or based on the level of coverage to which the member is entitled.

3. Payments for medical services received from non-participating providers do not accumulate towards your out-of-pocket maximums.

4. You will be required to pay for services at non-participating providers rendered at the time of your visit and seek reimbursement from TakeCare. Reimbursements must be submitted to TakeCare within ninety (90) days from the time you received the service from a non-participating provider. A Member's failure to submit a claim for reimbursement to TakeCare within ninety (90) days from the date of service will result in a denial of the claim.

5. TakeCare will reimburse for medical services based on eligible charges and/or as specified in your schedule of benefits. Please refer to the Reimbursement provisions within the member handbook for reimbursement requirements when submitting claims.

Service Area

This means the geographical area in which a member must continuously live or work to be eligible for enrollment or coverage under the subscriber's employer group plan.

Off-island Care Services

Travel Benefit to the Philippines

This benefit applies to members with prior-approved referral for off-island specialty care and hospitalization/ in-patient services that meet the medical necessity criteria as outlined by TakeCare's Medical Management Department. To avail of this benefit, a notice of benefit eligibility must be properly completed and signed prior to the member's departure from Guam. Services covered by this travel benefit is limited to approved specialty care visits and consultations, diagnostic testing and imaging, outpatient surgery, rehabilitation therapy, outpatient chemotherapy and radiotherapy under participating Philippine providers. Eligibility for the travel benefit is subject to the terms and conditions based on the review by the Medical Management department. Approval of the requested services does not automatically guarantee eligibility for the travel benefit. This travel benefit is limited up to $500 U.S. Dollars and may be applied towards the purchase of nonrefundable economy/coach airline ticket and/or payment for lodging. It will be paid on a reimbursement basis and members will need to submit and provide the following documentation:

- Copy of approved referral
- Original and valid receipt(s) or
- Copy of airline ticket or lodging statements and proof of payment

A non-refundable economy/coach airline ticket for one (1) companion of a minor (below 18 years old, disabled or elderly (65 years old and above) will be covered but not to exceed $500 US Dollars. Approved companion of the minor child is limited to the minor's parent or legal guardian.

This benefit is not applicable for members with TakeCare as their secondary insurance.

Non compliance with the approved TakeCare treatment plan will not entitled the member to the travel benefit.

Services in the Philippines

Takecare offers an expanded network of providers in the Philippines for in-patient services, selected out-patient services, dental services, and pharmacy benefits. Service(s) must be prior coordinated and approved by TakeCare prior to member's departure from the service area.

Services not prior coordinated and approved by TakeCare will be subject to reimbursement and may be covered under the member's non-participating benefit.

For the most updated list of participating providers in the Philippines please refer to the provider directory or call TakeCare's Customer Service department.

Services in Hawaii and Mainland U.S.

Eligible off-island members will need to identify their primary care provider within thirty (30) days from open enrollment period or any qualifying event. Basic primary and preventive services must be prior coordinated and approved.

Failure to coordiinate these services and provide primary care provider information may result to services being covered under the member's non-participating benefit or not being covered at all.

Out of Service Area/ Off Island Services

All out of service area services including but not limited to specialty care and elective hospitalization services are subject to priot authorization and approval from TakeCare otherwise these services will not be covered under the member's plan even if provided by directly contracted providers or providers under TakeCare's rented network. Prior approved services done through a directly contracted provider will be covered based on the member's non-participating provider benefit. Please refer to your Schedule of Benefits for furhter detauls on these services.

Urgent Care and Emergency Care Services

Urgent Care

Urgent Care services are available within the service area through contracted providers. If you are out of the service area, urgent care services must be received in a doctor's office or an urgent care facility. Notification is required to TakeCare within 48 hours or as soon as reasonably possible from the initial receipt of out of service area urgent care services. If no notification was received by TakeCare, your service will be denied. Please refer to your schedule of benefits for specific coverage levels for certain benefits.

Emergency Care Services

In an emergency, seek immediate medical attention and make sure you or someone else notifies TakeCare within 48 hours or as soon as reasonably possible after initial receipt of services to inform TakeCare of the location, duration and nature of the service provided. If no notification was received by TakeCare, your service will be denied.

TakeCare covers emergency medical services worldwide. Emergency services are medically necessary medical or hospital services required as the result of a medical condition manifesting itself by the sudden onset of symptoms of sufficient severity, which may include severe pain, such that a reasonable person would expect the absence of immediate medical attention to result in:

- placing your health in serious jeopardy,
- serious impairment to your bodily functions, or
- serious dysfunction of any bodily part.

Examples of emergencies include heart attack, stroke, poisoning and sudden inability to breathe. Services received at a hospital emergency room for conditions that are not defined as an emergency are not covered. Please refer to your schedule of benefits for specific coverage levels for certain benefits.

Emergency ground ambulance services required for transport to an emergency treatment facility are covered. Air ambulance services are not covered. Ground ambulance services not used for bonafide emergency transport are not covered.

Emergency care services done through a non-directly contracted provider will be paid and covered using TakeCare's Usual, Customary, and Reasonable ("UCR) Charges policy. Any inpatient admission/hospitalization resulting from an emergency room visit are not covered unless prior approved and authorized by TakeCare.

Payment Responsibilities

Premiums

The monthly premium for you and your eligible dependents will be handled by you or your employer. Check with your employer for any applicable employee contributions. Your employer will notify you of any change in the employee contribution.

Non-Premium Related Charges

The member is responsible to pay for any costs above the Usual, Customary and Reasonable (UCR) charges or eligible charges including any applicable copayment, co-insurance, deductible and non-covered services.

■ Co-payments

When you receive care, you may be responsible for paying a portion of your expense known as a co-payment. Your required co-payment amounts are outlined in the schedule of benefits. Your co-payment amounts will vary depending on the type of care you received (e.g. specialty care).

■ Co-insurance

Depending on your TakeCare plan, you may be required to pay a portion of your expenses known as co-insurance. Co-insurance is the percentage of the expenses that you are responsible for paying because your TakeCare plan does not cover them at 100%. Though the co-insurance percentage remains the same based on your plan, the amount you must pay will vary depending on the cost of the services you received.

■ Deductible

This is the amount that you incur and must pay before your TakeCare plan coverage begins. The accumulation of your deductible is on a per member per benefit period of the policy. Deductibles do not count towards the out-of-pocket maximum and may be applied to medical and/or pharmacy coverage as specified on your schedule of benefits. Please follow these instructions for tracking your deductible.

Deductible Members' Instructions:

1. Subscribers with a deductible on their medical plan will have to pay for all eligible charges until their single deductible is met for each individual member (at least three (3) individual members under a family coverage must meet each of their individual deductible before the family deductible will be met). Deductible amounts are non-transferable from one plan to another and from one member to another regardless of changes in plans or subscribers.

2. Only claims for covered services from a participating provider within the TakeCare network will be accumulated towards the participating provider deductible based on eligible charges. Likewise, eligible charges for covered services from a non-participating provider will only accumulate towards the non-participating provider deductible. Non-covered services do not accumulate towards either the participating provider or non-participating provider deductible. Please refer to your schedule of benefits for specific coverage levels for certain benefits.

3. Full payments of services are the responsibility of the member at the time of the doctor, laboratory or pharmacy visit until deductibles are met.

4. After review and confirmation that your deductible has been met, medical plan benefits as specified in the schedule of benefits will be in effect.

5. TakeCare encourages participating and non-participating providers to submit claims for eligible charges for accumulation towards the member's deductible. However, it is the member's responsibility to keep track of their deductible amount and to provide sufficient proof to TakeCare that their plan's deductible is met and satisfied before TakeCare pays for any covered services. Claim forms for deductibles, along with original receipts and all required documentation, must be submitted no later than ninety (90) days from the date your deductible is met.

Out-of-pocket maximum

A limit is placed on the maximum amount of money you are required to pay through co-payments and co-insurance during a benefit year. This limit is called your out-of-pocket maximum. It helps ensure that your share of medical costs never becomes a barrier to you receiving health care.

- During a benefit period when co-payment and co-insurance payments reach the out-of-pocket maximum amount specified in your schedule of benefits, no further payments will be required for plan covered medical office visits, hospital confinements and prescription drugs received during the remainder of the benefit period.

- Health services may require a co-payment, and/or co-insurance at the time of service. When such co-payment and/or co-insurance for covered services made during one benefit period total the amount set forth in the schedule of benefits as the out-of-pocket maximum, then no further co-payment and/or co-insurance will be imposed for the remainder of that benefit period. This provision applies to the basic medical health services and specifically excludes eyeglasses, dental services, amounts in excess of eligible charges, or other supplemental benefits such as chiropractic and acupuncture services. Deductible requirements and amounts paid for supplemental medical benefits do not accumulate towards an individual or family out-of-pocket maximum. Members are required to maintain receipts of co-payments and/or co-insurance and provide these as evidence to TakeCare's Customer Service Department when the out-of-pocket maximum is reached.

It is your responsibility to submit proof of reaching your out-of-pocket maximum to TakeCare's Customer Service or TakeCare's Claims Department. Claim forms for out-of-pocket maximums, along with original receipts and all required documentation, must be submitted no later than ninety (90) days from the date your out-of-pocket maximum is met.

Please refer to your schedule of benefits for specific coverage levels for certain benefits.

Reimbursement Provisions

When a participating provider treats you, that provider will submit a claim to our office. However, if you should receive treatment from a non-participating provider, you will need to pay for the services and seek reimbursement from TakeCare. To be reimbursed for covered services paid by you and/or your dependents, you are required to submit a completed Deductible, Reimbursement, and Out-of-Pocket Member Claim form to TakeCare, along with original receipts and all required documentation stated in the form. Claim forms for reimbursement must be submitted no later than ninety (90) days from the date of service. A Member's failure to submit a claim for reimbursement to TakeCare within ninety (90) days from the date of service will result in a denial of the claim.

Likewise, all completed supporting documents needs to be submitted within thirty (30) days from the receipt of the inital reimbursement submission, otherwise claim reimbursement will be denied.

All reimbursement amounts from non-participating providers will be based on TakeCare's eligible charges. TakeCare will not process any claim forms or supporting documentation submitted in a foreign language unless the documentation is translated to English. Reimbursements are generally issued within thirty (30) business days from receipt of a completed claim form and supporting documentation.

All requirements as stated in the Deductible, Reimbursement and Out-of-Pocket Maximum Claim form must be submitted with a completed form before the form will be accepted by a TakeCare representative for processing. If medical records are in a foreign language and receipts are in foreign currency, the records will need to be translated to English and currency and/or receipts converted to U.S. currency.

General Information

Coordinating Benefits

You must notify TakeCare by calling the TakeCare Customer Service Department if you or a covered family member have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage".

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. TakeCare will determine which coverage is primary according to the National Association of Insurance Commissioner's guidelines. When we are the primary payer, we will pay the benefits described in your schedule of benefits. When are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance based on TakeCare's Coordination of Benefit ("COB") Policy.

Coordinating your benefits with your health plans will maximize your coverage for eligible expenses, minimize your out-of-pocket costs and prevent any payment duplication.

- In order to ensure proper coordination, you must inform TakeCare of any other health coverage for which you or your dependents may be eligible.

- When you have double coverage, insurance regulations require the primary insurer to make payments on the claim before the secondary insurer makes payment on any outstanding balance due.

- The primary and secondary insurer is determined in accordance with the National Association of Insurance Commissioner's guidelines.

- If you are covered under a retiree plan and you are actively working with benefits through your active employer, the active plan is primary and the retiree plan is secondary.

- If TakeCare pays for more benefits than appropriate, TakeCare will recover excess benefit payment from you, the plan with primary responsibility, or any other person or entity that benefited from the overpayment.

Coordination of Benefits with Medicare

You must inform TakeCare if you are eligible for Medicare benefits. TakeCare will coordinate care to determine the correct application of benefits available from Medicare.

- Medicare is a federal health insurance program for people who are age sixty-five (65) and older, for some younger people with disabilities, and for people with end-stage kidney disease.

- The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits three (3) months before you turn age sixty-five (65).

- If you or your dependent is a Medicare beneficiary and a TakeCare member, then you or your dependent have dual or double coverage which is subject to the coordination of benefits guidelines in accordance with the National Association of Insurance Commissioners.

- If you or your dependent is a Medicare beneficiary, care must be received through a Medicare contracted facility and/or from a Medicare contracted physician in order for any benefits under the TakeCare plan to apply for the care.

- It should be noted that failure to cooperate with TakeCare in its efforts to coordinate benefits and/or collection of claims paid with Medicare could result in a reduction in benefits or your termination from the TakeCare plan.

- If you or your dependent are sixty-five (65) years of age or older, you should contact your local Social Security Office or the TakeCare Customer Service Department for more information on Medicare eligibility and the application process.

Non-duplication of benefits with Workman's Compensation

Services for work-related injuries are not a covered benefit under any of the TakeCare plans. Please contact your employer for Workman's Compensation benefit information.

If TakeCare pays for services related to work injuries, TakeCare will recover payments from you or any other person or entity that benefited from the overpayment.

Third-Party Medical Expenses

Third Party Liability ("TPL") claims are claims that resulted to injuries from the actions of another person (third-party) such as injury in a motor vehicle accident ("MVA") and other injuries that are covered under some other type of insurance.

In cases involving TPL, TakeCare will not provide coverage and claims are not payable when the member has been treated for an injury or illness allegedly caused another party.

TakeCare will not provide any coverage and payment for claims that are otherwise covered under automobile insurance of no-fault insurance.

TakeCare has the "right or subrogation" the "right of reimbursement" and the "right of recovery," in the event of an inllness, injury or condition caused by a third party. Please refer to Section V of the Appendix in this Member Handbook for more information.

For additional information and assistance regarding your third-party claim, call the TakeCare Customer Service Department.

Changes in coverage

Ending Coverage (Termination of Benefits)

Generally, your TakeCare membership ends when your employer's group policy ends. However, TakeCare may revoke your membership for one of the following reasons:

- **Failure to pay** required premiums, co-payments and co-insurance, deductible, or any fees or charges for non-covered services.

- **Fraud or deception** in your enrollment application and any new changes affecting member information and/or eligibility status, including information on third-party insurers which is required for coordination of benefits.

- **Allowing unauthorized use** of your TakeCare identification card.

- **Consistently uncooperative, abusive, unruly, or disruptive behavior** that interferes with the provision of services or administration of the plan.

- **Absence from the service area** for more than ninety (90) consecutive days.

- **Continued refusal** of recommended medical treatment.

- **Loss of eligibility** as outlined in "Eligiblity-Covering Your Family Members" and "COBRA" sections.

- **Failure to cooperate** with TakeCare coordination of benefits and third-party liability rights.

- **Voluntary or involuntary termination** in a manner determined by your employer.

- A spouse's coverage will end on the day of the **divorce**.

- A **common-law spouse's** coverage will end on the day the couple is **no longer living together or no longer meets TakeCare eligibility requirements.**

- On a **child's** twenty-sixth (26th) birthday.

- If a claim for reimbursement is found to be **fraudulent** after all required grievance actions have been completed.

If your membership is terminated, you will be provided with a statement of creditable coverage and will be informed of the effective date of termination.

Under no circumstances will your membership be terminated due to health status or need for health care services.

You and/or your dependent may terminate your medical and dental coverage during your open enrollment period only or upon termination of employment.

Rescission of Benefits - TakeCare may rescind you or your covered dependents' coverage back to the initial date of coverage if you or your dependents commits fraud or has made an intentional misrepresentation of material fact prohibited by your TakeCare plan. In such cases of fraud or an intentional misrepresentation of fact, you and your dependents and your employer shall be jointly and severally liable for all health care services provided to you or your dependents. TakeCare shall provide you or your dependents with thirty (30) days written notice prior to rescinding coverage.

Notifying you of any changes in your plan

Your employer is responsible for notifying you of any changes in your plan benefits.

Notifying us of any change in your status

You are required to notify us of any changes to the information you provided on the enrollment application within thirty-one (31) days of the change. This information includes relocation, a new address, marital status, the status of any of your dependents and any additional health coverage. Simply call the TakeCare Customer Service Department or contact your employer to make changes. Failure to notify TakeCare could result in termination from the health plan or denial of covered services or claims paid.

COBRA

If your employer is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, you and your covered dependents may be entitled to continuation of coverage under your employer's group health care plan. Members may qualify for continuation of coverage for one of the following reasons:

- Termination or separation from employment for reasons other than gross misconduct.
- Reduction of work hours.
- Subscriber's death.
- Your spouse ceases to be eligible due to divorce or legal separation.
- A child ceases to be an eligible dependent.

Your employer is responsible for providing you notice of your right to receive continuing coverage under COBRA. All TakeCare eligibility requirements apply, such as requirement to be residing within the TakeCare designated service area.

Common-law spouses and domestic partners are not eligible for continuing coverage under COBRA.

Note: It is the responsibility of your employer group to administer your continuing coverage under COBRA. You must make payments directly to your employer and not at TakeCare's office.

For a detailed list of plan exclusions, please refer to your plan schedule of benefits ("SOB").

Responding to Your Concerns

Appeal and grievance procedures

As a TakeCare member, you have the right to submit an Appeal or Grievance to the TakeCare Customer Service Department, whom will serve as your primary contact and will also assist you in the Appeals and Grievance procedure. TakeCare will make every attempt to resolve the issue as described in the policy between you and TakeCare and your employer.

Appeal

As a member, you have the right to appeal an Adverse Benefit Determination. If you feel that you have been denied a service, claim, or referral under your health plan which you believe is a covered service, you may file an Appeal.

There are two methods of appeal: Internal and External. The Internal Appeal is to TakeCare itself; the External Appeal is to the federal Office of Personnel Management (OPM). During the Internal Appeal, you may request additional information about the Adverse Benefit Determination made by TakeCare and may ask TakeCare to reconsider its determination. Adverse Benefit Determinations arising under Medical and Dental Health Plans are subject to the Internal Appeal Process.

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

Members appealing an Adverse Benefit Determination must follow the procedures set forth in the Appendix which is attached to this member handbook.

Grievance

A grievance is referred to as a formal complaint or dissatisfaction with the service you received. Grievance includes complaints about the quality of care or non-quality of care services at any of our contracted network facilities, providers or with any administrative processes you received.

- Non-quality of care services include complaints about administrative processes, contractual issues, sales processes or other marketing and disenrollment issues.
- Quality of care services include complaints about clinical services, provider/behavioral services and access to care.

Our TakeCare Grievance Coordinator will send you an acknowledgement letter within five [5] calendar days of receiving your letter and will also indicate the next steps that will be taken to ensure your concerns are addressed accordingly.

Within thirty [30] calendar days, the Grievance Coordinator will send you a final response letter indicating the final action taken to resolve your issue. In some cases, TakeCare will need additional time to address your issue. If such time is needed, the Grievance Coordinator will send you another letter notifying you of the additional time required and the status of your grievance.

TakeCare will provide you a response to your grievance and the response is final. No further action is required from TakeCare are TakeCare respond to your grievance.

TakeCare Member Rights and Responsibilities

As a TakeCare member, you have the right to:

Timely, quality care

- Choice of a qualified primary care physician and contracting hospital. Your primary care physician will discuss with you the appropriate services that best fits your needs in the event you need hospital services.

- Candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.

- Timely access to your primary care physician and referrals to specialists when medically necessary.

- Receive emergency services when you, as a prudent layperson acting reasonably, believed that an emergency medical condition existed. Payment will not be withheld in cases where you have acted as a prudent layperson with an average knowledge of health and medicine in seeking emergency services.

- Actively participate in decisions regarding your health and treatment options.

- Receive urgent care services when travelling outside the plan's services area or in the plan's service area when unusual or extenuating circumstances prevent you from obtaining care from your primary care physician.

Treatment with dignity and respect

- Be treated with dignity and respect and to have your right to privacy recognized in all settings.

- Exercise these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, or your natural origin, cultural or educational background, economic, or health status, English proficiency, reading skills, or source of payment for your health care. Expect these rights to be upheld by TakeCare and contracting providers.

- Have confidential treatment of all communications and records pertaining to your care. TakeCare adopts and implements written policies and procedures to protect the confidentiality of member information used for any purpose. These policies include the protection of any information that can be used to identify a member, employee access to private information, and routine and special consent. Routine consent covers the use of identifiable infomation that is needed for treatment, coordination of care, quality measurement and improvement (including surveys), utilization reviews, billing or fraud detection. Your routine consent is given to TakeCare when you sign your enrollment form. Unless required by law, special consent or written permission from you shall be obtained before medical records or individual member data can be made available to any person who is not directly responsible for your health care or responsible for making payments for the cost of such care. This includes release to employers. In the event you are unable to give consent, TakeCare will follow applicable Territorial, State and Federal laws concerning consent.

- Extend your rights to any person who may have legal responsibility to make decisions on your behalf regarding your care.

- Refuse treatment or leave a medical facility, even against the advice of a physician, provided you accept the responsibility and consequences of the decision, which could result in denial of coverage due to failure to substantially follow your treatment plan. However, your refusal in no way limits or otherwise precludes you from receiving other medically necessary covered services for which you consent.

- Complete an Advance Directive, Living Will or other directive and give it to your primary care physician or provider to include in your health records.

- Receive timely access to your health records and any information that pertains to them by contacting your primary care physician.

Health plan information

- Receive information about TakeCare and covered services.

- Receive information about and know the names and qualifications of contracted physicians, health care professionals, and providers involved in your treatment.

- Receive information about an illness, the full course of treatment options, and prospects for recovery in terms you can understand, including how treatment decisions are made by the primary care physician.

- Receive information regarding how treatment decisions are made by your primary care physician or TakeCare, including payment structure.

- Receive information about your medications - what they are, how to take them and possible side effects.

- Receive as much information about any proposed treatment or procedures as you may need in order to give an informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, any alternate course of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

- Receive reasonable continuity of care, including information about continuing health care requirements following discharge from inpatient or outpatient facilities. Also to know, in advance, the time and location of an appointment as well as the physician providing the care.

- Be advised if a physician proposes to engage in experimental or investigational procedures affecting your care or treatment. You have the right to refuse to participate in such research projects.

- Be informed of continuing health care requirements following discharge from inpatient or outpatient facilities.

- Examine and receive an explanation of any bills for non-covered services, regardless of payment source.

Timely problem resolution

- Make complaints and request appeals about TakeCare or care provided without discrimination and expect problems to be fairly examined and appropriately addressed within the timeframe set by the plan to adhere to accrediting and regulatory bodies. You may choose to have a service or treatment decision, if it meets certain criteria, reviewed by a physician or panel of physicians who are not affiliated with the health plan. This process is called an independent external review.

As a member of TakeCare you have the responsibility to:

- Provide TakeCare, your physicians, other health care professionals and contracting providers, to the degree possible the information needed in order to care for you.

- Participate in understanding and doing your part to improve your health condition, by following treatment plans, instructions and care that you have agreed on with your physician(s).

- Behave in a manner that supports the care provided to other patients and the general functioning of the facility.

- Accept the financial responsibility of any co-payment,co-insurance or deductible associated with services receivedwhile under the care of a physician or while a patient at a facility

- Review information regarding covered services, policies and procedures as stated in your member materials or evidence of coverage information.

- Ask questions regarding your care, your primary care physician or TakeCare. If you have a suggestion, concern, complaint, or payment issue, we recommend you call the TakeCare Customer Service Department at Guam (671) 647-3526, CNMI (670) 235-7687 or Palau (680) 488-4715. These contact numbers are also on your TakeCare member ID card.

Glossary

While TakeCare is dedicated to making its services easily accessible and understandable, the "language" of health care can sometimes be very confusing. To help you understand some of the terms you may encounter, we offer the following definitions:

Benefits - Means services covered by TakeCare.

Benefit Period - A twelve (12) month period that begins on the effective date or anniversary of the group policy.

Case Management - Is a multidisciplinary process that coordinates quality resources and facilitates flexible, individualized treatment goals in conjunction with the member's primary care physician. It provides cost-effective options for selected individuals with complex needs.

Chronic Condition - Is a physical or mental state that requires ongoing medical treatment or social services intervention beyond thirty (30) days.

Co-insurance - Is the percentage of the medical expenses that you are responsible for paying because your TakeCare plan does not cover them at 100%. Though the co-insurance percentage remains the same for your plan, the amount you must pay will vary depending upon the cost of the services you receive.

Co-payments - Are costs payable by the member at the time covered services are received. Co-payments are a fixed dollar amount that are paid to the provider at the time of service. Co-payments are in addition to the premium paid by an employer, any payroll contributions required by your employer and any deductible.

Covered Services - Medically necessary services or supplies provided under your group policy and schedule of benefits for emergencies or those services which have been authorized through your primary care physician and TakeCare.

Custodial Care - Care furnished for the purpose of meeting personal needs which could be provided by persons without professional skills or training, such as assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by TakeCare.

Customer Service - A department in TakeCare dedicated to answering your questions concerning your membership, benefits, grievances and appeals.

Deductible - Means the amount of covered benefit that must be incurred and paid by the member before benefits become payable under the TakeCare plan.

Diagnostic Imaging and X-ray - Outpatient diagnostic imaging and radiological services in support of basic health care to be used in the screening or detection of disease which may include: CT Scans, MRIs, Ultrasound, and Nuclear Medicine. Some services may require prior authorization by TakeCare.

Durable Medical Equipment (DME) - Coverage is based on your schedule of benefits and treatment plan as defined by a licensed participating physician. Members are responsible for any required deposits.

Eligible Charges - Means the maximum charge for which TakeCare will reimburse the provider for a covered service. An Eligible Charge is not necessarily the same as the usual, reasonable, customary, maximum, actual or prevailing charge or fee.

Eligible Charges shall apply only to covered services and is further defined as follows:

i) For participating providers, Eligible Charges shall be the contracted rate paid by TakeCare.

ii) For all non-participating provider services not identified herein, Eligible Charges shall be the same as the usual, customary and reasonable charges in the geographic area. In addition, the member shall be responsible for any amount by which the usual, customary and reasonable fees in the geographic area exceed the amount TakeCare is obligated to pay the provider for the covered services rendered.

iii) If the Eligible Charge is higher that the provider's billed charge, the billed charge will become the Eligible Charge.

iv) For emergency care received from a non-participating provider, the member's total out-of-pocket costs for covered services shall be the applicable member share under the non participating provider benefit plus the difference between, the billed charges and TakeCare's Usual, Customary and Reasonable charges.

v) In the event that a required co-payment or a combination of a required co-payment and co-insurance is in excess of Eligible Charges, the member will be required to pay no more than the Eligible Charges.

Eligible Dependent(s) - Means a Subscriber's Children, Child, Spouse or person(s) other than the Subscriber who are eligible for enrollment in a Health Plan.

Emergency Services - Are medically necessary medical or hospital services required as a result of a medical condition manifesting itself by the sudden onset of symptoms of sufficient severity, which may include severe pain, such that a reasonable person would expect the absence of immediate medical attention to result in (1) placing the member's health in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily part.

Facility - Is any building or premise in which health care services or the administration of this health plan is carried out.

Formulary - Is a list of medications approved by TakeCare to be used by your participating provider for your treatment.

Grandfathered Health Plan - Means a group Health Plan which was in existence on March 23, 2010 which is the date of enactment of the Patient Protection and Affordable Care Act. At least one person must have been enrolled in the plan on that date. However, grandfathered status is not generally affected by new enrollment changes after March 23, 2010, but is limited as to the extent that it may eliminate benefits offered and increase cost sharing provisions.

Grievance - Includes complaints about the quality of care for services at any of our contracted network facilities, providers or with any administrative processes you received.

Hospital - Is any general acute care facility designated by TakeCare in the Service Area, in TakeCare's Provider Directory, or a facility utilized by a member during a Medical Emergency

Hospital Services - Are services and supplies performed or supplied by a hospital on an inpatient or outpatient basis.

Infancy - The earliest period of childhood for babies over eight (8) weeks to one (1) year of age.

Medical Emergency - Means the sudden unexpected onset of illness or injury which requires the immediate care and attention of a qualified physician, and which, if not treated immediately, would jeopardize the life of or impair the long term health of the member. An emergency condition manifests itself by acute symptoms of sufficient severity, including, but not limited to severe pain, such that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the afflicted individual or in the case of a pregnant woman, the health of the woman or the unborn child, in serious jeopardy,

- serious impairment to bodily functions, or

- serious dysfunction of a bodily organ or part.

Medical Necessity - Refer to medical services or hospital services which are determined by TakeCare to be rendered for the treatment or diagnosis of an injury or illness.

Member - The subscriber or any eligible dependent who is covered and under a TakeCare policy.

Member Handbook - This document that explains covered services and defines your rights and responsibilities as a member of TakeCare.

Newborn - A baby from birth to eight (8) weeks of age.

Non-Formulary - Drugs that are not on TakeCare's formulary list.

Non-Participating Providers - A health care provider not contracted with TakeCare to provide covered services or procedures for subscribers and their dependents. Member's non-participating benefits apply. Please consult your schedule of benefits for specific non-participating benefit information.

Outpatient Facility - An outpatient facility is defined as a surgical facility or treatment facility which provides therapeutic (both surgical and non-surgical) treatment and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. The definition of an outpatient facility includes such places as ambulatory surgical center, community mental health center, comprehensive outpatient rehabilitation facility, and End Stage Renal Disease treatment facility.

Outpatient Services - Means medical care provided either outside of a hospital or health care facility setting or at a hospital or health care facility when room and board charges are not incurred.

Open Enrollment Period - Means the thirty-one (31) days, or some other period agreed to by TakeCare and the Group, usually commencing one (1) month prior to the Group's renewal date or at a mutually acceptable time, at least annually, during which TakeCare Subscribers may add or delete Eligible Dependents and all eligible Subscribers are given the opportunity to select from among the alternative health benefit plans offered by the Group.

Participating Providers - Means a physician employed by TakeCare or any person, organization, health facility, institution or physician who has entered into a contract with TakeCare to provide services to members.

Preferred Provider - A Preferred Provider is a participating provider that has entered into a written agreement with TakeCare to provide care or treatment at a preferential or greater discounted rate which allows TakeCare to provide greater coverage to you. The participating providers which are identified herein as preferred providers are subject to change from time-to-time depending on the terms and rates for services of the written agreements. Please be sure to check with TakeCare's Medical Management Department to confirm the identity of preferred providers.

Premium - The amount paid by the subscriber and the employer for each member enrolled under the agreement for the provision of medical and/or dental care.

Prescription Drugs - TakeCare will cover prescription drugs listed on the TakeCare formulary or non-formulary prescription drug when medically necessary and authorized by TakeCare.

If a generic medication is available, it will be dispensed in place of the brand name medication.

For certain prescription drugs, TakeCare reserves the right to require prior authorization to ensure that the following coverage criteria are met:

- The prescription drugs is for the treatment of a covered medical condition.
- Established step-therapy guidelines that are developed and maintained by our pharmacy benefit manager.
-The use of the prescription drug in the treatment of the member is medically necessary.
-The prescription drug is prescribed according to established, documented, and approved indications which are supported by the weight of scientific evidence.

Primary Care Physician (PCP) - Means a Participating Provider within the Service Area that provides "front line" health care as opposed to specialty care. Generally, a Primary Care Physician is a family practitioner, internist, pediatrician or obstetrician-gynecologist (OB-GYN). A Primary Care Physician may also be a medical group or clinic providing primary care. The FHP Clinic is an example of a Primary Care Physician.

Prior Authorization - A formal process requiring a provider to obtain approval by the TakeCare Medical Management Department for the provision of covered services/procedures before they are done. Without such prior approval, the service, procedure, medication, or equipment is not covered. TakeCare's Medical Management Department review the physician's orders to ensure that the service, procedure, medication, or equipment is medically necessary.

Provider - Means any person, organization, health facility, or institution licensed by a Country, State, or Territory to deliver or furnish health care services.

Primary Care - Outpatient office visits provided by a member's primary care physician, i.e. family practice, internist, pediatrician, or obstetrician-gynecologist.

Prosthetics - Are articles or equipment, other than dental, designed to replace all or part of a permanently inoperative or malfunctioning body part or organ. Please refer to the schedule of benefits for prosthetic coverage under your plan, if any.

Referral - A formal written recommendation by your primary care physician or a contracted health care provider for you to receive services from a specialist or consultant.

Respite Care - Short-term, intermittent care, often for persons with chronic or debilitating conditions. One of the goals is to provide rest for family members or caregivers from the burden and stress of sustained caregiving.

Self-Referral - Arrangements for care made by the patient rather than the provider. Self-referrals for covered services and procedures that require prior authorization will be covered only with approval from TakeCare's Medical Management Department.

Service Area - Means the geographical area in which a member must continuously live or work to be eligible for enrollment or coverage under the subscriber's employer group plan.

Skilled Nursing Facility - Means a facility designated by TakeCare, which has the staff and equipment to provide skilled nursing care and other related health services.

Spouse - The subscriber's legally recognized husband or wife.

Subscriber - The person who enrolls in a TakeCare plan and meets all the applicable eligibility requirements of TakeCare, and for whom health plan premiums have been received by TakeCare.

Urgent Care - Is the delivery of ambulatory care needed to treat an unforeseen condition on an unscheduled, walk-in basis, that requires immediate medical treatment in a facility outside of a hospital emergency department such as Urgent Care Facility; the outpatient department of a hospital; clinic; or doctor's office for the treatment of acute pain, acute infection, or protection of public health. An urgent condition is not life-threatening but may cause serious medical problems if not promptly treated.

Urgent Care Facility - Means a public or private facility primarily providing Urgent Care and Outpatient Services.

Urgent Care Services - Are services to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency department.

Usual, Customary, and Resonable (UCR) - The amount paid for a medical service in a geographic area based on what participating providers in the area usually charge for the same or similar service.

Waiting Period - Means the length of time that must pass before a Group employee becomes eligible for the benefits under a Health Plan.

Appendix

I. APPEAL

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

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

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

Members appealing an Adverse Benefit Determination must follow the procedures set forth in this Appendix on Appeals.

II. DEFINITIONS

For the purposes of this Appendix on Appeals, the following definitions shall apply:

Adverse Benefit Determination. An Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment (for pre-service or post-service claims) that is based on:

1. A determination that a benefit is not a covered benefit;
2. The imposition of a preexisting condition, exclusion, source of injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
3. A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

A Rescission is considered an Adverse Benefit Determination.

Appeal. An appeal means a request by a member for review and reconsideration of an Adverse Benefit Determination. For the purposes of this Appendix on Appeals, the terms "appeal" and "claim" may be used interchangeably.

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

Claim. A claim means a member's assertion that a particular service, benefit or payment is covered under a plan. For the purposes of this Appendix on Appeals, the terms "appeal" and "claim" may be used interchangeably.

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

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

Concurrent Care Extension Claim. A Concurrent Care Extension Claim means a claim whereby a member has received approval from TakeCare for concurrent care and wishes to extend the course of treatment beyond the period of time or number of treatments previously approved by TakeCare.

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

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

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

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

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

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

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

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

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

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

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

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

III. INTERNAL APPEAL PROCESS

A. PROCEDURES FOR INTERNAL APPEAL

1. When to Request an Internal Appeal.

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

b. **Urgent Care Claim.** If your appeal is an Urgent Care Claim or Concurrent Care Claim involving urgent care, your request may be filed immediately with the TakeCare Customer Service Department. In the event an appeal of an Urgent Care Claim needs to be made outside of normal business hours (including weekends and holidays), you may contact TakeCare's Health Plan Administrator at (671) 488-7107. TakeCare will appoint an individual at TakeCare to provide you with an Internal Appeal Determination (whether adverse or not), taking into account the medical exigencies, not later than seventy-two (72) hours after receipt of your appeal by TakeCare. The individual who decides your Urgent Care Claim will not be someone involved in the initial Adverse Benefit Determination. The Individual who decides your Urgent Care Claim will be a health professional with training relevant to the claim if the Adverse Benefit Determination is based in whole or in part on medical judgment, including whether a given treatment is experimental, investigational, or not medically necessary or appropriate. If you fail to provide TakeCare with sufficient information to determine whether, or to what extent, benefits may be covered or payable under TakeCare's Plan, TakeCare shall notify you not later than twenty-four (24) hours after receipt of the appeal, of the specific information required. You will be provided reasonable time, but not less than forty-eight (48) hours, to provide TakeCare with the information. Thereafter, TakeCare will notify you of its Internal Appeal Determination no later than forty-eight (48) hours after the earlier of TakeCare's receipt of the requested information or the end of the time given to the Claimant to provide the information. TakeCare shall accept and acknowledge Urgent Care Claims orally and may also provide its determination in these situations orally to the Claimant. Written notification of the Internal Appeal Determination shall be provided to Claimant within three (3) calendar days of any oral determination made by TakeCare.

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

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

2. **Procedure to Request Internal Appeal.**

a. **Request for Appeal Form.** You may file an Internal Appeal by sending a Request for Appeal Form to the Appeals Coordinator, TakeCare Customer Service Department by faxing the request to (671) 647-3542; sending it by mail to P.O. Box 6578, Tamuning, Guam 96931; or by hand delivery at Baltej Pavilion, Suite 108, 415 Chalan San Antonio, Tamuning, Guam 96913. A Request for Appeal Form is attached to the Notice of Claim of Denial or Adverse Benefit Determination form or is available from TakeCare's Customer Service Department. If you have any questions or concerns about or during the Internal Appeal process, you may contact the TakeCare Customer Service Department at (671) 647-3526.

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

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

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

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

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

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

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

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

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

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

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

4. **Notice.**

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

IV. EXTERNAL APPEAL PROCESS

A. PROCEDURES FOR EXTERNAL APPEAL

1. **When to Request an External Appeal.**

a. **Time Limit.** You or your Authorized Representative may file a written External Appeal with the External Appeal Examiner ("Examiner") within four (4) months after the date of receipt of a Notice of Denial of Internal Appeal from TakeCare. If there is no corresponding date four (4) months after the date of receipt of such a Notice, then your request must be filed by the first day of the fifth month following the receipt of the Notice. For example, if the date of receipt of the Notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

b. **Dental Health Plans Excepted.** Adverse Benefit Determinations arising under Medical Health Plans only are subject to the External Appeal Process. Adverse Benefit Determinations arising under Dental Health Plans are not subject to the External Appeal Process.

2. **Examiner; Independent Reviewer.**

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

3. **Procedure to Request External Appeal.**

a. **Request for External Appeal Form.** The External Appeal of an Adverse Benefit Determination of an Internal Appeal Determination may be initiated by sending the Request for External Appeal form which is attached to the Notice of Denial of Internal Appeal. The forms are also available at the TakeCare Customer Service Department. The Request for External Appeal may be sent electronically to DisputedClaim@opm.gov; by faxing the request to (202) 606-0036; or by sending it by mail to P.O. Box 791, Washington, DC 20044.

If a Claimant has any questions or concerns during the External Appeal Process, the Claimant can call the OPM at the toll free number, (877) 549-8152; the Employee Benefits Security Administration (EBSA) at (866) 444-EBSA (3272); or the Guam Department of Revenue and Taxation, 1240 Army Drive, Barrigada, Guam 96921, (671) 635-1844.

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

4. **Procedure for Preliminary Review.**

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

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

(1) Claimant's certificate of coverage or benefit;
(2) A copy of the Adverse Benefit Determination;
(3) A copy of the Internal Appeal Determination;
(4) A summary of the claim;
(5) An explanation of TakeCare's Adverse Benefit Determination and Internal Appeal Determination; and
(6) All documents and information considered in making the Adverse Benefit Determination or Internal Appeal Determination including any additional information that may have been provided to TakeCare or relied upon by TakeCare during the Internal Appeal Process.

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

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

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

5. **Review Process.**

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

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

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

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

(1) A general description of the reason for the request for External Appeal, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial, including denial codes);
(2) The date the Examiner received the assignment to conduct the External Appeal and the date of the Examiner's decision;
(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
(5) A statement that the determination is binding except to the extent that other remedies may be available under applicable jurisdiction or Federal law to either TakeCare or to the Claimant;

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

e. After an External Appeal Decision, the Examiner will maintain records of all claims and notices associated with the External Appeal Process for six (6) years. The Examiner must make such records available for examination by the Claimant or TakeCare upon request.

6. **Reversal of TakeCare's Determination.**

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

B. **EXPEDITED EXTERNAL APPEAL**

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

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

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

2. **Procedure to Request Expedited External Appeal.**

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

b. If a Claimant has any questions or concerns during the Expedited External Appeal Process, the Claimant can call the OPM at the toll free number, (877) 549-8152; the EBSA at (866) 444-EBSA (3272); or the Guam Department of Revenue and Taxation, 1240 Army Drive, Barrigada Guam, (671) 635-1844. The Claimant may submit additional information concerning the denied claim to the OPM at the mailing address listed above. If the Claimant does submit additional information to the OPM, the information will be shared with TakeCare in order to give TakeCare an opportunity to reconsider the denial. Information concerning the Claimant's right to privacy during the External Appeal Process was provided in the Notice of Privacy Act Rights statement attached to the Notice of Denial of Claim or Adverse Benefit Determination or Notice of Denial of Internal Appeal from TakeCare.

3. **Examiner; Independent Reviewer.**

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

4. **Procedure for Preliminary Review.**

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

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

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

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

5. **Review Process.**

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

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

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

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

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

6. **Reversal of TakeCare's Determination.**

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

V. SUBROGATION, RIGHT OF REIMBURSEMENT AND RIGHT OF RECOVERY

TakeCare reserves the "right of subrogation" the "right of reimbursement" and the "right of recovery," in the event of an illness, injury or condition caused by a third party or with respect to which a "first party payor" has liability, for which TakeCare has paid or is being requested to pay benefits under this Plan or for which TakeCare chooses to advance benefits.

A. **Definitions**

Third Party. The term "third party" means any party actually, possibly, or potentially responsible for making any payment to or for the benefit of a Member due to a Member's injury, illness or condition. The term "third party" includes (without limitation) the liability insurer of such party or any insurance coverage.

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

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

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

B. **Subrogation**

TakeCare shall be subrogated to all rights of recovery that a Member has against any third party with respect to any payment made by the third party to a Member due to a Member's injury, illness, or condition to the full extent of benefits provided or to be provided by TakeCare.

C. **Reimbursement**

In addition, if a Member receives any payment from any third party or lnsurance Coverage as a result of an injury, illness, or condition, TakeCare has the right to recover from, and be reimbursed by, the Member for all amounts TakeCare has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the Member receives from any third party.

D. **Right of Recovery**

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

E. **Constructive Trust**

By accepting benefits (whether the payment of such benefits is made to the Member or made on behalf of the Member to any provider) from TakeCare, the Member agrees that if he or she receives any payment from any third party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Member's fiduciary duty to TakeCare and the Plan, and will give TakeCare rights to recover equitable and money damages from the Member and to terminate the Member's health benefits.

F. **Lien Rights**

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

G. **First-Priority Claim**

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

H. **Applicability to All Settlements and Judgments**

The terms of this entire subrogation, reimbursement and right of recovery provision shall apply to each and every settlement or judgment related to the injury, illness or condition of the Member, and TakeCare is entitled to full recovery regardless of whether any liability for payment is admitted by any third party and regardless of whether the settlement or judgment received by the Member's identifies any medical benefit TakeCare provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. TakeCare is entitled to recover from any and all settlements or judgments, including (without limitation) those designated as pain and suffering, non-economic damages, and/or general damages only.

I. **Cooperation**

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

J. **Right of Investigation**

TakeCare has the right to conduct an investigation regarding the injury, illness, or condition of any Member to identify any potentially liable third party. Each Member receiving or entitled to benefits from TakeCare acknowledges or is deemed to acknowledge that TakeCare has such right of investigation.

K. **Interpretation**

In the event that any claim is made that any part of this subrogation, reimbursement and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, TakeCare shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision in accordance with the most recent U.S. Supreme Court decision on ERISA cases on health insurance subrogation. (See U.S. Airways v. McCutchen, 2013 WL 1567371 (2013).

L. **Jurisdiction**

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

M. **PPACA Compliance**

In the event that any applicable provision of TakeCare's right of subrogation, reimbursement and recovery is contrary to federal law or regulation, TakeCare's rights shall be deemed modified to the extent necessary to comply with federal laws and regulations.

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