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 plan maximum?	No overall plan maximum for most services. Some benefits and services have coverage limitation.	This plan complies with Affordable Care Act (ACA) of 2010 with respect to provision on lifetime and annual limits. https://www.healthcare.gov/health-care-law-protections/lifetime-and-yearly-limits/
What is the overall deductible?	$0/Individual or $0/Family for Participating Providers $300/Individual or $900/Family for Non-Participating 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 combined in network and out of network providers Medical: $2,000 individual / $6,000 family 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 copay/office visit	30% coinsurance	----------None----------
	Specialist visit	$35 copay/office visit	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)	No charge for blood work; $20 copay/office visit for x-ray	30% coinsurance	----------None----------
	Imaging (CT/PET scans, MRIs)	$50 copay/office visit	30% coinsurance	Referral from your Primary Care Physician and Prior Authorization (written approval) from TakeCare is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.takecareasia.com or www.elixirsolutions.com	Generic drugs (Tier 1)	$10 copay/ prescription (Retail); No charge (Mail Order)	30% coinsurance	Prescription from a licensed Physician is required. Limited to a 30 day supply for retail and 90-day supply for mail order. Coverage is based on TakeCare's formulary.
	Preferred brand drugs (Tier 2)	$20 copay/ prescription (Retail); No charge (Mail Order)	30% coinsurance	Prescription from a licensed Physician is required. Limited to a 30 day supply for retail and 90-day supply for mail order. Coverage is based on TakeCare's formulary.
	Non-preferred brand drugs (Tier 3)	$50 copay/ prescription (Retail); $200 copay/ prescription (Mail Order)	30% coinsurance	Prescription from a licensed Physician is required. Limited to a 30 day supply for retail and 90-day supply for mail order. Coverage is based on TakeCare's formulary.

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)	
	Specialty drugs (Tier 4 and Tier 5)	$400 copay/prescription for Preferred Specialty Drugs; $500 copay/ prescription for Non-Preferred Specialty Drugs	30% coinsurance	Prescription from a licensed Physician is required. Limited to 30-day supply for retail and 90-day supply for mail order is not available. Requires prior authorization and approval from TakeCare.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay	30% coinsurance	Prior Authorization (written approval) is required from TakeCare.
	Physician/surgeon fees	$20 copay primary care $35 copay specialist care	30% coinsurance	Prior Authorization (written approval) is required from TakeCare.
If you need immediate medical attention	Emergency room care	$100 copay	$100 copay	Copayment/Coinsurance are waived if admitted. Applicable hospitalization co-payment/ coinsurance apply 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	No Charge	No Charge	
	Urgent care	$20 copay per visit at FHP and at Preferred Providers Monday to Friday within business hours; $35 copay at Preferred Providers within the service area or at FHP after regular business hours, Saturdays, Sundays and Holidays; $35 copay at Non Preferred Providers 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 co-pay outside the service area	

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	Facility fee (e.g., hospital room)	$100 copay/admission	30% coinsurance	Prior Authorization (written approval) is required from TakeCare.
	Physician/surgeon fees	No Charge	30% coinsurance	Prior Authorization (written approval) is required from TakeCare.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit	30% coinsurance	Referral from your Primary Care Physician is required.
	Inpatient services	No Charge	30% coinsurance	Prior Authorization (written approval) is required from TakeCare.
If you are pregnant	Office visits	$20 copay/visit	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. Eligible Subscriber or Spouse only. Coverage is limited to the Service Area. Does not cover Stillborn Fetus Treatments.
	Childbirth/delivery professional services	No Charge	30% coinsurance	Does not cover stillborn fetus treatments
	Childbirth/delivery facility services	$100 copay	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	$20 copay/visit	Not Covered	Available through FHP Home Health only or through TakeCare's Participating Provider outside the Service Area with Prior Authorization (written approval) from TakeCare.
	Rehabilitation services	$35 copay	30% coinsurance	Limited to 20 days per member per benefit year. Occupational Therapy and Speech Therapy not covered. Prior Authorization (written approval) is required from TakeCare.
	Habilitation services	Not Covered	Not Covered	----------None----------
	Skilled nursing care	$100 copay/admission	30% coinsurance	Limited to 30 days per member per benefit year. Prior Authorization (written approval) is required from TakeCare.
	Durable medical equipment	$35 copay	Not Covered	Prior Authorization (written approval) is required from TakeCare. Treatment plan from a licensed Physician 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)	
	Hospice services	$20 copay/visit	No Covered	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	30% coinsurance	Coverage limited to one exam/year.
	Children's glasses	Not Covered	Not Covered	----------None----------
	Children's dental check-up	Not Covered	Not Covered	----------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.)

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

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

- Blood and Blood Products
- Autism Spectrum Disorder
- Chiropractic Care
- ESRD
- Routine Eye Care (Adult)
- Weight Loss Medication
- 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.

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 copayment	$35
Hospital (facility) copayment	$100
Other coinsurance	0%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$210**

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 copayment	$35
Hospital (facility) copayment	$100
Other coinsurance	0%

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$520
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$520**

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

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) copayment	$100
Other coinsurance	0%

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	$440
Coinsurance	$0
What isn't covered	
Limits or exclusions	$210
The total Mia would pay is	**$650**

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.