



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 FEHB Plan brochure (RI 73-776) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB 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 FEHB 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 <u>deductible</u>?	\$ 3,000/Self Only \$ 3,000/ Self Plus One \$ 6,000/Self and Family The deductible applies to both in and out of network expenses. Does not apply to preventive services.	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> 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 <u>deductible</u>?	Yes. Preventive care services are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$3,000/Self Only \$6,000/Self Plus One (\$3,000 per covered individual) \$6,000/Self and Family (\$3,000 per covered individual) Separately for Medical and Prescription drugs. The out of pocket maximum applies to both in and out of network expenses.	The <u>out-of-pocket limit</u> , 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 <u>out-of-pocket limit</u>?	Premiums, balance-billed charges, deductible amounts, member share for contraceptive devices, dental services, vision hardware, 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.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.takecareasia.com or call 1-877-484-2411 for a list of <u>network providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a provider in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> 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	20% <u>coinsurance</u>	30% <u>coinsurance</u>	—————none—————
	<u>Specialist</u> visit	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Referral from your Primary Care Physician is required.
	Other practitioner office visit	All charges above \$25 for Chiropractor	Not covered	Coverage is limited to 10 visits and \$25/visit.
	<u>Preventive care/screening/immunization</u>	No charge	30% <u>coinsurance</u>	Not subject to plan deductible.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> ; No charge blood and lab work	30% <u>coinsurance</u>	—————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)	
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	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.envisionrx.com	Generic drugs	\$10 copay/ prescription (Retail); \$0 copay/ prescription (Mail Order)	30% <u>coinsurance</u>	Prescription from a licensed Physician is required. Limited to 30-day supply for retail and 90-day supply for mail order.
	Preferred brand drugs	\$40 copay/ prescription (Retail) \$80 copay/ prescription (Mail Order)	30% <u>coinsurance</u>	Prescription from a licensed Physician is required. Limited to 30-day supply for retail and 90-day supply for mail order. Applies to non-brand maintenance only.
	Non-preferred brand drugs	\$100 copay/ prescription (Retail) \$160 copay/ prescription (Mail Order)	30% <u>coinsurance</u>	Prescription from a licensed Physician is required. Limited to 30-day supply for retail and 90-day supply for mail order. Requires prior authorization and approval from TakeCare.
	<u>Specialty drugs</u>	\$100 copay/ prescription (Retail) for Preferred Specialty; \$250 copay/prescription (Retail) for Non Preferred Specialty	30% <u>coinsurance</u>	Prescription from a licensed Physician is required. Limited to 30-day supply for retail. Requires prior authorization and approval from TakeCare.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior Authorization and approval is required from TakeCare.
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior Authorization and approval is required from TakeCare.
If you need immediate medical attention	Emergency room care	\$75 copay	\$75 copay	Copayment/ coinsurance are waived if admitted. Hospitalization co-payment/ co-insurance apply in such case. 48 hour notification requirement. See FEHB Plan brochure for details.
	<u>Emergency medical transportation</u>	No charge	No charge	Ground Transportation only

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
	<u>Urgent care</u>	\$75 copay	Not covered	Available at FHP Health Center in the Service Area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior Authorization and approval required from TakeCare.
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior Authorization and approval required from TakeCare.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Referral from Primary Care Physician required.
	Inpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior Authorization and approval required from TakeCare.
If you are pregnant	Prenatal and postnatal care	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Does not cover routine sonograms and maternity-related services outside the Service Area.
	Delivery and all inpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Does not cover routine sonograms and maternity-related services outside the Service Area.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Does not cover care requested for the convenience of the patient or the patient's family.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Unlimited for outpatient and up to two (2) consecutive months per condition.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Services are subject to medical necessity.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 100 days confinement per calendar year. Does not cover custodial care and subject to medical appropriateness as determined by the physician and approval by TakeCare.
	<u>Durable medical equipment</u>	No charge	Not covered	Does not cover motorized wheelchairs, motorized beds, CPAP and BPAP supplies and insulin pumps.
	<u>Hospice services</u>	No charge	Not covered	This benefit is limited to a maximum of up to 180 days per lifetime.
	Children's eye exam	No charge	30% <u>coinsurance</u>	_____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 your child needs dental or eye care	Children's glasses	All charges above \$100 per calendar year	Not covered	Available through FHP Vision center only.
	Children's dental check-up	No charge for preventive services; 20% <u>coinsurance</u> for restorative and simple extractions; 75% <u>coinsurance</u> for prosthodontics.	Not covered	Coverage limited to preventive services, x rays and oral examination. 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 FEHB brochure for more information and a list of any other <u>excluded services</u> .)			
<ul style="list-style-type: none"> • Cosmetic Surgery • Long-Term Care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. (except for services approved and authorized by TakeCare) • Private-Duty Nursing 	<ul style="list-style-type: none"> • Weight loss programs 	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)			
<ul style="list-style-type: none"> • Acupuncture • Applied Behavioral Analysis ("ABA") • Bariatric Surgery • Dental Care Adult 	<ul style="list-style-type: none"> • Health Education Classes • Massage Therapy 	<ul style="list-style-type: none"> • Organ Transplants 	

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at [contact number] or visit www.opm.gov/insure/health. 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-FEHB 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 FEHB brochure. If you need assistance, you can contact: 1-877-484-2411.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

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

About these Coverage Examples:



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

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

- The plan's overall deductible \$3,000
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$40
Coinsurance	\$1865
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,965

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

- The plan's overall deductible \$3,000
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$870
Coinsurance	\$98
<i>What isn't covered</i>	
Limits or exclusions	\$34
The total Joe would pay is	\$4,002

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

- The plan's overall deductible \$3,000
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$75
Coinsurance	\$115
<i>What isn't covered</i>	
Limits or exclusions	\$162
The total Mia would pay is	\$3,352