

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-877-484-2411. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.takecareasia.com or call 1-877-484-2411 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>plan maximum</u>?	No overall plan maximum for most services. Some benefits and services have coverage limitation.	This plan complies with Affordable Care Act (ACA) of 2010 with respect to provision on lifetime and annual limits. https://www.healthcare.gov/health-care-law-protections/lifetime-and-yearly-limits/
What is the overall <u>deductible</u>?	\$0 for in-network providers. \$300/Individual or \$900/family for out-of-network providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible amount has been met.
Are there services covered before you meet your <u>deductible</u>?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	
What is the <u>out-of-pocket limit</u> for this plan?	For combined <u>in network and out of network providers</u> Medical: \$4,200 individual / \$8,400 family Prescription: \$4,200 individual / \$8,400 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Copayments</u> for certain services, <u>premiums</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.	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> .	If you use an in-network health care <u>provider</u> , this Plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the terms in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . The following definitions shows how this Plan defines the different kinds of <u>providers</u> .

		<p>In-network Provider - Means a physician employed by TakeCare or any person, organization, health facility, institution or physician who has entered into a contract with TakeCare to provide services to members. This term is used interchangeably with "Participating Provider".</p> <p>Preferred Provider - A participating or in-network provider that has entered into a written agreement with TakeCare to provide care or treatment at a preferential or greater discounted rate which allows TakeCare to provide greater coverage to you. The Participating Providers which are identified by the Plan as preferred providers are subject to change from time-to-time depending on the terms and rates for services of the written agreements. Please be sure to check with TakeCare's Medical Management Department to confirm the identity of preferred providers.</p> <p>Out-of-network Provider - A health care provider not contracted with TakeCare to provide covered services or procedures for subscribers and their dependents. A member's non-participating or out-of-network benefits will apply. This term is used interchangeably with "Non-Participating Provider".</p>
Does this Plan have an off-island network	Yes.	Off-island care is limited to directly contracted providers in Continental United States, Hawaii, Asia and the Philippines. Referral from your Primary Care Physician <u>and</u> Prior Authorization (written approval) from TakeCare is required.
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.
Does this Plan have a Service Area?	Yes.	This Plan's Service Area is Guam, CNMI and Palau. You must continuously reside in the Service Area to remain eligible for coverage under the Plan. When selecting a Primary Care Physician, you must select a Primary Care Physician from the island in which you reside. If you are absent from the Service Area for more than ninety (90) consecutive days during a benefit period, you are no longer eligible for the Plan and your coverage under the Plan may be terminated. Any services outside the Service Area requires referral from your Primary Care Physician and Prior Authorization (written approval) from TakeCare.



- All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a deductible applies.
- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **eligible charge** for the service. For example, if the Plan's **eligible charge** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the Plan pays for covered services is based on the **eligible charge**. If an **out-of-network provider** charges more than the **eligible charge**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **eligible charge** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- "**Eligible charges**" means the maximum charge for which TakeCare will reimburse the Provider for a covered service. An eligible charge is not necessarily the same as a usual, reasonable, customary, maximum, actual or prevailing charge or fee.
- This Plan may encourage you to use Participating Providers by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness <ul style="list-style-type: none"> • Including inhaled medication and administration not dispensed through a pharmacy • Injectables and other medications not dispensed through a pharmacy • Including cast and cast supplies • Telemedicine Services 	\$20 copay per visit	30% coinsurance	This benefit is not eligible for travel and/or airfare benefit. Coverage is limited to the Service Area. Required documentation must be provided for Telemedicine Services.
	<u>Specialist visit</u> <ul style="list-style-type: none"> • Including inhaled medication and administration not dispensed through a pharmacy • Injectables and other medications not dispensed through a pharmacy • Including cast and cast supplies • Telemedicine Services 	\$35 copay per visit	30% coinsurance	Referral from your TakeCare Participating Primary Care Physician is required. Required documentation must be provided for Telemedicine Services.

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)	
<p>If you visit a health care <u>provider's office</u> or clinic</p>	<p><u>Preventive care/screening/immunization</u></p> <ul style="list-style-type: none"> • All services rates A or B by the U.S. Preventive Care Task Force • Annual Physical Exam for Adults • Annual Visual Exam for Adults • Routine Hearing Screening for Children age 18 years old and below • Routine Vision Screening for Children age 18 years old and below • Well Women Care <ul style="list-style-type: none"> ○ Screening Mammogram and Routine Pap Smear ○ Contraceptives based on PPACA mandated provision with a valid provider prescription ○ Purchased or rented breast pumps ○ Sterilization (Traditional Tubal Ligation and with Fulguration) • Well Baby Care • Well Child Care • Routine Immunization 	<p>No copay, co-insurance and/or deductible for covered services</p>	<p>30% coinsurance</p>	<p>Purchased or rented breast pumps once every benefit period – 100% covered up to the actual cost but not to exceed \$200 per member per benefit period at Participating Pharmacy.</p> <p>Well Baby Care (Means from birth up to 2 years old)</p> <p>Well Child Care (Means 2 years old up to 18 years old)</p> <p>Routine Immunization (Shall be based on CDC guidelines).</p> <p>This benefit is not eligible for travel and/or airfare benefit.</p> <p>Not subject to deductible for Participating Providers.</p> <p>Coverage is limited to the Service Area.</p>

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)	
<p>If you visit a health care <u>provider's</u> office or clinic</p>	<p><u>Cardiac Care</u></p> <ul style="list-style-type: none"> • Specialist Care Office Visit • Outpatient Cardiac Therapy/Rehabilitation • Inpatient Cardiac Surgery (including insertion of single/dual pacemaker) • Inpatient Cardiac Therapy/Rehabilitation 	<p>\$35 copay for Specialist Care office visit and Outpatient Cardiac Therapy/Rehabilitation</p> <p>\$100 copay per admission for inpatient Cardiac Surgery and inpatient Cardiac Therapy/Rehabilitation</p>	<p>30% coinsurance</p>	<p>Referral from your Primary Care Physician is required and Prior Authorization (written approval) from TakeCare.</p> <p>Coverage for Outpatient Cardiac Therapy/Rehabilitation is limited to 20 visits per Member per benefit period.</p> <p>Coverage for Inpatient Cardiac Therapy/Rehabilitation is limited to 30 days per Member per benefit period</p> <p>Coverage for treatment/ services and charges for heart valves, single/dual pacemakers, pacemakers monitors, coronary stents and accessories such as pacemaker batteries and leads, including the cost of the devices, their placement, repair or replacement and related hospital charges and any related complications is subject to a combined \$100,000 in and out-of-network benefit limitation outside the Philippines or \$200,000 in the Philippines.</p> <p>All eligible claims with diagnoses related to these services are counted towards the benefit limitation, including the Travel Benefit.</p>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	<u>Oncology Care Services</u> <ul style="list-style-type: none"> Specialist Care Office Visit Outpatient Radiation & Chemotherapy Inpatient Radiation & Chemotherapy 	\$35 copay for Specialist Care office visit and outpatient Radiation & Chemotherapy \$100 copay per admission for inpatient Radiation & Chemotherapy	30% coinsurance	Referral from your Primary Care Physician is required and prior Authorization (written approval) from TakeCare.
	<u>Oncology Care – Chemotherapy Drugs</u> <ul style="list-style-type: none"> Injectable Specialty 	Injectable - \$400 copay per medication/drug Specialty - \$500 copay per medication/drug	30% coinsurance	Referral from your Primary Care Physician is required and Prior Authorization (written approval) from TakeCare. The cost of Chemotherapy Drugs are only covered if administered at the FHP Cancer Center within the Service area.
	<u>Other practitioner office visit – Chiropractor</u> Services are limited to: <ul style="list-style-type: none"> 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 	All costs above \$25 per visit and all costs after the 10 th visit for Chiropractor	All costs	Coverage is limited to 10 visits per benefit period at \$25 per visit. Ancillary services (e.g. X-rays) are not covered. Coverage is limited to the Service Area.
If you have a test	<u>Routine Laboratory</u> (diagnostic test, blood work)	No copay, co-insurance and/or deductible for blood work and routine laboratory	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)	
If you have a test	Imaging (CT/PET scans, MRIs)	\$50 copay	30% coinsurance	Referral from your Primary Care Physician <u>and</u> Prior Authorization (written approval) from TakeCare is required.
	Nuclear Medicine	\$35 copay	30% coinsurance	Referral from your Primary Care Physician <u>and</u> Prior Authorization (written approval) from TakeCare is required.
	Plain film X-ray, Ultrasound, EEG, EKG, ECG	\$20 copay	30% coinsurance	Referral from your Primary Care Physician is required.
	Diagnostic Mammogram and other Diagnostic Tests	\$20 copay	30% coinsurance	-----None-----
	Specialty Laboratory (Any laboratory services costing in excess of \$200)	\$50 copay	30% coinsurance	Referral from your Primary Care Physician <u>and</u> Prior Authorization (written approval) from TakeCare is required.
	Diagnostic Sleep Study	\$50 copay	30% coinsurance	Referral from your Primary Care Physician <u>and</u> Prior Authorization (written approval) from TakeCare is required.
	Allergy Testing and Treatment	\$35 copay	30% coinsurance	Referral from your Primary Care Physician is required and Prior Authorization (written approval) from TakeCare. Coverage is limited to \$500 per member per benefit period.
	Health Education, Wellness and Disease Management Programs including any related laboratory services	No copay, co-insurance and/or deductible for covered services	All costs	Services are available and provided through TakeCare Wellness Department Coverage is limited to the Service Area. Not subject to deductible.

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)	
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.takecareasia.com or www.elixirsolutions.com</p>	Generic drugs (Tier 1)	\$10 copay per 30-day Retail Drug prescription; \$20 copay per 90-day Retail Drug at either Kmart or SuperDrug; No cost for Mail Order Drug prescription	30% coinsurance	Valid prescription from a licensed Physician is required. Limited to a 30-day supply for Retail at all participating pharmacies and 90-day supply for Retail at Kmart or SuperDrug pharmacies or Mail Order. 90-day supply for Retail applies after an initial 30-day fill. Other dispensing limitations may apply.
	Preferred brand drugs (Tier 2)	\$20 copay per 30-day Retail Drug prescription; \$40 copay per 90-day Retail Drug at either Kmart or SuperDrug; No cost for Mail Order Drug prescription	30% coinsurance	Valid prescription from a licensed Physician is required. Limited to a 30-day supply for Retail at all participating pharmacies and 90-day supply for Retail at Kmart or SuperDrug pharmacies or Mail Order. 90-day supply for Retail applies after an initial 30-day fill. Other dispensing limitations may apply.
	Non-preferred brand drugs (Tier 3)	\$50 copay per 30-day Retail Drug prescription; \$1000 copay per 90-day Retail Drug at either Kmart or SuperDrug; \$200 copay for Mail Order Drug prescription	30% coinsurance	Valid prescription from a licensed Physician is required. Limited to a 30-day supply for Retail at all participating pharmacies and 90-day supply for Retail at Kmart or SuperDrug pharmacies or Mail Order. 90-day supply for Retail applies after an initial 30-day fill. Requires Prior Authorization (written approval) from TakeCare. Other dispensing limitations may apply.

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)	
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <u>www.takecareasia.com</u> or <u>www.elixirsolutions.com</u></p>	<p><u>Preferred and Non-Preferred Specialty drugs</u> (Tier 4 and Tier 5) (Other than Chemotherapy drugs)</p>	<p>\$400 copay per Retail Preferred Specialty Drug prescription; \$500 copay for Retail Non-Preferred Specialty Drug prescription</p>	<p>30% coinsurance</p>	<p>Valid prescription from a licensed Physician is required. Limited to a 30-day supply for Retail and 90-day supply for Mail Order is NOT available.</p> <p>Requires Prior Authorization (written approval) from TakeCare.</p> <p>Other dispensing limitations may apply.</p>
	<p><u>Highly Specialized Drugs</u> (Tier 6)</p>	<p>\$500 copay per Retail Drug prescription</p>	<p>All costs</p>	<p>Valid prescription from a licensed Physician is required. Limited to a 30-day supply for Retail and 90-day supply for Mail Order is NOT available.</p> <p>Requires Prior Authorization (written approval) from TakeCare.</p> <p>There is no coverage for the first 30-day supply for Retail and coverage will not exceed \$45,000 per member per benefit period after the first 30-day supply.</p> <p>Other dispensing limitations may apply.</p>
	<p><u>Weight Loss Medication</u></p>	<p>Coverage is based on the tier of the drug</p>	<p>Coverage is based on the tier of the drug</p>	<p>Subject to prior authorization and benefit coverage criteria such as but not limited to Body Mass Index (“BMI”) and/or co-morbidities.</p>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 copay	30% coinsurance	Prior Authorization (written approval) is required from TakeCare.
	Physician/surgeon fees	\$20 copay primary care \$35 copay specialist care	30% coinsurance	Prior Authorization (written approval) is required from TakeCare.
	Sterilization <ul style="list-style-type: none"> • Non-preventive traditional outpatient tubal ligation • Non-preventive outpatient tubal ligation with fulguration • Vasectomy 	\$35 copay	30% coinsurance	Prior Authorization (written approval) is required from TakeCare.
	Anesthesia, Cast and Facility Supplies	No copay, co-insurance and/or deductible for covered services	30% coinsurance	Prior Authorization (written approval) is required from TakeCare.
	Internal Prosthetic supplies, devices and implants Coverage applies to the following: <ul style="list-style-type: none"> ▪ Joints ▪ Pacemakers, stents and leads ▪ Heart Valves ▪ Intraocular lens 	20% co-insurance	30% co-insurance	Prior Authorization (written approval) is required from TakeCare.
	External Prosthetic (In accordance with the Women's Health and Cancer Rights Act of 1998) <ul style="list-style-type: none"> ▪ Coverage applies only to post mastectomy surgical bra 	20% coinsurance	30% coinsurance	Prior Authorization (written approval) is required 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)	
	End Stage Renal Disease (ESRD)	20% coinsurance	All costs	Referral from the eligible member's TakeCare Participating Primary Care Provider and Prior Authorization (written approval) from TakeCare is required.
If you need immediate medical attention	<u>Emergency room care</u>	\$100 copay	\$100 copay	<p>Co-payment/Co-insurance is waived if admitted. Applicable hospitalization co-payment/ co-insurance apply to all services including costs related to out-patient emergency.</p> <p>Notification is required to TakeCare within 48 hours after receiving emergency services otherwise these services are not covered.</p> <p>Hospital admission or in-patient services resulting from an emergency room care requires Prior Authorization (written approval) from TakeCare.</p> <p>Not subject to deductible.</p>
	<u>Emergency medical transportation</u>	No copay, co-insurance and/or deductible for covered services	No copay, co-insurance and/or deductible for covered services	<p>Ground Ambulance transportation only.</p> <p>Notification is required to TakeCare within 48 hours after receiving emergency medical transportation otherwise these services are not covered.</p> <p>Not subject to deductible.</p>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Urgent care</u>	<p>\$20 copay per visit at FHP and at Preferred Providers Monday to Friday from 8am to 5pm;</p> <p>\$35 copay at Preferred Providers within the service area or at FHP from 5pm and onwards, Saturdays, Sundays and Holidays;</p> <p>\$35 copay at Non Preferred Providers within the service area regardless of the day or time of the week;</p> <p>\$100 copay outside the service area</p>	<p>All costs within the service area outside FHP, Preferred Providers and Non-Preferred Providers.</p> <p>\$100 copay outside the service area</p>	<p>Available at FHP Health Center, Preferred Providers and Non-Preferred Providers only within the Service Area.</p> <p>Notification is required by TakeCare within 48 hours for urgent care services received outside the service area. Otherwise these services may not be covered.</p>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room and board including Psychiatric Facility)	\$100 copay per admission	30% coinsurance	Prior Authorization (written approval) is required from TakeCare. Limited to a hospital semi-private room
	Physician/surgeon fees (including Mental Health)	No copay, co-insurance and/or deductible for covered services	30% coinsurance	Prior Authorization (written approval) is required from TakeCare
	Other inpatient services including laboratory, radiology, anesthesia, and prescriptions	No copay, co-insurance and/or deductible for covered services	30% coinsurance	Prior Authorization (written approval) is required from TakeCare
	Ostomy, colostomy, urinary supplies, cast and facility supplies	No copay, co-insurance and/or deductible for covered services	30% coinsurance	Prior Authorization (written approval) is required from TakeCare
	Blood and Blood Products	20% coinsurance	30% coinsurance	Prior Authorization (written approval) is required from TakeCare. Coverage is limited up to \$20,000 per member per benefit period.
	Breast Reconstructive Surgery (In accordance with the Women's Health and Cancer Rights Act of 1998) <ul style="list-style-type: none"> ▪ Hospitalization / Surgery 	20% coinsurance	30% coinsurance	Prior Authorization (written approval) is required from TakeCare.
	Skilled Nursing Facility	\$100 copay per admission	30% coinsurance	Prior Authorization (written approval) is required from TakeCare. Coverage is limited to a maximum of 30 days per Member per benefit period.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Inpatient Rehabilitation and Habilitation Services <ul style="list-style-type: none"> • Cardiac Rehabilitation and Physical Therapy • Speech and Occupational Therapy 	No copay and/or co-insurance for cardiac rehabilitation and physical therapy; All costs for speech and occupational therapy	30% coinsurance for cardiac rehabilitation and physical therapy; All costs for speech and occupational therapy	Prior Authorization (written approval) is required from TakeCare. Coverage is limited to a maximum of 30 days per Member per benefit period.
	Robotic Surgery/Robotic Suite	\$100 copay per admission	30% co-insurance	Prior Authorization (written approval) is required from TakeCare.
If you need mental health, behavioral health, or substance abuse services	Outpatient services <ul style="list-style-type: none"> • Telemedicine Services 	\$20 copay per visit	30% coinsurance	Required documentation must be provided for Telemedicine Services.
	Inpatient services	No copay, co-insurance and/or deductible for covered services	30% coinsurance	Referral from your Primary Care Physician <u>and</u> Prior Authorization (written approval) is required from TakeCare for inpatient services.
If you are pregnant	Office visits	\$20 copay per visit	30% coinsurance	Eligible Subscriber or Spouse only. Coverage is limited to the Service Area.
	Childbirth/delivery professional services	No copay, co-insurance and/or deductible for covered services	30% coinsurance	Prior Authorization (written approval) is required from TakeCare for hospital stays beyond 48 hours for a vaginal delivery, or 96 hours for a cesarean section.
	Childbirth/delivery facility services	\$100 copay per admission	30% coinsurance	Subscriber or Spouse only. Coverage is limited to the Service Area. Does not cover Stillborn Fetus Treatments.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you receive care in the Philippines	Inpatient and Outpatient	No copay and/or co-insurance for covered services. Plan deductible applies.	All Cost	Co-payments and coinsurance are waived for Members receiving care at Participating Providers in the Philippines. Prior Authorization (written approval) is required from TakeCare. Inpatient admission is limited to the lowest private room (does not apply to package services).
Airfare Benefit	Airfare Benefit for hospital-to-hospital transfer to Preferred off-island and Participating Philippine Providers	No copay and/or co-insurance for covered services. Plan deductible applies.	All cost	Prior Authorization (written approval) is required from TakeCare. For air transportation of a hospitalized member who requires treatment for hospital-to-hospital transfers at a Preferred off-island and/or Participating Philippine Provider Members not following TakeCare's approved treatment plan is not eligible for travel benefit. Conditions and limitations apply as specified in the Member Handbook.
If you need help recovering or have other special health needs	<u>Home health care</u>	\$20 copay per visit	All Cost	Available through FHP Home Health only or through TakeCare's Participating Provider outside the Service Area with Prior Authorization (written approval) from TakeCare

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Rehabilitation services</u> <ul style="list-style-type: none"> Physical Therapy 	\$35 copay	30% coinsurance	<p>Referral from your Primary Care Physician is required and Prior Authorization (written approval) from TakeCare</p> <p>Coverage is limited to 20 visits per member per benefit period combined with Speech Therapy and Occupational Therapy.</p>
	<u>Habilitation services</u> <ul style="list-style-type: none"> Speech Therapy Occupational Therapy 	\$35 copay	30% coinsurance	<p>Referral from your Primary Care Physician is required and Prior Authorization (written approval) from TakeCare</p> <p>Coverage is limited to 20 visits per member per benefit period combined with Physical Therapy.</p>
	<u>Durable medical equipment</u> <ul style="list-style-type: none"> Coverage for rental of the following equipment: <ul style="list-style-type: none"> Manual and semi-automatic hospital beds, standard wheelchair, walk aid (canes, crutches and walkers), oxygen concentrators (excluding supplies), CPAP/BIPAP Coverage for the following purchased equipment: <ul style="list-style-type: none"> Walk aid (canes, crutches and walkers), CPAP/BIPAP 	\$35 copay	All Cost	<p>Treatment plan from your Primary Care Physician is required and Prior Authorization (written approval) from TakeCare. Services are subject to TakeCare's benefit coverage guidelines and medical necessity.</p> <p>Length of rental need is dependent upon licensed participating physician's treatment plan.</p> <p>Oxygen coverage excludes supplies and is covered if part of a home health treatment plan.</p>

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)	
				<p>Coverage is limited within the Service Area.</p> <p>CPAP/BIPAP coverage is limited to \$500 per eligible member per benefit period</p>
	Non-Preventive Refraction	\$20 copay	30% coinsurance	Services are subject to TakeCare's benefit coverage guidelines and 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)	
If you need help recovering or have other special health needs	Autism Spectrum Disorder Coverage	\$35 copay	All cost	<p>Referral from your Primary Care Physician is required and Prior Authorization (written approval) from TakeCare.</p> <p>Coverage is limited to \$25,000 per member per benefit year for eligible members aged 16 to 21 years old and up to \$75,000 per member per benefit year for eligible members aged 15 years old and below. Services are subject to TakeCare's benefit coverage guidelines and medical necessity.</p> <p>All eligible claims with diagnoses related to these services are counted towards the benefit limitation, including the Travel Benefit.</p>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Coverage for complications of newborn or infancy care and/or congenital abnormalities, e.g. premature birth.	20% coinsurance	30% coinsurance	<p>Referral from your Primary Care Physician is required and Prior Authorization (written approval) from TakeCare.</p> <p>Coverage for complications of newborn or infancy care and/or congenital abnormalities including all claims related to the diagnosis are subject to a combined \$50,000 in and out-of-network benefit limitation.</p> <p>All eligible claims with diagnoses related to these services are counted towards the benefit limitation, including the Travel Benefit.</p>
	<u>Hospice services</u>	\$20 copay per visit	All Cost	<p>Available through FHP Home Health only.</p> <p>Coverage is limited to the Service Area.</p> <p>This benefit is limited to 180 days per lifetime. Prior Authorization (written approval) required from TakeCare.</p> <p>TakeCare will cover home or facility visits by our FHP Home Health team excluding any facility accommodation and lodging expenses.</p>

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)	
	Out-Patient Executive Check Up	All cost above Php17,905 or \$400	All cost	<p>Services needs to be prior coordinated and scheduled with TakeCare.</p> <p>Services are covered up to the actual cost but not to exceed Php17,905 per member per benefit period at Participating Providers with ECU Package in the Philippines or the actual cost but not to exceed \$400 per member per benefit period within the Service Area or at other Non-Philippine Participating Providers. Benefit is not convertible to cash if unused during a benefit period and cannot be applied towards other services</p> <p>This benefit is not eligible for travel and/or airfare benefit.</p>

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)	
Travel Benefit	Travel Benefit including airfare and lodging	All cost above \$500 per occurrence	All cost	<p>Prior Authorization (written approval) and coordination is required from TakeCare prior to departure from Guam and/or CNMI. Applicable only to approved referrals by TakeCare's Medical Management Department.</p> <p>Airfare and/or lodging expenses coverage for eligible members for any approved specialty care visits, consultations, treatments and hospitalization services to Preferred Philippine providers. Executive check up, preventive services and/or primary care services, and non-compliance to contracted/participating physician determined treatment do not qualify for this benefit.</p> <p>Conditions and limitations apply as specified in the Member Handbook.</p>
If your child needs dental or eye care	Children's eye exam	No copay, co-insurance and/or deductible for covered services	30% coinsurance	Limited to one exam per benefit year
	Children's glasses	All Cost	All Cost	Not covered under this plan
	Children's dental check-up	All Cost	All Cost	Not covered under this plan

Exclusions and Limitations

Services and benefits for care and conditions as described below shall be excluded from coverage under this Plan unless specifically included as a supplemental benefit.

General Exclusions

The following services are not covered by TakeCare:

- A. (1) All services not specifically included in the “Schedule of Benefits” and/or the Member Handbook,
(2) Services rendered without authorization from a member’s Primary Care Physician and TakeCare,
(3) Emergency and/or urgent care services where TakeCare was not informed within the time prescribed by the Policy, and
(4) Services prior to a member’s start date of coverage or after the time coverage ends.
- B. TakeCare is not responsible for the cost of services, which are not medically necessary or not required in accordance with professionally recognized standards of medical practice.

Exclusions applicable to all medical benefits provided under your TakeCare Plan include:

- A member shall only be entitled to benefits for injuries or illnesses which require confinement in a hospital or in a skilled nursing facility during the term of a member’s coverage under the current Policy, but not for benefits prior to the effective date of the Policy or after the termination date of the Policy.
- AICD and/or AICD combination biventricular pacemaker, therapy and any other related devices, supplies, and replacements unless specified as covered in your Schedule of Benefits.
- Acupuncture care and all related services, medication and supplies, unless provided as a supplemental benefit.
- Air ambulance services.
- Any injury sustained or illness precipitated through the member’s commission of any illegal activity, whether or not the member is ever charged or convicted and whether it be a felony or only a petty misdemeanor, or in the member’s commission of a felony.
- Any injury sustained, in whole or in part, directly or indirectly resulting from the member driving under the influence of alcohol, illegal narcotics or a non-prescribed controlled substance.
- Any work related injury or illness subject to disability benefits or compensation pursuant to any Employer’s Liability Law, Workers’ Compensation Law or similar legislation even if the member does not claim the benefits.
- Any injury sustained while taking part in, but not limited to, amateur sports, professional sports, collegiate sports, contact sports, hazardous sports, combat sports, recreational sports or any physical activity, including those injuries while training or preparing for these activities.
- Benefits for an injury or illness when such services would have been rendered without charge except for the fact that the person is a member under the Plan.
- Blood and blood products and derivatives including whole blood, blood components, blood factor replacements, whether synthetic or natural unless specified as covered in your Schedule of Benefits.
- Care for military service connected disabilities to which the member is legally entitled to government benefits and/or care.

- Care provided while you are confined in a hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U.S.C. § 1729 as it relates to non-military services provided at a Veteran's Administration Hospital or facility.
- Care which is provided without charges to you or for which you are not obligated to pay, such as services obtained at a health fair.
- Care which you obtained from the United States Armed Forces or the Veteran's Administration as active duty military or veteran's health benefits will not be covered, unless such exclusion is prohibited by law.
- The cost of care for which another health and accident insurance is responsible because coverage is prorated based on several insurers being liable to pay for the same losses.
- Care that is not clinically appropriate for the treatment of your condition as determined by TakeCare's medical professional staff in coordination with the insured Member's licensed provider pursuant to the nationally recognized clinical criteria used by most health insurance plans in Hawaii and Continental United States.
- Charges in excess of reasonable amounts for services and supplies will not be covered under the Plan.
- Chiropractic care and all related services, medications and supplies such as ancillary services (e.g. X-rays) unless specified as covered in your Schedule of Benefits.
- Cochlear implants and any related services, medication and supplies.
- Complementary and Alternative medicine.
- Comfort Care.
- Contact lenses, examinations for contact lenses, visual perceptual evaluation and visual training; surgical correction of the eye for the purpose of refraction (e.g. Lasik surgery); intraocular lenses unless specified in your Schedule of Benefits; radial keratotomy intraocular lens implants and related procedures, services, supplies and medications.
- Continued services if you do not substantially follow your treatment plan.
- Custodial care, domiciliary care, respite care, residential care and hospice. Custodial or domiciliary care includes that care which consists of training in personal hygiene, routine nursing services and other forms of self-care. Custodial or domiciliary care also includes supervisory services by a physician or nurse for a person who is not under specific medical or surgical treatment to reduce his or her disability and to enable that person to live outside an institution providing such care.
- Dental care unless specified as covered in your Schedule of Benefits.
- Diagnosis and treatment of infertility, reversal of voluntary sterilization and services related to conception by artificial means including in vitro fertilization, embryo transfers and other related services, including medication.
- Drugs prescribed related to a non-covered benefit.
- Durable medical equipment unless covered in your Schedule of Benefits and specified in a treatment plan from a licensed physician contracted with TakeCare.
- Elective or voluntary enhancement procedures, surgeries, services, supplies and medications including, but not limited to, weight loss, hair growth, hair removal, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance. Procedures, services, supplies and medications until they are reviewed for safety efficacy and cost effectiveness and approved by TakeCare.
- End Stage Renal Disease (ESRD) and all related services, medications and supplies unless specified as covered in your Schedule of Benefits.
- Eternal Feeding.
- 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 and approved by TakeCare to be medically necessary and appropriate.
- Experimental medical, surgical and other health care procedures and services related thereto, and procedures and services not covered by Medicare unless specified as covered in your Schedule of Benefits.
- External prosthetic devices, disposable prosthetic and orthotic devices, prosthetic and orthotic devices and supplies available over-the-counter and corrective appliances, except plaster and fiberglass casts and unless specified as covered in your Schedule of Benefits.
- Eyeglasses, optical lenses and frames and any services related to the repair of such items, unless provided as a supplemental benefit.

- Fees for any missed appointments, transfer of records or copies of records.
- Hearing aid, and hearing aid evaluations (audiological examinations), including examinations related to the prescription or fitting of a hearing aid.
- Hospital take-home drugs.
- Hyperbaric Oxygen (HBO) treatment.
- If a benefit is not covered or excluded, all related hospital, surgical, medical treatments, prescription drugs, laboratory services, x-rays, as well as complications related thereto, are also excluded.
- Injuries excluded for treatment under the Plan include, but are not limited to, whether a driver or a passenger of racing, pace making or speed testing of any motor vehicle, off-roading, extreme sports, competitive fighting, sky diving/parachuting (single/tandem), base jumping/bungee cord jumping, whether such activity is formal and organized or informal and spontaneous.
- Inpatient services related to treatment of specific hospital acquired conditions or services needed to correct preventable medical errors or “never events”.
- Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition.
- Internal prosthetic devices except single chamber pacemakers and breast prostheses in accordance with the Women’s Health and Cancer Rights Act of 1998 and unless specified as covered in your Schedule of Benefits.
- Legislatively mandated benefits available through governmental agencies (federal, state, territorial, municipal or other governmental instrumentality or agency) or institutions to the extent that such benefits are available to the member at no cost.
- Medical and hospital care and costs for the infant child of a Member, unless this infant child is otherwise eligible for coverage under the Plan.
- Medicare eligible care and services which are rendered at a facility which is not a Medicare contracted facility, or which is rendered by a physician that is not a Medicare contracted physician.
- Motorized artificial limbs.
- No benefit shall be paid for the care and services of a stillborn fetus.
- No benefit shall be paid for routinely prescribed supplies after surgical services such as but not limited to compression garments stockings.
- No benefit will be paid for charges made by a provider for medical services provided through telephone conferences or interviews during which the member is not seen for treatment unless specified as covered in your Schedule of Benefits.
- No benefit will be paid for medical services furnished by immediate relatives or members of the member’s household unless services rendered by such persons are rendered as employees of a hospital, physician or other provider.
- No benefit will be paid for other non-medical expenses such as taxes, taxis, hotel rooms, etc. In no event will the Plan pay for air ambulance including the transportation of the remains of any deceased person.
- No benefit will be paid for services and supplies associated with growth hormone treatment.
- No benefit will be paid for 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.
- No benefit will be paid for services and supplies provided for penile implants of any type.
- No benefit will be paid for services and supplies provided to a dependent of a non-spouse dependent. Dependents of non-spouse dependents are not eligible for coverage unless such dependent becomes eligible for enrollment.
- No benefit will be paid for: (a) drugs or substances not approved by the Food and Drug Administration (FDA); or (b) drugs or substances not approved by FDA for the specific treatment of illness or injury being treated unless empirical clinical studies have proven the benefits of such drug or substance in treating the illness or injury; or (c) drugs or substances labeled “caution: limited by federal law to investigational use” unless specified as covered in your Schedule of Benefits.
- No benefit will be paid in connection with bariatric surgery, gastric bypass, banding, stapling or reversal.
- No benefit will be paid in connection with dental care or for any treatment to the teeth, jaws and dependent tissues ordinarily performed by a dentist unless specified as covered in your Schedule of Benefits.

- No benefit will be paid in connection with dialysis treatments unless specified as covered in your Schedule of Benefits
- No benefit will be paid for newly approved FDA treatment and/or procedures within one year from the date of FDA approval. Coverage after the one year period is subject to the review, determination and written approval of TakeCare's product committee.
- No benefit will be paid for 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 written approval of TakeCare's pharmacy committee.
- No benefits will be paid for services and supplies provided for cosmetic surgery or treatment, even for physiological reasons, unless the surgery or treatment is required pursuant to the Women's Health and Cancer Rights Act of 1998.
- No benefits will be paid for services and supplies provided for liposuction or any drug, food substitute, or supplement or any other product which is primarily for weight reduction, even if it is prescribed by a physician.
- No benefits will be paid for services and supplies provided in the course of organ donation whether for a member who is donating an organ or for someone who is donating an organ for transplantation into a member unless specified as covered in your Schedule of Benefits.
- No benefits will be paid for: (a) surgical excision or reformation of any sagging skin on any part of the body, including the face, neck, abdomen, arms, legs, or buttocks; (b) any services performed in connection with the enlargement, reduction, implantation or change in appearance in a portion of the body, including the breasts, abdomen, face, lips, jaw, chin, nose, ears or genitals; (c) hair transplantation; (d) face peels or abrasions of the skin; (e) electrolysis depilation; and (f) any other surgical or non-surgical procedures that are for cosmetic purposes, including keloids.
- No benefits will be paid in connection with mouth conditions due to abscess, periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar process, or the gingival tissue.
- Non-emergency ground ambulance services.
- Non-compliance to treatment.
- Occupational, speech, vision and massage therapy services and related medications and supplies, regardless of the conditions for which such services and supplies are provided, unless specified as covered in your Schedule of Benefits.
- Organ or tissue transplants, including, but not limited to, autologous bone marrow transplants and any related hospital, surgical, drug, laboratory, X-ray, or other medical services or supplies related or necessary as part of the transplant, including post transplant follow-up and drug therapy unless specified as covered in your Schedule of Benefits.
- Orthopedic footwear.
- Over-the-counter drugs, drugs for which a prescription from a licensed physician is not required under federal law or drugs for which there is a non-prescription equivalent available.
- Over-the-counter medical supplies including, but not limited to, gauze, bandages and other first aid products.
- Palliative Care.
- Personal convenience items such as, but not limited to, television, telephone and guest trays.
- Physical examinations and immunizations for the sole purpose of employment, insurance, travel, sports and educational requirements.
- Physical therapy and rehabilitation beyond Plan benefits.
- Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms.
- Robotic surgery and robotic suite including but not limited to related hospital charges unless specified as covered in your Schedule of Benefits.
- Specialty second opinion consultation initiated by a Covered Member.
- Services and medications related to the treatment of sexual dysfunction, including erectile dysfunction, impotency and anorgasmia or hyporgasmia.
- Services and supplies paid for directly or indirectly by any local, state, federal government agency or charitable institutions on the effective date of this Policy and/or which may be provided for during the benefit period.
- Services and supplies provided to the member after the member has expired (non-viable services and supplies).
- Services that are mandated to be provided rendered or billed by a school or a member of its staff.

- Sleep studies/polysomnogram unless specified as covered in your Schedule of Benefits.
- Terminated pregnancy (non-medically necessary) unless the health of the mother is at risk or in cases of rape, incest or fetal abnormality.
- To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within our control results in our facilities, personnel, or financial resources being unavailable to provide or arrange for the provisions of a basic or supplemental health service or supplies in accordance with this Plan.
- The Plan is not an insurer against, nor liable for the negligence or other wrongful act or omission of any physician, hospital, hospital employee or other provider, or for any act or omission of any member.
- The Plan will not guarantee the availability of or undertake to provide any services of any third party.
- The Plan will not pay for benefits as a result of TakeCare's rescission of a subscriber or member's coverage back to the initial date of coverage in the event of fraud or intentional misrepresentation of material fact as prohibited by the terms of the Plan or TakeCare's policies.
- Transsexual surgery and related services and medications unless specified as covered in your Schedule of Benefits.
- Treatment of illness or injuries, which are intentionally self-induced or self-inflicted, if not connected to a medical condition, either mental or physical.
- Treatment of temporomandibular joint diseases (TMJ). This includes, but is not limited to: (a) services of a dentist; (b) bite plates; (c) braces to straighten teeth; (d) orthognathic surgery to correct a bite defect; (e) surgical procedures in direct treatment of TMJ, including surgery on the joint itself or on the Hyoid bone; (f) arthrogram or other X-ray to the TMJ, and also including magnetic resonance imaging; or (g) biofeedback of the insertion of TENS units or related devices.
- Weight loss medications and procedures, including anorexients, anti-obesity agents, appetite suppressants or anorexiginic agents.
- Benefits and services not specified as covered.