Office of the Speaker
TINA ROSE MUÑA BARNES
I Mina'Trentai Singko Na Liheslaturan Guahan

10/26/2020

Mr. Shawn Anderson
United States Attorney
District Guam & Northern Marianas

Mr. Fred Nishihara
Deputy Attorney General
Consumer Protection Division

Director Dafne Shimizu
Acting Commissioner
Banking and Insurance Commission

RE: Denial of Health Insurance Coverage During a Pandemic

Hafa Adai! As our Island combats a Public Health Emergency, it appalls me that certain entities feel that they are exempt from their contractual obligation and their duty to become responsible corporate citizens. As the Speaker of the 35th Guam Legislature, I am further concerned now that this gross negligence has been brought to the forefront by the investigative work of KUAM, that an Insurance Provider has deemed that "no benefit will be paid in connection with epidemic related treatment" as specified under the General Exclusions of their Schedule of Benefits – I am concerned that local residents may choose to not seek medical care for COVID-19 fearing the exorbitant costs of treatment. As a result, we may end up further spreading COVID-19 or in the worst-case scenario, be responsible for the loss of a loved one.

Doing my due diligence, I reached out the individual who received the denial for medical care and received in my possession the denial letter (attached). Citing a stipulation on page 22 of their Schedule of Benefits (also attached) as a reason for denial, it states that *"To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within our control results in our facilities, personnel, or financial resources being unavailable to provide or arrange for the provisions of a basic or supplemental health service or supplies in accordance with this Plan."*

While I am not an attorney, and my experience as an investigator at the Public Defender's Service Corporation does not qualify me as an expert in contract law, I read the aforementioned stipulation as "should there be a catastrophe, and it results in their facilities, personnel, or financial resources being unavailable – only then, will care not be provided." For example, should there be riots, typhoons, or any other natural disaster that resulted in the facility having to shut down, its medical personnel not able to report to work, and its financial resources being depleted as a result of this riot – only after **all** three conditions having been met, will care not be covered.

Address: 163 W. Chalan Santo Papa Hagåtña, GU 96910
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I did reach out to an Attorney who has tremendous experience in contract law and insurance defense, who shared with me *"That means they need not be held responsible for not providing services when they are rendered unable to do so because of those events. It does not mean they're allowed to pick and choose what they want. If they claim they can't provide one type of treatment because of the pandemic, they shouldn't be able to provide any other kind of treatment at that hospital."*

Taking this one step further, I examined the Families First Coronavirus Response Act, and the Coronavirus Aid, Relief, and Economic Security (CARES) Act to see if there is any provision in Federal Code that would mandate insurance coverage during this pandemic. While these two measures have made strides in mandating that private health insurance companies provide COVID-19 testing with no cost-sharing to the subscriber, it does not require that private health insurance companies mandate COVID-19 treatment. The Families First Coronavirus Response Act, in section 6001, did mention that local Legislatures may impose additional COVID-19 related standards and requirements on insurers – as long as any local measure does not prevent the application of federal law.

As far as I know, there is no Federal Law that states insurers must not provide care for COVID-19 related treatment. As such, I had reached out to local healthcare providers to get their input on my proposal to mandate this critical life-saving coverage. Based on my discussions with them, I was surprised to hear that with the exception of this one provider – all other local insurance providers have already been paying for COVID-19 related treatment. They did share with me that with this one provider, it seems to be their business model, to deny claims so that it can be dragged out through the appeals process – with the intent to ultimately delay payment to the healthcare facility that provided care.

While ultimately this particular constituent's concern should be addressed at the claims appeal process – I write to you because the statements made by healthcare providers, that it's now a business model to deny claims with the intent to delay payment, is simply not right. The particular constituent had no choice but to leave the hospital when he was informed that the critical service was not covered by his health insurance. I heard the pain and agony in this person's voice during the interview with local media, and its simply not acceptable to me when an insurance provider abandons a person in need.

While I did consider the possibility to mandate COVID-19 treatment by law, I think policy-making is something that needs to be done proactively – the reactive side is the enforcement of the policies that come out of this body. Based on the interpretation of my policy team, while we can still mandate this by law, at this point should I propose any measure to this extent, it would still not apply retroactively.

Upon reading the fine print used to justify this denial of care, I am confident that we do have laws in place to enforce gross negligence, misconduct, fraud as well as a breach of contract. When a person leaves the hospital to recover from a medical procedure – in this case a life-threatening pandemic, they need to focus on recovery – not loose sleep and stress over a $20,000 bill that they are on the hook for.

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My parents, Bill and Ann Muña, taught me the Spirit of *Inafa Maolek* – when I see a community in need, it is my duty to step up and serve. I know of one story due to the investigative work of our local media, and through my research and conversations with local health providers, I was made aware that this may be a general practice. I cannot stand by as this continues to happen. I am concerned that now that this instance has been made public, many more local residents may choose to not prioritize their health – potentially spreading COVID-19, and potentially making it too late to save a life.

The last time I introduced a measure to allow for greater access to healthcare as a result of similar horror stories from this same insurance company, I was criticized by their lobbyists. I was blackmailed, that I will be the reason that hundreds of employees of this company's sister-company and in-house medical facility, will be forced to be laid -off. While I find these arguments without merit, especially since almost daily, local media points out that we are short of doctors and nurses – I am not going to stand silent as our People are neglected, and not afforded critical life or death treatment. I hope you see my perspective, and investigate this matter to bring justice to this situation.

I stand by my position that there is adequate protections to prevent gross negligence, misconduct, fraud as well as a breach of contract – but should you think there needs to be greater enforcement powers, I am open to have this discussion. As always, thank you for your service to the People of Guam, and my door is always open to continue this dialogue further. I look forward to your response.

Sinseru yan Magahit,

Tina Rose Muña Barnes
Speaker, 35th Guam Legislature

Attached: Denial Letter & Schedule of Benefits

CC: **Mr. Joe Husslein**, TAKECARE
Mr. Frank Campillo, SELECTCARE
Mr. Frank Arriola, AETNA
Mr. Jerry Crisostomo, NETCARE

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TakeCare®
P.O. Box 6578 Tamuning, Guam 96931
Telephone: (671) 646-6956 Fax (671) 647-3520

Date: [redacted]

Patient Name: [redacted]
Subscriber Name:
Address:

TakeCare Member ID:
GMH Medical Record #:
GMH Patient Number:
Provider:
Admission Date:

Dear Member:

The purpose of this letter is to inform you that **no benefit will be paid in connection with epidemic related treatment** as specified under General Exclusions of your Schedule of Benefits. This determination is based upon TakeCare Insurance Guidelines and Policies, specifically written on page 22 of the Schedule of Benefits (see attached copy).

You may wish to discuss alternative arrangements for any further health care you may require with your attending or primary care physician. Should you or your physician wish a copy of the UM criteria used to arrive at the denial decision or if your physician wishes to discuss this case with our physician/reviewer, you or your physician may contact our reviewers at (671) 646-6956.

For a full listing of covered benefits, limitations and exclusions, please refer to your Member Handbook, Your Combined Evidence of Disclosure and Benefits.

As a TakeCare member, you have the right to appeal any decision made by TakeCare or its contracted providers. If you would like to appeal this decision, please submit your written appeal to:

TakeCare Insurance
ATTN: Customer Service Department
P. O. Box 6578
Tamuning, Guam 96931

Your written appeal must be received by TakeCare within 180 calendar days of the date of this letter. Along with your letter of appeal, please provide a copy of this letter and any other information you believe supports your appeal. If you have any questions regarding your right to appeal, please contact the TakeCare Customer Service department at 647-3526 on Guam or at 235-7687 in the CNMI from 8 a.m. to 5 p.m., Monday through Friday. You may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act if all required reviews of your claim have been completed and your claim has not been approved.

Sincerely,

Medical Management Department
TakeCare Insurance Company, Inc.

cc: Attending Provider (GMH) – [redacted]
Claims (TakeCare)
Utilization File (GMH)
Business Office (GMH)
Member Record (TakeCare)

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-877-484-2411. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.takecareasia.com or call 1-877-484-2411 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 for in-network providers. $300/Individual or $900/family for out-of-network providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible amount has been met.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	
What is the out-of-pocket limit for this plan?	For network providers Medical: $3,000 individual / $6,000 family Prescription: $3,000 individual / $6,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.takecareasia.com or call 1-877-484-2411 for a list of network providers.	If you use an in-network health care **provider**, this Plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the terms in-network, **preferred**, or participating for **providers** in their **network**. The following definitions show how this Plan defines the different kinds of **providers**. **In-network Provider** - 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. This term is used interchangeably with "Participating Provider".

		Preferred Provider - A participating or in-network 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 by the Plan 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. **Out-of-network Provider** - A health care provider not contracted with TakeCare to provide covered services or procedures for subscribers and their dependents. A member's non-participating or out-of-network benefits will apply. This term is used interchangeably with "Non-Participating Provider".
Does this Plan have an off-island network	Yes.	Off-island care is limited to directly contracted providers in Continental United States, Hawaii, Asia and the Philippines. Referral from your Primary Care Physician and Prior Authorization (written approval) from TakeCare is required.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.
Does this Plan have a Service Area?	Yes.	This Plan's Service Area is Guam, CNMI and Palau. You must continuously reside in the Service Area to remain eligible for coverage under the Plan. When selecting a Primary Care Physician, you must select a Primary Care Physician from the island in which you reside. If you are absent from the Service Area for more than ninety (90) consecutive days during a benefit period, you are no longer eligible for the Plan and your coverage under the Plan may be terminated. Any services outside the Service Area requires referral from your Primary Care Physician and Prior Authorization (written approval) from TakeCare.

All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness • Including inhaled medication and administration not dispensed through a pharmacy • Injectables and other medications not dispensed through a pharmacy • Including cast and cast supplies	$5 copay per visit at FHP, $7 copay per visit at Preferred Providers, $10 copay per visit at Non Preferred Providers	30% coinsurance	This benefit is not eligible for travel and/or airfare benefit. Coverage is limited to the Service Area.
	Specialist visit • Including inhaled medication and administration not dispensed through a pharmacy • Injectables and other medications not dispensed through a pharmacy • Including cast and cast supplies	$10 copay per visit	30% coinsurance	Referral from your TakeCare Participating Primary Care Physician is required.
	Preventive care/screening/immunization • All services rates A or B by the U.S. Preventive Care Task Force • Annual Physical Exam for Adults • Annual Visual Exam for Adults • Routine Hearing Screening for Children age 18 years old and below • Routine Vision Screening for Children age 18 years old and below • Well Women Care o Screening Mammogram and Routine Pap Smear o Contraceptives based on PPACA mandated provision with a valid provider prescription o Purchased or rented breast pumps o Sterilization (Traditional Tubal Ligation and with Fulguration)	No copay, co-insurance and/or deductible for covered services	30% coinsurance	Purchased or rented breast pumps once every benefit period – 100% covered at FHP; or up to the actual cost but not to exceed $200 per member per benefit period at Participating Providers outside FHP. Well Baby Care (Means from birth up to 2 years old) Well Child Care (Means 2 years old up to 18 years old) Routine Immunization (Shall be based on CDC guidelines). This benefit is not eligible for travel and/or airfare benefit. Not subject to deductible for Participating Providers.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	• Well Baby Care • Well Child Care • Routine Immunization			Coverage is limited to the Service Area.
If you visit a health care provider's office or clinic	Cardiac Care • Specialist Care Office Visit • Outpatient Cardiac Therapy/Rehabilitation • Inpatient Cardiac Surgery (including insertion of single/dual pacemaker) • Inpatient Cardiac Therapy/Rehabilitation	$10 copay for Specialist Care office visit and Outpatient Cardiac Therapy/ Rehabilitation $100 copay per admission for inpatient Cardiac Surgery and inpatient Cardiac Therapy/ Rehabilitation	30% co-insurance	Referral from your Primary Care Physician is required and Prior Authorization (written approval) from TakeCare. Coverage for Outpatient Cardiac Therapy/Rehabilitation is limited to 20 visits per Member per benefit period. Coverage for Inpatient Cardiac Therapy/Rehabilitation is limited to 30 days per Member per benefit period Coverage for treatment/ services and charges for heart valves, single/dual pacemakers, pacemakers monitors, coronary stents and accessories such as pacemaker batteries and leads, including the cost of the devices, their placement, repair or replacement and related hospital charges and any related hospital charges and any related complications is subject to a combined $100,000 in and out-of-network benefit limitation outside the Philippines or $200,000 in the Philippines.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Oncology Care Services • Specialist Care Office Visit • Outpatient Radiation & Chemotherapy • Inpatient Radiation & Chemotherapy	$10 copay for Specialist Care office visit and outpatient Radiation & Chemotherapy $100 copay per admission for inpatient Radiation & Chemotherapy	30% co-insurance	Referral from your Primary Care Physician is required and prior Authorization (written approval) from TakeCare.
	Oncology Care – Chemotherapy Drugs • Injectable • Specialty	Injectable - $400 copay Specialty - $600 copay	30% co-insurance	Referral from your Primary Care Physician is required and Prior Authorization (written approval) from TakeCare. The cost of Chemotherapy Drugs are only covered if administered at the FHP Cancer Center within the Service area.
	Other practitioner office visit – Chiropractor Services are limited to: • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application. • Osteopathic Manipulative Treatment (OMT) when provided by a licensed, trained and credentialed practitioner	All costs above $25 per visit and all costs after the 10th visit for Chiropractor	All cost	Coverage is limited to 10 visits per benefit period at $25 per visit. Ancillary services (e.g. X-rays) are not covered. Coverage is limited to the Service Area.
	Telemedicine	$5 copay per visit at FHP; All cost outside FHP	All cost	Referral from your TakeCare Participating Primary Care Physician is required. Telemedicine is limited to FHP only.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Routine Laboratory (diagnostic test, blood work)	No copay, co-insurance and/or deductible for blood work and routine laboratory	30% coinsurance	----------None----------
	Imaging (CT/PET scans, MRIs)	$50 copay	30% coinsurance	Referral from your Primary Care Physician and Prior Authorization (written approval) from TakeCare is required.
	Nuclear Medicine	$50 copay	30% co-insurance	Referral from your Primary Care Physician and Prior Authorization (written approval) from TakeCare is required.
	Plain film X-ray, Ultrasound, EEG, EKG, ECG, Stress Echocardiogram, Transthoracic Echocardiogram, Transesophageal Echocardiogram, DEXA Scan	$10 copay	30% co-insurance	Referral from your Primary Care Physician is required.
	Diagnostic Mammogram and other Diagnostic Tests	$10 copay	30% co-insurance	----------None----------
	Specialty Laboratory (Any laboratory services costing in excess of $200)	$50 copay	30% co-insurance	Referral from your Primary Care Physician and Prior Authorization (written approval) from TakeCare is required.
	Diagnostic Sleep Study	$50 copay	30% co-insurance	Referral from your Primary Care Physician and Prior Authorization (written approval) from TakeCare is required.
	Allergy Testing and Treatment	$10 copay	30% co-insurance	Referral from your Primary Care Physician is required and Prior Authorization (written approval) from TakeCare. Coverage is limited to $500 per member per benefit period.
	Health Education, Wellness and Disease Management Programs including any related laboratory services	No copay, co-insurance and/or deductible for covered services	All cost	Services are available and provided through TakeCare Wellness Department

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Coverage is limited to the Service Area. Not subject to deductible.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.takecareasia.com or www.envisionrx.com	Generic drugs (Tier 1)	$5 copay per Retail Drug prescription at Preferred Providers, $7 copay per Retail Drug prescription at Non-Preferred Providers; No cost for Mail Order Drug prescription	30% co-insurance	Valid prescription from a licensed Physician is required. Limited to a 30-day supply for Retail and 90-day supply for Mail Order. Other dispensing limitations may apply.
	Preferred brand drugs (Tier 2)	$20 copay per Retail Drug prescription; No cost for Mail Order Drug prescription	30% co-insurance	Valid prescription from a licensed Physician is required. Limited to a 30-day supply for Retail and 90-day supply for Mail Order. Other dispensing limitations may apply.
	Non-preferred brand drugs (Tier 3)	30% co-insurance per Retail Drug prescription; 50% co-insurance for Mail Order Drug prescription	70% coinsurance	Valid prescription from a licensed Physician is required. Limited to a 30-day supply for Retail and 90-day supply for Mail Order. Requires Prior Authorization (written approval) from TakeCare. Other dispensing limitations may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.takecareasia.com or www.envisionrx.com	Preferred and Non-Preferred Specialty drugs (Tier 4 and Tier 5) (Other than Chemotherapy drugs)	30% co-insurance per Retail Preferred Specialty Drug prescription; 50% co-insurance for Retail Non-Preferred Specialty Drug prescription	70% coinsurance	Valid prescription from a licensed Physician is required. Limited to a 30-day supply for Retail and 90-day supply for Mail Order is NOT available. Requires Prior Authorization (written approval) from TakeCare. Other dispensing limitations may apply.
	Highly Specialized Drugs (Tier 6)	$500 copay per Retail Drug prescription	All cost	Valid prescription from a licensed Physician is required. Limited to a 30-day supply for Retail and 90-day supply for Mail Order is NOT available. Requires Prior Authorization (written approval) from TakeCare. There is no coverage for the first 30-day supply for Retail and coverage will not exceed $45,000 per member per benefit period after the first 30-day supply. Other dispensing limitations may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay	30% coinsurance	Prior Authorization (written approval) is required from TakeCare.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	$10 copay	30% coinsurance	Prior Authorization (written approval) is required from TakeCare.
	Sterilization • Non-preventive traditional outpatient tubal ligation • Non-preventive outpatient tubal ligation with fulguration • Vasectomy	$10 copay	30% co-insurance	Prior Authorization (written approval) is required from TakeCare.
	Anesthesia, Cast and Facility Supplies	No copay, co-insurance and/or deductible for covered services	30% co-insurance	Prior Authorization (written approval) is required from TakeCare.
If you have outpatient surgery	Orthopedic Surgery	$100 copay per admission	30% co-insurance	Referral from your Primary Care Physician is required and Prior Authorization (written approval) from TakeCare. Coverage for treatment/services and charges relating to orthopedic surgery including the cost of any internal prosthetic devices such as but not limited to joints, screws, and plates; their placement; replacement and related hospital charges and any complications relating to orthopedic surgery is subject to a combined $100,000 in and out-of-network benefit limitation outside the Philippines or $200,000 in the Philippines.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	External Prosthetic (In accordance with the Women's Health and Cancer Rights Act of 1998) ▪ Coverage applies only to post mastectomy surgical bra	20% co-insurance	30% co-insurance	Prior Authorization (written approval) is required from TakeCare.
If you need immediate medical attention	Emergency room care	$100 copay	$100 copay	Co-payment/Co-insurance is waived if admitted. Applicable hospitalization co-payment/ co- insurance apply to all services including costs related to out- patient emergency. Notification is required to TakeCare within 48 hours after receiving emergency services otherwise these services are not covered. Hospital admission or in-patient services resulting from an emergency room care requires Prior Authorization (written approval) from TakeCare. Not subject to deductible
	Emergency medical transportation	No copay, co-insurance and/or deductible for covered services	No copay, co-insurance and/or deductible for covered services	Ground Ambulance transportation only. Notification is required to TakeCare within 48 hours after receiving emergency medical transportation otherwise these services are not covered. Not subject to deductible.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Urgent care	$10 copay per visit at FHP and at Preferred Providers Monday to Friday within business hours; $25 copay at FHP and at Preferred Providers Monday to Friday after business hours, Saturday & Sundays, and Holidays, within the service area; $25 copay at Non Preferred Providers (GMH) within the service area regardless of the day or time of the week; $100 copay outside the service area	All costs within the service area outside FHP, Preferred Providers and Non-Preferred Providers. $100 copay outside the service area	Available at FHP Health Center, Preferred Providers and Non-Preferred Providers (GMH) only within the Service Area. Notification is required to TakeCare within 48 hours after receiving urgent care services outside the Service Area otherwise these services are not covered.
If you have a hospital stay	Facility fee (e.g., hospital room and board including Psychiatric Facility)	$100 copay per admission	30% co-insurance	Prior Authorization (written approval) is required from TakeCare. Limited to a hospital semi-private room

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Physician/surgeon fees (including Mental Health)	No copay, co-insurance and/or deductible for covered services	30% co-insurance	Prior Authorization (written approval) is required from TakeCare
	Other inpatient services including laboratory, radiology, anesthesia, and prescriptions	No copay, co-insurance and/or deductible for covered services	30% co-insurance	Prior Authorization (written approval) is required from TakeCare
	Ostomy, colostomy, urinary supplies, cast and facility supplies	No copay, co-insurance and/or deductible for covered services	30% co-insurance	Prior Authorization (written approval) is required from TakeCare
	Blood and Blood Products	20% co-insurance	30% co-insurance	Prior Authorization (written approval) is required from TakeCare. Coverage is limited up to $20,000 per member per benefit period.
	Breast Reconstructive Surgery (In accordance with the Women's Health and Cancer Rights Act of 1998) ▪ Hospitalization / Surgery	20% co-insurance	30% co-insurance	Prior Authorization (written approval) is required from TakeCare.
	Skilled Nursing Facility	$100 copay per admission	30% co-insurance	Prior Authorization (written approval) is required from TakeCare. Coverage is limited to a maximum of 30 days per Member per benefit period.
	Inpatient Rehabilitation and Habilitation Services • Cardiac Rehabilitation and Physical Therapy • Speech and Occupational Therapy	No copay, co-insurance and/or deductible for cardiac rehabilitation and physical therapy;	30% co-insurance for cardiac rehabilitation and physical therapy; All costs for speech and occupational	Prior Authorization (written approval) is required from TakeCare. Coverage is limited to a maximum of 30 days per

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		All costs for speech and occupational therapy	therapy	Member per benefit period.
If you have a hospital stay	Robotic Surgery/Robotic Suite	$100 copay per admission	30% co-insurance	Prior Authorization (written approval) is required from TakeCare.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay per visit	30% coinsurance	----------None----------
	Inpatient services	No copay, co-insurance and/or deductible for covered services	30% coinsurance	Referral from your Primary Care Physician and Prior Authorization (written approval) is required from TakeCare for inpatient services.
If you are pregnant	Office visits	No copay, co-insurance and/or deductible for covered services	30% coinsurance	Coverage is limited to the Service Area.
	Childbirth/delivery professional services	No copay, co-insurance and/or deductible for covered services	30% coinsurance	Prior Authorization (written approval) is required from TakeCare for hospital stays beyond 48 hours for a vaginal delivery, or 96 hours for a cesarean section.
	Childbirth/delivery facility services	$100 copay per admission	30% coinsurance	Subscriber or Spouse only Coverage is limited to the Service Area. Does not cover Stillborn Fetus Treatments.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of Network Provider (You will pay the most)	
If you receive care in the Philippines	Inpatient and Outpatient	No copay and/or co-insurance for covered services. Plan deductible applies.	All cost	Co-payments and co-insurance are waived for Members receiving care at Participating Providers in the Philippines. Prior Authorization (written approval) is required from TakeCare.
Airfare Benefit	Airfare Benefit for hospital-to-hospital transfer to Preferred off-island and Participating Philippine Providers	No copay and/or co-insurance for covered services. Plan deductible applies.	All cost	Prior Authorization (written approval) is required from TakeCare. For air transportation of a hospitalized member who requires treatment for hospital-to-hospital transfers at a Preferred off-island and/or Participating Philippine Provider Members not following TakeCare's approved treatment plan is not eligible for travel benefit Conditions and limitations apply as specified in the Member Handbook.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Home health care	$10 copay per visit	All cost	Available through FHP Home Health only or through TakeCare's Participating Provider outside the Service Area with Prior Authorization (written approval) from TakeCare
If you need help recovering or have other special health needs	Rehabilitation services • Physical Therapy	$10 copay	20% co-insurance	Referral from your Primary Care Physician is required and Prior Authorization (written approval) from TakeCare Coverage is limited to 20 visits per member per benefit period
	Habilitation services • Speech Therapy • Occupational Therapy	All cost	All cost	----------None----------
If you need help recovering or have other special health needs	Durable medical equipment • Coverage for rental of the following equipment: o Manual and semi-automatic hospital beds, standard wheelchair, walk aid (canes, crutches and walkers), oxygen concentrators (excluding supplies).	$10 copay	All cost	Treatment plan from your Primary Care Physician is required and Prior Authorization (written approval) from TakeCare. Services are subject to TakeCare's benefit coverage guidelines and medical necessity. Length of rental need is dependent upon licensed participating physician's treatment plan. Oxygen coverage excludes supplies and is covered if part of a home health treatment plan. Coverage is limited to the

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Service Area.
	Non-Preventive Refraction	$10 copay	30% co-insurance	Services are subject to TakeCare's benefit coverage guidelines and medical necessity.
	Autism Spectrum Disorder Coverage	$10 copay	All cost	Referral from your Primary Care Physician is required and Prior Authorization (written approval) from TakeCare. Coverage is limited to $25,000 per member per benefit year for eligible members aged 16 to 21 years old and up to $75,000 per member per benefit year for eligible members aged 15 years old and below. Services are subject to TakeCare's benefit coverage guidelines and medical necessity.
If you need help recovering or have other special health needs	Coverage for complications of newborn or infancy care and/or congenital abnormalities	20% co-insurance	30% co-insurance	Referral from your Primary Care Physician is required and Prior Authorization (written approval) from TakeCare. Coverage for complications of newborn or infancy care and/or congenital abnormalities is subject to a combined $20,000 in and out-of-network benefit limitation.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	$10 copay per visit	All cost	Available through FHP Home Health only. Coverage is limited to the Service Area. This benefit is limited to 180 days per lifetime. Prior Authorization (written approval) required from TakeCare. TakeCare will cover home or facility visits by our FHP Home Health team excluding any facility accommodation and lodging expenses.
If you need help recovering or have other special health needs	Out-Patient Executive Check Up	All cost above Php14,175 or $315	All cost	Services needs to be prior coordinated and scheduled with TakeCare. Services are covered up to the actual cost but not to exceed Php 14,175 per member per benefit period at Participating Providers in the Philippines or the actual cost but not to exceed $315 per member per benefit period within the Service Area or at other Non-Philippine Participating Providers. Benefit is not convertible to cash if unused during a benefit period and cannot be applied towards other services This benefit is not eligible for travel and/or airfare benefit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
Travel Benefit	Travel Benefit including airfare and lodging	All cost above $500 per occurrence	All cost	Prior Authorization (written approval) and coordination is required from TakeCare prior to departure from Guam and/or CNMI. Applicable only to approved referrals by TakeCare's Medical Management Department. Airfare and/or lodging expenses coverage for eligible members for any approved specialty care visits, consultations, treatments and hospitalization services to Preferred Philippine providers. Executive check up, preventive services and/or primary care services do not qualify for this benefit. Conditions and limitations apply as specified in the Member Handbook.
If your child needs dental or eye care	Children's eye exam	No copay, co-insurance and/or deductible for covered services	30% co-insurance	Limited to one exam per benefit year.
	Children's glasses	All Cost	All cost	Not covered under this plan
	Children's dental check-up	All Cost	All cost	Not covered under this plan

Exclusions and Limitations

Services and benefits for care and conditions as described below shall be excluded from coverage under this Plan unless specifically included as a supplemental benefit.

General Exclusions
The following services are not covered by TakeCare:

A. (1) All services not specifically included in the "Schedule of Benefits" and/or the Member Handbook,
(2) Services rendered without authorization from a member's Primary Care Physician and TakeCare,
(3) Emergency and/or urgent care services where TakeCare was not informed within the time prescribed by the Policy, and
(4) Services prior to a member's start date of coverage or after the time coverage ends.

B. TakeCare is not responsible for the cost of services, which are not medically necessary or not required in accordance with professionally recognized standards of medical practice.

Exclusions applicable to all medical benefits provided under your TakeCare Plan include:

- A member shall only be entitled to benefits for injuries or illnesses which require confinement in a hospital or in a skilled nursing facility during the term of a member's coverage under the current Policy, but not for benefits prior to the effective date of the Policy or after the termination date of the Policy.
- AICD and/or AICD combination biventricular pacemaker, therapy and any other related devices, supplies, and replacements unless specified as covered in your Schedule of Benefits.
- Acupuncture care and all related services, medication and supplies, unless provided as a supplemental benefit.
- Air ambulance services.
- Any injury sustained or illness precipitated through the member's commission of any illegal activity, whether or not the member is ever charged or convicted and whether it be a felony or only a petty misdemeanor, or in the member's commission of a felony.
- Any injury sustained, in whole or in part, directly or indirectly resulting from the member driving under the influence of alcohol, illegal narcotics or a non-prescribed controlled substance.
- Any work related injury or illness subject to disability benefits or compensation pursuant to any Employer's Liability Law, Workers' Compensation Law or similar legislation even if the member does not claim the benefits.
- Any injury sustained while taking part in, but not limited to, amateur sports, professional sports, collegiate sports, contact sports, hazardous sports, combat sports, recreational sports or any physical activity, including those injuries while training or preparing for these activities.
- Benefits for an injury or illness when such services would have been rendered without charge except for the fact that the person is a member under the Plan.
- Blood and blood products and derivatives including whole blood, blood components, blood factor replacements, whether synthetic or natural unless specified as covered in your Schedule of Benefits.
- Care for military service connected disabilities to which the member is legally entitled to government benefits and/or care.
- Care provided while you are confined in a hospital or institution owned or operated by the United States Government of any of its agencies, except to the extent provided by 38 U.S.C. § 1729 as it relates to non-military services provided at a Veteran's Administration Hospital or facility.
- Care which is provided without charges to you or for which you are not obligated to pay, such as services obtained at a health fair.

- Care which you obtained from the United States Armed Forces or the Veteran's Administration as active duty military of veteran's health benefits will not be covered, unless such exclusion is prohibited by law.
- The cost of care for which another health and accident insurance is responsible because coverage is prorated based on several insurers being liable to pay for the same losses.
- Care that is not clinically appropriate for the treatment of your condition as determined by TakeCare's medical professional staff in coordination with the insured Member's licensed provider pursuant to the nationally recognized clinical criteria used by most health insurance plans in Hawaii and Continental United States.
- Charges in excess of reasonable amounts for services and supplies will not be covered under the Plan.
- Chiropractic care and all related services, medications and supplies such as ancillary services (e.g. X-rays) unless specified as covered in your Schedule of Benefits.
- Cochlear implants and any related services, medication and supplies.
- Contact lenses, examinations for contact lenses, visual perceptual evaluation and visual training; surgical correction of the eye for the purpose of refraction (e.g.,. Lasik surgery); intraocular lenses; radial keratotomy intraocular lens implants and related procedures, services, supplies and medications.
- Continued services if you do not substantially follow your treatment plan.
- Custodial care, domiciliary care, respite care, residential care and hospice. Custodial or domiciliary care includes that care which consists of training in personal hygiene, routine nursing services and other forms of self-care. Custodial or domiciliary care also includes supervisory services by a physician or nurse for a person who is not under specific medical or surgical treatment to reduce his or her disability and to enable that person to live outside an institution providing such care.
- Dental care unless specified as covered in your Schedule of Benefits.
- Diagnosis and treatment of infertility, reversal of voluntary sterilization and services related to conception by artificial means including in vitro fertilization, embryo transfers and other related services, including medication.
- Durable medical equipment unless covered in your Schedule of Benefits and specified in a treatment plan from a licensed physician contracted with TakeCare.
- Elective or voluntary enhancement procedures, surgeries, services, supplies and medications including, but not limited to, weight loss, hair growth, hair removal, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance. Procedures, services, supplies and medications until they are reviewed for safety efficacy and cost effectiveness and approved by TakeCare.
- End Stage Renal Disease (ESRD) and all related services, medications and supplies unless specified as covered in your Schedule of Benefits.
- Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician and approved by TakeCare to be medically necessary and appropriate.
- Experimental medical, surgical and other health care procedures and services related thereto, and procedures and services not covered by Medicare unless specified as covered in your Schedule of Benefits.
- External prosthetic devices, disposable prosthetic and orthotic devices, prosthetic and orthotic devices and supplies available over-the-counter and corrective appliances, except plaster and fiberglass casts and unless specified as covered in your Schedule of Benefits.
- Eyeglasses, optical lenses and frames and any services related to the repair of such items, unless provided as a supplemental benefit.
- Fees for any missed appointments, transfer of records or copies of records.
- Hearing aid, and hearing aid evaluations (audiological examinations), including examinations related to the prescription or fitting of a hearing aid.
- Hospital take-home drugs.
- Hyperbaric Oxygen (HBO) treatment.
- If a benefit is not covered or excluded, all related hospital, surgical, medical treatments, prescription drugs, laboratory services, x-rays, as well as complications related thereto, are also excluded.

- Injuries excluded for treatment under the Plan include, but are not limited to, whether a driver or a passenger of racing, pace making or speed testing of any motor vehicle, off-roading, extreme sports, competitive fighting, sky diving/parachuting (single/tandem), base jumping/bungee cord jumping, whether such activity is formal and organized or informal and spontaneous.
- Inpatient services related to treatment of specific hospital acquired conditions or services needed to correct preventable medical errors or "never events".
- Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition.
- Internal prosthetic devices except single chamber pacemakers and breast prostheses in accordance with the Women's Health and Cancer Rights Act of 1998 and unless specified as covered in your Schedule of Benefits.
- Legislatively mandated benefits available through governmental agencies (federal, state, territorial, municipal or other governmental instrumentality or agency) or institutions to the extent that such benefits are available to the member at no cost.
- Medical and hospital care and costs for the infant child of a Member, unless this infant child is otherwise eligible for coverage under the Plan.
- Medicare eligible care and services which are rendered at a facility which is not a Medicare contracted facility, or which is rendered by a physician that is not a Medicare contracted physician.
- Motorized artificial limbs.
- No benefit shall be paid for the care and services of a stillborn fetus.
- No benefit shall be paid for routinely prescribed supplies after surgical services such as but not limited to compression garments stockings.
- No benefit will be paid for charges made by a provider for medical services provided through telephone conferences or interviews during which the member is not seen for treatment unless specified as covered in your Schedule of Benefits.
- No benefit will be paid for medical services furnished by immediate relatives or members of the member's household unless services rendered by such persons are rendered as employees of a hospital, physician or other provider.
- No benefit will be paid for other non-medical expenses such as taxes, taxis, hotel rooms, etc. In no event will the Plan pay for air ambulance including the transportation of the remains of any deceased person.
- No benefit will be paid for services and supplies associated with growth hormone treatment.
- No benefit will be paid for services and supplies provided for circumcisions performed beyond thirty-one (31) days from the date of birth that are not determined to be medically necessary.
- No benefit will be paid for services and supplies provided for penile implants of any type.
- No benefit will be paid for services and supplies provided to a dependent of a non-spouse dependent. Dependents of non-spouse dependents are not eligible for coverage unless such dependent becomes eligible for enrollment.
- No benefit will be paid for: (a) drugs or substances not approved by the Food and Drug Administration (FDA); or (b) drugs or substances not approved by FDA for the specific treatment of illness or injury being treated unless empirical clinical studies have proven the benefits of such drug or substance in treating the illness or injury; or (c) drugs or substances labeled "caution: limited by federal law to investigational use" unless specified as covered in your Schedule of Benefits.
- No benefit will be paid in connection with bariatric surgery, gastric bypass, banding, stapling or reversal.
- No benefit will be paid in connection with dental care or for any treatment to the teeth, jaws and dependent tissues ordinarily performed by a dentist unless specified as covered in your Schedule of Benefits.
- No benefit will be paid in connection with dialysis treatments unless specified as covered in your Schedule of Benefits
- No benefit will be paid for newly approved FDA treatment and/or procedures within one year from the date of FDA approval. Coverage after the one year period is subject to the review, determination and written approval of TakeCare's product committee.
- No benefit will be paid for newly approved FDA drugs and medication within one year from the date of FDA approval. Coverage after the one year period is subject to the review, determination and written approval of TakeCare's pharmacy committee.

- No benefits will be paid for services and supplies provided for cosmetic surgery or treatment, even for physiological reasons, unless the surgery or treatment is required pursuant to the Women's Health and Cancer Rights Act of 1998.
- No benefits will be paid for services and supplies provided for liposuction or any drug, food substitute, or supplement or any other product which is primarily for weight reduction, even if it is prescribed by a physician.
- No benefits will be paid for services and supplies provided in the course of organ donation whether for a member who is donating an organ or for someone who is donating an organ for transplantation into a member unless specified as covered in your Schedule of Benefits.
- No benefits will be paid for: (a) surgical excision or reformation of any sagging skin on any part of the body, including the face, neck, abdomen, arms, legs, or buttocks; (b) any services performed in connection with the enlargement, reduction, implantation or change in appearance in a portion of the body, including the breasts, abdomen, face, lips, jaw, chin, nose, ears or genitals; (c) hair transplantation; (d) face peels or abrasions of the skin; (e) electrolysis depilation; and (f) any other surgical or non-surgical procedures that are for cosmetic purposes, including keloids.
- No benefits will be paid in connection with mouth conditions due to abscess, periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar process, or the gingival tissue.
- Non-emergency ground ambulance services.
- Occupational, speech, vision and massage therapy services and related medications and supplies, regardless of the conditions for which such services and supplies are provided, unless specified as covered in your Schedule of Benefits.
- Organ or tissue transplants, including, but not limited to, autologous bone marrow transplants and any related hospital, surgical, drug, laboratory, X-ray, or other medical services or supplies related or necessary as part of the transplant, including post transplant follow-up and drug therapy unless specified as covered in your Schedule of Benefits.
- Orthopedic footwear.
- Over-the-counter drugs, drugs for which a prescription from a licensed physician is not required under federal law or drugs for which there is a non-prescription equivalent available.
- Over-the-counter medical supplies including, but not limited to, gauze, bandages and other first aid products.
- Personal convenience items such as, but not limited to, television, telephone and guest trays.
- Physical examinations and immunizations for the sole purpose of employment, insurance, travel, sports and educational requirements.
- Physical therapy and rehabilitation beyond Plan benefits.
- Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms.
- Robotic surgery and robotic suite including but not limited to related hospital charges unless specified as covered in your Schedule of Benefits.
- Specialty second opinion consultation initiated by a Covered Member.
- Services and medications related to the treatment of sexual dysfunction, including erectile dysfunction, impotency and anorgasmy or hyporgasmy.
- Services and supplies paid for directly or indirectly by any local, state, federal government agency or charitable institutions on the effective date of this Policy and/or which may be provided for during the benefit period.
- Services and supplies provided to the member after the member has expired (non-viable services and supplies).
- Services that are mandated to be provided rendered or billed by a school or a member of its staff.
- Sleep studies/polysomnogram unless specified as covered in your Schedule of Benefits.
- Terminated pregnancy (non-medically necessary) unless the health of the mother is at risk or in cases of rape, incest or fetal abnormality.
- To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within our control results in our facilities, personnel, or financial resources being unavailable to provide or arrange for the provisions of a basic or supplemental health service or supplies in accordance with this Plan.
- The Plan is not an insurer against, nor liable for the negligence or other wrongful act or omission of any physician, hospital, hospital employee or other provider, or for any act or omission of any member.

- The Plan will not guarantee the availability of or undertake to provide any services of any third party.
- The Plan will not pay for benefits as a result of TakeCare's rescission of a subscriber or member's coverage back to the initial date of coverage in the event of fraud or intentional misrepresentation of material fact as prohibited by the terms of the Plan or TakeCare's policies.
- Transsexual surgery and related services and medications unless specified as covered in your Schedule of Benefits.
- Treatment of illness or injuries, which are intentionally self-induced or self-inflicted, if not connected to a medical condition, either mental or physical.
- Treatment of temporomandibular joint diseases (TMJ). This includes, but is not limited to: (a) services of a dentist; (b) bite plates; (c) braces to straighten teeth; (d) orthongnathic surgery to correct a bite defect; (e) surgical procedures in direct treatment of TMJ, including surgery on the joint itself or on the Hyoid bone; (f) arthrogram or other X-ray to the TMJ, and also including magnetic resonance imaging; or (g) biofeedback of the insertion of TENS units or related devices.
- Weight loss medications and procedures, including anorexients, anti-obesity agents, appetite suppressants or anorexiginic agents.
- Benefits and services not specified as covered.