**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**
**This is only a summary.** Please read the PSHB Plan brochure (**RI 73-929**) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the PSHB Plan brochure**. Benefits may vary if you have other coverage, such as Medicare. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can get the PSHB Plan brochure at www.takecareasia.com, and view the Glossary at https://www.healthcare.gov/sbc-glossary/. You can call 1-877-484-2411 to request a copy of either document.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $0/Self Only<br>$0/Self Plus One<br>$0/Self and Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible and for which services are subject to the deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | |
| **What is the out-of-pocket limit for this plan?** | $3,000/Self Only<br>$6,000/Self Plus One ($3,000 per covered individual)<br>$6,000/Self and Family ($3,000 per covered individual)<br>Separately for Medical and Prescription drugs. The out-of-pocket maximum applies to both in and out-of-network expenses. | The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services. This limit helps you plan for health care expenses. The "per covered individual" amount is the most that any one member would have to pay, regardless of whether the individual is enrolled in Self Plus One, or Self and Family. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges, deductible amounts, member share for contraceptive devices, dental services, vision hardware, | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |

| | | |
|---|---|---|
| | chiropractic services, charges in excess of our allowance, charges in excess of maximum benefit limitation and other supplemental benefits and services not covered by this plan. | |
| **Will you pay less if you use a network provider?** | Yes. See www.takecareasia.com or call 1-877-484-2411 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most, plus you may be balance billed) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $5 copay/visit at FHP; $15 copay/visit at Preferred Providers; $25 copay/visit at Non-Preferred Providers | 30% coinsurance | ————————none———————— |
| | Specialist visit | $40 copay/visit | 30% coinsurance | Referral from your Primary Care Physician is required. |
| | Other practitioner office visit | All charges above $25 for Chiropractor | Not covered | Coverage is limited to 20 visits and $25/visit. |
| | Preventive care/screening/ immunization | No charge | 30% coinsurance | ————————none———————— |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $5 copay/visit at FHP; $25 copay/visit outside FHP; No charge for blood and lab work | 30% coinsurance | ————————none———————— |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most, plus you may be balance billed) | |
| **If you have a test** | Imaging (CT/PET scans, MRIs) | $30 copay/visit at FHP; $40 copay/visit outside FHP | 30% coinsurance | Referral from your Primary Care Physician is required and prior authorization and approval from TakeCare. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.myvibrantrx.com/takecare | Generic drugs | $10 copay/ prescription (Retail) for Preferred Providers; $15 copay/ prescription (Retail) for Non-Preferred Providers; $0 copay/ prescription (Mail Order) | Not covered | Prescription from a licensed Physician is required. Limited to 30-day supply for retail and 90-day supply for mail order and SuperDrug. |
| | Preferred brand drugs | $30 copay/ prescription (Retail) for Preferred Providers; $40 copay/ prescription (Retail) for Non-Preferred Providers; $60 copay/ prescription (Mail Order) | Not covered | Prescription from a licensed Physician is required. Limited to 30-day supply for retail and 90-day supply for mail order and SuperDrug. Applies to non-brand maintenance only. |
| | Non-preferred brand drugs | $75 copay/ prescription (Retail) for Preferred Providers; $100 copay/ prescription (Retail) for Non-Preferred Providers; $160 copay/ prescription (Mail Order) | Not covered | Prescription from a licensed Physician is required. Limited to 30-day supply for retail and 90-day supply for mail order and SuperDrug. Requires prior authorization and approval from TakeCare. |
| | Specialty drugs | $100 copay/ prescription (Retail) for Preferred Specialty; $250 copay/prescription (Retail) for Non-Preferred Specialty; | Not covered | Prescription from a licensed Physician is required. Limited to 30-day supply for retail and 90-day for mail order and SuperDrug. Requires prior authorization and approval from TakeCare. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most, plus you may be balance billed) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $150 copay/visit | 30% coinsurance | Prior Authorization and approval is required from TakeCare. |
| | Physician/surgeon fees | $40 copay/visit | 30% coinsurance | Prior Authorization and approval is required from TakeCare. |
| **If you need immediate medical attention** | Emergency room care | $100 copay | $100 copay | Co-payment/ co-insurance are waived if admitted. Hospitalization co-payment/ co-insurance apply in such case. 48-hour notification requirement in service area is waived if not admitted. See PSHB Plan brochure for details. |
| | Emergency medical transportation | No charge | No charge | Ground Transportation only |
| | Urgent care | $15 copay/visit at FHP; $25 copay other in-network providers | 30% coinsurance | Available at FHP Health Center in the Service Area. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $150 copay/ day up to $750 maximum per admission | 30% coinsurance | Prior Authorization and approval required from TakeCare. |
| | Physician/surgeon fees | $40 copay/visit | 30% coinsurance | Prior Authorization and approval required from TakeCare. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $150 copay/visit | 30% coinsurance | Referral from Primary Care Physician required. |
| | Inpatient services | $150 copay/day up to $750 maximum per admission | 30% coinsurance | Prior Authorization and approval required from TakeCare. |
| **If you are pregnant** | Prenatal and postnatal care | $0 copay/visit | 30% coinsurance | Does not cover routine sonograms and maternity-related services outside the Service Area. |
| | Delivery and all inpatient services | $150 copay/day up to $750 maximum per admission | 30% coinsurance | Does not cover routine sonograms and maternity-related services outside the Service Area. |
| **If you need help recovering or have other special health needs** | Home health care | No charge | 30% coinsurance | Does not cover care requested for the convenience of the patient or the patient's family. |
| | Rehabilitation services | $15 copay/ visit | 30% coinsurance | Unlimited for outpatient and up to two (2) consecutive months per condition. |
| | Habilitation services | $15 copay/ visit | 30% coinsurance | Services are subject to medical necessity. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most, plus you may be balance billed) | |
| **If you need help recovering or have other special health needs** | Skilled nursing care | No charge | 30% coinsurance | Limited to 60 days confinement per benefit year. Does not cover custodial care and subject to medical appropriateness as determined by the physician and approval by TakeCare. |
| | Durable medical equipment | 15% coinsurance | Not covered | Does not cover motorized wheelchairs, motorized beds, replacement CPAP and BPAP supplies and insulin pumps. |
| | Hospice services | No charge | Not covered | ——————none—————— |
| **If your child needs dental or eye care** | Children's eye exam | No charge | 30% coinsurance | ——————none—————— |
| | Children's glasses | All charges above $100 per benefit year | Not covered | Available through in-network providers only. |
| | Children's dental check-up | No charge for preventive services | 30% coinsurance | Member is responsible for charges between covered charges and billed charges. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your plan's PSHB brochure for more information and a list of any other excluded services.)**

- Cosmetic Surgery
- Long-Term Care
- Non-emergency care when traveling outside the U.S. (except for services approved and authorized by TakeCare)
- Private-Duty Nursing
- Weight loss programs

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

- Acupuncture
- Applied Behavioral Analysis ("ABA")
- Bariatric Surgery
- Continuous Glucose Monitor
- Dental Care Adult
- Health Education Classes
- Massage Therapy
- Medical Foods
- Organ Transplants
- Preventive Medications
- Telehealth Services
- Weight Loss Medications
- Bariatric Surgery (Laparoscopic Sleeve Gastrectomy)
- Iatrogenic Fertility Preservation

**Your Rights to Continue Coverage:** You can get help if you want to continue your coverage after it ends. See the PSHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-877-484-2411 or visit www.health-benefits.opm.gov/pshb. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-PSHB individual policy), spouse equity

coverage, or receive temporary continuation of coverage (TCC). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's PSHB brochure. If you need assistance, you can contact: 1-877-484-2411.

**Does this plan provide Minimum Essential Coverage?** **Yes**

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

**Does this plan meet the Minimum Value Standards?** **Yes**

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

**Language Access Services:**

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

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

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

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

## About these Coverage Examples:

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

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **$150**
- **Other coinsurance** **20%**

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

| **Total Example Cost** | **$12,731** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $390 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$450** |

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **$150**
- **Other coinsurance** **20%**

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

| **Total Example Cost** | **$7,389** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $990 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$990** |

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **$150**
- **Other coinsurance** **20%**

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

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $300 |
| Coinsurance | $10 |
| *What isn't covered* | |
| Limits or exclusions | $210 |
| **The total Mia would pay is** | **$520** |

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