TakeCare Insurance Company, Inc.

www.takecareasia.com

Customer Service: 671-647-3526, 877-484-2411 (toll free), or customerservice@takecareasia.com

TakeCare
A TanHoldings Company

2025

A Health Maintenance Organization (High and Standard) Options, and High Deductible Health Plan (HDHP) Option

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details. This plan is accredited. See page 12.

Serving: *The Island of Guam, the Commonwealth of the Northern Mariana Islands, and the Republic of Belau (Palau)*

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 15 for requirements.

Only Postal Employees and Annuitants may enroll in this plan.

Enrollment codes for this Plan:

G4A High Option – Self Only
G4C High Option – Self Plus One
G4B High Option – Self and Family
G4D Standard Option – Self Only
G4F Standard Option – Self Plus One
G4E Standard Option - Self and Family
HJA High Deductible Health Plan (HDHP) – Self Only
HJC High Deductible Health Plan (HDHP) – Self Plus One
HJB High Deductible Health Plan (HDHP) – Self and Family

IMPORTANT

PSHB

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-929

Important Notice for Medicare-eligible Active Employees from TakeCare Insurance Company, Inc. About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the **TakeCare** prescription drug coverage for active employees is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means active employees and their covered family members do not need to enroll in an open market Medicare Part D plan and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your PSHB coverage as an active employee.

However, if you (as an active employee and your covered Medicare Part D-eligible family members) choose to enroll in an open market Medicare Part D plan, you can keep your PSHB coverage and your PSHB plan will coordinate benefits with Medicare.

Please be advised

If you lose or drop your PSHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov , or call the SSA at 800-772-1213 TTY 800-325-0778.

Additional Premium for Medicare's High Income Members
Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your PSHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return**. **You do not make any IRMAA payments to your PSHB plan**. Refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

You can get more information about open market Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, TTY 877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of TakeCare Insurance Company, Inc. under contract (CS 2825 PS) between itself and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits (FEHB) law, as amended by the Postal Service Reform Act, which created the Postal Service Health Benefits (PSHB) Program. Customer Service may be reached at 671-647-3526, via email at customerservice@takecareasia.com, or through our website at www.takecareasia.com. The address for the TakeCare administrative offices is:

TakeCare Insurance Company, Inc.
P.O. Box 6578
Tamuning, Guam 96931

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. If you are a Postal Service annuitant and you are eligible for Medicare Part D, or a covered Medicare Part D-eligible family member of a Postal Service annuitant, your prescription drug benefits are provided under our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP). You do not have a right to benefits that were available before January 1, 2025, under the FEHB Program unless those benefits are also shown in this PSHB Plan brochure.

OPM negotiates benefits and rates for each plan annually. Benefits are effective January 1, 2025. Rates are shown at the end of this brochure.

Plain Language

All Postal Service Health Benefits (PSHB) brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee and each covered family member, "we" means TakeCare.
- We limit acronyms to ones you know. OPM is the United States Office of Personnel Management. The FEHB Program is the Federal Employees Health Benefits Program administered by OPM and established under 5 U.S.C. chapter 89. The PSHB Program is the Postal Service Health Benefits Program established within the FEHB Program under 5 U.S.C. section 8903c. PSHB Plan means a health benefits plan offered under the PSHB Program. PSHB means Postal Service Health Benefits. If we use others, we tell you what they mean.
- Our brochure and other PSHB plans' brochures have the same format and similar descriptions to help you compare plans

Stop Health Care Fraud!

Fraud increases the cost of healthcare for everyone and increases your Postal Service Health Benefits Program premium. Fraud increases the cost of healthcare for everyone and increases your Postal Service Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the PSHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 671-647-3526 and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE
877-499-7295
OR go to https://hotlineintake.oig.opm.gov/etk-opm-ig-prod/page.request.do?page=page.efile.publicPage
The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

Do not maintain family members on your policy:

- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
- Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26)

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain PSHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, for example a member's gender identity or the fact that the covered benefit is sought in connection with gender-affirming care, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. **Ask questions if you have doubts or concerns.**
   - Ask questions and make sure you understand the answers.
   - Choose a doctor with whom you feel comfortable talking.
   - Take a relative or friend with you to help you take notes, ask questions and understand answers.
2. **Keep and bring a list of all the medications you take.**
   - Bring the actual medication or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
   - Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
   - Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
   - Make sure your medication is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
   - Read the label and patient package insert when you get your medication, including all warnings and instructions
   - Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
   - Contact your doctor or pharmacist if you have any questions.
   - Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.
3. **Get the results of any test or procedure.**
   - Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
   - Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
   - Ask what the results mean for your care.
4. **Talk to your doctor about which hospital or clinic is best for your health needs.**
   - Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
   - Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. **Make sure you understand what will happen if you need surgery.**

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - “Exactly what will you be doing?”
  - “About how long will it take?”
  - “What will happen after surgery?”
  - “How can I expect to feel during recovery?”
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission’s Speak Up™ patient safety program.

- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.

- www.ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.

- https://psnet.ahrq.gov/issue/national-patient-safety-foundation The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.

- www.bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.

- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions (“Never Events”)

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called “Never Events” or “Serious Reportable Events.”

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your PSHB plan will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use TakeCare's in-network providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

PSHB Facts

Coverage information

No pre-existing condition limitation	We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
Minimum essential coverage (MEC)	Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
Minimum value standard	Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.
Where you can get information about enrolling in the PSHB Program	See www.health-benefits.opm.gov/pshb for enrollment information as well as: • Information on the PSHB Program and plans available to you • A health plan comparison tool Note: Contact the USPS for information on how to enroll in a PSHB Program Plan through the PSHB System. Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your PSHB coverage. These materials tell you: • When you may change your enrollment • How you can cover your family members • What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire • What happens when your enrollment ends • When the next Open Season for enrollment begins We do not determine who is eligible for coverage. You will be responsible for making changes to your enrollment status through the PSHB System. In some cases, your employing or retirement office may need to submit documentation. For information on your premium deductions, you must also contact your employing or retirement office. Once enrolled in your PSHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.
Enrollment types available for you and your family	Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support. If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member.

You enroll in a PSHB Program Plan and make enrollment changes in the PSHB System located at www.health-benefits.opm.gov/pshb. For assistance with the PSHB System, call the PSHBP Helpline at (844) 451-1261. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment request. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

Use the PSHB System if you want to change from Self Only to Self Plus One or Self and Family, and to add or remove a family member.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive benefits. Please, report changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26 through the PSHB System. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one PSHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another PSHB plan *or FEHB plan.*

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the PSHB Program, change your enrollment, or cancel coverage using the PSHB System. For a complete list of QLEs, visit the PSHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, personnel/payroll office, or retirement office.

Family Member Coverage

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member, as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

Children's Equity Act

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the PSHB Program if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no PSHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the PSHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for PSHB coverage, you must continue your PSHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

For annuitants who are required to be enrolled in Medicare Part B as a condition to continue PSHB coverage in retirement: If you enroll in Medicare Part B and continue PSHB coverage in retirement, the child equity law applies to you and you cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your child(ren) live as long as the court/administrative order is in effect. You cannot be compelled to enroll or remain enrolled in Medicare Part B to maintain your PSHB enrollment as a condition to satisfy a court/administrative order. However, if you do not enroll (or remain enrolled) in Medicare Part B as required to continue your PSHB coverage in retirement (notwithstanding an existing court/administrative order), you will not be able to continue your PSHB coverage in retirement.

Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP)

Our PDP EGWP is only available to Postal Service annuitants who are Medicare Part D-eligible and their covered Medicare Part D-eligible family members. Our PDP EGWP is not an open market Medicare Part D Plan. If you are an active Postal Service employee, or covered family member, and become eligible to enroll in Medicare Part D, you are not eligible to enroll in our PDP EGWP. For assistance, contact TakeCare Customer Service at 671-647-3526 or via email at customerservice@takecareasia.com .

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage and premiums begin on January 1. If you joined at any other time during the year, your employing or retirement office will tell you the effective date of coverage.

When you retire

When you retire, you can usually stay in the PSHB Program. Generally, you must have been enrolled in the FEHB and/or PSHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

When PSHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

If you are eligible for coverage under spouse equity, you are only eligible to enroll in the FEHB Program. If you are not eligible for coverage under spouse equity and you are otherwise eligible for Temporary Continuation of Coverage (TCC), then you could enroll in TCC under the PSHB Program.

Upon divorce

If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You **must** enter the date of the divorce or annulment and remove your ex-spouse in the PSHB System. We may ask for a copy of the divorce decree as proof. If you need to change your enrollment type, you must use the PSHB System. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). Former spouses eligible for coverage under the spouse equity law are not eligible to enroll in the PSHB Program. However, former spouses eligible for coverage under the spouse equity law may enroll in the FEHB Program. (Former Spouses seeking but not yet adjudicated as eligible for Spouse Equity may be entitled to TCC under a PSHB plan in the interim).

Former spouses not meeting the spouse equity requirements may be eligible for TCC under the PSHB Program provided you otherwise meet the eligibility requirements for TCC. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

Medicare PDP EGWP

When a Postal Service annuitant who is Medicare Part D-eligible or their covered Medicare-eligible family member opts out of or disenrolls from our PDP EGWP, they will not have our prescription drug coverage under this plan. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for additional information at 671-647-3526 or via email at customerservice@takecareasia.com.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your PSHB enrollment after you retire, if you lose your Federal job, or if you are a covered child and you turn 26.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance . It explains what you have to do to enroll.

Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing PSHB Program coverage.

Converting to individual coverage

You may convert to a non-PSHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must contact us in writing within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the PSHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 671-647-3526 orcustomerservice@takecareasia.com

Section 1. How This Plan Works

TakeCare is a health maintenance organization (HMO) and gives you a choice of enrollment in a High Option, a Standard Option, or a High Deductible Health Plan (HDHP) Option. OPM requires that PSHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. TakeCare holds the following accreditation: Accreditation Association for Ambulatory Health Care (AAAHC). The pharmacy benefit manager that supports TakeCare holds accreditations from URAC and NCQA. To learn more about this plan's accreditation(s), please visit the following websites: www.aaahc.org or www.urac.org or www.ncqa.org

To get the highest level of coverage from this Plan, we recommend you see physicians, hospitals, and other providers that are contracted with us. These in-network providers coordinate your healthcare services. We are solely responsible for the selection of these providers in your area. Please view or download our most current Provider Directory at www.takecareasia.com for the most updated list of in-network Providers.

We emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our in-network providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from in-network plan providers you will not have to submit claim forms or pay bills. You pay only the copayment and coinsurance. HDHP Option members pay the coinsurance and deductibles as described in this brochure. Once you've accumulated the total deductible, you will have to submit a deductible claim form together with all the required documents.

You should join the High Option, Standard Option, or HDHP Option because you prefer the option's benefits, not because a particular provider is available. You cannot change Plans because a provider leaves our network. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These in-network providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies). TakeCare is a Mixed Model Plan. This means the doctors provide care in contracted medical centers or their own offices.

General features of our High and Standard Options

Deductibles

For the High and Standard Options, there are no deductibles to meet.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received from an in-network provider.

General features of our High Deductible Health Plan (HDHP) Option

Deductibles

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of PSHB plans. PSHB Program HDHPs also offer health savings accounts (HSAs) or health reimbursement arrangements (HRAs). Please see below for more information about these savings features.

> **Medical Deductible** - this HDHP Option offers a combined in-network and out-of-network medical deductible of $1,500 for Self Only or $3,000 for Self Plus One or $4,000 for Self and Family enrollment each calendar year. The deductible must be met before plan benefits are paid for care other than preventive care services. See pages 97-98 for details.

Prescription Drugs Deductible - this HDHP Option offers a combined in-network and out-of-network prescription drug deductible of $500 for Self Only or $1,000 for Self Plus One or $1,000 for Self and Family enrollment each calendar year. The deductible must be met before plan benefits are paid for care other than preventive care medications. See pages 97-98 for details.

Preventive Care Services & Medications

Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received from an in-network provider.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, excluding specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, not received VA (except for veterans with a service-connected disability) or Indian Health Service (IHS) benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Health education resources and accounts management tools

There are a variety of health resources and account management tools available to our members. Account management tools are also available from your chosen fiduciary to provide account balance and transaction history.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. You have two separate out-of-pocket annual maximums.

Medical Out-of-Pocket Annual Maximum

High Option: Your annual out-of-pocket expenses for covered medical services, including in-network and out-of-network copayments and coinsurance, cannot exceed $2,000 for Self Only or $4,000 for Self Plus One or $6,000 for Self and Family enrollment.
Standard Option: Your annual out-of-pocket expenses for covered medical services, including in-network and out-of-network copayments and coinsurance, cannot exceed $3,000 for Self Only or $6,000 for Self Plus One or $6,000 for Self and Family enrollment.
HDHP Option: Your annual out-of-pocket expenses for covered in-network medical services, including copayments and coinsurance, cannot exceed $3,000 for Self Only or $6,000 for Self Plus One or $6,000 for Self and Family enrollment.

Prescription Drugs Out-of-Pocket Annual Maximum

High Option: Your annual out-of-pocket in-network expenses for covered prescription drugs, including copayments and coinsurance, cannot exceed $2,000 for Self Only or $4,000 for Self Plus One or $6,000 for Self and Family enrollment.
Standard Option: Your annual out-of-pocket in-network expenses for covered prescription drugs, including copayments and coinsurance, cannot exceed $3,000 for Self Only or $6,000 for Self Plus One or $6,000 for Self and Family enrollment.
HDHP Option: Your annual out-of-pocket in-network expenses for covered prescription drugs, including copayments and coinsurance, cannot exceed $3,000 for Self Only or $6,000 for Self Plus One or $6,000 for Self and Family enrollment in any calendar year.

Under the **PDP EGWP Prescription Drug Benefit program**, the following applies:

High Option: Your annual out-of-pocket in-network expenses for covered prescription drugs, including copayments and coinsurance, cannot exceed $2,000 for Self Only or $4,000 for Self Plus One or $6,000 for Self and Family enrollment.
Standard Option: Your annual out-of-pocket in-network expenses for covered prescription drugs, including copayments and coinsurance, cannot exceed $2,000 for Self Only or $4,000 for Self Plus One or $6,000 for Self and Family enrollment.
HDHP Option: Your annual out-of-pocket in-network expenses for covered prescription drugs, including copayments and coinsurance, cannot exceed $2,000 for Self Only or $4,000 for Self Plus One or $6,000 for Self and Family enrollment in any calendar year.

Some expenses do not count toward the out-of-pocket maximum. See pages 27-28 for more information.

For all three of the plan options, an individual under Self Plus One or Self and Family enrollment will never have to satisfy more than what is required for the out-of-pocket maximum limit under a Self Only enrollment.

The IRS limits annual out-of-pocket expenses for covered medical services to no more than $7,000 for Self Only enrollment, and $14,000 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

Your rights and responsibilities

OPM requires that all PSHB plans provide certain information to their PSHB members. You may get information about us, our networks, and our providers. OPM's PSHB website www.opm.gov/healthcare-insurance/ lists the specific types of information that we must make available to you. Some of the required information is listed below:

- TakeCare Insurance Company, Inc., a Tan Holdings Company, has met all the licensing requirements needed on Guam, in the Commonwealth of the Northern Mariana Islands and the Republic of Belau (Palau) to conduct business as an insurance company.
- TakeCare is accredited by the Accreditation Association of Ambulatory Health Care (AAAHC), a distinction TakeCare has held since June 2016 as the first health plan on Guam accredited by AAAHC.
- TakeCare has been operating on Guam for 51 years.
- TakeCare wholly owns/operates the FHP Health and Vision Centers on Guam.
- TakeCare is a for-profit organization.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website at www.takecareasia.com. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 671-647-3526, or e-mail at customerservice@takecareasia.com, or write to TakeCare at P.O. Box 6578, Tamuning, Guam 96931. You may also contact us by fax at 671-647-3542 or visit our website at www.takecareasia.com

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website and click on TakeCare Privacy Notice (www.takecareasia.com/sites/default/files/takecare_member_npp_05292019.pdf) at the bottom of each page to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice.

Our service area is: The island of Guam, the Commonwealth of the Northern Mariana Islands, and the Republic of Belau (Palau).

Benefits Outside Our Service Area

If you reside in our service area, all non-emergency services you receive outside our service area must be prior authorized and approved for coverage to apply, even though your Plan option has an out of network benefit.

Please refer to Section 5(d) regarding your emergency care benefits inside and outside our service area.

If You Move Outside Our Service Area

If you or a covered family member moves outside of our service area, you can enroll in another plan; you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

If you choose to remain enrolled in this plan when you and/or your family members move outside our service area, you and/or your family will only be covered for emergency services. See Section 5(d). The only exception to this is your dependent children living out of the service area while you remain in the service area (see below).

Dependent Child(ren) Living Out of The Service Area

If your dependent child(ren) lives out of the service area while you remain in the service area (for example, if your child resides in California and you reside in Guam), coverage is available for that child(ren).

However, to be covered, the following information must be provided to TakeCare prior to non-emergency services being received:

- The child's name, address outside the service area, phone number
- Name and address of the child's primary care physician*

TakeCare can be reached at 671-647-3526 or toll-free, 877-484-2411, or via email at customerservice@takecareasia.com. In the absence of such information, non-emergency services will not be covered.

Your dependent child(ren) must receive prior approval before being treated by a specialist, receiving certain diagnostic tests, or is considering an elective outpatient or inpatient procedure.

*- for dependent child(ren) residing in Hawaii or the continental US, a primary care physician can be selected in advance by using the search tool available at www.multiplan.com. For all other locations, contact TakeCare.

In-Network Providers

We encourage you to access your benefits through our in-network providers to minimize higher out of pocket expenses for you and your dependents. In-network providers are physicians and medical professionals employed by TakeCare or any person, organization, health facility, institution or physician who has entered into a contract with TakeCare to provide services to our members. Please view or download the most current TakeCare Provider Directory at www.takecareasia.com for the most updated list of in-network providers.

Preferred In-Network Providers

These are in-network, directly contracted providers that have entered into a written agreement with TakeCare to provide care or treatment at preferential or better rates compared to other contracted or in-network providers and have demonstrated better outcomes based on a standard measurement set (HEDIS) by the National Committee for Quality Assurance ("NCQA") . The participating providers which are identified herein as preferred in-network providers are subject to change. Please check with TakeCare to confirm the preferential status of contracted/in-network providers.

Out-of-Network Providers

For out-of-network care, covered members pay 30% of our allowance plus any difference between our allowance and billed charges. Some services may not be covered under your Plan. Members enrolled in the HDHP option must meet their deductible first before any benefits will be paid.

Because we do not have contracts with out-of-network providers, some of these providers may require upfront payment from you at the time of service. If this occurs, you will need to seek reimbursement from TakeCare for its portion of the eligible charges.

Please note that Medicare beneficiaries only have coverage for services received at Medicare-contracted facilities on Guam, CNMI, Hawaii, and the continental United States. However, TakeCare will act as the primary payor for PSHB members with Medicare for preauthorized services received in-network in the Philippines. Otherwise, Medicare-eligible care and services will not be covered if non-emergency care and services are received at a facility or physician not contracted with Medicare.

Section 2. New for 2025

This is the first year for the Postal Service Health Benefits Program (PSHBP). This Section is not an official statement of benefits. For that, go to **Section 5. Benefits**.

Section 3. How You Get Care

Identification cards

TakeCare will mail you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the PSHB System enrollment confirmation.

You also have the convenience of displaying your ID card on your mobile device by downloading TakeCare's mobile app from the App Store (Apple) or GooglePlay (Android). You can also print a replacement card by using TakeCare's member portal. Go to https://portal.takecareasia.com/ for more information.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, you can request cards online at https://bit.ly/4cswNpL or call us at 671-647-3526, email at customerservice@takecareasia.com or write to us at TakeCare Insurance Company, Inc., P.O. Box 6578 Tamuning, Guam 96931.

Where you get covered care

You can receive covered care from "in-network" and "out-of-network" providers. You will only pay copayments and/or coinsurance, and not have to file claims when using in-network providers. If you use out-of-network providers, you can expect to pay more out of your pocket. Most out-of-network providers will also want you to pay during the time of service. If this occurs, TakeCare will reimburse you for the eligible charges. See below.

Medicare beneficiaries only have coverage for services received at Medicare-contracted facilities on Guam, CNMI, Hawaii, and the continental United States.

However, to ensure that members with Medicare coverage are able to access TakeCare's network of Philippine providers, TakeCare will act as the primary payor for PSHB members with Medicare for preauthorized services received in-network in the Philippines.

Otherwise, Medicare-eligible care and services will not be covered if non-emergency care and services are received at a facility or physician not contracted with Medicare.

- **In-network providers**

In-network providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by In-network Providers are covered when acting within the scope of their license or certification under applicable state law. We select and credential providers according to national quality and medical practice standards.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

We list in-network providers in our provider directory, which is updated monthly. You can view the current directory on our website at www.takecareasia.com

TakeCare recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in **gender affirming** health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

We provide Care Coordinators for complex conditions. See Section 5(i) for more information or contact TakeCare Medical Referral Services (MRS) at (671) 300-5995 or via email tc.mrs@takecareasia.com for assistance.

- **In-network facilities**

In-network facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We select and credential facilities to participate in our network according to national quality and medical practice standards.

	We list in-network facilities in our Provider Directory, which is updated monthly. You can view the current directory on our website at www.takecareasia.com
• **Balance Billing Protection**	PSHB Carriers must have clauses in their in-network (participating) provider agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.
• **Out-of-network providers and facilities**	Providers and facilities not participating in TakeCare's network are considered out-of-network providers and facilities. You can get care from out-of-network providers, but you will share in a greater portion of the cost of care. When using out-of-network providers and facilities, you will pay 30% of eligible charges based on our allowance plus any difference between our allowance and the actual billed charges. If you are enrolled in the HDHP option, you must satisfy the deductible before any charges will be covered. **Because we do not have agreements or contracts with out-of-network providers, they may require up front full payment during the time of service**. If this occurs, TakeCare will reimburse you for its portion of eligible charges. Note: Certain services **always require *prior approval***, regardless of whether they are received from an in-network or out-of-network provider or facility. If you self refer to a provider and or facility for services which require prior authorization, those services will not be covered.
What you must do to get covered care	It depends on the type of care you need. First, we recommend you and each family member choose a primary care provider. This decision is important since your primary care provider provides or arranges for most of your healthcare. To select or change your primary care provider, call us at 671-647-3526 or email at customerservice@takecareasia.com. You may choose to have a different primary care provider for each family member. If you are enrolled in the High or Standard options, you must receive a referral from your primary care provider to receive coverage for any specialist services (with the exception of OB/GYN). If you are enrolled in the HDHP option, you do not need a specialist referral. Other services require prior authorization from TakeCare Medical Referral Services (MRS) to be covered.
• **Primary care**	Your primary care provider can be a family practitioner, internist, obstetrician/gynecologist, or pediatrician for children under 18 years of age. Your primary care provider will provide most of your healthcare, or give you a referral to see a specialist if needed. If you want to change primary care providers or if your primary care provider leaves the Plan, contact us at 671-647-3526 or via email at customerservice@takecareasia.com. We will help you select a new one. You may change your primary care provider anytime. Your change to the new primary care provider will be effective immediately. A listing of in-network primary care providers can be found in our provider directory. Go to www.takecareasia.com to view the directory online.
• **Specialty care**	Your primary care provider will refer you to a specialist for needed care. However, you may see an OB/GYN within our network without a referral.

When you receive a referral from your primary care provider, you must return to the primary care provider after the consultation, unless your primary care provider authorized a certain number of visits without additional referrals. The primary care provider must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care provider gives you a referral. You may access mental healthcare and behavioral healthcare through your primary care provider for an initial consultation. You must return to your primary care provider after your consultation with the specialist. If your specialist recommends additional visits or services, your primary care provider will review the recommendation and authorize the visits or services as appropriate. You should not continue seeing the specialist after the initial consultation unless your primary care provider and TakeCare's Medical Referral Service (MRS) Department has authorized the referral.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care provider will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.
- Your primary care provider will create your treatment plan. The provider may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. If they decide to refer you to a specialist, ask if you can see your current specialist.
- If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- **Transitional care**

If you have a chronic and disabling condition and lose access to your specialist:

- because your coverage changed from the FEHB to the PSHB and your health plan does not participate in the PSHB; or
- because we drop out of the Postal Service Employees Health Benefits (PSHB) Program and you enroll in another PSHB program plan; or:
- because we terminate our contract with your specialist for other than cause; or
- because we reduce our service area and you enroll in another PSHB plan;

You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the PSHB program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

You need prior Plan approval for certain services

Since your primary care provider arranges most referrals to specialists and inpatient hospitalization, the prior authorization approval process only applies to care shown below.

- **Inpatient hospital admission**

Prior to your elective inpatient hospital admission, our Medical Referral Services (MRS) department evaluates the medical necessity of your proposed stay and the number of days required to treat your condition using nationally-recognized medical care guidelines.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 671-647-3526. If you are new to the PSHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to this PSHB plan, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the PSHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

- **Other services**

Your primary care provider has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

• All surgical procedures except circumcisions if done within 31 days from the date of birth
• Audiological exams
• Bariatric surgery
• CT scans
• Dialysis (out-of-network)
• Gender reassignment surgery
• Growth Hormone Therapy (GHT)
• Hospitalization
• Iatrogenic fertility preservation procedures
• MRIs
• Oncology consultations
• Out-of-area hospitalization
• Plastic/reconstructive consultation and procedures
• Podiatry procedures
• Sleep studies
• Specialty care follow up (testing and procedures)
• Transplants
• Other procedures including colonoscopy and endoscopy

Emergency services do not require prior authorization. However, you, your representative, the provider, or the hospital must notify us within forty-eight (48) hours, or as soon as reasonably possible, after initial receipt of services if the emergency services results in your admission to a hospital in our service area. If you receive emergency services outside our service area, you must notify us within forty-eight (48) hours, or as soon as reasonably possible, after initial receipt of services even if you're not admitted to a hospital facility.

How to request prior authorization for an elective hospital admission or for other services

First, your physician, your hospital, you, or your representative, must contact us at 671-300-5995 or via email at tc.mrs@takecareasia.com before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;

- patient’s name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you fail to provide the information we've requested within 60 days from the date of the request, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our customer service department and (2) your request names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within five days following the failure. Notification may be oral, unless you request written correspondence.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by contacting us at 671-647-3526 or via email at customerservice@takecareasia.com. You may also call Postal Service Insurance Operations (PSIO) at (202) 936-0002 between 8 a. m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, contacting us at 671-647-3526 or via email at customerservice@takecareasia.com. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

  A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

  If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

  If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

  You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

  Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **If your treatment needs to be extended**

  If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the prior authorization rules?

Services will not be covered.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, contact us at 671-674-3626 or email at customerservice@takecareasia.com

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in **Section 8**.

- **To reconsider a non-urgent care claim**

  Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

  1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

   You or your provider must send the information so that we receive it within 60 days of our request. Once the information is received, a decision will be made within 30 more days and we will write to you with our decision.

   If we do not receive the information within 60 days of our request, we will make a decision within 30 days of the date the information was first due based on the information already received. We will write to you with our decision.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider and make a decision regarding your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in **Section 8** of this brochure.

Note: If you are enrolled in our Medicare PDP EGWP and do not agree with our benefit coverage decision you have the right to appeal. See **Section 8(a)** for information about the PDP EGWP appeal process. For information about your PDP-EGWP coverage, contact VibrantRx Member Services at 844-826-3451 (TTY 711). Hours are 24 hours a day, 365 days a year. By mail, VibrantRx, PO Box 509097, San Diego, CA 92150, or at www.vibrantrx.com/takecare.

Post-service claim procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in **Section 8** of this brochure.

Section 4. Your Cost for Covered Services

This is what you will pay out-of-pocket for covered care:

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your primary care provider at the FHP Health Center, you pay a copayment of $5 per office visit, or $10 per office visit when you see a preferred in-network primary care provider, or $20 per office visit when you see another in-network primary care provider, if you are covered under the High Option. When you are admitted as an inpatient to an in-network hospital, you pay a $100 copayment per day up to $500 maximum per inpatient admission, if you are covered under the High Option.

Deductible

A deductible is a fixed expense you must pay for certain covered services and supplies before we start paying benefits for them. Copayment and coinsurance amounts do not count toward your deductible.

Under the High and Standard Options, there is no calendar year deductible.

Under the High Deductible Health Plan (HDHP) Option, there are separate plan deductibles for medical and prescription drugs. With the exception of Preventive Care Services and Medication coverages, you must first meet your plan deductible before your coverage begins.

> **Medical deductible** - the combined in-network and out-of-network medical deductible is considered satisfied and benefits are payable when your covered expenses reach $1,500 for Self Only or $3,000 for Self Plus One or $3,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied when at least two (2) covered family members have met their individual deductible in a calendar year.
>
> **Prescription Drug deductible** - the combined in-network and out-of-network prescription drug deductible is considered satisfied and benefits are payable when your covered expenses reach $500 for Self Only or $1,000 for Self Plus One or $1,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied when at least two (2) covered family members have met their individual deductible in a calendar year.

Encourage your healthcare provider to submit a claim to us on your behalf even if you haven't yet met your deductible. By doing so, we are able to track your out-of-pocket payments and credit your deductible during the year. Alternatively, a **TakeCare Deductible Claim Form** should be filled out immediately and submitted to us to ensure accurate and complete information on all doctors, lab or pharmacy visits. It is your responsibility to track and submit deductible expenses (e.g. encounter tickets, invoices, receipts) and the required documentation. Deductible claim forms should be submitted to our Customer Service department. Track your out-of-pocket expenses through the TakeCare Member Portal at https://portal.takecareasia.com/

Note: If you change PSHB plans during Open Season, the effective date of your new PSHB plan is January 1 of the next year, and a new deductible starts on January 1. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Coinsurance

Coinsurance is the percentage of our fee allowance that you must pay for your care. If you are covered by the High Deductible Health Plan (HDHP) Option, coinsurance doesn't begin until you have met your combined in-network and out-of-network plan deductible.

Example: Under the HDHP Option, once you've met your combined in-network and out-of-network plan deductible, you pay 20% coinsurance of our allowance for in-network services. Likewise, you pay 30% of our allowance plus any difference between our allowance and billed charges for out-of- network services once you've met your combined in-network and out-of-network plan deductible.

Differences between our Plan allowance and the bill

Our plan allowance is the maximum charge for which we will reimburse the provider for a covered service. For in-network providers, the allowance is the contracted rate paid by us. For out-of-network provider services outside our service area, allowance is the same as the usual, customary and reasonable charges in the geographic area. When using an out-of-network provider, you may be responsible for the difference between our allowance and billed charges in addition to your out-of-network copayment or coinsurance amount. For further details, see **Section 11** - *Definitions of Terms We Use in This Brochure*.

You should also see **Important Notice About Surprise Billing – Know Your Rights** below that describes your protections against surprise billing under the No Surprises Act.

Your Catastrophic Protection Out-of-pocket Maximum

For High, Standard, and HDHP Options, we pay 100% of our allowable amount for the remainder of the calendar year after out-of-pocket expenses for coinsurance and/or copayments exceed:

High Option: your combined in-network and out-of-network medical out-of-pocket maximum limit is $2,000 for Self Only enrollment, $4,000 for Self Plus One, or $6,000 for Self and Family enrollment. However, if you are using an out-of-network provider, you will continue to be responsible for any difference between our allowance and billed charges. Separately, your in-network prescription drug out-of-pocket maximum is $2,000 for Self Only enrollment, $4,000 for Self Plus One, or $6,000 for Self and Family enrollment.

Standard Option: your combined in-network and out-of-network medical out-of-pocket maximum limit is $3,000 for Self Only enrollment, $6,000 for Self Plus One or Self and Family enrollment. However, if you are using an out-of-network provider, you will continue to be responsible for any difference between our allowance and billed charges. Separately, your in-network prescription drug out-of-pocket maximum is $3,000 for Self Only enrollment, $6,000 for Self Plus One or Self and Family enrollment.

HDHP Option: your in-network out-of-pocket medical maximum limit of $3,000 is Self Only enrollment, $6,000 for Self Plus One or Self and Family enrollment. There is no out-of-pocket limit when using an out-of-network provider under this option. Separately, your in-network prescription drug out-of-pocket maximum limit is $3,000 for Self Only enrollment, $6,000 for Self Plus One or $6,000 for Self and Family enrollment.

For all three of the above options, an individual under Self Plus One or Self and Family enrollment will never have to satisfy more than what is required for the out-of-pocket maximum limit under a Self Only enrollment.

For members enrolled in our Plan's associated PDP EGWP, we are required to accumulate all members' actual out-of-pocket costs for Medicare-covered drugs, services and supplies toward the PSHB catastrophic maximum(s).

If you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP), the prescription drug out-of-pocket maximum is $2,000. After this maximum is met, we pay 100% of all eligible covered prescription drug benefits.

- **Services that don't count toward out-of-pocket maximum**

Under the High, Standard, and HDHP Options, your out-of-pocket payments for the following do not count toward your catastrophic protection out-of-pocket maximum:

- *Deductibles*
- *Contraceptive Devices*
- *Dental Services*

- *Vision Hardware*
- *Chiropractic Services*
- *Other supplemental benefits*
- *Charges in excess of our allowance*
- *Charges in excess of maximum benefit limitations*
- *Services not covered*

Be sure to keep accurate records of your copayments and coinsurance since you are responsible for informing us when you reach the maximum.

Carryover

If you changed to this PSHB Plan during Open Season from a plan with a catastrophic protection benefit, the effective date of the change is January 1, and covered expenses apply to this plan's catastrophic protection benefit starts on January 1.

Note: If you change PSHB plans during Open Season the effective date of your new PSHB plan is January 1 of the next year, and a new catastrophic protection accumulation starts on January 1. If you change plans at another time during the year, you must begin a new catastrophic protection accumulation under your new plan.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing – Know Your Rights in the US

The No Surprises Act (NSA) is a federal law that provides you with protections in the US and its territories against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

Providers and facilities not participating in TakeCare's network are considered out-of-network providers and facilities. You can get care from out-of-network providers, but you will share in a greater portion of the cost of care.

When using out-of-network providers and facilities, you will pay 30% of eligible charges based on our allowance plus any difference between our allowance and the actual billed charges. If you are enrolled in the HDHP option, you must satisfy the deductible before any charges will be covered. **Because we do not have agreements or contracts with out-of-network providers, they may require up front full payment during the time of service.** If this occurs, TakeCare will reimburse you for its portion of eligible charges.

Note: Certain services **always require *prior approval***, regardless of whether they are received from an in-network or out-of-network provider or facility. If you self refer to a provider and or facility for services which require prior authorization, those services will not be covered.

A surprise bill is an unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

TakeCare must comply with the NSA protections that hold you harmless from surprise bills in the US and its territories.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.takecareasia.com/NSA or contact us at 671-647-3526 or toll-free, 877-484-2411, or via email at customerservice@takecareasia.com.

Section 5. High and Standard Option Benefits Overview

This Plan offers High, Standard, and HDHP Options. The High and Standard Options are described in this Section. Make sure that you review the benefits that are available under the Option in which you are enrolled.

Section 5 is divided into subsections. Please read Important things you should keep in mind at the beginning of the subsections. Also read the general exclusions in **Section 6**; they apply to the benefits in the following subsections.

To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at 671-647-3526, email customerservice@takecareasia.com, or on our website at www.takecareasia.com

Each Option offers unique features:

	You Pay	
Benefit Description	**High**	**Standard**
Preventive Care Visit	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges
Primary Care Office Visit	***FHP Health Center:*** $5 copayment per visit ***Preferred in-network:*** $10 copayment per visit ***Other in-network:*** $20 copayment per visit ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges	***FHP Health Center:*** $5 copayment per visit ***Preferred in-network:*** $15 copayment per visit ***Other in-network:*** $25 copayment per visit ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges
Specialist Care Office Visit	***In-network:*** $40 copayment per visit ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges	***In-network:*** $40 copayment per visit ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges
Emergency Services *In Area* • Urgent care services at FHP Health Center	$15 copayment per visit	$15 copayment per visit
• Hospital emergency room	***In-network:*** $75 copayment per visit ***Out-of-network:*** $75 copay per visit	***In-network:*** $100 copayment per visit ***Out-of-network:*** $100 copay per visit
Emergency Services *Out of Area* • At a doctor's office or Urgent Care Clinic	***In-network:*** $50 copayment per visit ***Out-of-network:*** $50 copayment per visit	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 20% coinsurance of our allowance

Benefit Description - continued on next page

	You Pay	
Benefit Description (cont.)	**High**	**Standard**
• Hospital emergency room	***In-network:*** $100 copayment per visit ***Out-of-network:*** $100 copayment per visit	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 20% coinsurance of our allowance
Prescription drugs	**Retail** **Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $5 copayment Preferred Brand: $15 copayment Non-Preferred Brand: $50 copayment (Copayments per 90-day fill) Generic formulary: up to $15 copayment Preferred Brand: up to $40 copayment Non-Preferred Brand: up $105 copayment **Non-Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $10 copayment Preferred Brand: $25 copayment Non-Preferred Brand: $70 copayment (Copayments per 90-day fill) Generic formulary: up to $30 copayment Preferred Brand: up to $75 copayment Non-Preferred Brand: up $210 copayment **All In-network:** (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $200 copayment **Out-of-network:** No coverage except for out-of-area emergencies or approved referrals **Mail Order** **In-network:** (Copayments per 90-day fill) Generic formulary: $0 copayment Preferred Brand: $40 copayment Non-Preferred Brand: $100 copayment (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $200 copayment **Out-of-network:** No coverage	**Retail** **Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $10 copayment Preferred Brand: $30 copayment Non-Preferred Brand: $75 copayment (Copayments per 90-day fill) Generic formulary: up to $25 copayment Preferred Brand: up to $60 copayment Non-Preferred Brand: up $150 copayment **Non-Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $15 copayment Preferred Brand: $40 copayment Non-Preferred Brand: $100 copayment (Copayments per 90-day fill) Generic formulary: up to $45 copayment Preferred Brand: up to $120 copayment Non-Preferred Brand: up $300 copayment **All In-network:** (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $250 copayment **Out-of-network:** No coverage except for out-of-area emergencies or approved referrals **Mail Order** **In-network:** (Copayments per 90-day fill) Generic formulary: $0 copayment Preferred Brand: $60 copayment Non-Preferred Brand: $160 copayment (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $250 copayment **Out-of-network:** No coverage

Benefit Description - continued on next page

	You Pay	
Benefit Description (cont.)	**High**	**Standard**
Outpatient surgical facility	***In-network:*** $100 copayment per visit ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges	***In-network:*** $150 copayment per visit ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges
Inpatient hospital stay	***In-network:*** $100 copayment per day, up to $500 maximum per inpatient admission ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges	***In-network:*** $150 copayment per day, up to $750 maximum per inpatient admission ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges
Chiropractic services	***In-network:*** All charges above $25 per visit. Maximum of 20 visits per calendar year ***Out-of-network:*** Not covered	***In-network:*** All charges above $25 per visit. Maximum of 20 visits per calendar year ***Out-of-network:*** Not covered
Prescription eyeglasses or contact lenses	***In-network:*** All charges above $100 per benefit year ***Out-of-network:*** Not covered	***In-network:*** All charges above $100 per benefit year ***Out-of-network:*** Not covered
Adult hearing aid	***In-network:*** All charges above $300 per ear, every two years ***Out-of-network:*** Not covered	***In-network:*** All charges above $300 per ear, every two years ***Out-of-network:*** Not covered
Dental services	***In-network:*** Nothing for preventive services, 20% coinsurance of our allowance for covered charges for restorative and simple extractions, 75% coinsurance of our allowance for covered charges for prosthodontics ***Out-of-network:*** 30% coinsurance of of our allowance for covered charges for preventive services, 50% coinsurance of our allowance for covered charges for restorative and simple extractions, 95% coinsurance of our allowance for covered charges for prosthodontics. In addition, you are responsible for charges between covered charges and billed charges ***Annual Maximum Benefit:***$1,500 per member per year	***In-network:***Nothing for preventive services. All other dental services are not covered ***Out-of-network:*** 30% coinsurance of our allowance for covered charges for preventive services plus any difference between covered charges and billed charges. All other dental services are not covered ***Annual Maximum Benefit:***$1,500 per member per year

Benefit Description - continued on next page

	You Pay	
Benefit Description (cont.)	**High**	**Standard**
Your catastrophic protection for out-of-pocket expenses	Your combined in-network and out-of-network medical annual maximum for out-of-pocket expenses (coinsurance and copayments) for covered medical services is limited to $2,000 for Self Only enrollment, $4,000 for Self Plus One enrollment, or $6,000 for Self and Family enrollment. If you are using an out-of-network provider, you will continue to be responsible for any difference between our allowance and billed charges. Separately, your in-network prescription drug out-of-pocket maximum is $2,000 for Self Only enrollment, $4,000 for Self Plus One enrollment, or $6,000 for Self and Family enrollment. Under the PDP EGWP program, your in-network prescription drug out-of-pocket maximum limit is $2,000 for Self Only enrollment, $4,000 for Self Plus One or $6,000 for Self and Family enrollment. An individual under Self Plus One or Self and Family enrollment will never have to satisfy more than what is required for the out-of-pocket maximum limit under a Self Only enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses even if you reach your out-of-pocket maximum (e.g., expenses in excess of the Plan's allowable amount or benefit maximum). See page 24 for more information.	Your combined in-network and out-of-network medical annual maximum for out-of-pocket expenses (coinsurance and copayments) for covered medical services is limited to $3,000 for Self Only enrollment, $6,000 for Self Plus One enrollment or Self and Family enrollment. If you are using an out-of-network provider, you will continue to be responsible for any difference between our allowance and billed charges. Separately, your in-network prescription drug out-of-pocket maximum is $3,000 for Self Only enrollment, $6,000 for Self Plus One enrollment or Self and Family enrollment. Under the PDP EGWP program, your in-network prescription drug out-of-pocket maximum limit is $2,000 for Self Only enrollment, $4,000 for Self Plus One or $6,000 for Self and Family enrollment. An individual under Self Plus One or Self and Family enrollment will never have to satisfy more than what is required for the out-of-pocket maximum limit under a Self Only enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses even if you reach your out-of-pocket maximum (e.g., expenses in excess of the Plan's allowable amount or benefit maximum). See page 24 for more information.

Section 5. Preventive Care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the deductible.
- The Plan pays 100% for medical preventive care services (based on US Preventive Services Task Force Guidelines) listed in this Section as long as you use the in-network providers. If you choose to access preventive care from an out-of-network provider, you will not qualify for 100% preventive coverage.
- For all other covered expenses, please see the rest of **Section 5**.

Preventive Care Benefits	You pay	
Preventive care, adults	**High Option**	**Standard Option**
The following preventive services are covered at the time interval recommended at each of the links below: • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. This includes follow-up colonoscopies after a positive non-invasive stool-based screening test or direct visualization test. For a complete list of screenings go to the website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics-/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, breast cancer screening, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women, go to the Health and Human Services (HHS) website at https://www.hrsa.gov/womens-guidelines • Routine mammogram • To build your personalized list of preventive services, go to https://health.gov/myhealthfinder • Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Preventive care, adults - continued on next page

Preventive Care Benefits	You pay	
Preventive care, adults (cont.)	**High Option**	**Standard Option**
• Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: - Intensive nutrition and behavioral weight-loss counseling therapy - Family centered programs when medically identified to support obesity prevention and management by an in-network provider - When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications- When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not Covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines, go to https://brightfutures.aap.org • Children's immunizations endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html • You can also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Preventive care, children - continued on next page

Preventive Care Benefits	You pay	
Preventive care, children (cont.)	**High Option**	**Standard Option**
• Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: - Intensive nutrition and behavioral weight-loss counseling therapy - Family centered programs when medically identified to support obesity prevention and management by an in-network provider - When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications - When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not Covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel.*	*All charges*	*All charges*

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and claims are payable only if we determine they are for covered, medically necessary services.
- There are no deductibles for the High or Standard Options. There are separate Catastrophic Out-of-Pocket Maximums for medical services and prescription drugs. See **Section 4** - *Your Costs for Covered Services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- Using the FHP Health Center for your primary care will result in lower copayments for you.
- Copayments and coinsurance are waived when using in-network providers and facilities in the Philippines for prior-authorized services.
- A outpatient facility copayment applies to services performed in an ambulatory surgical center or the outpatient department of a hospital.
- For out-of-network services, you are responsible for 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
- To be covered for these benefits, you must follow your physician-prescribed treatment plan and all of our prior authorization processes for surgical and anesthesia services. Please call 671-647-3526 for more information.
- With the exception of OB/GYN, specialty care services require a written referral from your primary care physician.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See **Section 5(c)** for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay	
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***Preferred In-network:*** Primary Care - $10 copayment per visit, Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***Preferred In-network:*** Primary Care - $15 copayment per visit, Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Diagnostic and treatment services - continued on next page

Benefit Description	You pay	
Diagnostic and treatment services (cont.)	**High Option**	**Standard Option**
Professional services of physicians • During a hospital stay • In a skilled nursing facility • At home	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Off-island care for services received without prior authorization from TakeCare Medical Referral Services (MRS) department, except in the case of emergency.* • *Specialty care services aren't covered when received without written referral from your primary care physician, except in the case of OB/GYN services.*	*All charges*	*All charges*
Telehealth services	**High Option**	**Standard Option**
Consultations via phone, audio/video services using a computer, tablet, or smartphone with in-network primary care or specialty providers, including behavioral health, on or off island. For specialty consultations, referral by primary care provider is required and coverage is limited to certain specialties. Contact your provider regarding the availability of telehealth services and TakeCare for covered specialties.	***In-network:*** Nothing ***Out-of-network:*** All charges	***In-network:*** Nothing ***Out-of-network:*** All charges
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap test • Pathology • Electrocardiogram and EEG	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
• X-rays	***FHP Health Center:*** Nothing ***Preferred In-network:*** Nothing ***In-network:*** $20 copayment in addition to regular office visit copayment. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** $5 copayment in addition to regular office visit copayment. ***In-network:*** $25 copayment in addition to regular office visit copayment. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% of our allowance plus any difference between our allowance and billed charges.

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests (cont.)	**High Option**	**Standard Option**
• Non-routine mammograms • Ultrasound	***FHP Health Center:*** $5 copayment in addition to regular office visit copayment. ***In-network:*** $20 copayment in addition to regular office visit copayment. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** $5 copayment in addition to regular office visit copayment. ***In-network:*** $25 copayment in addition to regular office visit copayment.(Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Prior authorization required for the following services: • CT Scan • MRI • Sleep Studies	***FHP Health Center:*** $30 copayment in addition to regular office visit copayment. ***In-network:*** $40 copayment in addition to regular office visit copayment. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** $30 copayment in addition to regular office visit copayment. ***In-network:*** $40 copayment in addition to regular office visit copayment. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Prior authorization required for the following services: • Nuclear Medicine	***In-network:*** $40 copayment in addition to regular office visit copayment. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** $40 copayment in addition to regular office visit copayment. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Delivery Note: Here are some things to keep in mind: • You do not need to have your vaginal delivery pre-authorized by TakeCare if in the service area. However, prior authorization is required for vaginal delivery services (i.e., prenatal care, delivery, and postnatal care) outside the service area.	***In-network:*** Primary Care, Specialist - Nothing; Outpatient Facility - $100 copayment; Inpatient hospital - $100 copayment per day, up to $500 maximum per inpatient admission. ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Primary Care, Specialist - Nothing; Outpatient Facility - $150 copayment; Inpatient hospital - $150 copayment per day, up to $750 maximum per inpatient admission. ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**High Option**	**Standard Option**
• As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. • When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	***In-network:*** Primary Care, Specialist - Nothing; Outpatient Facility - $100 copayment; Inpatient hospital - $100 copayment per day, up to $500 maximum per inpatient admission. ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Primary Care, Specialist - Nothing; Outpatient Facility - $150 copayment; Inpatient hospital - $150 copayment per day, up to $750 maximum per inpatient admission. ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Breastfeeding and lactation support, supplies and counseling for each birth • Screening for gestational diabetes • Screening and counseling for prenatal and postpartum depression	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
• Blood pressure monitor for hypertension if prescribed by a healthcare professional	***In-network:*** Nothing ***Out-of-network:*** No coverage except for out-of-area emergencies or approved referrals	***In-network:*** Nothing ***Out-of-network:*** No coverage except for out-of-area emergencies or approved referrals
Not covered: • *Routine sonograms to determine fetal age, size, or gender.*	*All charges*	*All charges*

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**High Option**	**Standard Option**
• *Maternity-related services outside our service area unless pre-authorized by TakeCare's Medical Referral Services (MRS) department.*	*All charges*	*All charges*
Medical foods	**High Option**	**Standard Option**
Medical foods to treat physician-diagnosed Inborn Errors of Metabolism (IEM) including Phenylketonuria (PKU) as prescribed by a physician. ***Maximum Annual Benefit:*** $5,000 per covered individual	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Special food items which can be routinely obtained in grocery stores at the same or at a minimally higher cost than similar items (e.g., gluten-free cookies, gluten-free pasta).*	*All charges*	*All charges*
Family planning	**High Option**	**Standard Option**
Contraceptive counseling on an annual basis and a range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes: • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Surgically implanted FDA-approved contraceptives • Injectable FDA-approved contraceptive drugs (such as Depo Provera) • FDA-approved Intrauterine devices (IUDs) • FDA-approved Diaphragms **Note:** See additional Family Planning and Prescription drug coverage **Section 5(f)**. **Note:** This plan offers some type of voluntary sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described at https://bit.ly/3WdV3FW	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Family planning - continued on next page

Benefit Description	You pay	
Family planning (cont.)	**High Option**	**Standard Option**
Note: If the member chooses to use a branded product when a generic is available, the member will pay the difference between the brand and generic cost rather than paying "Nothing". However, if a branded product is considered medically necessary by the prescribing physician, it will be covered the same as a generic with no cost sharing for the member through the contraceptive exceptions process described at https://www.takecareasia.com/sites/default/files/fehb_contraceptive_benefit_coverage_rev06032024.pdf. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Definition of Infertility: To receive a diagnosis of infertility, an individual must be unable to conceive or produce conception after having intercourse without using birth control during a period of 1 year if the individual is under age 35, or during a period of 6 months if the individual is age 35 and older. For individuals without a partner or exposure to egg-sperm contact, a diagnosis of infertility can be received if the individual is not able to conceive or produce conception through artificial insemination. Infertility may also be established through evidence of medical history and diagnostic testing. **Diagnosis and treatment of infertility** specific to • Artificial insemination: (No less than six cycles annually) - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI)	***In-network:*** Specialist Care - $40 copayment per visit. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Specialist Care - 50% coinsurance of our allowance. (Coinsurance is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
• Injectable IVF-related drugs (up to three cycles annually) **Note:** We cover oral fertility drugs under Section 5(f) Prescription drug benefits.	***In-network:*** $15 copayment per injection in addition to the office visit copayment (Copayment is waived at in network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** $15 copayment per injection in addition to the office visit copayment (Copayment is waived at in network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered:	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High Option**	**Standard Option**
• *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization (IVF)* - *embryo transfer, gamete intra-fallopian transfer (GIFT)* - *zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*	*All charges*
Iatrogenic fertility preservation procedures (retrieval of and freezing of eggs or sperm) are covered for infertility caused by chemotherapy, pelvic radiotherapy, ovary or testicle removal and other gonadotoxic therapies for the treatment of disease as well as infertility associated with medical and surgical gender transition treatment. Covered services include the following procedures, when provided by or under the care or supervision of a physician: • Collection of sperm • Ovarian simulation, retrieval of eggs and fertilization • Sperm or egg cryo-preservation storage for up to one year **Notes:** • Fertility preservation procedures require prior authorization. See Section 3, Other services • Iatrogenic fertility preservation, including related Medical Travel Benefit charges, is limited to $10,000 per member per benefit year	***In-network:*** Specialist Care - $40 copayment per visit. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** Not covered.	***In-network:*** Specialist Care - $40 copayment per visit. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** Not covered.
Not covered: • *Embryo transfer* • *Long-term storage costs (greater than one year)* • *Egg harvesting or embryo implantation procedures beyond two attempts* • *Elective fertility preservation, such as egg freezing due to natural aging*	*All charges*	*All charges*

Benefit Description	You pay	
Allergy care	**High Option**	**Standard Option**
• Testing and treatment • Allergy injections	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
• Allergy serum	***In-network:*** nothing in addition to the office visit copayment. ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** nothing in addition to the office visit copayment. ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Provocative food testing and sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and Radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/ Tissue Transplants on page 55. • Respiratory and inhalation therapy • Cardiac rehabilitation following qualifying event/ condition is provided for up to 20 sessions per benefit period. • Intravenous (IV) / Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $20 copayment per visit ; Specialist - $40 copayment per visit; Outpatient Facility - $100 copayment; Inpatient hospital - $100 copayment per day, up to $500 maximum per inpatient admission. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $25 copayment per visit ; Specialist - $40 copayment per visit; Outpatient Facility - $150 copayment; Inpatient hospital - $150 copayment per day, up to $750 maximum per inpatient admission. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Treatment therapies - continued on next page

Benefit Description	You pay	
Treatment therapies (cont.)	**High Option**	**Standard Option**
Note: We only cover GHT when we pre-authorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services and related services and supplies that we determine are medically necessary. See "*Other services*" under "*You need prior Plan approval for certain services*" on page 19.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $20 copayment per visit ; Specialist - $40 copayment per visit; Outpatient Facility - $100 copayment; Inpatient hospital - $100 copayment per day, up to $500 maximum per inpatient admission. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $25 copayment per visit ; Specialist - $40 copayment per visit; Outpatient Facility - $150 copayment; Inpatient hospital - $150 copayment per day, up to $750 maximum per inpatient admission. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
• Dialysis - hemodialysis and peritoneal dialysis Note: Prior authorization approval is required when dialysis procedures are to be performed at an out-of-network facility or as a part of an elective hospital admission, even if in-network. Prior authorized covered services will be limited to providers in Guam, CNMI, and Palau, unless authorized by TakeCare.	***In-network:*** Primary Care - $20 copayment per visit ; Specialist Care - $40 copayment per visit; Outpatient Facility - $100 copayment; Inpatient hospital - $100 copayment per day, up to $500 maximum per inpatient admission. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges. Prior authorization is required.	***In-network:*** Primary Care - $250 copayment per visit ; Specialist Care - $40 copayment per visit; Outpatient Facility - $150 copayment; Inpatient hospital - $150 copayment per day, up to $750 maximum per inpatient admission. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges. Prior authorization is required.
Physical and occupational therapies	**High Option**	**Standard Option**
Unlimited outpatient services and up to two (2) consecutive months per condition for the services of each of the following: • Qualified physical therapists • Occupational therapists Note: We only cover therapy when a physician: • orders the care • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed.	***In-network:*** $15 copayment per office visit; nothing for home visits; nothing during covered inpatient admission. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** $15 copayment per office visit; nothing for home visits; nothing during covered inpatient admission. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Physical and occupational therapies - continued on next page

Benefit Description	You pay	
Physical and occupational therapies (cont.)	**High Option**	**Standard Option**
We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. These therapies also apply to habilitation services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may also include speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.	***In-network:*** $15 copayment per office visit; nothing for home visits; nothing during covered inpatient admission. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** $15 copayment per office visit; nothing for home visits; nothing during covered inpatient admission. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs, lifestyle modification programs* • *Equipment, supplies or customized devices related to rehabilitative therapies, except those provided under Section 5(a) Durable Medical Equipment* • *Services provided by schools or government programs* • *Developmental and Neuroeducational testing and treatment beyond initial diagnosis* • *Hypnotherapy* • *Psychological testing* • *Vocational rehabilitation*	*All charges*	*All charges*
Cardiac rehabilitation	**High Option**	**Standard Option**
• **Inpatient cardiac rehabilitation** following a heart transplant, bypass surgery or a myocardial infarction is covered for up to 90 days per benefit period. • **Outpatient cardiac rehabilitation** following a heart transplant, bypass surgery or a myocardial infarction is covered for up to 20 sessions per benefit period.	***In-network:*** Specialist Care - $40 copayment per office visit; nothing for home visits; nothing during covered inpatient admission. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Specialist Care - $40 copayment per office visit; nothing for home visits; nothing during covered inpatient admission. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Speech therapy	**High Option**	**Standard Option**
Unlimited visits for the services of: • Qualified Speech Therapist	***In-network:*** $15 copayment per office visit; nothing for home visits; nothing during covered inpatient admission. (Copayment is waived at in-network providers in the Philippines).	***In-network:*** $15 copayment per office visit; nothing for home visits; nothing during covered inpatient admission. (Copayment is waived at in-network providers in the Philippines).

Speech therapy - continued on next page

Benefit Description	You pay	
Speech therapy (cont.)	**High Option**	**Standard Option**
Note: Speech Therapy also applies to habilitation services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may also include physical/occupational therapies and other services for people with disabilities in a variety of inpatient and/or outpatient settings. All therapies are subject to medical necessity.	***In-network:*** $15 copayment per office visit; nothing for home visits; nothing during covered inpatient admission. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** $15 copayment per office visit; nothing for home visits; nothing during covered inpatient admission. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Hearing testing and treatment for adults, when medically necessary • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist • Hearing aid testing and evaluation for adults Adult hearing aid benefits and limits: (see Orthopedic and prosthetic devices, page 48) Note: Hearing testing for children through age 17 to determine the need for hearing correction is covered under **Preventive Care for Children**.	***In-network:*** Specialist Care - $40 copayment per visit. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Specialist Care - $40 copayment per visit. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Hearing services that are not shown as covered* • *Hearing aids, testing and examinations for children*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Annual eye exams through age 17 to determine the need for vision correction	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
• Annual eye exams for adults	***FHP Health or Vision Centers:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit. ***In-network:***Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit. ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health or Vision Centers:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit. ***In-network:***Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit. ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay	
Vision services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
• Refraction Exam Refraction exams will be covered as part of the annual eye exam if member meets any of the following criteria: 1. Fails a screening or risk assessment test; 2. Reports a visual problem; or 3. Cannot complete a screening (e.g. developmental delay) Otherwise, applicable member share for refraction exam applies.	***FHP Vision Center:*** $10 copayment per visit ***In-network:*** $15 copayment per visit ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Vision Center:*** $25 copayment per visit ***In-network:*** $40 copayment per visit ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
• Prescription eyeglasses or contact lenses	***In-network:*** All charges in excess of $100 per benefit year ***Out-of-network:*** All charges	***In-network:*** All charges in excess of $100 per benefit year ***Out-of-network:*** All charges
• Medical and surgical benefits for the diagnosis and treatment of diseases of the eye	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit. ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit. ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Eye exercises and orthoptics (vision therapy)* • *Radial keratotomy and other refractive surgery such as LASIK (Laser-Assisted Stromal In-situ Keratomileusis) surgery* • *Routine vision services outside the service area*	*All charges*	*All charges*

Benefit Description	You pay	
Foot care	**High Option**	**Standard Option**
• Foot care and podiatry services Note: When you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes, routine foot care may be covered. Prior authorization is required.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit. ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit. ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Routine footcare including: cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above.* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery).*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy (up to two (2) surgical bras per benefit year) • Internal prosthetic devices, such as spinal implants, bone segments, artificial disks, artificial joints, artificial plates, stents, leads, intraocular lenses, and surgically implanted breast implant following mastectomy. • Single and dual pacemakers, biventricular pacemakers, pacemaker monitors, accessories such as pacemaker batteries and leads, including the cost of the devices, their placement, repair or replacement and related Medical Travel Benefit, hospital, and surgical charges will accrue towards the **Pacemaker Annual Limit of $50,000 per member**. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit. In addition to the copayment, you are responsible for 10% coinsurance of our allowance for the device. ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit. In addition to the copayment, you are responsible for 10% coinsurance of our allowance for the device. (Copayment and coinsurance is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit. In addition to the copayment, you are responsible for 10% coinsurance of our allowance for the device. ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit. In addition to the copayment, you are responsible for 10% coinsurance of our allowance for the device. (Copayment and coinsurance is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) - Surgical and anesthesia services. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) - Services provided by a hospital or other facility, and ambulance services.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit. In addition to the copayment, you are responsible for 10% coinsurance of our allowance for the device. ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit. In addition to the copayment, you are responsible for 10% coinsurance of our allowance for the device. (Copayment and coinsurance is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit. In addition to the copayment, you are responsible for 10% coinsurance of our allowance for the device. ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit. In addition to the copayment, you are responsible for 10% coinsurance of our allowance for the device. (Copayment and coinsurance is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
• Orthopedic devices, such as braces	***FHP Clinic:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit. In addition to the copayment, you are responsible for 10% coinsurance of our allowance for the device. ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit. In addition to the copayment, you are responsible for 10% coinsurance of our allowance for the device. (Copayment and coinsurance is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	All charges
• External hearing aid for adults (limited to $300 maximum benefit per ear every two (2) years)	***In-network:*** All charges in excess of $300 per ear, every two years ***Out-of-network:*** All charges	***In-network:*** All charges in excess of $300 per ear, every two years ***Out-of-network:*** All charges

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
Not covered: • *Orthopedic and corrective shoes* • *Arch supports, foot orthotics, heel pads and heel cups* • *Artificial limbs* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Lumbosacral supports* • *Splints* • *Over-the-counter (OTC) items* • *Internal prosthetics such as heart valves, automatic implantable cardioverter defibrillator (AICD) and other implantable devices not specified above* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We will cover the rental or purchase of DME, at our option, including repair and adjustment. Covered items include: • Manual hospital beds • Standard manual wheelchairs • Crutches/walk aids • Oxygen Concentrators • Portable Oxygen Tanks • CPAP (Continuous Positive Airway Pressure) • BPAP (Bi-Level Positive Airways Pressure) Note: Prior authorization is required. Contact us at 671-300-5995 or via email at tc.mrs@takecareasia.com as soon as your your physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you DME at discounted rates and will tell you more about this service when you call.	***In-network:*** 15% coinsurance towards rental or purchase of covered equipment from an in-network provider. You will be advised of the coinsurance amount when the pre-authorization is issued. ***Out-of-network:*** All charges	***In-network:*** 15% coinsurance towards rental or purchase of covered equipment from an in-network provider. You will be advised of the coinsurance amount when the pre-authorization is issued. ***Out-of-network:*** All charges
We will cover the following devices with a written prescription: • Blood Glucose Monitors • Continuous Glucose Monitor (CGM) System, including transmitter and sensors, if patient is actively participating in TakeCare's Diabetes Management Program and meets criteria for coverage based on HbA1c level	***In-network:*** Nothing ***Out-of-network:*** All charges	***In-network:*** Nothing ***Out-of-network:*** All charges
Not covered: • *Motorized wheelchairs*	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
• *Motorized beds* • *CPAP and BPAP supplies including masks, other than those packaged by the manufacturer with a new machine* • *Insulin pumps*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
Home healthcare ordered by a physician, pre-authorized by us, and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide while under an active treatment plan with a home health agency including services such as: • Oxygen therapy, intravenous therapy and medications • Services ordered by a physician for members who are confined to the home • Nursing • Medical supplies included in the home health plan of care • Physical therapy, speech therapy, occupational therapy, and respiratory therapy	***In-network:***Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:***Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
Chiropractic services - You may self refer to an in-network licensed chiropractor for up to 20 visits per benefit year. 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.	***In-network:*** All charges above $25 per visit and all charges after your 20th visit in a benefit year. ***Out-of-network:*** All charges	***In-network:*** All charges above $25 per visit and all charges after your 20th visit in a benefit year. ***Out-of-network:*** All charges
Not covered: • *Consults and evaluations* • *Ancillary services for chiropractic purposes (e.g., x-rays)*	*All charges*	*All charges*

Benefit Description	You pay	
Alternative treatments	**High Option**	**Standard Option**
Acupuncture services - You may self refer to an in-network licensed acupuncture practitioner for up to 20 visits per benefit year. The Plan defines acupuncture as the practice of insertion of needles into specific exterior body locations to relieve pain, to induce surgical anesthesia, or for therapeutic purposes. These providers are required to submit itemized bills and their Federal Tax I.D. Number (if a United States provider) as outlined in **Section 7 -** *Filing a claim for covered services.*	***In-network:*** All charges above $25 per visit and all charges after 20th visit per benefit year. ***Out-of-network:*** All charges	***In-network:*** All charges above $25 per visit and all charges after 20th visit per benefit year. ***Out-of-network:*** All charges
Massage therapy services - You may self refer to an in-network, licensed massage therapist for up to 20 visits per benefit year. These providers are required to submit itemized bills and their Federal Tax I.D. Number (if a United States provider) as outlined in **Section 7 -** *Filing a claim for covered services.*	***In-network:*** $10 copayment per visit (up to 20 visits per benefit year). ***Out-of-network:*** All charges	***In-network:*** $10 copayment per visit (up to 20 visits per benefit year). ***Out-of-network:*** All charges
Not covered: • Chelation therapy except for acute arsenic, gold, mercury or lead poisoning; or use of Desferoxamine in iron poisoning • Naturopathic services and medicines • Homeopathic services and medicines • Rolfing	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Programs are administered through the TakeCare Wellness Center including: • Case Management Program for Chronic Diseases • Nicotine Cessation Program • Diabetes Prevention • Diabetes Self-Management • Group Fitness Program • Nutrition Coaching • Perinatal and Neonatal Program Note: For more information on these and other classes, see **Section 5(h) -** *Health Education Classes* or call the TakeCare Wellness Center at 671-300-7161 or via email at wellness@takecareasia.com.	Nothing. All health education classes are **FREE** to TakeCare members unless otherwise specified. Referral is required from your primary care physician. No referral is required for TakeCare's Group Fitness classes.	Nothing. All health education classes are **FREE** to TakeCare members unless otherwise specified. Referral is required from your primary care physician. No referral is required for TakeCare's Group Fitness classes.

Educational classes and programs - continued on next page

Benefit Description	You pay	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
Nicotine Cessation Program • primary care physician referral required • individual/group/telephone counseling • over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence - Nicotrol Nasal Spray - Nicotrol Inhaler - Chantix - Zyban - Bupropion hydrochloride - Nicorette Gum - Nicorette DS Gum - Habitrol Transdermal film - Nicoderm CQ Transdermal system - Commit Lozenge - Nicorette Lozenge - Nicotine Film - Nicotine Polacrilex, Gum, Chewing; Buccal - Thrive (Nicotine Polacrilex) Gum, Chewing; Buccal - Nicotine Polacrilex, Trocher/Lozenge - Nicotine Patch - Varenicline	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There are no deductibles for the High or Standard Options. There are separate Catastrophic Out-of-Pocket Maximums for medical services and prescription drugs. See **Section 4 -** *Your costs for covered services* for more information.
- Using the **FHP Health Center** for your primary care will result in lower copayments for you.
- Copayments and coinsurance are waived when using **in-network providers and facilities in the Philippines for prior-authorized services**.
- An **outpatient facility copayment** applies to services performed in an ambulatory surgical center or the outpatient department of a hospital.
- For **out-of-network services**, you are responsible for 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
- Be sure to read **Section 4 -** *Your costs for covered services* for valuable information about how cost-sharing works. Also read **Section 9** about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See *Section 5(c)* for benefits for services associated with a facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR MOST SURGICAL PROCEDURES.** Please refer to the prior authorization information shown in **Section 3** to be sure which services require prior authorization and identify which surgeries require prior authorization.
- To be covered for these benefits, you must follow your physician-prescribed treatment plan and all of our prior authorization processes for surgical and anesthesia services. Please call 671-647-3526 for more information.
- With the exception of OB/GYN, specialty care services require a written referral from your primary care physician.

Benefit Description	You pay	
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services are covered, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Circumcision • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery)	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $100 copayment per visit; Inpatient hospital - $100 copayment per day, up to $500 maximum per admission. *Copayment is waived at in-network facility in the Philippines.*	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $150 copayment per visit; Inpatient hospital - $150 copayment per day, up to $750 maximum per admission. *Copayment is waived at in-network facility in the Philippines.*

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• Surgical treatment of severe obesity (bariatric surgery). Surgery is limited to Roux-en-Y bypass, laparoscopic gastric band placement, laparoscopic sleeve gastrectomy, and vertical banded gastroplasty. Concerning bariatric surgery, the following conditions must be met: - Eligible members must be age 18 or over - Eligible members must weigh 100 pounds or 100% over their normal weight according to current underwriting standards - Eligible members must meet the National Institute of Health Guidelines - We may require you to participate in a non-surgical multidisciplinary program approved by us for six months prior to your bariatric surgery - We will determine the provider for the non-surgical program and surgery based on quality and outcomes. • Insertion of internal prosthetic devices. See **Section 5(a) –** *Orthopedic and prosthetic devices* for device coverage information • Cardiac surgery for the implantation of stents, leads and pacemaker • Cardiac surgery for the implantation of valves (Plan pays for the cost of procedure only) • Treatment of burns Note: For surgical family planning procedures see **Section 5(a) -** *Family Planning* Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $100 copayment per visit; Inpatient hospital - $100 copayment per day, up to $500 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $150 copayment per visit; Inpatient hospital - $150 copayment per day, up to $750 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot: see Sec 5(a)Foot care* • *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*	*All charges*	*All charges*

Benefit Description	You pay	
Reconstructive surgery	**High Option**	**Standard Option**
Covered services include: • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements. See **5(a) -** *Prosthetic devices* Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $100 copayment per visit; Inpatient hospital - $100 copayment per day, up to $500 maximum per admission. Copayment is waived at in-network facility in the Philippines. ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $150 copayment per visit; Inpatient hospital - $150 copayment per day, up to $750 maximum per admission. Copayment is waived at in-network facility in the Philippines. ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures are covered but limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures • TMJ surgery and other related non-dental treatment	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $100 copayment per visit; Inpatient hospital - $100 copayment per day, up to $500 maximum per admission. *Copayment is waived at in-network facility in the Philippines.*	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $150 copayment per visit; Inpatient hospital - $150 copayment per day, up to $750 maximum per admission. *Copayment is waived at in-network facility in the Philippines.*

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
	Out-of-network: 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental services related to treatment of TMJ*	*All charges*	*All charges*
Gender affirming surgery	**High Option**	**Standard Option**
Benefit covers procedures recommended by the current WPATH Standards of Care 8.0 without exclusions. Prior authorization is required for gender affirming surgery. There is no annual maximum benefit for covered procedures. Following current WPATH Standards of Care 8.0 for gender affirming surgeries, TakeCare requires the member to meet all of the following requirements: • Must be at least 18 years of age at the time prior authorization is requested • Diagnosis of gender dysphoria rendered by a qualified healthcare professional • Member has a strong desire to be rid of primary and/or secondary sex characteristics because of a marked incongruence with the member's identified gender • Member's gender dysphoria is not a symptom of another mental disorder or chromosomal abnormality • Gender dysphoria causes clinical distress or impairment in social, occupational, or other important areas of functioning	***In-network:*** Outpatient facility - $100 copayment per visit; Inpatient hospital - $100 copayment per day, up to $500 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** All charges	***In-network:*** Outpatient facility - $150 copayment per visit; Inpatient hospital - $150 copayment per day, up to $750 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** All charges
Not covered: • *Reversal of gender reassignment surgery* • *Any procedure not listed above*	*All charges*	*All charges*

Benefit Description	You pay	
Organ/tissue transplants	**High Option**	**Standard Option**
The following **solid organ transplants** are covered and subject to medical necessity and experimental/ investigational review by the Plan. Pre-authorization is required. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis] • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $100 copayment per visit; Inpatient hospital - $100 copayment per day, up to $500 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $150 copayment per visit; Inpatient hospital - $150 copayment per day, up to $750 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
The following **tandem blood or marrow stem cell transplants for covered transplants** are covered and subject to medical necessity review by the Plan. Pre-authorization is required. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $100 copayment per visit; Inpatient hospital - $100 copayment per day, up to $500 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $150 copayment per visit; Inpatient hospital - $150 copayment per day, up to $750 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below based on the requirements for hematopoietic stem cell transplant (HSCT) coverage of the American Society for Transplantation and Cellular Therapy (ASTCT) as published in 2020. For more information, go to https://bit.ly/ASTCTarticle. Not subject to medical necessity. Plan's denial is limited to indicators for transplant such as refractory or relapsed disease, cytogenetics, subtype, staging or the diagnosis. • **Allogeneic transplants** for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Hodgkin's lymphoma - relapsed - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Non-Hodgkin's lymphoma - relapsed - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $100 copayment per visit; Inpatient hospital - $100 copayment per day, up to $500 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $150 copayment per visit; Inpatient hospital - $150 copayment per day, up to $750 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• **Autologous transplants** for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Aggressive non-Hodgkin lymphomas - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Hodgkin's lymphoma - relapsed - Medulloblastoma - Multiple myeloma - Neuroblastoma - Non-Hodgkin's lymphoma - relapsed - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $100 copayment per visit; Inpatient hospital - $100 copayment per day, up to $500 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $150 copayment per visit; Inpatient hospital - $150 copayment per day, up to $750 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) are covered for members with a diagnosis listed below, subject to medical necessity review by the Plan. There is no defined age limits for the use of RIC for an allogeneic stem cell transplant. Refer to **Sec 3 -** *Other services* for prior authorization procedures.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $100 copayment per visit; Inpatient hospital - $100 copayment per day, up to $500 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $150 copayment per visit; Inpatient hospital - $150 copayment per day, up to $750 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• **Allogeneic transplants** for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma(CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • **Autologous transplants** for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $100 copayment per visit; Inpatient hospital - $100 copayment per day, up to $500 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $150 copayment per visit; Inpatient hospital - $150 copayment per day, up to $750 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
The following **blood or marrow stem cell transplants** are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence subject to prior authorization by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. **Section 9** has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $100 copayment per visit; Inpatient hospital - $100 copayment per day, up to $500 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $150 copayment per visit; Inpatient hospital - $150 copayment per day, up to $750 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• **Allogeneic transplants** for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • **Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC)** for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodysplastic Syndromes - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $100 copayment per visit; Inpatient hospital - $100 copayment per day, up to $500 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $150 copayment per visit; Inpatient hospital - $150 copayment per day, up to $750 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• **Autologous Transplants** for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis **Limited Benefits** • Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence subject to prior authorization by the Plan's medical director in accordance with the Plan's protocols. • Bone marrow stem cell donor search and testing for compatible unrelated donors up to $15,000 per procedure at a National Preferred Transplant Facility when you are the intended recipient.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $100 copayment per visit; Inpatient hospital - $100 copayment per day, up to $500 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $150 copayment per visit; Inpatient hospital - $150 copayment per day, up to $750 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
T**ransportation, food and lodging** - the following benefits are provided on a reimbursement basis, if you live over 60 miles from the transplant center and the services are pre-authorized by us: • Transportation limited to you and one escort to a National Preferred Transplant Network or other Company Approved Transplant Facility. • A $125 per day allowance for housing and food. This allowance excludes liquor and tobacco. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $100 copayment per visit; Inpatient hospital - $100 copayment per day, up to $500 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***FHP Health Center:*** Primary Care - $5 copayment per visit; Specialist Care - $40 copayment per visit ***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit; Outpatient facility - $150 copayment per visit; Inpatient hospital - $150 copayment per day, up to $750 maximum per admission. *Copayment is waived at in-network facility in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional anesthesia services provided in: • Inpatient hospital • Outpatient hospital • Skilled nursing facility • Ambulatory surgical center • Physician's office	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There are no deductibles for the High or Standard Options. There are separate Catastrophic Out-of-Pocket Maximums for medical services and prescription drugs. See **Section 4 -** *Your costs for covered services* for more information.
- Copayments and coinsurance are waived when using in-network providers and facilities in the Philippines for prior-authorized services.
- A outpatient facility copayment applies to services performed in an ambulatory surgical center or the outpatient department of a hospital.
- For out-of-network services, you are responsible for 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
- Be sure to read **Section 4 -** *Your costs for covered services* for valuable information about how cost-sharing works. Also read **Section 9** about coordinating benefits with other coverage, including with Medicare.
- The benefits in this Section are for the services provided by a facility (i.e. hospital, surgical center, etc.). Any benefits associated with professional services (i.e., physicians, etc.) are in **Sections 5(a)** or **5(b)**.
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FROM US FOR ELECTIVE HOSPITAL STAYS.** Please refer to **Section 3** to be sure which other services require prior authorization.
- To be covered for these benefits, you must follow your physician-prescribed treatment plan and all of our prior authorization processes for surgical and anesthesia services. Please call 671-647-3526 for more information.
- Referrals to doctors or facilities off-island must receive prior authorization from us. For services to be covered, a written referral must be made in advance by your physician and approved by the TakeCare Medical Referral Services (MRS) department.
- If you would like assistance with the coordination of any off-island services or have questions concerning the prior authorization process, please contact us at 671-300-5995 or via email at tc.mrs@takecareasia.com.

Benefit Description	You pay	
Inpatient hospital	**High Option**	**Standard Option**
Coverage includes room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you will need to pay the additional charge above the semiprivate room rate.	***In-network:*** $100 copayment per day up to $500 maximum per inpatient admission. Copayment is waived at in-network facility in the Philippines. ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** $150 copayment per day up to $750 maximum per inpatient admission. Copayment is waived at in-network facility in the Philippines. ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, x-rays and pathology tests • Administration of blood and blood products	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• Dressings, splints, casts and sterile tray services • Medical supplies and equipment including oxygen • Anesthetics, including nurse anesthetist services • Rehabilitative therapies - See **Section 5(a)** for benefit limitations	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Any inpatient hospitalization for dental procedure* • *Blood and blood products, whether synthetic or natural* • *Custodial care* • *Internal prosthetics except for those covered under **Section 5(a)** - Prosthetic and Orthopedic Devices.* • *Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Take-home items*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
Covered services include: • Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts and sterile tray services • Medical supplies including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	***In-network:*** $100 copayment per visit. *Copayments waived when using in-network providers in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** $150 copayment per visit. *Copayments waived when using in-network providers in the Philippines.* ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Blood and blood products, whether synthetic or natural*	*All charges*	*All charges*

Benefit Description	You pay	
Skilled nursing care facility benefits	**High Option**	**Standard Option**
The Plan provides a comprehensive range of benefits when full-time skilled nursing care and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. *Benefit Limits:* • *High Option – up to 100 days confinement per calendar year* • *Standard Option – up to 60 days confinement per calendar year* All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Custodial care* • *Skilled nursing facility services in the Philippines*	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility when approved by TakeCare's Medical Referral Services department. To be covered, services must be provided under the direction of a physician who certifies the patient is in the terminal stages of illness with a life expectancy of approximately six months or less. Covered services include: • Inpatient and outpatient care • Family counseling Note: This benefit is limited to a maximum of up to 180 days per lifetime.	***In-network:*** Nothing ***Out-of-network:*** All charges	***In-network:*** Nothing ***Out-of-network:*** All charges
Not covered: • *Independent nursing, homemaker services* • *Hospice-related services in the Philippines*	*All charges*	*All charges*

Benefit Description	You pay	
Ambulance	**High Option**	**Standard Option**
Local ground ambulance service is covered when medically necessary	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Transport that the Plan determined are not medically necessary* • *Air ambulance services*	*All charges*	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There are no deductibles for the High or Standard Options. There are separate Catastrophic Out-of-Pocket Maximums for medical services and prescription drugs. See **Section 4 -** *Your costs for covered services* for more information.
- In the event of an emergency or accident in the service area, seek immediate medical attention. If you are admitted as an inpatient to a hospital as a result of that emergency or accident, make sure you or someone else notifies TakeCare within forty-eight (48) hours or as soon as reasonably possible after initial receipt of services to inform us of the location, duration and nature of the services provided; otherwise, your care will not be covered.
- In the event of an emergency or accident outside the service area, seek immediate medical attention and make sure you or someone else notifies TakeCare within forty-eight (48) hours or as soon as reasonably possible after initial receipt of services to inform us of the location, duration and nature of the services provided; otherwise, your care will not be covered.
- Be sure to read **Section 4 -** *Your costs for covered services*, for valuable information about how cost- sharing works. Also read **Section 9** about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency?

In a life or limb threatening emergency, call 911 or go to the nearest hospital emergency room or other facility treatment. You do not need authorization from your primary care physician (PCP) before you go. A true emergency is covered no matter where you are.

Emergencies / Urgent Care in our service area: If you receive emergency care in our service area that results in your hospitalization, TakeCare Customer Service department must be notified within 48 hours unless it was not reasonably possible to do so at 671-647-3526 or by email at CustomerService@takecareasia.com, otherwise, your care will not be covered. If you are hospitalized within the service area at an out-of-network facility, we may arrange for your transfer to an in-network facility as soon as it is medically appropriate to do so.

When in the service area, notification is not required if your care is limited to urgent care or emergency room services only.

On Guam, if your primary care provider's office is closed, you may be able to access the FHP Urgent Care Center which is open from 8:00am – 8:00pm, Monday thru Saturdays, except Christmas, New Year's, and one staff development day per year.

Emergencies / Urgent Care outside our service area: If you receive emergency or urgent care outside our service area, even if you're not hospitalized, TakeCare Customer Service department must be notified within 48 hours unless it was not reasonably possible to do so at 671-647-3526 or by email at CustomerService@takecareasia.com, otherwise your care will not be covered. If you are hospitalized outside the service area, we may arrange for your transfer to an in-network facility as soon as it is medically appropriate to do so. If you are covered by Medicare on a primary basis, our coverage is secondary and will be dependent on what Medicare considers an eligible expense.

When you have to file a claim: Please refer to *Section 8* for information on how to file a claim, or contact our Customer Service Department at 671-647-3526.

Note: We do not coordinate benefits for outpatient prescription drugs.

Benefit Description	You pay	
Emergency/Urgent Care within our service area	**High Option**	**Standard Option**
• Urgent care services at the FHP Health Center - No appointment necessary - Including lab, x-ray, limited pharmacy services - Open from 8:00am – 8:00pm, Monday thru Saturdays, except Christmas, New Year's, and one staff development day per year.	$15 copayment per visit	$15 copayment per visit
• Urgent care at a doctor's office other than FHP or at Guam Memorial Hospital (GMH).	***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
• Emergency care as an outpatient at a hospital including doctors' services Note: We waive the ER copayment if you are admitted to the hospital and inpatient copayment will apply	***In-network:*** $75 copayment per emergency room visit ***Out-of-network:*** $75 copayment per emergency room visit	***In-network:*** $100 copayment per emergency room visit ***Out-of-network:*** $100 copayment per emergency room visit
Emergency/Urgent Care outside our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	***In-network:*** $50 copayment per visit ***Out-of-network:*** $50 copayment per visit	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 20% coinsurance of our allowance
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copayment if you are admitted to the hospital and inpatient copayment will apply	***In-network:*** $100 copayment per visit ***Out-of-network:*** $100 copayment per visit	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 20% coinsurance of our allowance
Not covered: • *Elective care or non-emergency care and follow-up care recommended by out-of-network providers that has not received prior authorization by the Plan* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area that has not received prior authorization by the Plan*	*All charges*	*All charges*

Benefit Description	You pay	
Ambulance	**High Option**	**Standard Option**
Professional ground ambulance service when medically necessary. Note: See *Section 5(c)* for coverage of non-emergency services.	Nothing	Nothing
Not covered: • *Transport the Plan determines is not medically necessary* • *Air ambulance*	*All charges*	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There are no deductibles for the High or Standard Options. There are separate Catastrophic Out-of-Pocket Maximums for medical services and prescription drugs. See **Section 4 -** *Your costs for covered services* for more information.
- Be sure to read **Section 4 -** *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read **Section 9** about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay	
Professional services	**High Option**	**Standard Option**
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other covered illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other covered illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit ; Outpatient facility - $100 copayment per visit ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit ; Outpatient facility - $150 copayment per visit ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Telehealth Services Treatment and counseling (including individual or group therapy visits) via phone, audio/video services using a computer, tablet, or smartphone with in-network behavioral health providers, on or off island.	***In-network:*** Nothing ***Out-of-network:*** All charges	***In-network:*** Nothing ***Out-of-network:*** All charges

Professional services - continued on next page

Benefit Description	You pay	
Professional services (cont.)	**High Option**	**Standard Option**
Applied Behavior Analysis (ABA) for the treatment of Autism Spectrum Disorder (ASD) is covered as any other condition, subject to prior authorization and benefit limitations. ASD is a condition that begins early in life and typically affect areas of a person's daily functioning. ASD is a group of developmental disabilities defined by uncharacteristic social interactions and communication (both verbal and nonverbal). The following benefit limitations apply: • Limited to children up to age 21 • Prior Authorization and treatment plan required • An Autism Spectrum Disorder diagnosis meeting minimum criteria such as, but not limited to, impairment in social interaction, lack of social reciprocity, delay in the development of spoken language and inflexible adherence to specific non-functional routines • Services must be performed by Qualified Autism Service Provider, Qualified Autism Service Professional, or Qualified Autism Service Paraprofessional • Travel and/or lodging expenses are not covered	***In-network:*** Specialist Care - $40 copayment per visit; Outpatient Facility - $100 copayment per visit; Inpatient hospital - $100 copayment per day, up to $500 maximum per admission. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges. ***Maximum Annual Benefit:*** $50,000 ages 9 and below, $25,000 ages 10 to 21	***In-network:*** Specialist Care - $40 copayment per visit; Outpatient Facility - $150 copayment per visit; Inpatient hospital - $150 copayment per day, up to $750 maximum per admission. (Copayment is waived at in-network providers in the Philippines). ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges. ***Maximum Annual Benefit:*** $50,000 ages 9 and below, $25,000 ages 10 to 21
Diagnostics	**High Option**	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	***In-network:*** Primary Care - $20 copayment per visit; Specialist Care - $40 copayment per visit ; Outpatient facility - $100 copayment per visit ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Primary Care - $25 copayment per visit; Specialist Care - $40 copayment per visit ; Outpatient facility - $150 copayment per visit ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Prior authorization required	***In-network:*** $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Benefit Description	You pay	
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment • Prior authorization required	***In-network:*** $100 copayment ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** $150 copayment ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not Covered	**High Option**	**Standard Option**
• *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 to be medically necessary* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the benefit table beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- To be covered for these benefits, you must follow your physician-prescribed treatment plan and all of our prior authorization processes for prescription drugs. Please call 671-647-3526 for more information.
- Federal law prevents the pharmacy from accepting unused medications.
- There are no deductibles for the High and Standard Options. Your in-network copayments or coinsurance amounts for prescription drugs only apply toward your prescription out-of-pocket maximum; they will not apply toward the medical services out-of-pocket maximum. See **Section 4 -** *Your costs for covered services* for more information.
- Copayments and coinsurance are waived when using selected in-network pharmacy providers in the Philippines for prior-authorized services.
- By using the **Mail Order** program, you can reduce your monthly copayment expense.
- Be sure to read **Section 4 -** *Your costs for covered services*, for valuable information about how cost-sharing works. Also read **Section 9** about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at an in-network pharmacy or, if you prefer, by mail through Birdi, formerly Elixir Mail Order Pharmacy, for a maintenance medication.
- **We use a formulary.** The TakeCare Formulary is a list of over 1600 prescription drugs that physicians use as a guide when prescribing medications for patients. The Formulary plays an important role in providing safe, effective and affordable prescription drugs to TakeCare members. It also allows us to work together with physicians and pharmacies to ensure that our members are getting the drug therapy they need. A Pharmacy and Therapeutics Committee consisting of Plan physicians and pharmacists evaluate prescription drugs based on safety, effectiveness, quality treatment and overall value. The committee considers first and foremost the safety and effectiveness of a medication before reviewing the cost. Note: Formulary is subject to change.
- **Prior authorization.** Your physician will need to request prior authorization for some non-formulary drugs. Physicians may initiate the prior authorization request simply by phoning, faxing, or emailing in the request. Requests are generally processed within 2 business days, but it may take up to 10 business days if additional information is needed from the physician.
- **There are dispensing limitations.** Prescription drugs will be dispensed for up to a 30-day supply or one commercially prepared unit per copayment (i.e., one inhaler, one vial of ophthalmic medication, one tube of ointment). For drugs that could be habit forming, the prescription unit is set at a smaller quantity for the protection and safety of our members.
- A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a FDA-approved generic drug is available, and your physician has not specified "Dispense as Written" for the name brand drug, you will have to pay the non-formulary copayment plus the cost difference between this drug and the generic drug.

- Updating of prior authorizations may be required. Clinical edits (limitations) can be used for safety reasons, quantity limitations and benefit plan exclusions and may require preauthorization.
- Prescription drugs can also be obtained through the Birdi, formerly Elixir Mail Order Pharmacy, mail order program for up to a 90-day supply of oral medication; 6 vials of insulin; or 3 commercially prepared units (i.e., inhaler, vials ophthalmic medication or topical ointments or creams). You pay nothing for a 90-day supply of generic medications through mail order. You can save expense for a 90-day supply of brand and non-formulary medications through mail order. For mail order customer service, call toll-free 1-855-BirdiRx or 1-855-247-3479 (TTY 711), 8AM to 8PM EST, Monday through Friday and 9AM to 5PM EST on Saturdays or go to www.birdirx.com
- **Why use generic drugs?** To reduce your out-of-pocket expenses! A generic drug is the chemical equivalent of a corresponding brand name drug. Generic drugs are less expensive than brand name drugs; therefore, you may reduce your out-of-pocket costs by choosing to use a generic drug.
- W**hen you do have to file a claim:** Please refer to *Section 7* for information on how to file a pharmacy claim, or contact our Customer Service Department at 671-647-3526, toll free 877-484-2411, or customerservice@takecareasia.com.
- **Our Pharmacy Benefit Manager is MedImpact, formerly Elixir Solutions. Learn more at www.medimpact.com**
- **Medicare and Prescription Drug Coverage:** Refer to notification printed on inside front cover of this brochure.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a physician and obtained from an in-network pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered*. • Diabetic supplies limited to disposable needles and syringes for the administration of covered medications. • Weight loss medication, subject to prior authorization and benefit coverage criteria such as but not limited to Body Mass Index ("BMI") and/or co-morbidities. • Drugs to treat gender dysphoria • Oral fertility drugs Note: Insulin and other glucose-lowering agents for diabetes are covered as Preventive Medications (see below).	**RETAIL** **Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $5 copayment Preferred Brand: $15 copayment Non-Preferred Brand: $50 copayment (Copayments per 90-day fill) Generic formulary: up to $15 copayment Preferred Brand: up to $40 copayment Non-Preferred Brand: up $105 copayment **Non-Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $10 copayment Preferred Brand: $25 copayment Non-Preferred Brand: $70 copayment (Copayments per 90-day fill) Generic formulary: up to $30 copayment Preferred Brand: up to $75 copayment Non-Preferred Brand: up $210 copayment **All In-network:** (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $200 copayment **Out-of-network:** No coverage except for out-of-area emergencies or approved referrals	**RETAIL** **Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $10 copayment Preferred Brand: $30 copayment Non-Preferred Brand: $75 copayment (Copayments per 90-day fill) Generic formulary: up to $25 copayment Preferred Brand: up to $60 copayment Non-Preferred Brand: up $150 copayment **Non-Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $15 copayment Preferred Brand: $40 copayment Non-Preferred Brand: $100 copayment (Copayments per 90-day fill) Generic formulary: up to $45 copayment Preferred Brand: up to $120 copayment Non-Preferred Brand: up $300 copayment **All In-network:** (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $250 copayment **Out-of-network:** No coverage except for out-of-area emergencies or approved referrals

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Note: If there is no generic equivalent available, you will still have to pay the non-formulary copay if your physician did not specify "Dispense as Written" on the prescription.	**RETAIL** **Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $5 copayment Preferred Brand: $15 copayment Non-Preferred Brand: $50 copayment (Copayments per 90-day fill) Generic formulary: up to $15 copayment Preferred Brand: up to $40 copayment Non-Preferred Brand: up $105 copayment **Non-Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $10 copayment Preferred Brand: $25 copayment Non-Preferred Brand: $70 copayment (Copayments per 90-day fill) Generic formulary: up to $30 copayment Preferred Brand: up to $75 copayment Non-Preferred Brand: up $210 copayment **All In-network:** (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $200 copayment **Out-of-network:** No coverage except for out-of-area emergencies or approved referrals **MAIL ORDER** **In-network:** (Copayments per 90-day fill) Generic formulary: $0 copayment Preferred Brand: $40 copayment Non-Preferred Brand: $100 copayment (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $200 copayment **Out-of-network:** No coverage	**RETAIL** **Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $10 copayment Preferred Brand: $30 copayment Non-Preferred Brand: $75 copayment (Copayments per 90-day fill) Generic formulary: up to $25 copayment Preferred Brand: up to $60 copayment Non-Preferred Brand: up $150 copayment **Non-Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $15 copayment Preferred Brand: $40 copayment Non-Preferred Brand: $100 copayment (Copayments per 90-day fill) Generic formulary: up to $45 copayment Preferred Brand: up to $120 copayment Non-Preferred Brand: up $300 copayment **All In-network:** (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $250 copayment **Out-of-network:** No coverage except for out-of-area emergencies or approved referrals **MAIL ORDER** **In-network:** (Copayments per 90-day fill) Generic formulary: $0 copayment Preferred Brand: $60 copayment Non-Preferred Brand: $160 copayment (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $250 copayment **Out-of-network:** No coverage

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described at https://bit.ly/3WdV3FW If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov Note: For additional Family Planning benefits see **Section 5(a)**	Nothing	Nothing
• Growth hormone	$5 copayment each	$5 copayment each
• Generic Opioid Reversal (Rescue) Agents Note: Coverage limited to naloxone-based injectables and the OTC version of naloxone 4mg nasal spray without cost-share to members. Other opioid reversal (rescue) agents are covered as any other covered medication. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/	***In-network:*** Nothing ***Mail Order:*** Nothing ***Out-of-network:*** All charges	***In-network:*** Nothing ***Mail Order:*** Nothing ***Out-of-network:*** All charges

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• Drugs for sexual dysfunction are covered when Plan criteria is met. For information about these criteria and dose limits, please have the prescribing physician call MedImpact, formerly Elixir Solutions, at 1-800-788-2949. • Oral fertility drugs to include covered IVF-related drugs, up to three cycles annually.	***In-network:*** 50% coinsurance of our allowance per prescription unit or refill limit ***Out-of-network:*** Not covered	***In-network:*** 50% coinsurance of our allowance per prescription unit or refill limit ***Out-of-network:*** Not covered
Preventive medications	**High Option**	**Standard Option**
The following are covered: • Preventive Medications with a USPSTF recommendation of A or B. These may include some over-the-counter vitamins, and nicotine replacement medications. This listing is subject to change during the year. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations • Formulary drugs and devices for the management of conditions listed below are also covered without cost-share, even if over-the-counter, if prescribed by a healthcare professional and filled at an in-network pharmacy: - Angiotensin Converting Enzyme (ACE) inhibitors for congestive heart failure, diabetes, and/or coronary artery disease - Anti-resorptive therapy for osteoporosis and/or osteopenia - Beta-blockers for congestive heart failure and/or coronary artery disease - Blood pressure monitor for hypertension	***In-network:*** Nothing: when prescribed by a healthcare professional and filled by a network pharmacy ***Out-of-network:*** No coverage except for out-of-area emergencies or approved referrals	***In-network:*** Nothing: when prescribed by a healthcare professional and filled by a network pharmacy ***Out-of-network:*** No coverage except for out-of-area emergencies or approved referrals

Preventive medications - continued on next page

Benefit Description	You pay	
Preventive medications (cont.)	**High Option**	**Standard Option**
- Inhaled corticosteroids and peak flow meters for asthma - Insulin and other glucose-lowering agents for diabetes - Opioid dependence treatments for opioid addiction - Selective Serotonin Reuptake Inhibitors (SSRIs) for depression - Statins for heart disease and/or diabetes Note: Rather than paying "nothing" when using an In-network provider, if the member chooses to use a branded product when a generic is available, they will pay the difference between the brand and generic cost. Note: To receive this benefit a prescription from a doctor must be presented to pharmacy	***In-network:*** Nothing: when prescribed by a healthcare professional and filled by a network pharmacy ***Out-of-network:*** No coverage except for out-of-area emergencies or approved referrals	***In-network:*** Nothing: when prescribed by a healthcare professional and filled by a network pharmacy ***Out-of-network:*** No coverage except for out-of-area emergencies or approved referrals
Not covered	**High Option**	**Standard Option**
• *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Drugs or substances not approved by the Food and Drug Administration (FDA)* • *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 approval of TakeCare's pharmacy committee.* • *Hospital take-home drugs* • *Medical supplies (such as dressing, and antiseptics)* • *Non-prescription medications unless specifically indicated elsewhere*	*All charges*	*All charges*

Not covered - continued on next page

Benefit Description	You pay	
Not covered (cont.)	**High Option**	**Standard Option**
• *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them* • *Replacement of lost, stolen or destroyed medication*	*All charges*	*All charges*

Section 5(f)(a). PDP EGWP Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- **This Medicare Prescription Drug Coverage (EGWP) is provided by VibrantRx (PDP)**, contracted by Medicare and sponsored by TakeCare Insurance Company. For information about your PDP-EGWP coverage, contact VibrantRx Member Services at 844-826-3451 (TTY 711). Hours are 24 hours a day, 365 days a year.
- If you are a Postal Service annuitant and their covered Medicare-eligible family member, you will be automatically group enrolled in our PDP EGWP. Contact us for additional information at (671) 647-3526 or customerservice@takecareasia.com.

Note: Notify us as soon as possible if you or your eligible family member is already enrolled in a Medicare Part D Plan. Enrollment in our PDP EGWP will cancel your enrollment in another Medicare Part D plan.

There are advantages to being enrolled in our PDP EGWP:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.

We cover drugs, medications, and supplies as described below and on the following pages.

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused drugs, medications, and supplies.
- Be sure to read **Section 4 -** *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read **Section 9** for information about how we pay if you have other coverage.
- If you choose to opt out of or disenroll from our PDP EGWP, see **Section 9** for additional PDP EGWP information and for our opt-out and disenrollment process. Contact us for assistance with the PDP EGWP opt out and disenrollment process at VibrantRx Member Services at 844-826-3451 (TTY 711). Hours are 24 hours a day, 365 days a year. By mail, VibrantRx, PO Box 509097, San Diego, CA 92150, or at www.vibrantrx.com/takecare

Warning:If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage.

Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll during Open Season or for a qualifying life event (QLE).

If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact VibrantRx Member Services for assistance at 844-826-3451 (TTY 711). Hours are 24 hours a day, 365 days a year. By mail, VibrantRx, PO Box 509097, San Diego, CA 92150, or at www.vibrantrx.com/takecare

Each new enrollee will receive from VibrantRx a description of our PDP EGWP Summary of Benefits, a combined prescription drug/Plan identification card, a mail order form/patient profile and a pre-addressed reply envelope.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. Your prescribers must have Medicare-approved prescriptive authority.
- **Where you can obtain prescription drugs.** You must fill the prescription at an in-network pharmacy or, if you prefer, by mail through Birdi, formerly Elixir Mail Order Pharmacy, for a maintenance medication. For assistance locating a PDP EGWP network pharmacy, visit our website at www.vibrantrx.com/takecare or call 844-826-3451 (TTY 711).
- **We use a formulary.** The VibrantRx Formulary is a list of over 1600 prescription drugs that physicians use as a guide when prescribing medications for patients. The Formulary plays an important role in providing safe, effective and affordable prescription drugs to TakeCare members. It also allows us to work together with physicians and pharmacies to ensure that our members are getting the drug therapy they need. A Pharmacy and Therapeutics Committee consisting of Plan physicians and pharmacists evaluate prescription drugs based on safety, effectiveness, quality treatment and overall value. The committee considers first and foremost the safety and effectiveness of a medication before reviewing the cost. *Note: Formulary is subject to change.*
- **Prior authorization.** Your physician will need to request prior authorization for some non-formulary drugs. Physicians may initiate the prior authorization request simply by phoning, faxing, or emailing in the request. Requests are generally processed within 2 business days, but it may take up to 10 business days if additional information is needed from the physician.
- **There are dispensing limitations.** Prescription drugs will be dispensed for up to a 30-day supply or one commercially prepared unit per copayment (i.e., one inhaler, one vial of ophthalmic medication, one tube of ointment). For drugs that could be habit forming, the prescription unit is set at a smaller quantity for the protection and safety of our members.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a FDA-approved generic drug is available, and your physician has not specified "Dispense as Written" for the name brand drug, you will have to pay the non-formulary copayment plus the cost difference between this drug and the generic drug.
- **Updating of prior authorizations may be required.** Clinical edits (limitations) can be used for safety reasons, quantity limitations and benefit plan exclusions and may require preauthorization.
- Prescription drugs can also be obtained through the Birdi, formerly Elixir Mail Order Pharmacy, mail order program for up to a 90-day supply of oral medication; 6 vials of insulin; or 3 commercially prepared units (i.e., inhaler, vials ophthalmic medication or topical ointments or creams). You pay nothing for a 90-day supply of generic medications through mail order. You pay two (2) copayments for a 90-day supply of brand and non-formulary medications through mail order. For mail order customer service, call toll-free 1-855-BirdiRx or 1-855-247-3479 (TTY 711), 8AM to 8PM EST, Monday through Friday and 9AM to 5PM EST on Saturdays or go to www.birdirx.com
- **Why use generic drugs?** To reduce your out-of-pocket expenses! A generic drug is the chemical equivalent of a corresponding brand name drug. Generic drugs are less expensive than brand name drugs; therefore, you may reduce your out-of-pocket costs by choosing to use a generic drug.
- **When you do have to file a claim:** Please refer to **Section 7** for information on how to file a pharmacy claim, or contact our Customer Service Department at 671-647-3526, toll free 877-484-2411, or customerservice@takecareasia.com.
- **If we deny your claim and you want to appeal**, you, your representative, or your prescriber must request an appeal following the process described in **Section 8(a) -** *Medicare PDP EGWP Disputed Claims Process*. The PDP EGWP appeals process has 5 levels. If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions in the decision letter on how to move to the next level of appeal.

PDP EGWP Catastrophic Maximum - under this PDP EGWP, your prescription drug out-of-pocket maximum limit is $2,000 for Self Only, $4,000 for Self Plus One or $6,000 for Self and Family. An individual under Self Plus One or Self and Family enrollment will never have to satisfy more than what is required for the out-of-pocket maximum limit under a Self Only enrollment.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a physician and obtained from an in-network pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Diabetic supplies limited to disposable needles and syringes for the administration of covered medications. • Weight loss medication, subject to prior authorization and benefit coverage criteria such as but not limited to Body Mass Index ("BMI") and/or co-morbidities. • Drugs to treat gender dysphoria • Oral fertility drugs Note: Insulin and other glucose-lowering agents for diabetes are covered as Preventive Medications (see below). Note: If there is no generic equivalent available, you will still have to pay the non-formulary copay if your physician did not specify "Dispense as Written" on the prescription.	**RETAIL** **Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $5 copayment Preferred Brand: $15 copayment Non-Preferred Brand: $50 copayment (Copayments per 90-day fill) Generic formulary: up to $15 copayment Preferred Brand: up to $40 copayment Non-Preferred Brand: up $105 copayment **Non-Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $10 copayment Preferred Brand: $25 copayment Non-Preferred Brand: $70 copayment (Copayments per 90-day fill) Generic formulary: up to $30 copayment Preferred Brand: up to $75 copayment Non-Preferred Brand: up $210 copayment **All In-network:** (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $200 copayment **Out-of-network:** No coverage except for out-of-area emergencies or approved referrals **MAIL ORDER**	**RETAIL** **Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $10 copayment Preferred Brand: $30 copayment Non-Preferred Brand: $75 copayment (Copayments per 90-day fill) Generic formulary: up to $25 copayment Preferred Brand: up to $60 copayment Non-Preferred Brand: up $150 copayment **Non-Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $15 copayment Preferred Brand: $40 copayment Non-Preferred Brand: $100 copayment (Copayments per 90-day fill) Generic formulary: up to $45 copayment Preferred Brand: up to $120 copayment Non-Preferred Brand: up $300 copayment **All In-network:** (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $250 copayment **Out-of-network:** No coverage except for out-of-area emergencies or approved referrals **MAIL ORDER**

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
	In-network: (Copayments per 90-day fill) Generic formulary: $0 copayment Preferred Brand: $40 copayment Non-Preferred Brand: $100 copayment (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $200 copayment **Out-of-network:** No coverage	**In-network:** (Copayments per 90-day fill) Generic formulary: $0 copayment Preferred Brand: $60 copayment Non-Preferred Brand: $160 copayment (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $250 copayment **Out-of-network:** No coverage
• Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described at https://bit.ly/3WdV3FW Note: For additional Family Planning benefits see **Section 5(a)**	Nothing	Nothing
• Growth hormone	$5 copayment each	$5 copayment each
• Generic Opioid Reversal (Rescue) Agents Note: Coverage limited to naloxone-based injectables and the OTC version of naloxone 4mg nasal spray without cost-share to members. Other opioid reversal (rescue) agents are covered as any other covered medication. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/	***In-network:*** Nothing ***Mail Order:*** Nothing ***Out-of-network:*** All charges	***In-network:*** Nothing ***Mail Order:*** Nothing ***Out-of-network:*** All charges
	In-network: 50% coinsurance of our allowance per prescription unit or refill limit	***In-network:*** 50% coinsurance of our allowance per prescription unit or refill limit

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• Drugs for sexual dysfunction are covered when Plan criteria is met. For information about these criteria and dose limits, please have the prescribing physician call MedImpact, formerly Elixir Solutions, at 1-800-788-2949. • Oral fertility drugs to include covered IVF-related drugs, up to three cycles annually.	***In-network:*** 50% coinsurance of our allowance per prescription unit or refill limit ***Out-of-network:*** Not covered	***In-network:*** 50% coinsurance of our allowance per prescription unit or refill limit ***Out-of-network:*** Not covered
Preventive medications	**High Option**	**Standard Option**
The following are covered: • Preventive Medications with a USPSTF recommendation of A or B. These may include some over-the-counter vitamins, and nicotine replacement medications. This listing is subject to change during the year. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations • Formulary drugs and devices for the management of conditions listed below are also covered without cost-share, even if over-the-counter, if prescribed by a healthcare professional and filled at an in-network pharmacy: - Angiotensin Converting Enzyme (ACE) inhibitors for congestive heart failure, diabetes, and/or coronary artery disease - Anti-resorptive therapy for osteoporosis and/or osteopenia - Beta-blockers for congestive heart failure and/or coronary artery disease - Blood pressure monitor for hypertension - Inhaled corticosteroids and peak flow meters for asthma - Insulin and other glucose-lowering agents for diabetes - Opioid dependence treatments for opioid addiction - Selective Serotonin Reuptake Inhibitors (SSRIs) for depression - Statins for heart disease and/or diabetes Note: Rather than paying "nothing" when using an In-network provider, if the member chooses to use a branded product when a generic is available, they will pay the difference between the brand and generic cost. Note: To receive this benefit a prescription from a doctor must be presented to pharmacy.	***In-network:*** Nothing ***Out-of-network:*** No coverage except for out-of-area emergencies or approved referrals	***In-network:*** Nothing ***Out-of-network:*** No coverage except for out-of-area emergencies or approved referrals

Benefit Description	You pay	
Not covered	**High Option**	**Standard Option**
• *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Drugs or substances not approved by the Food and Drug Administration (FDA)* • *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 approval of TakeCare's pharmacy committee.* • *Hospital take-home drugs* • *Medical supplies (such as dressing, and antiseptics)* • *Non-prescription medications unless specifically indicated elsewhere* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them* • *Replacement of lost, stolen or destroyed medication* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Nicotine Cessation programs benefit. See page 52.	*All charges*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Copayments and coinsurance are waived when using in-network dental providers in the Philippines for prior-authorized services.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your PSHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your PSHB Plan. See **Section 9 -** *Coordinating benefits with other coverage*.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See **Section 5(c)** for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read **Section 4 -** *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read **Section 9** about coordinating benefits with other coverage, including with Medicare.
- Your out-of-pocket payments for covered dental services do not count toward your catastrophic out-of-pocket maximum.
- **Annual Dental Maximum Benefit** is $1,500 per member per benefit year.

Benefit Description	You pay	
Accidental injury benefit	**High Option**	**Standard Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Note: If you are outside the service area and receive services from an out-of-network dentist, we will reimburse you up to $100.00.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Covered dental services	**High Option**	**Standard Option**
OFFICE VISIT • Oral examination and treatment plan; vitality test; and oral cancer exam. X-rays, including bitewings (once a year) and panoramic (once every three years).	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
PREVENTIVE SERVICES • Prophylaxis (once every 6 months); sealants (up to age 12); annual topical application of fluoride (up to age 12)	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
RESTORATIVE DENTISTRY • Amalgam - one, two or three surfaces. • Composite - one or two surfaces, anterior only.	***In-network:*** 20% coinsurance of our allowance for covered charges ***Out-of-network:*** 50% coinsurance of our allowance plus any difference between our allowance and billed charges.	All charges

Covered dental services - continued on next page

Benefit Description	You pay	
Covered dental services (cont.)	**High Option**	**Standard Option**
Note: Posterior composites are not covered; however, an allowance for a comparable silver amalgam restoration will be made. The difference in fees is the member's responsibility.	***In-network:*** 20% coinsurance of our allowance for covered charges ***Out-of-network:*** 50% coinsurance of our allowance plus any difference between our allowance and billed charges.	All charges
SIMPLE EXTRACTIONS • Simple extraction for fully erupted teeth only	***In-network:*** 20% coinsurance of our allowance for covered charges ***Out-of-network:*** 50% coinsurance of our allowance plus any difference between our allowance and billed charges.	All charges
PROSTHODONTICS • Full and partial dentures • Crowns and bridges • Repair • Relining and/or reconstruction of dentures.	***In-network:*** 75% coinsurance of our allowance for covered charges ***Out-of-network:*** 95% coinsurance of our allowance plus any difference between our allowance and billed charges.	All charges
Annual Maximum Benefit	**High Option**	**Standard Option**
• Dental Plan Maximum Benefit	All charges in excess of maximum benefit of $1,500 per member per benefit year.	All charges in excess of maximum benefit of $1,500 per member per benefit year.
Not Covered	**High Option**	**Standard Option**
• *Oral Surgery* • *Prescription Drugs* • *Orthodontics*	*All charges*	*All charges*

Section 5(h). Wellness and Other Special Features

Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see *Section 8*).
Medical Travel Benefit	TakeCare offers a Medical Travel Benefit to its PSHB members, making it easier to travel to the Joint Commission-accredited St. Luke's Hospitals, The Medical City, or other in-network providers in the Philippines when they receive a pre-authorized, elective inpatient or outpatient procedure, excluding emergencies, screenings, executive checkups, primary care, dental, home health, hospice, mental health & substance misuse disorder treatment or maternity-related services. The travel benefit provides up to $500 toward the cost of round-trip airfare between Guam and Manila, ground transportation between the airport and the hospital, and lodging in Manila. There is no limit to the number of times this benefit can be used during the year once all medical and pre-authorization requirements are met. Members can choose one of two options for airfare, transportation and lodging expenses: • TakeCare will arrange and pay in advance up to $500 for the member's airfare, transportation, and lodging, **or** • The member can elect to receive a $500 travel allowance for expenses. The member will be responsible for their own travel arrangements and will be reimbursed by TakeCare, up to the $500 allowance. Please note that documentation will be required as part of the reimbursement process. Frequent flyer mile points are not reimbursable. For either option, the member is responsible for any airfare, transportation, and lodging expenses in excess of $500 and any penalties/fees associated with member-initiated travel changes or cancellations. If the patient is an under age 18 dependent or a disabled individual, TakeCare will pay or reimburse up to $500 for the airline ticket for an adult escort, up to a maximum of $1,000 for two escorts when there are two or more patients on a single approved referral trip.

	Approved escorts are limited to legal parents, legal guardians, or the individual caregiver responsible for the disabled member's care. TakeCare will not extend the Medical Travel Benefit coverage to escorts not enrolled under the same TakeCare plan as the minor or disabled adult patient(s). For the purposes of this benefit, a disabled individual is defined as a person who is dependent on a caregiver for all activities of daily living (eating, bathing, etc) as certified in writing by their attending physician. Non-compliance with required treatment guidelines as defined by TakeCare's provider and Medical Management will result in non-eligibility under the travel benefit. Notes: • Medical Travel Benefit claim payments, related to a pacemaker and related services, will accumulate towards the Pacemaker Annual Limit of $50K. See *Sec 5(a) - Orthopedic and Prosthetic Devices.* • TakeCare-covered PSHB members with primary coverage through Medicare or another insurance carrier are not eligible for the Medical Travel Benefit. • To learn more about this benefit, contact TakeCare Customer Service at 671-647-3526.
Information Accessibility	TakeCare is committed to ensuring every member can access information about their health plan with dignity, equality, comfort, and independence. To achieve this goal, TakeCare provides an accessibility widget on its website, translation, and hearing impaired services. To learn more, go to www.takecareasia.com/multi-language.pdf
Preventive Services and Screenings Program	Members are encouraged to avail of the following services and screenings, most of which are covered at 100%: • Flu Vaccination for Adults, ages 18-64. • Biometric screening through the member's TakeCare primary care provider or TakeCare Wellness health fairs. • Pre natal visit to a TakeCare participating obstetrician gynecologist within the first trimester. • Six or more Well-Child visits during the first 15 months of life. • Compliance with insulin medication for at least 75% of their treatment period for adult members, ages 18-75, diagnosed with Type I or II Diabetes. • Compliance with asthma controller medication for at least 75% of their treatment period for adult members, ages 19-50, with asthma. • Annual Physical Exam through the member's TakeCare participating primary care provider. • Annual Physical Exam and colorectal cancer screening for member ages 50 and above through TakeCare's participating primary care provider with any of the following services: Colonoscopy; Sigmoidoscopy; and fecal occult blood test once per benefit year as part of the member's annual physical examination. • Annual Physical Exam and breast cancer and screening mammogram for women between 40 to 69 through TakeCare's participating primary care provider once per benefit year. • Annual Physical Exam and cervical cancer screening for ages 21 to 64 with pap smear through TakeCare's participating primary care provider once per benefit year. • Annual Dental Exam through TakeCare's participating providers. • Annual Vision Exam through TakeCare's participating providers.

Health Education Classes	Health education classes and wellness programs are FREE to TakeCare Members unless otherwise specified. Referrals are not required for registration or enrollment. The Wellness Team may request for recent medical records. For more information about these classes, call the TakeCare Wellness Team at 671-300-7161 or 671-300-7108 or email wellness@takecareasia.com. To register for a class, go to wellnesscenter.takecareasia.com/v2/#book **Case Management Program for Chronic Diseases** is intended for members with chronic diseases such as diabetes mellitus, cardiovascular disease (CVD), and/or other related cardiometabolic risks. The program provides a one-on-one, person-centered approach to chronic disease and risk factor management, including but not limited to blood sugar management, cholesterol management, controlling blood pressure, weight management, medication adherence, and coordination of care with the patient's primary care provider. **Evolt 360 Body Scanner** is a simple-to-use tool that provides information about a body through more than 40 measurements in just 60 seconds. The personalized, detailed report includes measures such as muscle mass, fat mass, total water, and nutrient profile. **Diabetes Self-Management Education and Support (DSMES) Program**, recognized by the American Diabetes Association, provides persons with diabetes (PWD) the knowledge, skills, and confidence to accept responsibility for their self-management. This includes collaborating with their healthcare team, making informed decisions, solving problems, developing personal goals and action plans, and coping with emotions and life stresses. The program is delivered through one-on-one or group class sessions. Each participant has a person-centered DSMES plan with outcomes measured, and an action-oriented behavioral change plan will be developed to reach their personal behavioral goal/s. **Diabetes Prevention Program (DPP)** – Prevent T2, recognized by the Centers for Disease Control, helps members with pre-diabetes adopt lifestyle changes such as healthier eating habits, reducing stress, and getting more physically active. Diabetes Prevention Program is not a fad diet or a simple exercise class. It's a year-long program focused on long-term changes and lasting results. It provides a long-term commitment to good health by learning new habits, gaining new skills, building confidence to make the change, and support from other participants who share similar goals and struggles. **Eat Right Workshops** are designed to educate and empower individuals with the knowledge and skills necessary to make informed choices about their dietary habits and culinary endeavors. This program combines elements of cooking, nutrition, and healthy eating to promote a holistic approach to well-being. **Fitness Program** encourages members to increase daily physical activities and exercise to meet the recommendations established by the American College of Sports Medicine (ACSM) to improve quality of life and reduce the risk of chronic conditions. Programs include Group Fitness Classes, Sports Series, Self-Reported Fitness Activities, fitness partners, etc. **Nutrition and Health Education Program** provides a person-centered approach to educate members on weight management, performance, and nutritional needs. Using evidence-based strategies, members, with the guidance of certified nutrition consultants, will create solutions to reaching their weight and nutritional goals and identify how to reinforce positive food habits and behaviors. Individuals with high-risk diabetes complications and/or chronic kidney disease may be referred to a Registered Dietitian for individual Medical Nutrition Therapy (MNT).

	Quit Now - Nicotine Cessation Program assists members with quitting tobacco use and other nicotine delivery devices. In partnership with the Public Health and Social Services Tobacco Prevention and Control Program, TakeCare refers members seeking tobacco and nicotine cessation services to the Tobacco-Free Guam Quitline. Quit aids, including Wellbutrin (bupropion), Chantix (varenicline), and nicotine patches, are available at a $0-copay to assist members with their quit journey. Requirements include confirmed enrollment with the Quitline, valid prescription, and prior authorization. **Perinatal and Neonatal Care Management** - Marianas Physician Group (MPG), a TakeCare Preferred In-Network Provider, offers in-clinic Maternal Services (Prenatal Services, Breastfeeding Education, Post-natal Services). TakeCare provides coverage for prenatal and postpartum services with in-network certified midwives. Perinatal support services such as Lamaze, and infant breastfeeding classes are offered free of charge. Without proper prenatal care and self-care throughout each pregnancy, the chance of premature births becomes much greater. In collaboration with Valenz Health and RGA, expecting mothers can access dedicated case management expert and nurse consultants to support them with high-risk pregnancies.

Section 5. High Deductible Health Plan Benefits Overview

This Plan offers High, Standard, and High Deductible Health Plan (HDHP) Options. The HDHP Option benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind* about these benefits at the beginning of each subsection. Also read **Section 6 -** *General Exclusions*; they apply to benefits in the following subsections.

To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 671-647-3526, email at customerservice@takecareasia.com, or visit our website at www.takecareasia.com

Our HDHP Option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. This option gives you greater control over how you use your healthcare benefits.

When you enroll in this HDHP Option, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment.

With the HDHP Option, preventive medical care and preventive medications are covered in full if you use in-network providers. As you receive other non-preventive medical care, you must meet the Plan's medical deductible before we pay benefits described in the following pages. Separately, you must meet the Plan's prescription drug deductible before we pay non-preventive prescription benefits described in the following pages. You can choose to use funds available in your HSA to make payments toward the deductibles, towards other eligible expenses, or you can pay these charges entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP Option includes five key components, 1) in-network preventive care services, 2) traditional medical coverage healthcare that is subject to the medical and prescription drug deductibles, 3) savings, 4) catastrophic protection for out-of-pocket expenses, and 5) health education resources and account management tools.

- **Preventive care**

  The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, preventive prescription medications and devices, tobacco cessation programs, obesity weight loss programs, disease management and wellness programs. These services are covered at 100% if you use a network provider and the services are described in **Section 5 -** *Preventive care.* **You do not have to meet the deductible before these services are covered**.

- **Traditional medical coverage**

  After you have paid the Plan's medical deductible, we pay benefits under traditional medical coverage described in **Sections 5(a-e)**. The Plan typically pays 80% of our allowance for covered charges for in-network care and 70% of our allowance for out-of-network care.

  Covered services include:

  - Medical services and supplies provided by physicians and other healthcare professionals
  - Surgical and anesthesia services provided by physicians and other healthcare professionals
  - Hospital services; other facility or ambulance services
  - Emergency services/accidents
  - Mental health and substance misuse treatment benefits

- **Prescription drug coverage**

  After you have met the Plan's prescription drug deductible, we pay benefits under the prescription drug coverage described in **Sections 5(f) and 5(f)(a)**.

  We cover the following medications and supplies that are prescribed by a physician and obtained from a retail pharmacy or through our mail order program:

  - Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered*.
  - Weight loss medication, subject to prior authorization and benefit coverage criteria such as but not limited to Body Mass Index ("BMI") and/or co-morbidities.
  - Drugs to treat gender dysphoria

- **Savings**

  Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see the next Section for more details).

- **Health Savings Accounts (HSAs)**

  By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA (except for veterans with a service-connected disability) and/or Indian Health Services (IHS) benefits within the last three months or do not have other health insurance coverage other than another High Deductible Health Plan.

  In 2025, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $33.58 per month for a Self Only enrollment or $81.05 per month for a Self Plus One enrollment or $90.02 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is $4,300 for an individual and $8,550 for a family. See maximum contribution information on page 99. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

  Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

  HSA features include:

  - A choice of having your HSA administered by ASC Trust Fund or Bank of Guam or another qualified financial institution
  - Your contributions to the HSA are tax deductible
  - You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
  - Your HSA earns tax-free interest
  - You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
  - Your unused HSA funds and interest accumulate from year to year
  - Your HSA is portable - it's owned by you and is yours to keep, even when you leave Federal employment or retire
  - When you need it, funds up to the actual HSA balance are available.

Important consideration if you want to participate in a Healthcare Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA healthcare flexible spending account, this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

- **Health Reimbursement Arrangements (HRA)**

If you are not eligible for an HSA (e.g., you are enrolled in Medicare or have another health plan), we will administer and provide an HRA instead. **You must notify us that you are ineligible for an HSA.**

In 2025, we will give you an HRA credit of $493.03 per year for a Self Only enrollment or $1,190.22 per year for a Self Plus One enrollment or $1,321.78 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by ASC Trust Fund.
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment.
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP.
- Unused credits carryover from year to year.
- HRA credit does not earn interest.
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans.
- An HRA does not affect your ability to participate in a Healthcare Flexible Spending Account (HCFSA). However, you must meet HCFSA eligibility requirements.

- **Catastrophic protection for out-of-pocket expenses**

Your in-network out-of-pocket maximum limit for covered medical services is $3,000 per person or, $6,000 per Self Plus One enrollment or, $6,000 Self and Family enrollment. There is no out-of-pocket limit when using an out-of-network provider under this option. Separately, your in-network prescription drug out-of-pocket maximum limit is $3,000 for Self Only enrollment, $6,000 for Self Plus One enrollment, or $6,000 for Self and Family enrollment. If you are enrolled in our PDP EGWP, see page 149 for additional information about your out-of-pocket maximum.

Certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (e.g., deductibles, expenses in excess of the Plan's allowable amount or benefit maximum). Refer to page 26 for more information.

- **Health education resources and account management tools**

HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your healthcare and your healthcare dollars.

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	You are responsible for establishing an HSA for yourself with ASC Trust, Bank of Guam, or another qualified financial institution as this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS). Upon establishing an HSA for yourself, you will need to inform us about your account information so we can coordinate the premium pass through deposits to your account. You can notify us by completing and submitting an HSA Pass Through form.	ASC Trust is the HRA fiduciary for this Plan.
Fees	The HSA set-up fee is paid by us. $12.50 per quarter administrative fee charged by ASC Trust $2.00 monthly administrative fee charged by Bank of Guam Fees are subject to change and you may incur additional fees. Contact the financial institution for details.	$12.50 per quarter administrative fee charged by ASC Trust. Fees are subject to change and you may incur additional fees. Contact the financial institution for details.
Eligibility	You must: • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA (except for veterans with a service-connected disability) and/or Indian Health Service (IHS) benefits in the last three months • Complete and return all banking paperwork	You must: • Enroll in this HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.

Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. This is called a Premium Pass Through. Premium pass through contributions are based on the effective date of your enrollment in the HDHP. Note: If your effective date in the HDHP is after the 1st of the month, the earliest your HSA will be established is the 1st of the following month. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.
• **Self Only enrollment**	For 2025, a monthly premium pass through of $33.58 will be made by the HDHP directly into your HSA each month.	For 2025, your HRA annual credit is $402.93 (the amount will be prorated based on the length of enrollment during the calendar year).
• **Self Plus One enrollment**	For 2025, a monthly premium pass through of $81.05 will be made by the HDHP directly into your HSA each month.	For 2025, your HRA annual credit is $972.65 (the amount will be prorated based on the length of enrollment during the calendar year).
• **Self and Family enrollment**	For 2025, a monthly premium pass through of $90.02 will be made by the HDHP directly into your HSA each month.	For 2025, your HRA annual credit is $1,080.22 (the amount will be prorated based on the length of enrollment during the calendar year).
Contributions/credits	For 2025, the maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $4,300 for an individual and $8,550 for a family. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution.	The full HRA credit will be available, subject to proration, on your effective date of enrollment. The HRA does not earn interest.

	You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12-month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. You may rollover funds you have in other HSAs to this HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSAs earn tax-free interest (does not affect your annual maximum contribution). Additional contributions are discussed on page 101.	
• **Self Only enrollment**	You may make an annual maximum contribution of $3,897.07	You cannot contribute to the HRA.
• **Self Plus One enrollment**	You may make an annual maximum contribution of $7,627.35	You cannot contribute to the HRA.
• **Self and Family enrollment**	You may make an annual maximum contribution of $7,469.78	You cannot contribute to the HRA.
Access funds	You can access funds in your HSA by the following methods: • Visa® debit card (ASC only) • ATM card (ASC only) • Checks • Direct cash withdraws	For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through the HDHP. For expenses not covered by the HDHP (e.g., dental orthodontia), a reimbursement form will be sent to you upon your request.
Distributions/withdrawals • **Medical** • **Dental** • **Other qualified expenses**	You can pay eligible out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) using the funds available in your HSA.	You can pay eligible out-of-pocket expenses for individuals covered under the HDHP.

	See IRS Publications 502 and 969 for information on eligible expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.	Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA. See IRS Publications 502 and 969 for information on eligible expenses. Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.
• **Non-qualified expenses**	If you are under age 65, withdrawal of funds for non-qualified expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified expenses
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • We receive a completed Premium pass-through Form from you. • We receive a record of your enrollment, initially establish your HSA account with the fiduciary you've chosen, and contribute the minimum amount required to establish an HSA. • The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you.	Funds are not available until: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). The entire amount of your HRA will be available to you upon your enrollment in the HDHP.

	After TakeCare receives the enrollment and contributions from OPM and your HSA account has been created and funded, you can withdraw funds up to the amount contributed for any eligible expenses incurred on or after the date the HSA was initially established.	
Account owner	PSHB enrollee	TakeCare Insurance Company
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 97 for HSA eligibility.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If you have an HSA

- **Contributions**

  All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

  If you newly enroll in an HDHP during Open Season, your effective date is January 1st, or if you enroll at any other time and have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

- **Over age 55 additional contributions**

  If you are age 55 or older, the IRS permits you to make additional contributions to your HSA. The allowable additional contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the IRS website at www.irs.gov or request a copy of IRS Publication 969 by calling 1-800-829-3676. www.ustreas.gov/offices/public-affairs/hsa/

- **If you die**

  If you have not named beneficiary and you are married, your HSA becomes your spouse's; otherwise, your HSA becomes part of your taxable estate.

- **Qualified expenses**

  You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.

  When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

  For detailed information of IRS-allowable expenses, request a copy of IRS Publications 502 and 969 by calling 1-800-829-3676, or visit the IRS website at www.irs.gov and click on "Forms and Publications." Note: Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses**

  You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- **Tracking your HSA balance**

  You will receive a periodic statement that shows the "premium pass through", withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.

- **Minimum reimbursements from your HSA**

  You can request reimbursement in any amount.

If you have an HRA

- **Why an HRA is established**

  If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.

- **How an HRA differs**

  Please review the chart on page 97 which details the differences between an HRA and an HSA. The major differences are:

  - you cannot make contributions to an HRA
  - funds are forfeited if you leave the HDHP
  - an HRA does not earn interest
  - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. PSHB law does not permit qualified medical expenses to include services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

If You Have an HSA

- **Contributions**

  All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

  If you newly enroll in an HDHP during Open Season and your effective date is after January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

- **Over age 55 additional contributions**

  If you are age 55 or older, the IRS permits you to make additional contributions to your HSA. The allowable additional contribution is $1,000 per year. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the IRS website at www.irs.gov or request a copy of IRS Publication 969 by calling 1-800-829-3676.

- **If you die**

  If you have not named a beneficiary and you are married, your HSA becomes your spouse's, otherwise, it becomes part of your taxable estate.

- **Qualified expenses**

  You can pay for "qualified expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.

  When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

  For detailed information of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS Website at www.irs.gov and click on "Forms and Publications."

  Note: Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses**

  You may withdraw money from your HSA for items other than qualified expenses, but the withdrawal amount will be subject to income tax and, if you are under 65 years old, you will pay an additional 20% penalty tax on the amount withdrawn.

- Tracking your HSA balance

  You will receive a periodic statement that shows the “premium pass through”, withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.

- **Minimum reimbursements from your HSA**

  You can request reimbursement in any amount.

If You Have an HRA

- **Why an HRA is established**

If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you.

You must tell us if you become ineligible to contribute to an HSA.

- **How an HRA differs from a HSA**

Please review the chart starting on page 97 which details the differences between an HRA and an HSA. The major differences are:

- you cannot make contributions to an HRA
- funds are forfeited if you leave the HDHP
- an HRA does not earn interest
- HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. PSHB law does not permit qualified medical expenses to include services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

Section 5. Preventive Care

Important things you should keep in mind about these benefits:

- **Preventive care services listed in this section are not subject to a deductible.**
- The Plan pays 100% for medical preventive care services (based on US Preventive Services Task Force Guidelines) listed in this Section **as long as you use the in-network providers**. If you choose to access preventive care from an out-of-network provider, you will not qualify for 100% preventive coverage.
- For all other covered expenses, please see **Section 5 –** *Traditional medical coverage subject to the deductible*.
- The in-network preventive care charges paid under this Section does not count against or use up your HSA or HRA funds.

Benefit Description	You pay
Preventive care, adults	**HDHP**
The following preventive services are covered at the time interval recommended at each of the links below: • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. This includes follow-up colonoscopies after a positive non-invasive stool-based screening test or direct visualization test. For a complete list of screenings go to the U. S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, breast cancer screening, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women please visit the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/ • Routine mammograms • Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/	*Not subject to deductible* ***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Preventive care, adults - continued on next page

Benefit Description	You pay
Preventive care, adults (cont.)	**HDHP**
• To build your personalized list of preventive services, go to https://health.gov/myhealthfinder • Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: - Intensive nutrition and behavioral weight-loss counseling therapy - Family centered programs when medically identified to support obesity prevention and management by an in-network provider - When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See **Section 5(f)** for cost share requirements for anti-obesity medications - When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See **Section 5(b)** for surgery requirements and cost share	*Not subject to deductible* ***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Preventive care, children	**HDHP**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines, go to https://brightfutures.aap.org • Children's immunizations endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html • You can also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https://www.uspreventiveservicestaskforce.org	*Not subject to deductible* ***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**HDHP**
• Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: - Intensive nutrition and behavioral weight-loss counseling therapy - Family centered programs when medically identified to support obesity prevention and management by an in-network provider - When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See **HDHP Section 5(f)** for cost share requirements for anti-obesity medications - When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See **HDHP Section 5(b)** for surgery requirements and cost share	*Not subject to deductible* ***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*

Section 5. Traditional Medical Coverage Subject to the Deductible

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network preventive medical care and preventive medications are covered at 100% and are not subject to their respective calendar year deductibles.
- The **medical deductible** is $1,500 per person ($3,000 per Self Plus One enrollment, or $3,000 per Self and Family enrollment). The medical deductible applies to almost all benefits under Traditional medical coverage. See **Sections 5(a-e)**. You must pay your medical deductible before benefits for covered services may begin, except for Preventive Care Services.
- The **prescription drug deductible** is $500 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The prescription deductible applies to retail and mail order pharmacy benefits. See **Sections 5(f) and 5(f)(a)**. You must pay your prescription drug deductible before your prescription drug coverage may begin, except for Preventive Medications.
- With the exception of Preventive Care Services coverage, you must first meet your medical deductible before your coverage begins. The Self Plus One or Self and Family deductible can be satisfied when at least two (2) covered family members have met their individual deductible in a calendar year.
- With the exception of Preventive Medications coverage, you must first meet your prescription drug deductible before your coverage begins. The Self Plus One or Self and Family deductible can be satisfied when at least two (2) covered family members have met their individual deductible in a calendar year.
- Under this HDHP Option, you are responsible for your coinsurance and copayments for covered expenses.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance and copayments total $3,000 per person, $6,000 per Self Plus One enrollment or $6,000 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (e.g., expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance). An individual under Self Plus One or Self and Family enrollment will never have to satisfy more than what is required for the out-of-pocket maximum limit under a Self Only enrollment. See page 149 if you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).
- In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits apply.
- Be sure to read **Section 4 -** *Your costs* for covered services, for valuable information about how cost-sharing works. Also, read **Section 9** about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Deductibles before coverage begins	**HDHP**
Under this HDHP Option, medical services and prescription drug coverages are each subject to meeting separate deductibles. A deductible applies to almost all benefits in this Section. In the **You pay** column, we say "No deductible" when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible. When you receive covered services from in-network or out-of-network providers, you are responsible for paying the eligible charges until you meet the deductible. The Self Plus One and Self and Family deductibles can be satisfied when at least two (2) covered family members have met their individual deductibles in a calendar year. After you meet the deductible, we pay our portion of eligible charges (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum for covered **in-network services**. Once you've met the out-of-pocket maximum, we pay eligible charges at 100% for the balance of the year for in-network services. For covered **out-of-network services**, in addition to your indicated coinsurance or copayments, you are always responsible for the difference between our allowance and billed charges. *There is no catastrophic out-of-pocket maximum when using out-of-network services.* You may choose to pay the deductibles, coinsurance and copayments from your HSA or HRA, or you can pay it out-of-pocket. Please refer to page 26 for information about your out-of-pocket maximum and services/expenses that do not count towards your out-of-pocket maximum.	**Medical deductible** - You are responsible for 100% of eligible charges until you meet the combined in-network and out-of-network medical deductible of $1,500 for Self Only or $3,000 for Self Plus One or $3,000 for Self and Family enrollment. **Prescription drug deductible** - You are responsible for 100% of eligible charges until you meet the combined in-network and out-of-network prescription drug deductible of $500 for Self Only or $1,000 for Self Plus One or $1,000 for Self and Family enrollment.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The **medical deductible** is $1,500 for Self Only enrollment, $3,000 per Self Plus One enrollment, or $3,000 for a Self and Family enrollment). each calendar year. The Self Plus One and Self and Family medical deductible can be satisfied by one or more family members. The medical deductible applies to all benefits in **Sections 5(a-e)**, unless we indicate differently.
- After you have satisfied your medical deductible, benefits begin for covered medical services.
- Using the FHP Health Center for your primary care will result in lower copayments for you.
- After you've met your medical deductible, copayments and coinsurance are waived when using in-network providers and facilities in the Philippines for prior-authorized services.
- A outpatient facility copayment applies to services performed in an ambulatory surgical center or the outpatient department of a hospital.
- For out-of-network services, you are first responsible for meeting the medical deductible and then 30% coinsurance of our allowance plus any difference between our allowance and billed charges. *There is no catastrophic out-of-pocket maximum for out-of-network services.*
- To be covered for these benefits, you must follow your physician-prescribed treatment plan and all of our prior authorization processes for surgical and anesthesia services. Please call 671-647-3526 for more information.
- With the exception of OB/GYN, specialty care services require a written referral from your primary care physician.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See **Section 5(c)** for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	Once you've met your medical deductible, you pay...
Diagnostic and treatment services	**HDHP**
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion • During a hospital stay • In a skilled nursing facility	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Off-island care for services received without prior authorization from TakeCare Medical Management department, except in the case of emergency.*	*All charges*

Benefit Description	Once you've met your medical deductible, you pay...
Telehealth Services	**HDHP**
Consultations via phone, audio/video services using a computer, tablet, or smartphone with in-network primary care or specialty providers, including behavioral health, on or off island. For specialty consultations, referral by primary care provider is required and coverage is limited to certain specialties. Contact your provider regarding the availability of telehealth services and TakeCare for covered specialties.	***In-network:*** Nothing ***Out-of-network:*** All charges
Lab, X-ray and other diagnostic tests	**HDHP**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • Electrocardiogram and EEG	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
• X-rays • Non-routine mammograms • CT Scans/MRI/Nuclear Medicine/Sleep Studies (prior authorization required) • Ultrasound	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Maternity care	**HDHP**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes • Delivery Note: Here are some things to keep in mind: • You do not need to have your vaginal delivery pre-authorized by TakeCare if in the service area. However, prior authorization is required for vaginal delivery services (i.e., prenatal care, delivery, and postnatal care) outside the service area. • As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period.	***In-network:*** Primary care, Specialist - Nothing; Outpatient Facility, Inpatient Hospital - 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Maternity care - continued on next page

Benefit Description	Once you've met your medical deductible, you pay...
Maternity care (cont.)	**HDHP**
• When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under **Section 5(c)** and Surgical benefits **Section 5(b)**. Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	***In-network:*** Primary care, Specialist - Nothing; Outpatient Facility, Inpatient Hospital - 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
• Breastfeeding and lactation support, supplies and counseling for each birth • Screening for gestational diabetes • Screening and counseling for prenatal and postpartum depression	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
• Blood pressure monitor for hypertension if prescribed by a healthcare professional	***In-network:*** Nothing ***Out-of-network:*** No coverage except for out-of-area emergencies or approved referrals
Not covered: • *Routine sonograms to determine fetal age, size or sex* • *Maternity-related services outside our service area unless pre-authorized by TakeCare's Medical Management Department.*	*All charges*

Benefit Description	Once you've met your medical deductible, you pay...
Medical foods	**HDHP**
Medical foods to treat physician-diagnosed Inborn Errors of Metabolism (IEM) including Phenylketonuria (PKU) as prescribed by a physician. ***Maximum Annual Benefit:*** *$5,000 per covered individual*	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered • *Special food items which can be routinely obtained in grocery stores at the same or at a minimally higher cost than similar items (e.g., gluten-free cookies, gluten-free pasta).*	*All charges*
Family planning	**HDHP**
Contraceptive counseling on an annual basis.	***Not subject to deductible*** ***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes: • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Surgically implanted FDA-approved contraceptives • Injectable FDA-approved contraceptive drugs (such as Depo Provera) • FDA-approved Intrauterine devices (IUDs) • FDA-approved Diaphragms Note: See additional Family Planning and Prescription drug coverage Section 5(f). Note: This plan offers some type of voluntary sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described at www.takecareasia.com/sites/default/files/fehb_contraceptive_benefit_coverage_rev06032024.pdf	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Family planning - continued on next page

Benefit Description	Once you've met your medical deductible, you pay...
Family planning (cont.)	**HDHP**
Note: If the member chooses to use a branded product when a generic is available, the member will pay the difference between the brand and generic cost rather than paying "Nothing". However, if a branded product is considered medically necessary by the prescribing physician, it will be covered the same as a generic with no cost sharing for the member through the contraceptive exceptions process described at www.takecareasia.com/sites/default/files/fehb_contraceptive_benefit_coverage_rev06032024.pdf If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing counseling*	*All charges*
Infertility services	**HDHP**
Definition of Infertility: To receive a diagnosis of infertility, an individual must be unable to conceive or produce conception after having intercourse without using birth control during a period of 1 year if the individual is under age 35, or during a period of 6 months if the individual is age 35 and older. For individuals without a partner or exposure to egg-sperm contact, a diagnosis of infertility can be received if the individual is not able to conceive or produce conception through artificial insemination. Infertility may also be established through evidence of medical history and diagnostic testing. **Diagnosis and treatment of infertility specific to** • Artificial insemination: (No less than six cycles annually) - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI)	***In-network:*** Specialty Care - 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Injectable IVF-related drugs (up to three cycles annually) Note: Oral fertility drugs are covered under **Sections 5(f) -** *Prescription Drug Benefits*	***In-network:*** $15 copayment in addition to the office visit coinsurance after you've met your deductible. ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization*	*All charges*

Infertility services - continued on next page

Benefit Description	Once you've met your medical deductible, you pay...
Infertility services (cont.)	**HDHP**
- *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *Zygote transfer* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Iatrogenic fertility preservation procedures (retrieval of and freezing of eggs or sperm) are covered for infertility caused by chemotherapy, pelvic radiotherapy, ovary or testicle removal and other gonadotoxic therapies for the treatment of disease as well as infertility associated with medical and surgical gender transition treatment. Covered services include the following procedures, when provided by or under the care or supervision of a physician: • Collection of sperm • Ovarian simulation, retrieval of eggs and fertilization • Sperm or egg cryo-preservation storage for up to one year Fertility preservation procedures requires prior authorization. See **Section 3 -** *Other services.* Iatrogenic fertility preservation, including related Medical Travel Benefit charges, is limited to $10,000 per member per benefit year.	***In-network:*** Specialty Care - 20% coinsurance of our allowance ***Out-of-network:*** Not covered
Not covered: • *Embryo transfer* • *Long-term storage costs (greater than one year)* • *Egg harvesting or embryo implantation procedures beyond two attempts* • *Elective fertility preservation, such as egg freezing due to natural aging*	*All charges*
Allergy care	**HDHP**
• Testing and treatment	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
• Allergy injections - Allergy serum	***In-network:*** $150 copayment ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered:	*All charges*

Allergy care - continued on next page

Benefit Description	Once you've met your medical deductible, you pay...
Allergy care (cont.)	**HDHP**
• *Provocative food testing and sublingual allergy desensitization*	*All charges*
Treatment therapies	**HDHP**
• Chemotherapy and Radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 130. • Organ/Tissue Transplants • Respiratory and inhalation therapy • Cardiac rehabilitation following qualifying event/ condition is provided for up to 20 sessions per benefit period • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. We only cover GHT when we prior authorize the treatment. We will ask you to submit information that establishes the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies we determine are medically necessary. See *Other services* under *You need prior Plan approval for certain services* on page 20.	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
• Dialysis - hemodialysis and peritoneal dialysis Note: Prior authorization approval is required when dialysis procedures are to be performed at an out-of-network facility or as a part of an elective hospital admission, even if in-network. Prior authorized covered services will be limited to providers in Guam, CNMI, and Palau, unless authorized by TakeCare.	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges. Prior authorization is required.
Physical and occupational therapies	**HDHP**
Unlimited outpatient services and up to two (2) consecutive months per condition for the services of each of the following: • qualified physical therapists • qualified occupational therapists Note: We only cover therapy when a physician: • orders the care • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Physical and occupational therapies - continued on next page

Benefit Description	Once you've met your medical deductible, you pay...
Physical and occupational therapies (cont.)	**HDHP**
• indicates the length of time the services are needed. We will only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. These therapies also apply to habilitation services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may also include speech pathology therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs, lifestyle modification programs* • *Equipment, supplies or customized devices related to rehabilitative therapies, except those provided under Section (a) Durable Medical Equipment* • *Services provided by schools or government programs* • *Developmental and Neuroeducational testing and treatment beyond initial diagnosis* • *Hypnotherapy* • *Psychological testing* • *Vocational Rehabilitation*	*All charges*
Cardiac rehabilitation	**HDHP**
Inpatient cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is covered for up to 90 days per benefit period. Outpatient cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is covered for up to 20 sessions per benefit period.	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Speech therapy	**HDHP**
Unlimited visits for the services of a qualified Speech Therapist Note: Speech therapy also applies to habilitation services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may also include physical/occupational therapies and other services for people with disabilities in a variety of inpatient and/or outpatient settings. All therapies are subject to medical necessity.	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Benefit Description	Once you've met your medical deductible, you pay...
Hearing services (testing, treatment, and supplies)	**HDHP**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist. Note: For routine hearing screening performed during a child's preventive care visit, see **HDHP Section 5 -** *Preventive care for children*	***In-network:*** Specialist Care - 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
• Hearing testing and treatment for adults when medically indicated for other than hearing aids Note: Hearing exams for children through age 17 covered under **HDHP Section 5** - *Preventive care for children* Note: for adult hearing device coverage information, see **HDHP Sec. 5(a)** - *Orthopedic and prosthetic devices*	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Hearing services that are not shown as covered* • *Hearing aids, testing and examinations for children*	*All charges*
Vision services (testing, treatment, and supplies)	**HDHP**
Medical and surgical benefits for the diagnosis and treatment of diseases of the eye • Annual eye examinations for adults Note: See **HDHP Section 5 -** *Preventive care for children* for coverage of eye exams for children	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Prescription eyeglasses or contact lenses	***In-network:*** All charges in excess of $100 per benefit year ***Out-of-network:*** All charges
Refraction Exam Refraction exams will be covered as part of the annual eye exam if member meets any of the following criteria: • Fails a screening or risk assessment test; • Reports a visual problem; or • Cannot complete a screening (e.g. developmental delay) Otherwise, applicable member share for refraction exam applies.	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Eye exercises and orthoptics (vision therapy)* • *Radial keratotomy and other refractive surgery such as LASIK*	*All charges*

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	Once you've met your medical deductible, you pay...
Vision services (testing, treatment, and supplies) (cont.)	**HDHP**
• *Routine vision services outside the service area*	*All charges*
Foot care	**HDHP**
Foot care and podiatry services Note: When you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes, routine foot care may be covered.	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Routine foot care including: cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	**HDHP**
• Artificial eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy (up to (2) surgical bras per benefit year) • Internal prosthetic devices, such as spinal implants, bone segments, artificial disks, artificial plates, stents, leads, intraocular lens implants, cochlear implants, and surgically implanted breast implant following mastectomy. • Single and dual pacemakers, biventricular pacemakers, pacemaker monitors, accessories such as pacemaker batteries and leads, including the cost of the devices, their placement, repair or replacement and related Medical Travel Benefit, hospital, and surgical charges will accrue towards the **Pacemaker Annual Limit of $50,000 per member**. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • External hearing aids for adults (**benefit limited to $300 per ear, every two (2) years**) • Orthopedic devices, such as braces	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Orthopedic and prosthetic devices - continued on next page

Benefit Description	Once you've met your medical deductible, you pay...
Orthopedic and prosthetic devices (cont.)	**HDHP**
Note: See **HDHP Section 5(b)** for coverage of the surgery to insert the device.	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Orthopedic and corrective shoes* • *Arch supports, foot orthotics, heel pads and heel cups* • *Artificial joints and limbs* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Lumbosacral supports* • *Splints* • *Over-the-counter (OTC) items* • *Internal prosthetics such as heart valves, automatic implantable cardioverter defibrillator (AICD) and other implantable devices not specified above* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*
Durable medical equipment (DME)	**HDHP**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Manual hospital beds • Standard manual wheelchairs • Crutches/walk aids • Oxygen Concentrators • Portable Oxygen Tanks • CPAP (Continuous Positive Airway Pressure) • BPAP (Bi-Level Positive Airways Pressure) Note: Pre-authorization is required. Contact us at 671-300-5995 or via email at tc.mrs@takecareasia.com as soon as your physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
We will cover the following devices with a written prescription: • Blood Glucose Monitors	***Not subject to deductible.*** ***In-network:*** Nothing ***Out-of-network:*** All charges

Durable medical equipment (DME) - continued on next page

Benefit Description	Once you've met your medical deductible, you pay...
Durable medical equipment (DME) (cont.)	**HDHP**
• Continuous Glucose Monitor (CGM) System, including transmitter and sensors, if patient is actively participating in TakeCare's Diabetes Management Program and meets criteria for coverage based on HbA1c level	***Not subject to deductible.*** ***In-network:*** Nothing ***Out-of-network:*** All charges
Not covered: • *Motorized wheel chairs* • *Motorized beds* • *CPAP and BPAP supplies including masks other than those packaged by the manufacturer with a new machine* • *Insulin pumps*	*All charges*
Home health services	**HDHP**
Home healthcare ordered by a physician, pre-authorized by us, and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide while under an active treatment plan with a home health agency including services such as: • Oxygen therapy, intravenous therapy and medications. • Services ordered by a physician for members who are confined to the home. • Nursing • Medical supplies included in the home health plan of care. • Physical therapy, speech therapy, occupational therapy, and respiratory therapy.	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative.* • *Home care services in the Philippines.*	*All charges*
Chiropractic	**HDHP**
Chiropractic services - You may self refer to an in-network licensed chiropractor for up to 20 visits per calendar year. Services are limited to: • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	***In-network:*** All charges above $25 per visit and all charges after 20th visit ***Out-of-network:*** All charges

Chiropractic - continued on next page

Benefit Description	Once you've met your medical deductible, you pay...
Chiropractic (cont.)	**HDHP**
• Osteopathic Manipulative Treatment ("OMT") when provided by a licensed, trained and credentialed practitioner.	***In-network:*** All charges above $25 per visit and all charges after 20th visit ***Out-of-network:*** All charges
Not covered: • *Consults and evaluations* • *Ancillary services for chiropractic purposes (e.g., x-rays)*	*All charges*
Alternative treatments	**HDHP**
Acupuncture Services - You may self refer to an in-network licensed acupuncture practitioner for up to 20 visits per benefit year. The Plan defines acupuncture as the practice of insertion of needles into specific exterior body locations to relieve pain, to induce surgical anesthesia, or for therapeutic purposes. These providers are required to submit itemized bills and their Federal Tax I.D. Number (if a United States provider) as outlined in Section 7, Filing a claim for covered services.	***In-network:*** All charges above $25 per visit and all charges after the 20th visit in a benefit year. ***Out-of-network:*** All charges
Massage Therapy - You may self refer to a participating, licensed massage therapist for up to 20 visits per benefit year. These providers are required to submit itemized bills and their Federal Tax I.D. Number (if a United States provider) as outlined in **Section 7 -** *Filing a claim for covered services.*	***In-network:*** $10 copayment per visit (up to 20 visits per benefit year). ***Out-of-network:*** All charges
Not covered: • *Chelation therapy except for acute arsenic, gold, mercury or lead poisoning; or use of Desferoxamine in iron poisoning* • *Naturopathic services and medicines* • *Homeopathic services and medicines* • *Rolfing*	*All charges*
Educational classes and programs	**HDHP**
Programs are administered through the TakeCare Wellness Center including: • Case Management Program for Chronic Diseases • Nicotine Cessation Program • Diabetes Prevention • Diabetes Self-Management • Group Fitness Program • Nutrition Coaching	Nothing. Not subject to deductible. All health education classes are **FREE** to TakeCare members unless otherwise specified. Referral is required from your primary care physician. No referral is required for TakeCare's Group Fitness classes.

Educational classes and programs - continued on next page

Benefit Description	Once you've met your medical deductible, you pay...
Educational classes and programs (cont.)	**HDHP**
• Perinatal and Neonatal Program Note: For more information on these and other classes, see **Section 5(h)** - *Health Education Classes* or call the TakeCare Wellness Center at 671-300-7161 or via email at wellness@takecareasia.com.	Nothing. Not subject to deductible. All health education classes are **FREE** to TakeCare members unless otherwise specified. Referral is required from your primary care physician. No referral is required for TakeCare's Group Fitness classes.
Nicotine Cessation Program • primary care physician referral required • individual/group/telephone counseling • over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence - Nicotrol Nasal Spray - Nicotrol Inhaler - Chantix - Zyban - Bupropion hydrochloride - Nicorette Gum - Nicorette DS Gum - Habitrol Transdermal film - Nicoderm CQ Transdermal system - Commit Lozenge - Nicorette Lozenge - Nicotine Film - Nicotine Polacrilex, Gum, Chewing; Buccal - Thrive (Nicotine Polacrilex) Gum, Chewing; Buccal - Nicotine Polacrilex, Trocher/Lozenge - Nicotine Patch - Varenicline	Not subject to deductible. Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The **medical deductible** is $1,500 for Self Only enrollment, $3,000 per Self Plus One enrollment, or $3,000 for a Self and Family enrollment). each calendar year. The Self Plus One and Self and Family medical deductible can be satisfied by one or more family members. The medical deductible applies to all benefits in **Sections 5(a-e)**, unless we indicate differently.
- After you have satisfied your medical deductible, benefits begin for covered medical services.
- Using the FHP Health Center for your primary care will result in lower copayments for you.
- After you've met your medical deductible, copayments and coinsurance are waived when using in-network providers and facilities in the Philippines for prior-authorized services.
- A outpatient facility copayment applies to services performed in an ambulatory surgical center or the outpatient department of a hospital.
- For out-of-network services, you are first responsible for meeting the medical deductible and then 30% coinsurance of our allowance plus any difference between our allowance and billed charges. There is no catastrophic out-of-pocket maximum for out-of-network services.
- Be sure to read **Section 4 -** *Your costs for covered services* for valuable information about how cost-sharing works. Also read **Section 9** about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See **Section 5(c)** for benefits for services associated with a facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR SOME SURGICAL PROCEDURES**. Please refer to the prior authorization information shown in **Section 3** to be sure which services require prior authorization and identify which surgeries require prior authorization.
- To be covered for these benefits, you must follow your physician-prescribed treatment plan and all of our prior authorization processes for surgical and anesthesia services. Please call 671-647-3526 for more information.
- With the exception of OB/GYN, specialty care services require a written referral from your primary care physician.

Benefit Description	Once you've met your deductible, you pay...
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Anesthesia and related professional services • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Circumcision	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Surgical procedures - continued on next page

Benefit Description	Once you've met your deductible, you pay...
Surgical procedures (cont.)	
• Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of severe obesity (bariatric surgery). Surgery is limited to Roux-en-Y bypass, laparoscopic gastric band placement, laparoscopic sleeve gastrectomy, and vertical banded gastroplasty. Please note the following conditions must be met: - Eligible members must be age 18 or over - Eligible members must weigh 100 pounds or 100% over their normal weight according to current underwriting standards - Eligible members must meet the National Institute of Health guidelines - We may require you to participate in a non-surgical multidisciplinary program approved by us for six (6) months prior to your bariatric surgery - We will determine the provider for the non-surgical program and surgery based on quality and outcomes. • Insertion of internal prosthetic devices. See **5(a) - *Orthopedic and prosthetic devices*** for device coverage information • Cardiac surgery for the implantation of stents, leads and pacemaker • Cardiac surgery for the implantation of valves • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. Plan pays for the cost of the insertion only.	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot Care on page 119.* • *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*	*All charges*

Benefit Description	Once you've met your deductible, you pay...
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm (e.g., protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes). • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedema - breast prostheses and surgical bras and replacements. See page 119. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures • TMJ surgery and other related non-dental treatment	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Oral implants and transplants*	*All charges*

Oral and maxillofacial surgery - continued on next page

Benefit Description	Once you've met your deductible, you pay...
Oral and maxillofacial surgery (cont.)	
• *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental services related to treatment of TMJ*	*All charges*
Gender affirming surgery	
Benefit covers procedures recommended by the current WPATH Standards of Care 8.0 without exclusions. Prior authorization is required for gender affirming surgery. There is no annual maximum benefit for covered procedures. Following current WPATH Standards of Care 8.0 for gender affirming surgeries, TakeCare requires the member to meet all of the following requirements: • Must be at least 18 years of age at the time prior authorization is requested • Diagnosis of gender dysphoria rendered by a qualified healthcare professional • Member has a strong desire to be rid of primary and/or secondary sex characteristics because of a marked incongruence with the member's identified gender • Member's gender dysphoria is not a symptom of another mental disorder or chromosomal abnormality • Gender dysphoria causes clinical distress or impairment in social, occupational, or other important areas of functioning	***In-network:*** Outpatient facility and Inpatient facility - 20% coinsurance of our allowance. *Coinsurance is waived at in-network facilities in the Philippines.* ***Out-of-network:*** All charges.
Not covered: • *Reversal of gender reassignment surgery* • *Any procedure not listed above*	*All charges*
Organ/tissue transplants	
These **solid organ transplants** are covered. These solid organ transplants are subject to medical necessity and experimental/investigational review by the Plan. Pre-authorization is required. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Organ/tissue transplants - continued on next page

Benefit Description	Once you've met your deductible, you pay...
Organ/tissue transplants (cont.)	
• Heart/lung • Intestinal transplants • Isolated small intestine • Small intestine with the liver • Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-Pancreas • Liver • Lung: single/bilateral/lobar • Pancreas	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Pre-authorization is required. • **Autologous tandem transplant**s for - AL Amyloidosise - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below based on the requirements for hematopoietic stem cell transplant (HSCT) coverage of the American Society for Transplantation and Cellular Therapy (ASTCT) as published in 2020. For more information, go to https://bit.ly/ASTCTarticle. Not subject to medical necessity. Plan's denial is limited to indicators for transplant such as refractory or relapsed disease, cytogenetics, subtype, staging or the diagnosis. • **Allogeneic transplants** for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Organ/tissue transplants - continued on next page

Benefit Description	Once you've met your deductible, you pay...
Organ/tissue transplants (cont.)	
- Hodgkin's lymphoma - relapsed - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Non-Hodgkin's lymphoma - relapsed - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • **Autologous transplants** for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Aggressive non-Hodgkin lymphomas - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Hodgkin's lymphoma - relapsed - Medulloblastoma - Multiple myeloma - Neuroblastoma - Non-Hodgkin's lymphoma - relapsed - Pineoblastoma	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Organ/tissue transplants - continued on next page

Benefit Description	Once you've met your deductible, you pay...
Organ/tissue transplants (cont.)	
- Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review and prior authorization by the Plan. There is no defined age limits for the use of RIC for an allogeneic stem cell transplant. Refer to *Other services* in *Section 3* for prior authorization procedures. • **Allogeneic transplants** for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma(CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • **Autologous transplants** for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Organ/tissue transplants - continued on next page

Benefit Description	Once you've met your deductible, you pay...
Organ/tissue transplants (cont.)	
The following blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • **Allogeneic transplants** for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle cell anemia • **Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC)** for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myelodysplasia/Myelodysplastic Syndromes - Multiple sclerosis - Myeloproliferative disorders (MDDs)	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Organ/tissue transplants - continued on next page

Benefit Description	Once you've met your deductible, you pay...
Organ/tissue transplants (cont.)	
- Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • **Autologous Transplants** for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis **Limited Benefits** • Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence subject to prior authorization by the Plan's medical director in accordance with the Plan's protocols. • Bone marrow stem cell donor search and testing for compatible unrelated donors up to $15,000 per procedure at a National Preferred Transplant Facility when you are the intended recipient. Transportation, food and lodging - the following benefits are provided, if you live over 60 miles from the transplant center and the services are pre-authorized by us:	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Organ/tissue transplants - continued on next page

Benefit Description	Once you've met your deductible, you pay...
Organ/tissue transplants (cont.)	
• Transportation limited to you and one escort to a National Preferred Transplant Network or other Company Approved Transplant Facility. • A $125 per day allowance for housing and food. This allowance excludes liquor and tobacco. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional anesthesia services provided in: • Inpatient hospital • Outpatient hospital • Skilled nursing facility • Ambulatory surgical center • Physician's office	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The medical deductible is $1,500 for Self Only enrollment, $3,000 per Self Plus One enrollment, or $3,000 for a Self and Family enrollment). each calendar year. The Self Plus One and Self and Family medical deductible can be satisfied by one or more family members. The medical deductible applies to all benefits in Sections 5(a-e), unless we indicate differently.
- After you have satisfied your medical deductible, benefits begin for covered medical services.
- Using the FHP Health Center for your primary care will result in lower copayments for you.
- After you've met your medical deductible, copayments and coinsurance are waived when using in-network providers and facilities in the Philippines for prior-authorized services.
- A outpatient facility copayment applies to services performed in an ambulatory surgical center or the outpatient department of a hospital.
- For out-of-network services, you are first responsible for meeting the medical deductible and then 30% coinsurance of our allowance plus any difference between our allowance and billed charges. There is no catastrophic out-of-pocket maximum for out-of-network services.
- Be sure to read **Section 4 -** *Your costs for covered services* for valuable information about how cost-sharing works. Also read **Section 9** about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See **Section 5(c)** for benefits for services associated with a facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FROM US FOR ELECTIVE HOSPITAL STAYS.** Please refer to the prior authorization information shown in **Section 3** to be sure which services require prior authorization and identify which surgeries require prior authorization.
- To be covered for these benefits, you must follow your physician-prescribed treatment plan and all of our prior authorization processes for surgical and anesthesia services. Please call 671-647-3526 for more information.
- Referrals to doctors or facilities off-island must receive prior authorization from us. For services to be covered, a written referral must be made in advance by your physician and approved by the TakeCare Medical Referral Services (MRS) department.
- If you would like assistance with the coordination of any off-island services or have questions concerning the prior authorization process, please contact us at 671-300-5995 or via email at tc.mrs@takecareasia.com.

Benefit Description	Once you've met your deductible, you pay...
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you will be responsible for the additional charge above the semiprivate room rate. Other hospital services and supplies, such as: • Operating, recovery, maternity and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Rehabilitative therapies - See **Section 5(a)** for benefit limitation	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Any inpatient hospitalization for dental procedure* • *Blood and blood products, whether synthetic or natural* • *Custodial care* • *Internal prosthetics except for those covered under **Section 5(a)** - Prosthetic and Orthopedic Devices* • *Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Take-home items*	*All charges*

Benefit Description	Once you've met your deductible, you pay...
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Blood and blood derivatives*	*All charges*
Skilled nursing care facility benefits	
Skilled nursing facility (SNF): The Plan provides a comprehensive range of benefits when full-time skilled nursing care and confinement in a skilled nursing facility is medically appropriate as determined by a physician and approved by the Plan. *Limited to 100 days per calendar year* All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a physician	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Custodial care*	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility when approved by TakeCare's Medical Management Department. Services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six (6) months or less. Services include: • inpatient and outpatient care • family counseling	***In-network:*** Nothing ***Out-of-network:*** All charges

Hospice care - continued on next page

Benefit Description	Once you've met your deductible, you pay...
Hospice care (cont.)	
Note: This benefit is limited to a maximum of up to 180 days per lifetime	***In-network:*** Nothing ***Out-of-network:*** All charges
Not covered: • *Independent nursing, homemaker services*	*All charges*
Ambulance	
Local professional ambulance service when medically necessary	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered: • *Transport that we determine are not medically necessary* • *Air ambulance services*	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **In the event of an emergency or accident in the service area**, seek immediate medical attention. If you are admitted as an inpatient to a hospital as a result of that emergency or accident, make sure you or someone else notifies TakeCare within forty-eight (48) hours or as soon as reasonably possible after initial receipt of services to inform us of the location, duration and nature of the services provided; *otherwise, your care will not be covered.*
- **In the event of an emergency or accident outside the service area**, seek immediate medical attention and make sure you or someone else notifies TakeCare within forty-eight (48) hours or as soon as reasonably possible after initial receipt of services to inform us of the location, duration and nature of the services provided; *otherwise, your care will not be covered.*
- The medical deductible is $1,500 for Self Only enrollment, $3,000 per Self Plus One enrollment, or $3,000 for a Self and Family enrollment) each calendar year. The Self Plus One and Self and Family medical deductible can be satisfied by one or more family members. The medical deductible applies to all benefits in **Sections 5(a-e)**, unless we indicate differently.
- After you have satisfied your medical deductible, benefits begin for covered medical services.
- Be sure to read **Section 4 -** *Your costs for covered services* for valuable information about how cost-sharing works. Also read **Section 9** about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency?

In a life or limb threatening emergency, call 911 or go to the nearest hospital emergency room or other facility treatment. You do not need authorization from your primary care physician (PCP) before you go. A true emergency is covered no matter where you are.

Emergencies / Urgent Care in our service area: If you receive emergency care in our service area that results in your hospitalization, TakeCare Customer Service department must be notified within 48 hours unless it was not reasonably possible to do so at 671-647-3526 or by email at CustomerService@takecareasia.com, *otherwise, your care will not be covered.* If you are hospitalized within the service area at an out-of-network facility, we may arrange for your transfer to an in-network facility as soon as it is medically appropriate to do so.

When in the service area, notification is not required if your care is limited to urgent care or emergency room services only.

On Guam, if your primary care provider's office is closed, you may be able to access the FHP Urgent Care Center which is open from 8:00am – 8:00pm, Monday thru Saturdays, except Christmas, New Year's, and one staff development day per year.

Emergencies / Urgent Care outside our service area: If you receive emergency or urgent care outside our service area, *even if you're not hospitalized*, TakeCare Customer Service department must be notified within 48 hours unless it was not reasonably possible to do so at 671-647-3526 or by email at CustomerService@takecareasia.com, *otherwise your care will not be covered.* If you are hospitalized outside the service area, we may arrange for your transfer to an in-network facility as soon as it is medically appropriate to do so. If you are covered by Medicare on a primary basis, our coverage is secondary and will be dependent on what Medicare considers an eligible expense.

When you have to file a claim: Please refer to *Section 8* for information on how to file a claim, or contact our Customer Service Department at 671-647-3526.

Benefit Description	Once you've met your deductible, you pay...
Emergency/Urgent Care within our service area	
• Urgent care services at the FHP Health Center - No appointment necessary - Including lab, x-ray, limited pharmacy services - Open from 8:00am – 8:00pm, Monday thru Saturdays, except Christmas, New Year's, and one staff development day per year.	$75 copayment per visit
• Urgent care at a doctor's office other than FHP or at Guam Memorial Hospital (GMH).	***In-network:*** $75 copayment per visit ***Out-of-network:*** $75 copayment per visit plus any difference between our allowance and billed charges.
• Emergency care as an outpatient in a hospital, including doctors' services Note: We waive the ER copayment if you are admitted to the hospital.	***In-network:*** $100 copayment per visit ***Out-of-network:*** $100 copayment per visit
Emergency/Urgent Care outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital. If you are covered by Medicare on a primary basis, our coverage is secondary and will be dependent on what Medicare considers an eligible expense.	***In-network:*** $100 copayment per visit ***Out-of-network:*** $100 copayment per visit
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area has not received prior authorization by the Plan.*	*All charges*

Benefit Description	Once you've met your deductible, you pay...
Ambulance	
Professional ambulance service when medically necessary. Note: See **Section 5(c)** for coverage of non-emergency services.	Nothing
Not covered: • *Transport that the Plan determines is not medically necessary* • *Air ambulance*	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The medical deductible is $1,500 for Self Only enrollment, $3,000 per Self Plus One enrollment, or $3,000 for a Self and Family enrollment). each calendar year. The Self Plus One and Self and Family medical deductible can be satisfied by one or more family members. The medical deductible applies to all benefits in **Sections 5(a-e)**, unless we indicate differently.
- After you have satisfied your medical deductible, benefits begin for covered medical services.
- Be sure to read ***Section 4 -*** *Your costs for covered services* for valuable information about how cost-sharing works. Also, read **Section 9** about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefits Description	Once you've met your deductible, you pay...
Professional services	
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other covered illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Telehealth Services	***In-network:*** Nothing ***Out-of-network:*** All charges

Professional services - continued on next page

Benefits Description	Once you've met your deductible, you pay...
Professional services (cont.)	
Treatment and counseling (including individual or group therapy visits) via phone, audio/video services using a computer, tablet, or smartphone with in-network behavioral health providers, on or off island.	***In-network:*** Nothing ***Out-of-network:*** All charges
Applied Behavior Analysis (ABA) for the treatment of Autism Spectrum Disorder (ASD) is covered as any other condition, subject to prior authorization and benefit limitations. ASD is a condition that begins early in life and typically affect areas of a person's daily functioning. ASD is a group of developmental disabilities defined by uncharacteristic social interactions and communication (both verbal and nonverbal). The following ABA benefit limitations apply: • Limited to children up to age 21 • Prior Authorization and treatment plan required • An Autism Spectrum Disorder diagnosis meeting minimum criteria such as, but not limited to, impairment in social interaction, lack of social reciprocity, delay in the development of spoken language and inflexible adherence to specific non-functional routines • Services must be performed by Qualified Autism Service Provider, Qualified Autism Service Professional, or Qualified Autism Service Paraprofessional • Travel and/or lodging expenses are not covered	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges. ***Maximum Annual Benefit:*** $50,000 ages 9 and below, $25,000 ages 10 to 21
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Prior authorization required	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.

Benefits Description	Once you've met your deductible, you pay...
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment • Prior authorization required	***In-network:*** 20% coinsurance of our allowance ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Not covered	
• *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 physician to be medically necessary and appropriate* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the benefit table beginning on the next page. If you are covered under the PDP EGWP, see **Section 5(f)(a)**.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- To be covered for these benefits, you must follow your physician-prescribed treatment plan and all of our prior authorization processes for prescription drugs. Please call 671-647-3526 for more information.
- The prescription drug deductible is $500 for Self Only enrollment, $1,000 per Self Plus One enrollment, or $1,000 for a Self and Family enrollment each calendar year. The Self Plus One and Self and Family prescription drug deductible can be satisfied by one or more family members. The prescription drug deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your prescription drug deductible, your prescription drug coverage begins.
- Your in-network copayments for prescription drugs only apply toward your prescription out-of-pocket maximum; they will not apply toward the medical services out-of-pocket maximum. See **Section 4 -** *Your costs for covered services* for more information about how cost-sharing works.
- After you have satisfied your prescription drug deductible, copayments and coinsurance are waived when using selected in-network pharmacy providers in the Philippines for prior-authorized services.
- By using the Mail Order program, you can reduce your monthly copayment expense.
- Read **Section 9** about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at an in-network pharmacy or, if you prefer, by mail through Birdi, formerly Elixir Mail Order Pharmacy, for a maintenance medication.
- **We use a formulary.** The TakeCare Formulary is a list of over 1600 prescription drugs that physicians use as a guide when prescribing medications for patients. The Formulary plays an important role in providing safe, effective and affordable prescription drugs to TakeCare members. It also allows us to work together with physicians and pharmacies to ensure that our members are getting the drug therapy they need. A Pharmacy and Therapeutics Committee consisting of Plan physicians and pharmacists evaluate prescription drugs based on safety, effectiveness, quality treatment and overall value. The committee considers first and foremost the safety and effectiveness of a medication before reviewing the cost. Note: Formulary is subject to change.
- **Prior authorization.** Your physician will need to request prior authorization for some non-formulary drugs. Physicians may initiate the prior authorization request simply by phoning, faxing, or emailing in the request. Requests are generally processed within 2 business days, but it may take up to 10 business days if additional information is needed from the physician.
- **There are dispensing limitations.** Prescription drugs will be dispensed for up to a 30-day supply or one commercially prepared unit per copayment (i.e., one inhaler, one vial of ophthalmic medication, one tube of ointment). For drugs that could be habit forming, the prescription unit is set at a smaller quantity for the protection and safety of our members.

- A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a FDA-approved generic drug is available, and your physician has not specified "Dispense as Written" for the name brand drug, you will have to pay the non-formulary copayment plus the cost difference between this drug and the generic drug.
•Updating of prior authorizations may be required. Clinical edits (limitations) can be used for safety reasons, quantity limitations and benefit plan exclusions and may require preauthorization.
- Prescription drugs can also be obtained through the Birdi, formerly Elixir Mail Order Pharmacy, mail order program for up to a 90-day supply of oral medication; 6 vials of insulin; or 3 commercially prepared units (i.e., inhaler, vials ophthalmic medication or topical ointments or creams). You pay nothing for a 90-day supply of generic medications through mail order. You can save expense for a 90-day supply of brand and non-formulary medications through mail order. For mail order customer service, call toll-free 1-855-BirdiRx or 1-855-247-3479 (TTY 711), 8AM to 8PM EST, Monday through Friday and 9AM to 5PM EST on Saturdays or go to www.birdirx.com
- **Why use generic drugs?** To reduce your out-of-pocket expenses! A generic drug is the chemical equivalent of a corresponding brand name drug. Generic drugs are less expensive than brand name drugs; therefore, you may reduce your out-of-pocket costs by choosing to use a generic drug.
- **When you do have to file a claim:** Please refer to **Section 7** for information on how to file a pharmacy claim, or contact our Customer Service Department at 671-647-3526, toll free 877-484-2411, or customerservice@takecareasia.com.
- Our Pharmacy Benefit Manager is MedImpact, formerly Elixir Solutions. Learn more at www.medimpact.com
- **Medicare and Prescription Drug Coverage:** Refer to notification printed on inside front cover of this brochure.

Benefits Description	Once you've met your deductible, you pay...
Covered medications and supplies	
We cover the following medications and supplies prescribed by a physician and obtained from an in-network pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered*. • Diabetic supplies limited to disposable needles and syringes for the administration of covered medications. • Weight loss medication, subject to prior authorization and benefit coverage criteria such as but not limited to Body Mass Index ("BMI") and/or co-morbidities. • Drugs to treat gender dysphoria Note: Insulin and other glucose-lowering agents for diabetes are covered as Preventive Medications (see below).	**RETAIL** **Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $15 copayment Preferred Brand: $30 copayment Non-Preferred Brand: $75 copayment (Copayments per 90-day fill) Generic formulary: up to $25 copayment Preferred Brand: up to $60 copayment Non-Preferred Brand: up $150 copayment **Non-Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $20 copayment Preferred Brand: $40 copayment Non-Preferred Brand: $100 copayment (Copayments per 90-day fill) Generic formulary: up to $45 copayment Preferred Brand: up to $120 copayment Non-Preferred Brand: up $300 copayment **All In-network:** (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $250 copayment **Out-of-network:** 30% coinsurance of average wholesale price plus any difference between average wholesale price and billed charges.

Covered medications and supplies - continued on next page

Benefits Description	Once you've met your deductible, you pay...
Covered medications and supplies (cont.)	
	MAIL ORDER **In-network:** (Copayments per 90-day fill) Generic formulary: $0 copayment Preferred Brand: $60 copayment Non-Preferred Brand: $160 copayment (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $250 copayment **Out-of-network:** No coverage
• Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. • Contraceptive coverage is available at no cost to PSHB members, subject to meeting the deductible. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described at https://www.takecareasia.com/sites/default/files/fehb_contraceptive_benefit_coverage_rev06032024.pdf Note: For additional Family Planning benefits see **HDHP Section 5(a)**	Nothing
• Growth hormone	***In-network:*** $5 copayment each dose ***Out-of-network:*** All charges
• Generic Opioid Reversal (Rescue) Agents Note: Coverage limited to naloxone-based injectables and the OTC version of naloxone 4mg nasal spray without cost-share to members, subject to meeting the deductible. Other opioid reversal (rescue) agents are covered as any other covered medication. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/	***In-network:*** Nothing ***Mail Order:*** Nothing ***Out-of-network:*** 30% of our allowance plus any difference between our allowance and billed charges

Covered medications and supplies - continued on next page

Benefits Description	Once you've met your deductible, you pay...
Covered medications and supplies (cont.)	
• Drugs for sexual dysfunction are covered when Plan criteria is met. For information about these criteria and dose limits, please have the prescribing physician call MedImpact, formerly Elixir Solutions, at 1-800-788-2949. • Oral fertility drugs to include covered IVF-related drugs, up to three cycles annually.	***In-network:*** 50% coinsurance of our allowance per prescription unit or refill limit ***Out-of-network:*** Not covered
Preventive medications	
Medications to promote better health as recommended by ACA. • Preventive medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a healthcare professional and filled by an in-network pharmacy. These may include some over-the-counter vitamins, and nicotine replacement medications. This listing is subject to change during the year. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations • Formulary drugs and devices for the management of conditions listed below are also covered without cost-share, even if over-the-counter, if prescribed by a healthcare professional and filled at an in-network pharmacy: - Angiotensin Converting Enzyme (ACE) inhibitors for congestive heart failure, diabetes, and/or coronary artery disease - Anti-resorptive therapy for osteoporosis and/or osteopenia - Beta-blockers for congestive heart failure and/or coronary artery disease - Blood pressure monitor for hypertension - Inhaled corticosteroids and peak flow meters for asthma - Insulin and other glucose-lowering agents for diabetes - Opioid dependence treatments for opioid addiction - Selective Serotonin Reuptake Inhibitors (SSRIs) for depression - Statins for heart disease and/or diabetes Note: Rather than paying "nothing" when using an In-network provider, if the member chooses to use a branded product when a generic is available, they will pay the difference between the brand and generic cost.	***In-network:*** Nothing. Not subject to deductible. ***Out-of-network:*** No coverage except for out-of-area emergencies or approved referrals

Preventive medications - continued on next page

Benefits Description	Once you've met your deductible, you pay...
Preventive medications (cont.)	
Note: To receive this benefit a prescription from a doctor must be presented to pharmacy	***In-network:*** Nothing. Not subject to deductible. ***Out-of-network:*** No coverage except for out-of-area emergencies or approved referrals
Not covered	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs or substances not approved by the Food and Drug Administration (FDA)* • *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 approval of TakeCare's pharmacy committee.* • *Hospital take-home drugs* • *Medical supplies (such as dressing and antiseptics)* • *Non-prescription medications unless specifically indicated elsewhere* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them* • *Replacement of lost, stolen or destroyed medication* *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Nicotine Cessation Program benefit. See page 124.*	*All charges*

Section 5(f)(a). PDP EGWP Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- **This Medicare Prescription Drug Coverage (EGWP) is provided by VibrantRx (PDP)**, contracted by Medicare and sponsored by TakeCare Insurance Company. For information about your PDP-EGWP coverage, contact VibrantRx Member Services at 844-826-3451 (TTY 711). Hours are 24 hours a day, 365 days a year.
- If you are a Postal Service annuitant and their covered Medicare-eligible family member, you will be automatically group enrolled in our PDP EGWP. Contact us for additional information at (671) 647-3526 or customerservice@takecareasia.com

Note: Notify us as soon as possible if you or your eligible family member is already enrolled in a Medicare Part D Plan. Enrollment in our PDP EGWP will cancel your enrollment in another Medicare Part D plan.

There are advantages to being enrolled in our PDP EGWP:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.

We cover drugs, medications, and supplies as described below and on the following pages.

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused drugs, medications, and supplies.
- Under this HDHP Option, the prescription drug deductible is $500 for Self Only enrollment, $1,000 per Self Plus One enrollment, or $1,000 for a Self and Family enrollment each calendar year. The Self Plus One and Self and Family prescription drug deductible can be satisfied by one or more family members. The prescription drug deductible applies to all benefits in this Section unless we indicate differently. Non-prescription services covered by the plan are subject to the HDHP medical deductible. For more information, see page 108
- After you have satisfied your prescription drug deductible, your prescription drug coverage begins.
- Your in-network copayments for prescription drugs only apply toward your prescription out-of-pocket maximum; they will not apply toward the medical services out-of-pocket maximum.
- After you have satisfied your prescription drug deductible, copayments and coinsurance are waived when using selected in-network pharmacy providers in the Philippines for prior-authorized services.
- Be sure to read **Section 4 -** *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read **Section 9** for information about how we pay if you have other coverage.
- If you choose to opt out of or disenroll from our PDP EGWP, see **Section 9** for additional PDP EGWP information and for our opt-out and disenrollment process. Contact us for assistance with the PDP EGWP opt out and disenrollment process at VibrantRx Member Services at 844-826-3451 (TTY 711). Hours are 24 hours a day, 365 days a year. By mail, VibrantRx, PO Box 509097, San Diego, CA 92150, or at www.vibrantrx.com/takecare

Warning:If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage.

Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll during Open Season or for a qualifying life event (QLE).

If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact VibrantRx Member Services for assistance at 844-826-3451 (TTY 711). Hours are 24 hours a day, 365 days a year. By mail, VibrantRx, PO Box 509097, San Diego, CA 92150, or at www.vibrantrx.com/takecare

Each new enrollee will receive from VibrantRx a description of our PDP EGWP Summary of Benefits, a combined prescription drug/Plan identification card, a mail order form/patient profile and a pre-addressed reply envelope.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. Your prescribers must have Medicare-approved prescriptive authority.
- **Where you can obtain prescription drugs.** You must fill the prescription at an in-network pharmacy or, if you prefer, by mail through Birdi, formerly Elixir Mail Order Pharmacy, for a maintenance medication. For assistance locating a PDP EGWP network pharmacy, visit our website at www.vibrantrx.com/takecare or call 844-826-3451 (TTY 711).
- **We use a formulary.** The VibrantRx Formulary is a list of over 1600 prescription drugs that physicians use as a guide when prescribing medications for patients. The Formulary plays an important role in providing safe, effective and affordable prescription drugs to TakeCare members. It also allows us to work together with physicians and pharmacies to ensure that our members are getting the drug therapy they need. A Pharmacy and Therapeutics Committee consisting of Plan physicians and pharmacists evaluate prescription drugs based on safety, effectiveness, quality treatment and overall value. The committee considers first and foremost the safety and effectiveness of a medication before reviewing the cost. *Note: Formulary is subject to change.*
- **Prior authorization.** Your physician will need to request prior authorization for some non-formulary drugs. Physicians may initiate the prior authorization request simply by phoning, faxing, or emailing in the request. Requests are generally processed within 2 business days, but it may take up to 10 business days if additional information is needed from the physician.
- **There are dispensing limitations.** Prescription drugs will be dispensed for up to a 30-day supply or one commercially prepared unit per copayment (i.e., one inhaler, one vial of ophthalmic medication, one tube of ointment). For drugs that could be habit forming, the prescription unit is set at a smaller quantity for the protection and safety of our members.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a FDA-approved generic drug is available, and your physician has not specified "Dispense as Written" for the name brand drug, you will have to pay the non-formulary copayment plus the cost difference between this drug and the generic drug.
- **Updating of prior authorizations may be required.** Clinical edits (limitations) can be used for safety reasons, quantity limitations and benefit plan exclusions and may require preauthorization.
- Prescription drugs can also be obtained through the Birdi, formerly Elixir Mail Order Pharmacy, mail order program for up to a 90-day supply of oral medication; 6 vials of insulin; or 3 commercially prepared units (i.e., inhaler, vials ophthalmic medication or topical ointments or creams). You pay nothing for a 90-day supply of generic medications through mail order. You pay two (2) copayments for a 90-day supply of brand and non-formulary medications through mail order. For mail order customer service, call toll-free 1-855-BirdiRx or 1-855-247-3479 (TTY 711), 8AM to 8PM EST, Monday through Friday and 9AM to 5PM EST on Saturdays or go to www.birdirx.com
- **Why use generic drugs?** To reduce your out-of-pocket expenses! A generic drug is the chemical equivalent of a corresponding brand name drug. Generic drugs are less expensive than brand name drugs; therefore, you may reduce your out-of-pocket costs by choosing to use a generic drug.
- **When you do have to file a claim:** Please refer to **Section 7** for information on how to file a pharmacy claim, or contact our Customer Service Department at 671-647-3526, toll free 877-484-2411, or customerservice@takecareasia.com.

- **If we deny your claim and you want to appeal**, you, your representative, or your prescriber must request an appeal following the process described in **Section 8(a)** - *Medicare PDP EGWP Disputed Claims Process*. The PDP EGWP appeals process has 5 levels. If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions in the decision letter on how to move to the next level of appeal.

PDP EGWP Catastrophic Maximum - under this PDP EGWP, your prescription drug out-of-pocket maximum limit is $2,000 for Self Only, $4,000 for Self Plus One or $6,000 for Self and Family. An individual under Self Plus One or Self and Family enrollment will never have to satisfy more than what is required for the out-of-pocket maximum limit under a Self Only enrollment.

Benefits Description	Once you've met your deductible, you pay...
Covered medications and supplies	
We cover the following medications and supplies prescribed by a physician and obtained from an in-network pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Diabetic supplies limited to disposable needles and syringes for the administration of covered medications. • Weight loss medication, subject to prior authorization and benefit coverage criteria such as but not limited to Body Mass Index ("BMI") and/or co-morbidities. • Drugs to treat gender dysphoria Note: Insulin and other glucose-lowering agents for diabetes are covered as Preventive Medications (see below).	**RETAIL** **Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $15 copayment Preferred Brand: $30 copayment Non-Preferred Brand: $75 copayment (Copayments per 90-day fill) Generic formulary: up to $25 copayment Preferred Brand: up to $60 copayment Non-Preferred Brand: up $150 copayment **Non-Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $20 copayment Preferred Brand: $40 copayment Non-Preferred Brand: $100 copayment (Copayments per 90-day fill) Generic formulary: up to $45 copayment Preferred Brand: up to $120 copayment Non-Preferred Brand: up $300 copayment **All In-network:** (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $250 copayment **Out-of-network:** 30% coinsurance of average wholesale price plus any difference between average wholesale price and billed charges.

Covered medications and supplies - continued on next page

Benefits Description	Once you've met your deductible, you pay...
Covered medications and supplies (cont.)	
	MAIL ORDER **In-network:** (Copayments per 90-day fill) Generic formulary: $0 copayment Preferred Brand: $60 copayment Non-Preferred Brand: $160 copayment (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $250 copayment **Out-of-network:** 30% coinsurance of average wholesale price plus any difference between average wholesale price and billed charges.
• Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. • Contraceptive coverage is available at no cost to PSHB members, subject to meeting the deductible. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described at https://www.takecareasia.com/sites/default/files/fehb_contraceptive_benefit_coverage_rev06032024.pdf Note: For additional Family Planning benefits see **Section 5(a)**	Nothing
• Growth hormone	***In-network:*** $5 copayment each dose ***Out-of-network:*** All charges
• Generic Opioid Reversal (Rescue) Agents Note: Coverage limited to naloxone-based injectables and the OTC version of naloxone 4mg nasal spray without cost-share to members, subject to meeting the deductible. Other opioid reversal (rescue) agents are covered as any other covered medication. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/	***In-network:*** Nothing ***Mail Order:*** Nothing ***Out-of-network:*** 30% of our allowance plus any difference between our allowance and billed charges

Covered medications and supplies - continued on next page

Benefits Description	Once you've met your deductible, you pay...
Covered medications and supplies (cont.)	
• Drugs for sexual dysfunction are covered when Plan criteria is met. For information about these criteria and dose limits, please have the prescribing physician call MedImpact, formerly Elixir Solutions, at 1-800-788-2949. • Oral fertility drugs to include covered IVF-related drugs, up to three cycles annually.	***In-network:*** 50% coinsurance of our allowance per prescription unit or refill limit ***Out-of-network:*** Not covered
Preventive medications	
Medications to promote better health as recommended by ACA. • Preventive medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a healthcare professional and filled by an in-network pharmacy. These may include some over-the-counter vitamins, and nicotine replacement medications. This listing is subject to change during the year. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations • Formulary drugs and devices for the management of conditions listed below are also covered without cost-share, even if over-the-counter, if prescribed by a healthcare professional and filled at an in-network pharmacy: - Angiotensin Converting Enzyme (ACE) inhibitors for congestive heart failure, diabetes, and/or coronary artery disease - Anti-resorptive therapy for osteoporosis and/or osteopenia - Beta-blockers for congestive heart failure and/or coronary artery disease - Blood pressure monitor for hypertension - Inhaled corticosteroids and peak flow meters for asthma - Insulin and other glucose-lowering agents for diabetes - Opioid dependence treatments for opioid addiction - Selective Serotonin Reuptake Inhibitors (SSRIs) for depression - Statins for heart disease and/or diabetes Note: Rather than paying "nothing" when using an In-network provider, if the member chooses to use a branded product when a generic is available, they will pay the difference between the brand and generic cost.	***In-network:*** Nothing. Not subject to deductible. ***Out-of-network:*** No coverage except for out-of-area emergencies or approved referrals

Preventive medications - continued on next page

Benefits Description	Once you've met your deductible, you pay...
Preventive medications (cont.)	
Note: To receive this benefit a prescription from a doctor must be presented to pharmacy	***In-network:*** Nothing. Not subject to deductible. ***Out-of-network:*** No coverage except for out-of-area emergencies or approved referrals
Not covered	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs or substances not approved by the Food and Drug Administration (FDA)* • *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 approval of TakeCare's pharmacy committee.* • *Hospital take-home drugs* • *Medical supplies (such as dressing and antiseptics)* • *Non-prescription medications unless specifically indicated elsewhere* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them* • *Replacement of lost, stolen or destroyed medication* *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Nicotine Cessation program Benefit. See page 124.*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Copayments and coinsurance are waived when using in-network dental providers in the Philippines for prior-authorized services.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your PSHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your PSHB Plan. See **Section 9 -** *Coordinating benefits with other coverage.*
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See **Section 5(c)** for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read **Section 4 -** *Your costs for covered services*, for valuable information about how cost-sharing works. Also read **Section 9** about coordinating benefits with other coverage, including with Medicare.
- Annual Dental Maximum Benefit is $1,500 per member per benefit year.
- Dental coverage under the HDHP Option is not subject to the Medical or Prescription Drug Deductible. However, your out-of-pocket payments for covered dental services do not count toward your medical or prescription drug catastrophic out-of-pocket maximums.

Benefits Description	You pay
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Note: If you are outside the service area and receive services from a out-of-network dentist, we will reimburse you up to $100.00.	***In-network:*** Nothing ***Out-of-network:*** 30% coinsurance of our allowance plus any difference between our allowance and billed charges.
Covered Services	
OFFICE VISIT • X-rays, including bitewings (once a year) and panoramic (once every three years) oral examination and treatment plan; vitality test; and oral cancer exam	Nothing
PREVENTIVE SERVICES • Prophylaxis (once every 6 months); sealants (up to age 12); annual topical application of fluoride (up to age 12);	Nothing
RESTORATIVE DENTISTRY • Amalgam –one, two or three surfaces. • Composite—one or two surfaces, anterior only. • Posterior composites are not covered.	20% of our allowance for covered charges

Covered Services - continued on next page

Benefits Description	You pay
Covered Services (cont.)	
Note: an allowance for a comparable silver amalgam restoration will be made. The difference in fees is the member's responsibility.	20% of our allowance for covered charges
SIMPLE EXTRACTIONS • Simple extraction for fully erupted teeth only	20% of our allowance for covered charges
PROSTHODONTICS • Full and partial dentures • Crowns and bridges • Repair • Relining and/or reconstruction of dentures	75% of our allowance for covered charges
Annual Maximum Benefit	
Dental Plan Annual Maximum Benefit	All charges in excess of maximum benefit of $1,500 per member per benefit year
Not Covered	
• *Oral Surgery* • *Prescriptions* • *Orthodontics*	*All charges*

Section 5(h). Wellness and Other Special Features

Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Medical Travel Benefit	TakeCare offers a Medical Travel Benefit to its PSHB members, making it easier to travel to the Joint Commission-accredited St. Luke's Hospitals, The Medical City, or other in-network providers in the Philippines when they receive a pre-authorized, elective inpatient or outpatient procedure, excluding emergencies, screenings, executive checkups, primary care, dental, home health, hospice, mental health & substance misuse disorder treatment or maternity-related services. The travel benefit provides up to $500 toward the cost of round-trip airfare between Guam and Manila, ground transportation between the airport and the hospital, and lodging in Manila. There is no limit to the number of times this benefit can be used during the year once all medical and pre-authorization requirements are met. Members can choose one of two options for airfare, transportation and lodging expenses: • TakeCare will arrange and pay in advance up to $500 for the member's airfare, transportation, and lodging, or • The member can elect to receive a $500 travel allowance for expenses. The member will be responsible for their own travel arrangements and will be reimbursed by TakeCare, up to the $500 allowance. Please note that documentation will be required as part of the reimbursement process. Frequent flyer mile points are not reimbursable. For either option, the member is responsible for any airfare, transportation, and lodging expenses in excess of $500 and any penalties/fees associated with member-initiated travel changes or cancellations.

	If the patient is an under age 18 dependent or a disabled individual, TakeCare will pay or reimburse up to $500 for the airline ticket for an adult escort, up to a maximum of $1,000 for two escorts when there are two or more patients on a single approved referral trip. Approved escorts are limited to legal parents, legal guardians, or the individual caregiver responsible for the disabled member's care. TakeCare will not extend the Medical Travel Benefit coverage to escorts not enrolled under the same TakeCare plan as the minor or disabled adult patient(s). For the purposes of this benefit, a disabled individual is defined as a person who is dependent on a caregiver for all activities of daily living (eating, bathing, etc) as certified in writing by their attending physician. Non-compliance with required treatment guidelines as defined by TakeCare's provider and Medical Management will result in non-eligibility under the travel benefit. Notes: • Medical Travel Benefit claim payments, related to a pacemaker and related services, will accumulate towards the Pacemaker Annual Limit of $50K. See *Sec 5(a) - Orthopedic and Prosthetic Devices*. • TakeCare-covered PSHB members with primary coverage through Medicare or another insurance carrier are not eligible for the Medical Travel Benefit. • To learn more about this benefit, contact TakeCare Customer Service at 671-647-3526.
Information Accessibility	TakeCare is committed to ensuring every member can access information about their health plan with dignity, equality, comfort, and independence. To achieve this goal, TakeCare provides an accessibility widget on its website, translation, and hearing impaired services. To learn more, go to www.takecareasia.com/multi-language.pdf
Preventive Services and Screenings Program	Members are encouraged to avail of the following services and screenings, most of which are covered at 100%: • Flu Vaccination for Adults, ages 18-64. • Biometric screening through the member's TakeCare primary care provider or TakeCare Wellness health fairs. • Pre natal visit to a TakeCare participating obstetrician gynecologist within the first trimester. • Six or more Well-Child visits during the first 15 months of life. • Compliance with insulin medication for at least 75% of their treatment period for adult members, ages 18-75, diagnosed with Type I or II Diabetes. • Compliance with asthma controller medication for at least 75% of their treatment period for adult members, ages 19-50, with asthma. • Annual Physical Exam through the member's TakeCare participating primary care provider. • Annual Physical Exam and colorectal cancer screening for member ages 50 and above through TakeCare's participating primary care provider with any of the following services: Colonoscopy; Sigmoidoscopy; and fecal occult blood test once per benefit year as part of the member's annual physical examination. • Annual Physical Exam and breast cancer and screening mammogram for women between 40 to 69 through TakeCare's participating primary care provider once per benefit year.

	• Annual Physical Exam and cervical cancer screening for ages 21 to 64 with pap smear through TakeCare's participating primary care provider once per benefit year. • Annual Dental Exam through TakeCare's participating providers. • Annual Vision Exam through TakeCare's participating providers.
Health Education Classes	Health education classes and wellness programs are FREE to TakeCare Members unless otherwise specified. Referrals are not required for registration or enrollment. The Wellness Team may request for recent medical records. For more information about these classes, call the TakeCare Wellness Team at 671-300-7161 or 671-300-7108 or email wellness@takecareasia.com. To register for a class, go to wellnesscenter.takecareasia.com/v2/#book **Case Management Program for Chronic Diseases** is intended for members with chronic diseases such as diabetes mellitus, cardiovascular disease (CVD), and/or other related cardiometabolic risks. The program provides a one-on-one, person-centered approach to chronic disease and risk factor management, including but not limited to blood sugar management, cholesterol management, controlling blood pressure, weight management, medication adherence, and coordination of care with the patient's primary care provider. **Evolt 360 Body Scanner** is a simple-to-use tool that provides information about a body through more than 40 measurements in just 60 seconds. The personalized, detailed report includes measures such as muscle mass, fat mass, total water, and nutrient profile. **Diabetes Self-Management Education and Support (DSMES) Program**, recognized by the American Diabetes Association, provides persons with diabetes (PWD) the knowledge, skills, and confidence to accept responsibility for their self-management. This includes collaborating with their healthcare team, making informed decisions, solving problems, developing personal goals and action plans, and coping with emotions and life stresses. The program is delivered through one-on-one or group class sessions. Each participant has a person-centered DSMES plan with outcomes measured, and an action-oriented behavioral change plan will be developed to reach their personal behavioral goal/s. **Diabetes Prevention Program (DPP)** – Prevent T2, recognized by the Centers for Disease Control, helps members with pre-diabetes adopt lifestyle changes such as healthier eating habits, reducing stress, and getting more physically active. Diabetes Prevention Program is not a fad diet or a simple exercise class. It's a year-long program focused on long-term changes and lasting results. It provides a long-term commitment to good health by learning new habits, gaining new skills, building confidence to make the change, and support from other participants who share similar goals and struggles. **Eat Right Workshops** are designed to educate and empower individuals with the knowledge and skills necessary to make informed choices about their dietary habits and culinary endeavors. This program combines elements of cooking, nutrition, and healthy eating to promote a holistic approach to well-being.

	Fitness Program encourages members to increase daily physical activities and exercise to meet the recommendations established by the American College of Sports Medicine (ACSM) to improve quality of life and reduce the risk of chronic conditions. Programs include Group Fitness Classes, Sports Series, Self-Reported Fitness Activities, fitness partners, etc. **Nutrition and Health Education Program** provides a person-centered approach to educate members on weight management, performance, and nutritional needs. Using evidence-based strategies, members, with the guidance of certified nutrition consultants, will create solutions to reaching their weight and nutritional goals and identify how to reinforce positive food habits and behaviors. Individuals with high-risk diabetes complications and/or chronic kidney disease may be referred to a Registered Dietitian for individual Medical Nutrition Therapy (MNT). **Quit Now - Nicotine Cessation Program** assists members with quitting tobacco use and other nicotine delivery devices. In partnership with the Public Health and Social Services Tobacco Prevention and Control Program, TakeCare refers members seeking tobacco and nicotine cessation services to the Tobacco-Free Guam Quitline. Quit aids, including Wellbutrin (bupropion), Chantix (varenicline), and nicotine patches, are available at a $0-copay to assist members with their quit journey. Requirements include confirmed enrollment with the Quitline, valid prescription, and prior authorization. **Perinatal and Neonatal Care Management** - Without proper prenatal care and self-care throughout each pregnancy, the chance of premature births becomes much greater. In collaboration with Valenz Health and RGA, expecting mothers can access dedicated case management expert and nurse consultants to support them with high-risk pregnancies.

Section 5(i). Health Education Resources and Account Management Tools

Special features	Description
Account management tools	**If you have a Health Savings Account (HSA):** • You will receive a statement outlining your account balance and activity • You may also access your account on-line at: - Bank of Guam - www.bankofguam.com - ASC Trust Corporation - www.asctrust.com **If you have a Health Reimbursement Arrangement (HRA):** • You will receive a statement outlining your account balance and activity • You may also access your account on-line at: - ASC Trust Corporation - www.asctrust.com
Consumer choice information	As a member of this HDHP, you may choose any provider. However, you will reduce your out-of-pocket expense if you see a in-network provider and even more if you use the FHP Health Center. Directories are available online at www.takecareasia.com Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.takecareasia.com/PSHB2025
Care support	Patient safety information is available in the Brochure, page 5. TakeCare provides care coordination in support of members with a complex diagnosis or condition. In addition, TakeCare's case management program offers supportive services to members with multiple chronic conditions to reduce occurrence of catastrophic events and costly hospital admission. For those members diagnosed with and/or being evaluated for gender dysphoria, care coordination is available to assist and support them as they seek gender-affirming care and services in the community. Please contact TakeCare Medical Referral Services (MRS) for more information at (671) 300-5995 or via email tc.mrs@takecareasia.com
Member portal	The TakeCare Member Portal is a convenient, secure online tool that allows you access to your claims and health plan information, our health risk assessment questionnaire, as well as wellness resources through TakeCare's Healthwise Knowledgebase, 24 hours a day, 7 days a week. To learn more, go to https://portal.takecareasia.com/
TakeCare App	TakeCare's mobile app gives you the ability to search our network of providers, display your member ID card, learn more about TakeCare's wellness programs, view our monthly group fitness schedule, access Affinity Rewards and wellness partners. It also helps you manage your wellness and fitness incentives! Find the app by searching "TakeCare App" in your mobile device's app store.
Rx search tool	TakeCare makes this search tool available to assist members and non-members determine what prescription medications are covered by the plan, their therapeutic class, if there are any restrictions, and assigned coverage tier. The tier assigned determines your copayment for that medication. The link for the tool can be found at www.takecareasia.com/PSHB2025 under "Useful Links'.

Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in **Section 5** of this brochure.

Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see **Section 3 -** *When you need prior Plan approval for certain services*.

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus is carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the PSHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received).

See *Section 3* for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures.

When you see in-network providers, receive services at in-network hospitals and facilities, or obtain your prescription drugs at in-network pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible. **If you see an out-of-network provider, you may have to pay for the services up front and request a reimbursement from us.**

There are four types of claims. Three of the four - Urgent care claims, Pre-service claims, and Concurrent review claims - usually involve access to care where you need to request and receive **prior authorization** to receive coverage for a particular service or supply covered under this Brochure. The fourth type - Post-service claims - is a claim for payment of benefits after services or supplies have been received. See **Section 3** for more information on these claims/requests and **Section 11** for the definitions of these four types of claims.

In most cases, providers and facilities will file claims for you. However, you may need to file a claim when you receive emergency services from out-of-network providers. Check with the provider.

If you need to file a claim, here is the process:

Medical, prescription, and dental services

When you need to file a claim – such as for services you received outside the Plan's service area – you will need to submit it on a standard Health Insurance Claim Form (CMS-1500) or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number, and ID number
- Name, address and tax ID# of the provider or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis and/or medical records
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services
- W9 tax form completed by out-of-network providers.

Note: Canceled checks, cash receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

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

For claims questions and assistance, contact us at 671-647-3526 or via email at customerservice@takecareasia.com or visit our website at www.takecareasia.com.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.
Your authorized representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice requirements	If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes. For more information, go to www.takecareasia.com/multi-language.pdf

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in **Sections 3, 7 and 8** of this brochure, please visit www.takecareasia.com/fehb-claims-information or call the TakeCare Customer Service Department at 671-647-3526. If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) and you disagree with our **pre-service or post-service** decision about your prescription drug benefits, please, follow Medicare's appeals process outlined in **Section 8a -** *Medicare PDP EGWP Disputed Claims Process*.

Please follow this Postal Service Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In **Section 3 -** *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

To make your request, please contact our Customer Service Department by writing to TakeCare Customer Service Department, PO Box 6578, Tamuning GU 96931 or calling 671-647-3526 or via email at customerservice@takecareasia.com.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Disagreements between you and the HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at TakeCare Customer Service Department, P.O. Box 6578, Tamuning, Guam 96931; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim or

b) Write to you and maintain our denial or.

c) Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Postal Service Insurance Operations (PSIO), 1900 E Street, Room 3443, NW, Washington, DC 20415.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM’s review within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 671-647-3526 or toll-free at 877-484-2411 or via email at customerservice@takecareasia.com. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's PSIO at (202) 936-0002 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Reminder: If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D PDP EGWP you may appeal an adverse pre-service or post-service determination through Medicare's appeals process. See **Section 8a**.

Section 8(a). Medicare PDP EGWP Disputed Claims Process

When a claim is denied in whole or in part, you may appeal the denial.

This Medicare Prescription Drug Coverage (EGWP) is provided by VibrantRx, a Prescription Drug Plan (PDP) offered by TakeCare Insurance Company. For information about your PDP-EGWP coverage, contact VibrantRx Member Services at 844-826-3451 (TTY 711). Hours are 24 hours a day, 365 days a year. By mail, VibrantRx, PO Box 509097, San Diego, CA 92150, or at www.vibrantrx.com/takecare.

The coverage decisions and appeals process outlined here deals only with problems related to your Medicare Part D benefits and coverage for prescription drugs, including payments. If you have an issue with how your medical benefits are handled, refer to the process outlined in **Section 8 -** *The Disputed Claim Process.*

This is a brief summary of VibrantRx's coverage decisions and appeals process. For a complete explanation of this process, please refer to VibrantRx's Evidence of Coverage document, a copy of which you received when you enrolled or is available online at www.myvibrantrx.com/takecare.

Making an appeal regarding your Part D prescription coverage

If VibrantRx makes a coverage decision, whether before or after a service is received, and you are not satisfied, you can "*appeal*" the decision. An appeal is a formal way of asking VibrantRx to review and change a coverage decision we have made. Under certain circumstances, you can request an expedited or "*fast appeal*" of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a **Level 1** Appeal. In this appeal, VibrantRx will review the coverage decision made to check to see if the coverage rules were properly followed. When VibrantRx has completed the review, they will give you, their decision.

In limited circumstances, a request for a **Level 1** appeal will be dismissed, which means VibrantRx won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If VibrantRx dismisses a request for a Level 1 appeal, they will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If VibrantRx does not dismiss your case but say no to all or part of your **Level 1** appeal, you can go on to a **Level 2** appeal. The **Level 2** appeal is conducted by an independent review organization that is not connected to VibrantRx. For Part D drug appeals, if VibrantRx says no to all or part of your appeal you will need to ask for a **Level 2** appeal. If you are not satisfied with the decision at the **Level 2** appeal, you may be able to continue through additional levels of appeal.

Here's a brief description of what occurs at the first three appeal levels.

Level	Description
	1. **Decide if you need a "standard appeal" or a "fast appeal."** A "standard appeal" is usually made within 7 days. A "fast appeal" is generally made within 72 hours. If your health requires it, ask for a "fast appeal". 2. **You, your representative, doctor, or other prescriber must contact VibrantRx and make your Level 1 appeal**. If your health requires a quick response, you must ask for a "fast appeal". 3. **VibrantRx must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available at https://www.myvibrantrx.com/takecare. 4. **You must make your appeal request within 60 calendar days** from the date on the written notice VibrantRx sent to tell you our answer on the coverage decision. 5. **VibrantRx will consider your appeal.** For fast appeals, VibrantRx must give you an answer *within 72 hours after receiving your appeal.* For standard appeals, VibrantRx must give you an answer *within 7 calendar days after receiving your appeal.* • **If VibrantRx's answer is yes to part or all of what you requested,** they are also required to make payment to you within 30 calendar days after receiving your request

1

- **If VibrantRx says no to your appeal**, you decide if you want to continue with the appeals process below and make *another* appeal.

2

1. **You (or your representative or your doctor or other prescriber) must contact the independent review organization**, contracted by Medicare, and ask for a review of your case.
2. **The independent review organization reviews your appeal**. A "standard appeal" decision is usually made within 7 days. A "fast appeal" decision is generally made within 72 hours. If your health requires it, ask for a "fast appeal".
   - **If the independent review organization says yes to part or all of your *"fast appeal"*,** VibrantRx must provide the drug coverage that was approved by the review organization **within 24 hours** after receiving the decision from the review
   - **If the independent review organization says yes to part or all of your *"standard appeal"*,** VibrantRx must provide the drug coverage that was approved by the review organization **within 72 hours** after receiving the decision from the review
   - **If the independent review organization says no to part or all of your appeal**, it means they agree with VibrantRx's decision not to approve your request (or part of your request). In this case, the independent review organization will send you a letter explaining the decision and advising you of the right to a Level 3 appeal if the dollar value of the drug coverage being requested meets a certain minimum threshold.
3. If your case meets the requirements, you choose whether you want to take your appeal further.
4. There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
5. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal

3-5

1. The Level 3 appeal is handled by an Administrative Law Judge or attorney
2. VibrantRx's Evidence of Coverage document, which you received when you enrolled, tells you more about Levels 3, 4, and 5 of the appeals. Or go to www.myvibrantrx.com/takecare for more information about these appeal levels.

For a complete explanation of the appeals process, please refer to VibrantRx's Evidence of Coverage document, a copy of which you received when you enrolled or is available online at www.myvibrantrx.com/takecare.

For information about your PDP-EGWP coverage, contact VibrantRx Member Services at 844-826-3451 (TTY 711). Hours are 24 hours a day, 365 days a year, or visit www.vibrantrx.com/takecare.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare 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 payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.takecareasia.com.

When we are the primary payor, we will pay the benefits described in this brochure. When we are the secondary payor, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

Please see **Section 4 -** *Your Costs for Covered Services*, for more information about how we pay claims.

TRICARE and CHAMPVA

TRICARE is the healthcare program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended PSHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these programs, eliminating your PSHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended PSHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these state programs, eliminating your PSHB premium. For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgement, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgement, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some PSHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your PSHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your PSHB plan so that your plans can coordinate benefits. Providing your PSHB information may reduce your out-of-pocket cost.

Clinical trials

TakeCare covers care for clinical trials according to definitions listed below and as stated on specific pages of this brochure.

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan covers some of these costs, providing the plan determines the services are medically necessary.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. TakeCare does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "When do I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

Important Note: Subject to limited exceptions, Postal Service annuitants entitled to Medicare Part A and their eligible family members who are entitled to Medicare Part A are required to enroll in Medicare Part B to maintain eligibility for the PSHB Program in retirement.

If you are required to enroll in Medicare Part B and fail to do so at your first opportunity, you may be disenrolled (annuitants) and/or your family members removed from coverage.

For more information on these requirements, please contact TakeCare Customer Service at 671-647-3526 or via email at customerservice@takecareasia.com

The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare. When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 671-647-3526 or see our website at www.takecareasia.com.

We waive some of your TakeCare copayments or coinsurance if the Original Medicare Plan is your primary payor as follows:

- Medical services and supplies provided by physicians and other healthcare professionals
- Outpatient surgery

When you have primary coverage by Original Medicare (either Part A&B, or Part A Only), we will only provide secondary coverage if the care and services you receive are from a facility or physician contracted with Medicare on Guam, CNMI, Hawaii, or the continental United States.

Please take note that Medicare does not contract with any facilities or physicians in the Philippines, or outside the United States and its territories. However, to ensure that PSHB members with Medicare coverage are able to access TakeCare's network of Philippine providers, TakeCare will act as the primary payor for PSHB members with Medicare for preauthorized services received in-network in the Philippines.

Refer to Section 5(d) for coverage specifics and notification requirements in the event of an emergency outside the United States or its territories.

Please review the following examples which illustrates your cost share if you are also enrolled in Medicare Part B and our High Option. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description: Deductible
High Option You pay without Medicare: $0
High Option You pay with Medicare Part B: $0

Benefit Description: Catastrophic Protection Out-of-Pocket Maximum
High Option You pay without Medicare: $2,000 Self Only / $2,000 each Self Plus One / $6,000 Self and Family
High Option You pay with Medicare Part B: $2,000 Self Only / $2,000 each Self Plus One /$6,000 Self and Family

Benefit Description: Part B Premium Reimbursement Offered
High Option You receive without Medicare: NA
High Option You receive with Medicare Part B: Not offered

Benefit Description: Primary Care Provider
High Option You pay without Medicare: $5 copayment FHP / $10 copayment Preferred In-Network / $20 copayment Other In-Network High Option You pay with Medicare Part B: $0

B**enefit Description: Specialist**
High Option You pay without Medicare: $40 copayment
High Option You pay with Medicare Part B: $0

Benefit Description: Inpatient Hospital
High Option You pay without Medicare: $100 copayment per day, up to $500 maximum per admission
High Option You pay with Medicare Part B: $100 copayment per day, up to $500 maximum per admission

Benefit Description: Outpatient Surgery Facility
High Option You pay without Medicare: $100 copayment per visit
High Option You pay with Medicare Part B: $0

Tell us about your Medicare coverage

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

Medicare Advantage (Part C)

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another non-PSHB plan's Medicare Advantage plan and also remain enrolled in our PSHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended PSHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant, you can suspend your PSHB coverage to enroll in a Medicare Advantage plan, eliminating your PSHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

Medicare prescription drug coverage (Part D)

When we are the primary payor, we process the claim first. If you (as an active employee eligible for Medicare Part D or their covered Medicare Part D-eligible family member) enroll in any open market Medicare Part D plan and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by that Medicare Part D plan and consider them for payment under the PSHB plan.

Note: If you are a Postal Service annuitant or their covered Medicare-eligible family member enrolled in our Medicare Part D PDP EGWP, this does not apply to you because you may not be enrolled in more than one Medicare Part D plan at the same time. If you opt out of or disenroll from our PDP EGWP you do not have our PSHB Program prescription drug coverage and we are not a secondary payor for prescription drug benefits.

Medicare Prescription Drug Plan (PDP) Drug Plan Employer Group Waiver Plan (EGWP)

If you are enrolled in Medicare Part A and/or Part B, you will be automatically group enrolled into our Medicare PDP EGWP. Our PDP EGWP is a prescription drug benefit for Postal Service annuitants and their covered Medicare-eligible family members. This allows you to receive benefits that will never be less than the standard prescription drug coverage that is available to members with non-PDP EGWP prescription drug coverage. But more often you will receive benefits that are better than members with standard non-PDP EGWP prescription drug coverage. **Note:You have the choice to opt out of or disenroll from our PDP EGWP at any time and may obtain prescription drug coverage outside of the PSHB Program.**

When you are enrolled in our Medicare PDP EGWP for your prescription drug benefits you continue to have our medical coverage.

Members with higher incomes may have a separate premium payment for their Medicare Part D Prescription Drug Plan (PDP) benefit. Please refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to an additional premium.

For people with limited income and resources, Extra Help is a Medicare program to help with Medicare prescription drug plan costs. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213 TTY 800-325-0778. You may also contact TakeCare Customer Service at 671-647-3526 or via email at customerservice@takecareasia.com

The PDP EGWP opt out process:
If you were automatically group enrolled into our PDP EGWP and choose to opt out, contact VibrantRx Member Services at 844-826-3451 (TTY 711). Hours are 24 hours a day, 365 days a year.

The PDP EGWP disenrollment process:
When you are enrolled in our PDP EGWP, you may choose to disenroll at any time. Contact VibrantRx Member Services at 844-826-3451 (TTY 711). Hours are 24 hours a day, 365 days a year.

Warning:If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage.

Note:If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll when and if you are eligible. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance at (617) 647-3526 or customerservice@takecareasia.com.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have PSHB coverage on your own as an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have PSHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Postal Service and your position is excluded from the PSHB (your employing office will know if this is the case) and you are not covered under PSHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Postal Service and your position is not excluded from the PSHB (your employing office will know if this is the case) and...		
• You have PSHB coverage on your own or through your spouse who is also an active employee		✓
• You have PSHB coverage through your spouse who is an annuitant	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a Postal employee receiving Workers' Compensation		✓*
8) Are a Postal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30-month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30-month coordination period)**		✓
• Medicare based on ESRD **(after the 30-month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have PSHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Non-PSHB Benefits Available to Plan Members

The benefits described in this Section are not part of the PSHB contract or premium, and you cannot file a PSHB disputed claim about them. Fees you pay for these services do not count toward PSHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines.

These are summaries only. For full information about these benefits, their cost, and how to enroll, please refer to the special brochures describing these programs available at www.takecareasia.com/PSHB2025 or contact TakeCare at 671- 647-3526 or customerservice@takecareasia.com.

Affinity Rewards

TakeCare's Affinity Rewards is a FREE membership rewards program for all TakeCare members, both subscribers and their dependents. Members enjoy benefits and discounts from over 50 participating shopping, dining, entertainment, and service partners.

Receive a stamp from any of our partners for each visit. Submit three (3) completed Affinity Rewards stamp cards to TakeCare Customer Service to receive a prize. For TakeCare App users, visit the TakeCare Customer Service office when you complete one (1) digital Affinity Rewards Card to receive a prize. All submitted Affinity Reward cards will be entered into a quarterly raffle drawing.

Go to www.takecareasia.com, or use the TakeCare Mobile App, or contact us at affinityrewards@takecareasia.com for more information about the program.

Wellness Incentive Package

TakeCare offers its PSHB members additional wellness benefits and incentives through its Wellness Incentive Package included with their enrollment in any one of TakeCare's medical plan options for 2025.

TakeCare's non-PSHB Wellness Incentive Package aims to provide additional benefits to Federal members in Guam, CNMI, and Palau that are not part of the Postal Service Health Benefit Plan ("PSHBP"). The package includes Executive Check-Up coverage, cash incentive options to encourage a better and healthier lifestyle through completion of health screenings, achieving healthy outcomes, participation in fitness activities, and other health related discounts and programs.

For more information, see the 2025 TakeCare Wellness Incentive Package brochure for more benefit and incentive details at www.takecareasia.com/PSHB2025, at your agency's benefit briefing, or contact TakeCare at 671- 647-3526.

Fitness Partner Program

TakeCare offers its PSHB members access to a comprehensive list of fitness facilities on Guam and Saipan through its Fitness Partner Program. Free fitness partner memberships are available, subject to meeting the monthly fitness activity requirement.

You must be enrolled in one of TakeCare's medical plan options for 2025 and you must submit a completed Fitness Partner Program application to TakeCare no later than December 9, the last day of Open Season, to participate in the Fitness Partner Program in 2025.

If you are currently enrolled in the Fitness Partner Program and you don't want to make any changes, your enrollment will be automatically renewed for 2025. However, you will need to again register with your chosen fitness partner during your first visit in the new year.

For newly eligible federal employees and their dependents, enrollment in the Fitness Partner Program is allowed during the year, outside of Open Season, as long as enrollment takes place within 60 days of becoming eligible.

For more information, see the 2025 TakeCare Fitness Partner Program brochure for a list of participating fitness facilities, details about the monthly fitness activity requirement, as well as enrollment information and FAQs, at www.takecareasia.com/PSHB2025, at your agency's benefit briefing, or contact TakeCare at 671- 647-3526.

Supplemental Dental Coverage

TakeCare offers a dental plan to supplement the dental coverage provided in the TakeCare PSHB plan option you have selected. Supplemental dental coverage will be coordinated with your PSHB dental coverage.

You must be enrolled in one of TakeCare's medical plan options for 2025 and you must submit a completed Supplemental Dental application to TakeCare no later than December 9, the last day of Open Season, to participate in the Supplemental Dental Coverage in 2025.

For more information, see the 2025 TakeCare Supplemental Dental brochure, available only during Open Season, for more benefit details, rates, and enrollment information, at www.takecareasia.com/PSHB2025, at your agency's benefit briefing, or contact TakeCare at 671- 647-3526.

You must enroll during each Open Season to participate in this coverage. This coverage does not automatically renew.

Section 11. Definitions of Terms We Use in This Brochure

Allowance

An allowance is the maximum charge for which TakeCare will reimburse the provider for a covered service. An allowance is not necessarily the same as a usual, reasonable, customary, maximum, actual or prevailing charge or fee. For in-network providers, allowance shall be the contracted rate paid by TakeCare. For all out-of-network provider services, allowance 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.

You should also see *Section 4 Important Notice About Surprise Billing – Know Your Rights* that describes your protections against surprise billing under the No Surprises Act.

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.

OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Catastrophic limit

A catastrophic limit is the annual accumulated amount you pay for copayments and coinsurance. See page 26 for specific amounts.

Clinical trials cost categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. TakeCare does not cover these costs.

Coinsurance

See Section 4, page 25

Copayment	See Section 4, page 25
Cost-sharing	See Section 4, page 25
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Any type of care provided according to Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post hospital Skilled Nursing Facility care; or c) is a level such that you have reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. Custodial care includes any type of care where the primary purpose is to attend to your daily living activities which do not require the continuing attention of trained medical or paramedical personnel. Examples include but are not limited to assistance in walking, getting in and out of bed, bathing, dressing, feeding, changes of dressing of non-infected wounds, residential care and adult day care, protective and supportive care including educational services and rest cures. Day to day care that can be provided by a non-medical individual or custodial care that lasts longer than 90 days may be considered Long Term Care. **Custodial care is not covered by the Plan.**
Deductible	See Section 4, page 25
Experimental or investigational services	Our Benefit Interpretation Policy Committee determines whether or not treatments, procedures and drugs are no longer considered experimental or investigational. Our determinations are based on the safety and efficacy of new medical procedures, technologies, devices and drugs.
Health Reimbursement Arrangement (HRA)	An HRA is a tax-sheltered account designed to reimburse medical expenses. The fund in this type of account can best be described as "credits". These credits are applied toward your medical expenses until they are exhausted at which time you must pay any remaining deductible and coinsurance amounts up to the catastrophic limit.
Health Savings Account (HSA)	An HSA is a consumer-oriented tax advantaged savings account. HSAs allow for tax deductible contributions as well as tax free earnings and withdrawals for qualified medical expenses.
Healthcare professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.
In-Network Providers	In-network providers are physicians and medical professionals employed by TakeCare or any person, organization, health facility, institution or physician who have entered into a contract with TakeCare to provide services to our members. These providers have met TakeCare's credentialing standards and quality of care requirement. Please view or download the most current TakeCare Provider Directory at www.takecareasia.com for the most updated list of in-network providers.
Infertility	To receive a diagnosis of infertility, an individual must be unable to conceive or produce conception after having intercourse without using birth control during a period of 1 year if the individual is under age 35, or during a period of 6 months if the individual is age 35 and older. For individuals without a partner or exposure to egg-sperm contact, a diagnosis of infertility can be received if the individual is not able to conceive or produce conception through artificial insemination. Infertility may also be established through evidence of medical history and diagnostic testing.
Medical necessity	Medical necessity refers to medical services or hospital services which are determined by us to be: • Rendered for the treatment or diagnosis of an injury or illness; and

	• Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and • Not furnished primarily for the convenience of the member, the attending physician, or other provider of service; and • Furnished in the most economically efficient manner which may be provided safely and effectively to the member.
Medicare Part A	Part A helps cover inpatient hospital stays, skilled nursing facility care, hospice care, and some health care.
Medicare Part B	Part B covers medically necessary services like doctors' services and tests, outpatient care, home health services, durable medical equipment, and other medical services.
Medicare Part C	Part C is a Medicare Advantage plan that combines the coverage of Medicare Part A and Part B. Part C typically also covers additional benefits like, dental, vision, and hearing services. Some Part C plans also include Medicare Part D coverage.
Medicare Part D	Medicare Part D plans provide coverage for prescription drugs. Private insurers contract with CMS on an annual basis for the right to offer Part D plans. Part D can be offered as a standalone Prescription Drug Plan (PDP) or as part of a Medicare Advantage Prescription Drug Plan (MAPD).
Medicare Part D EGWP	A Medicare Part D Employer Group Waiver Plan (EGWP) is a type of Medicare prescription drug plan that can be offered to employees and retirees of certain companies, unions, or government agencies, which allows for flexibility and enhanced coverage of traditional Medicare pharmacy benefits. Examples of Medicare Part D EGWPs are Medicare Advantage Prescription Drug (MAPD) plan EGWPs that include both health and drug benefits, as well as Prescription Drug Plan (PDP) EGWPs, which only cover the prescription drug benefit.
Out-of-Network Providers	These are providers with whom TakeCare has not entered into a contract agreement. For out-of-network care, covered members pay 30% of our allowance plus any difference between our allowance and billed charges. Some services may not be covered under your Plan. Members enrolled in the HDHP option must meet their medical or prescription drug deductible first before any benefits will be paid. Because we do not have contracts with out-of-network providers, some of these providers may require upfront payment from you at the time of service. If this occurs, you will need to seek reimbursement from TakeCare for its portion of the eligible charges.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Preferred In-Network Providers	These are in-network, directly contracted providers that have entered into a written agreement with TakeCare to provide care or treatment at preferential or better rates compared to other contracted or in-network providers and have demonstrated better outcomes based on a standard measurement set (HEDIS) monitored by the National Committee for Quality Assurance (NCQA) . The providers which are identified as preferred in-network providers are subject to change. Please check with TakeCare to confirm the preferential status of contracted/in-network providers.
Premium pass through contribution to HSA/ HRA	The amount of money we contribute to your HSA or HRA. See page 97 for more information.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Surprise bill	An unexpected bill you receive for: • emergency care – when you have little or no say in the facility or provider from whom you receive care, or for • non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for • air ambulance services furnished by nonparticipating providers of air ambulance services.
Us/We	Us and We refer to TakeCare Insurance Company (TakeCare)
Urgent care claims	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law. A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health • Waiting could seriously jeopardize your ability to regain maximum function, or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims usually involve pre-service claims and not post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 671-647-3526 or toll-free at 877-484-2411 or customerservice@takecareasia.com. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
You	You refers to the enrollee and each covered family member.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of Benefits for the High and Standard Options of TakeCare Insurance Company - 2025

- Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this PSHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.takecareasia.com/PSHB2025.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- This is a summary of in-network benefits only. To view out-of-network benefits, see **Section 5**.

Benefits	When you see in-network providers, you pay...	Page
Medical services provided by in-network physicians: Diagnostic and treatment services provided in the office	**High Option** - Office visit copayment: $5 primary care at FHP Health Center $10 primary care at Preferred in-network providers $20 primary care at other in-network providers $40 in-network specialist **Standard Option** - Office visit copayment: $5 primary care at FHP Health Center $15 primary care at Preferred in-network providers $25 primary care at other in-network providers $40 in-network specialist Note: Copayments waived for covered prior-authorized services when received through in-network providers in the Philippines.	36
Services provided by a hospital: Inpatient Services	**High Option** - $100 copayment per day up to $500 maximum per inpatient admission **Standard Option** - $150 copayment per day up to $750 maximum per inpatient admission Note: Copayments waived for covered prior-authorized services when received through in-network providers in the Philippines.	65
Services provided by a hospital: Outpatient Services	**High Option** - $100 copayment per visit **Standard Option** - $150 copayment per visit Note: Copayments waived for covered prior-authorized services when received through in-network providers in the Philippines.	66
Urgent Care/Emergency benefits: In-area	**High Option** - FHP Health Center -$15 copayment; PCP physician - $20 copayment; Emergency Room - $75 copayment **Standard Option** - FHP Health Center -$15 copayment; PCP physician - $25 copayment; Emergency Room - $100 copayment	70

Benefits	When you see in-network providers, you pay...	Page
Urgent Care/Emergency benefits: Out of Area		
• Doctor's office or Urgent Care Center	**High Option** - $50 copayment **Standard Option** - 20% coinsurance of our allowance	70
• Hospital Emergency Room	**High Option** - $100 copayment **Standard Option** - 20% coinsurance of our allowance	70
Mental health and substanceuse disorder treatment:	**High Option** Primary Care: $20 copayment per visit Outpatient Facility: $100 copayment per visit Inpatient Facility: $100 copayment per day, up to $500 maximum per admission **Standard Option** Primary Care: $25 copayment per visit Outpatient Facility: $150 copayment per visit Inpatient Facility: $150 copayment per day, up to $750 maximum per admission	70
Prescription drugs: • Retail pharmacy Note: You can reduce your out of pocket expense by using a **Preferred In-network** pharmacy or **Mail Order.**	**High Option** **Non-Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $10 copayment Preferred Brand: $25 copayment Non-Preferred Brand: $70 copayment Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $250 copayment (Copayments per 90-day fill) Generic formulary: up to $30 copayment Preferred Brand: up to $75 copayment Non-Preferred Brand: up $210 copayment **Standard Option** **Non-Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $15 copayment Preferred Brand: $40 copayment Non-Preferred Brand: $100 copayment Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $250 copayment (Copayments per 90-day fill) Generic formulary: up to $45 copayment Preferred Brand: up to $120 copayment Non-Preferred Brand: up $300 copayment	76

Benefits	When you see in-network providers, you pay...	Page
Prescription drugs: • Mail order	**High Option** **In-network:** (Copayments per 90-day fill) Generic formulary: $0 copayment Preferred Brand: $40 copayment Non-Preferred Brand: $100 copayment (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $200 copayment **Standard Option** **In-network:** (Copayments per 90-day fill) Generic formulary: $0 copayment Preferred Brand: $60 copayment Non-Preferred Brand: $160 copayment (Copayment per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $250 copayment	76
Dental care	**High Option** - Nothing for preventive services and coinsurance for other covered services. **Standard Option** - Nothing for preventive services. All other dental services are not covered.	88
Special features:		
• Medical Travel Benefit	For eligible care which has been preauthorized by TakeCare's Medical Referral Services (MRS) department, the Medical Travel Benefit covers up to $500 toward the cost of round-trip airfare between Guam and Manila, ground transportation between the airport and the hospital, and lodging.	90
• Information Accessibility	TakeCare is committed to ensuring every member can access information about their health plan with dignity, equality, comfort, and independence. To achieve this goal, TakeCare provides an accessibility widget on its website, translation, and hearing impaired services. To learn more, go to www.takecareasia.com/multi-language.pdf	91
Protection against catastrophic costs (out-of-pocket maximum):		
• Medical		26

	High Option - Nothing for eligible medical services after $2,000 for Self Only enrollment, or $4,000 for Self Plus One enrollment, or $6,000 for Self and Family. **Standard Option** - Nothing for eligible medical services after $3,000 for Self Only enrollment, or $6,000 for Self Plus One enrollment or $6,000 for Self and Family. For the above two options, an individual under Self Plus One or Self and Family enrollment will never have to satisfy more than what is required for the out-of-pocket maximum limit under a Self Only enrollment.	
• Prescription drugs	**High Option** - Nothing for covered prescription drugs after $2,000 for Self Only enrollment, or $4,000 for Self Plus One enrollment, or $6,000 for Self and Family. Under the PDP EGWP program, your in-network prescription drug out-of-pocket maximum limit is $2,000 for Self Only enrollment, $4,000 for Self Plus One or $6,000 for Self and Family enrollment. **Standard Option** - Nothing for covered prescription drugs after $3,000 for Self Only enrollment, or $6,000 for Self Plus One enrollment, or $6,000 for Self and Family. Under the PDP EGWP program, your in-network prescription drug out-of-pocket maximum limit is $2,000 for Self Only enrollment, $4,000 for Self Plus One or $6,000 for Self and Family enrollment. For the above two options, an individual under Self Plus One or Self and Family enrollment will never have to satisfy more than what is required for the out-of-pocket maximum limits under a Self Only enrollment.	26

Summary of Benefits for the HDHP Option of TakeCare Insurance Company - 2025

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this PSHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.takecareasia.com/PSHB2025. If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

In 2025 for each month you are eligible for the HSA, TakeCare will deposit $33.58 per month for Self Only enrollment or $81.05 per month for Self Plus One or $90.02 per month for Self and Family enrollment to your HSA. For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of $402.93 for Self Only or $972.65 for Self Plus One or $1,080.22 for Self and Family.

With the exception of Preventive Care Services coverage, you must first meet your medical deductible before your coverage begins. The Self Plus One or Self and Family deductible can be satisfied when at least two (2) covered family members have met their individual deductible in a calendar year.

With the exception of Preventive Medications coverage, you must first meet your prescription drug deductible before your coverage begins. The Self Plus One or Self and Family deductible can be satisfied when at least two (2) covered family members have met their individual deductible in a calendar year.

This is a summary of benefits for in-network providers only. To view out-of-network benefits, see **HDHP Section 5**.

Benefits when seeing an in-network provider	Once you've met your deductible, you pay...	Page
Preventive medical services and preventive prescription drugs	Nothing (deductibles waived)	105
Services provided by physicians: Diagnostic and treatment services provided in the office	20% coinsurance of our allowance	110
Services provided by a hospital: Inpatient Services	20% coinsurance of our allowance	65
Services provided by a hospital: Outpatient Services	20% coinsurance of our allowance	66
Urgent Care/Emergency benefits: In-area		
• Urgent Care Center or Doctor's Office	$75 copayment per visit	139
• Hospital Emergency Room	$100 copayment per visit *(copayment waived if admitted)*	139
Urgent Care/Emergency benefits: Out-of-area		
• Urgent Care Center or Doctor's Office	$100 copayment per visit	139
• Hospital Emergency Room	$100 copayment per visit *(copayment waived if admitted)*	139
Mental health and substance use disorder treatment:	20% coinsurance of our allowance	141
Prescription drugs: • Retail pharmacy Note: You can reduce your out of pocket expense by using a **Preferred In-network** pharmacy or **Mail Order**.	**Non-Preferred In-network:** (Copayments per 30-day fill) Generic formulary: $20 copayment Preferred Brand: $40 copayment Non-Preferred Brand: $100 copayment Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $250 copayment	145

	(Copayments per 90-day fill) Generic formulary: up to $45 copayment Preferred Brand: up to $120 copayment Non-Preferred Brand: up $300 copayment	
Prescription drugs: • Mail order	**In-network:** (Copayments per 90-day fill) Generic formulary: $0 copayment Preferred Brand: $60 copayment Non-Preferred Brand: $160 copayment (Copayments per 30-day fill) Preferred Specialty drugs: $100 copayment Non-Preferred Specialty drugs: $250 copayment	145
Dental care	Nothing for preventive services and coinsurance for other covered services.	155
Special features:		
• Medical Travel Benefit	For eligible care which has been preauthorized by TakeCare's Medical Referral Services (MRS) department, the Medical Travel Benefit covers up to $500 toward the cost of round-trip airfare between Guam and Manila, ground transportation between the airport and the hospital, and lodging.	157
• Information Accessibility	TakeCare is committed to ensuring every member can access information about their health plan with dignity, equality, comfort, and independence. To achieve this goal, TakeCare provides an accessibility widget on its website, translation, and hearing impaired services. To learn more, go to www.takecareasia.com/multi-language.pdf	158
Protection against catastrophic costs (out-of-pocket maximum):		
• Medical	Nothing for eligible medical services after $3,000 for Self Only enrollment, or $6,000 for Self Plus One enrollment or $6,000 for Self and Family. An individual under Self Plus One or Self and Family enrollment will never have to satisfy more than what is required for the out-of-pocket maximum limit under a Self Only enrollment.	26
• Prescription drugs	Nothing for covered prescription drugs after $3,000 for Self Only enrollment, or $6,000 for Self Plus One enrollment, or $6,000 for Self and Family. Under the PDP EGWP program, your in-network prescription drug out-of-pocket maximum limit is $2,000 for Self Only enrollment, $4,000 for Self Plus One or $6,000 for Self and Family enrollment.	26

	An individual under Self Plus One or Self and Family enrollment will never have to satisfy more than what is required for the out-of-pocket maximum limits under a Self Only enrollment.	

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2025 Rate Information for TakeCare Insurance Company

To compare your PSHB health plan options please go to www.health-benefits.opm.gov/pshb.

To review premium rates for all PSHB health plan options please go to www.opm.gov/healthcare-insurance/pshb/premiums/

Guam, CNMI, Palau (Belau)

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
High Option, Self Only	G4A	$197.39	$65.79	$427.67	$142.55
High Option, Self Plus One	G4C	$394.62	$131.54	$855.01	$285.00
High Option, Self and Family	G4B	$567.47	$189.16	$1,229.53	$409.84
Standard Option, Self Only	G4D	$142.37	$47.46	$308.48	$102.82
Standard Option, Self Plus One	G4F	$285.27	$95.09	$618.08	$206.03
Standard Option, Self and Family	G4E	$469.91	$156.63	$1,018.13	$339.37
HDHP Option, Self Only	HJA	$48.35	$16.12	$104.77	$34.92
HDHP Option, Self Plus One	HJC	$116.72	$38.91	$252.90	$84.30
HDHP Option, Self and Family	HJB	$129.63	$43.21	$280.87	$93.62