This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.takecareasia.com or by calling 1-877-484-2411 or (671) 647-3526.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** person **/ $750** family. Does not apply to participating providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$2,000** person **/ $6,000** family separately for Medical and Prescription Drugs. No out-of-pocket limit for non-participating providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, deductible amounts, supplemental benefits and non-participating/out-of-network and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.takecareasia.com or call 1-877-484-2411 or (671)647-3526 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: Call (671) 647-3526 or 1-877-484-2411 or visit us at www.takecareasia.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-EBSA (3272) to request a copy.

Do I 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 the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **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 **allowed amount** for the service. For example, if the plan's **allowed amount** 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 **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- 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	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 co-pay/visit at FHP; 20% co-insurance/ visit outside FHP	30% co-insurance	————————none————————
	Specialist visit	20% co-insurance/ visit	30% co-insurance	Referral from your Primary Care Physician is required and prior authorization and approval from TakeCare.
	Other practitioner office visit	All charges above $25 for Chiropractor	Not covered	Coverage is limited to 10 visits and $25/visit.
	Preventive care/screening/immunization	No charge	30% co-insurance	————————none————————
If you have a test	Diagnostic test (x-ray, blood work)	No charge for blood work and $10 co-pay/visit at FHP; 20% co-insurance/ visit outside FHP for x-ray	30% co-insurance	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	$10 co-pay/visit at FHP; 20% co-insurance/ visit outside FHP	30% co-insurance	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.takecareasia.com	Generic drugs	$5 co-pay/ prescription at FHP 20% co-insurance/ prescription outside FHP (Retail), No charge (Mail Order)	30% co-insurance	Prescription from a licensed Physician is required. Limited to a 30 day supply for retail and 90-day supply for mail order.
	Preferred brand drugs	$15 co-pay/ prescription at FHP 20% co-insurance/ prescription outside FHP (Retail), No charge (Mail Order)	30% co-insurance	Prescription from a licensed Physician is required. Limited to a 30 day supply for retail and 90-day supply for mail order.
	Non-preferred brand drugs	$50 co-pay/ prescription at FHP 50% co-insurance/ prescription outside FHP (Retail), 50% co-insurance/ prescription (Mail Order)	70% co-insurance	Prescription from a licensed Physician is required. Limited to a 30 day supply for retail and 90-day supply for mail order. Requires prior authorization and approval from TakeCare.
	Specialty drugs	$500 co-pay/ prescription at FHP $1,000 co-pay/ prescription outside FHP (Retail),	70% co-insurance	Prescription from a licensed Physician is required. Limited to 30-day supply for retail, 90-day supply for mail order is not available. Requires prior authorization and approval from TakeCare.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	30% co-insurance	Prior authorization and approval is required from TakeCare.
	Physician/surgeon fees	20% co-insurance	30% co-insurance	Prior authorization and approval is required from TakeCare.
If you need immediate medical attention	Emergency room services	20% co-insurance	20% co-insurance	Co-payment/Co-insurance are waived if admitted. Hospitalization co-payment/ co-insurance apply in such case.
	Emergency medical transportation	20% co-insurance	20% co-insurance	Ground transportation only.
	Urgent care	$10 co-pay/ visit M-F within business hours $25 co-pay/ visit M-F after business hours, Sat & Sun, and Holidays within the service area, 20% co-insurance outside the service area	Not covered within the service area; 20% co-insurance outside the service area	Available at FHP Health Center only
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	30% co-insurance	Prior authorization and approval is required from TakeCare.
	Physician/surgeon fee	20% co-insurance	30% co-insurance	Prior authorization and approval is required from TakeCare
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 co-pay/visit	30% co-insurance	Referral from Primary Care Physician.
	Mental/Behavioral health inpatient services	20% co-insurance	30% co-insurance	Prior authorization and approval is required from TakeCare.
	Substance use disorder outpatient services	$10 co-pay/visit	30% co-insurance	Referral from Primary Care Physician
	Substance use disorder inpatient services	20% co-insurance	30% co-insurance	Prior authorization and approval is required from TakeCare.
If you are pregnant	Prenatal and postnatal care	No charge at FHP; 20% co-insurance/ visit outside FHP	30% co-insurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Delivery and all inpatient services	20% co-insurance	30% co-insurance	Does not cover Stillborn Fetus Treatments.
If you need help recovering or have other special health needs	Home health care	$10 co-pay	Not covered	Available through FHP Home Health only.
	Rehabilitation services	20% co-insurance	30% co-insurance	Limited to 30 days per member per benefit year. Prior authorization and approval is required from TakeCare.
	Habilitation services	20% co-insurance	30% co-insurance	Limited to 20 days per member per benefit year. Prior authorization and approval is required from TakeCare.
	Skilled nursing care	20% co-insurance	30% co-insurance	Limited to 30 days per member per benefit year. Prior authorization and approval is required from TakeCare.
	Durable medical equipment	20% co-insurance	Not covered	Prior authorization and approval is required from TakeCare. Treatment plan from a licensed Physician is required.
	Hospice service	$10 co-pay	Not covered	Available through FHP Home Health only. This benefit is limited to 180 days per lifetime. Prior authorization and approval required from TakeCare.
If your child needs dental or eye care	Eye exam	No charge	30% co-insurance	Limited to one exam per benefit year.
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic Care
- Routine Eye Care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-484-2411 or (671) 647-3526. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: TakeCare Customer Service at (671) 647- 3526 or 1-877-484-2411, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or http://www.dol.gov/ebsa/healthreform, or the Guam Department of Insurance at (671) 635-1843 through 1846 or https://www.guamtax.com/.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,580
- **Patient pays** $960

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$50
Coinsurance	$900
Limits or exclusions	$10
Total	**$960**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,870
- **Patient pays** $530

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$470
Coinsurance	$60
Limits or exclusions	$0
Total	**$530**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.