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. $1,000/ individual or $3,000/ 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.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network providers Medical and Prescription: $2,000 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, deductible amounts, 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.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
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.

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	20% coinsurance	30% coinsurance	Coverage is limited to the Service Area.
	Specialist visit	20% coinsurance	30% coinsurance	Referral from your Primary Care Physician is required.
	Preventive care/screening/ immunization	No charge for covered services	30% coinsurance	Based on services rated A and B by the US Preventive Care Task Force. You may have to pay for services that aren't preventative. Ask your provider if the services needed are preventative. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	Referral from your Primary Care Physician is required for x-ray.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	Referral from your Primary Care Physician and Prior Authorization (written approval) from TakeCare is required.

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 takecareasia.com or medimpact.com	Generic drugs (Tier 1)	$5 copay per 30-day Retail Drug prescription; $10 copay per 90-day Retail Drug prescription at Preferred Pharmacies; No cost for Mail Order Drug prescription	All costs	Valid prescription from a licensed Physician is required. Limited to a 30-day supply for Retail at all participating pharmacies and 90-day supply for Retail at Preferred Pharmacies or Mail Order. 90-day supply for Retail applies after an initial 30-day fill. Other dispensing limitations may apply.
	Preferred brand drugs (Tier 2)	$15 copay per 30-day Retail Drug prescription; $30 copay for 90-day Retail Drug prescription at Preferred Pharmacies; No cost for Mail Order Drug prescription	All costs	Valid prescription from a licensed Physician is required. Limited to a 30-day supply for Retail at all participating pharmacies and 90-day supply for Retail at Preferred Pharmacies or Mail Order. 90-day supply for Retail applies after an initial 30-day fill. Other dispensing limitations may apply.
	Non-preferred brand drugs (Tier 3)	30% coinsurance per 30-day Retail Drug prescription; 30% coinsurance copay per 90-day Retail Drug at Preferred Pharmacies; $150 copay for Mail Order Drug prescription	All costs	Valid prescription from a licensed Physician is required. Limited to a 30-day supply for Retail at all participating pharmacies and 90-day supply for Retail at Preferred Pharmacies or Mail Order. 90-day supply for Retail applies after an initial 30-day fill. Requires Prior Authorization (written approval) from TakeCare. Other dispensing limitations may apply.
	Injectables, including specialty injectable drugs (Tier 4)	30% coinsurance per Retail Preferred Specialty Drug prescription	All costs	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.
	Specialty, excluding injectable drugs (Tier 5)	20% coinsurance per Retail Preferred Specialty Drug Prescription, up to $250 out of pocket maximum	All costs	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.

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	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Prior Authorization (written approval) is required from TakeCare.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	Prior Authorization (written approval) is required from TakeCare.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Copayment/Coinsurance are waived if admitted. Applicable hospitalization co-payment/ coinsurance applies to all services including costs related to out-patient emergency. Hospital admission or in-patient services resulting from an emergency room care requires Prior Authorization (written approval) from TakeCare. Not subject to deductible. Limited to ground transportation only Urgent Care Services available at FHP Health Center, Preferred Providers and Non-Preferred Providers (GMH) only within the Service Area.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Prior Authorization (written approval) is required from TakeCare.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	Prior Authorization (written approval) is required from TakeCare.
Outpatient Telemedicine	Telemedicine Services (primary care visit, specialist follow up visit and behavioral health)	20% coinsurance	All costs	Required documentation must be provided for Telemedicine Services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	Referral from your Primary Care Physician is required.
	Inpatient services	20% coinsurance	30% coinsurance	Prior Authorization (written approval) is required from TakeCare.
If you are pregnant	Office visits	No Charge	30% coinsurance	Does not cover stillborn fetus treatments
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	

For more information about limitations and exceptions, see the plan or policy document at www.takecareasia.com.

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 help recovering or have other special health needs	Home health care	20% coinsurance	No Coverage	Available through FHP Home Health only.
	Rehabilitation services	20% coinsurance	30% coinsurance	Limited to 20 and 10 per member per benefit year for Speech Therapy and Occupational Therapy respectively. Prior Authorization (written approval) is required from TakeCare.
If you need help recovering or have other special health needs	Habilitation services	20% coinsurance	30% coinsurance	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 combined with Physical Therapy.
	Skilled nursing care	20% coinsurance	30% coinsurance	Limited to 60 days per member per benefit year. Prior Authorization (written approval) is required from TakeCare.
	Durable medical equipment	20% coinsurance	30% coinsurance	Prior Authorization (written approval) is required from TakeCare. Treatment plan from a licensed Physician is required. CPAP/BIPAP coverage is limited to $500 per eligible member per benefit period. CPAP and BiPap supplies included in the initial device packaging is covered.
	Hospice services	20% coinsurance	30% coinsurance	Available through FHP Home Health only. This benefit is limited to 180 days per lifetime. Prior Authorization (written approval) is required from TakeCare.
If your child needs dental or eye care	Children's eye exam	No Charge	No Coverage	Coverage limited to one exam/year.
	Children's glasses	No Coverage	No Coverage	----------None----------
	Children's dental check-up	No Coverage	No Coverage	----------None----------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery
- Private Duty Nursing
- Weight Loss Programs
- Routine Foot Care
- Dental Care (Adult and non-preventive pediatric services)
- Hearing Aids
- Non-emergency care outside the U.S. (except for services approved and authorized by TakeCare)
- Infertility Treatment
- Long Term Care
- Stillborn Fetus Treatments

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care
- Autism Spectrum Disorder Coverage
- Routine eye care (Adult)
- Telemedicine

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: TakeCare Customer Service at (671) 647- 3526 or 1-877-484-2411.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Chinese/Mandarin: 关于我们的健康或药物计划的问题，请联系翻译员，电话号码是 1-671-647-3526。

Korean: 건강 또는 의약품 플랜에 대한 답변은 1-671-647-3526 번으로 통역사에게 문의하십시오.

Tagalog: Para sa mga sagot tungkol sa ating kalusugan o plano sa gamot, makipag-ugnayan sa isang tagapagsalin, sa 1-671-647-3526.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$85
Coinsurance	$1,866
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,011**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$240
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,100**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$560
What isn't covered	
Limits or exclusions	$210
The total Mia would pay is	**$780**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: TakeCare Customer Service at 671.647.3526

The plan would be responsible for the other costs of these EXAMPLE covered services.