TakeCare

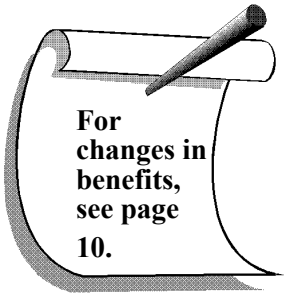
http://www.takecareasia.com

2012

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

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

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 8 for requirements.



Enrollment codes for this Plan:

- **JK1 High Option - Self Only**
- **JK2 High Option - Self and Family**
- **JK4 Standard Option - Self Only**
- **JK5 Standard Option - Self and Family**
- **KX1 High Deductible Health Plan (HDHP) - Self Only**
- **KX2 High Deductible Health Plan (HDHP) - Self and Family**

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-776

Important Notice from TakeCare About
Our Prescription Drug Coverage and Medicare

OPM has determined that the TakeCare prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

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

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

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

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048).

Table of Contents

Cover Page 1
Important Notice 1
Table of Contents 1
Introduction 3
Plain Language 3
Stop Health Care Fraud! 3
Preventing Medical Mistakes 4
Section 1. Facts about our Plans 7
- How we pay providers 7
- General features of our High and Standard Option 7
- General features of our High Deductible Health Plan (HDHP) 7
- Your rights 8
- Service Area 9

Section 2. How we change for 2012 10
- Changes to this Plan 10

Section 3. How you get care 11
- Identification cards 11
- Where you get covered care 11
  - Plan providers 11
  - Plan facilities 11
- Non-network providers and facilities 11
- What you must do to get covered care 12
  - Primary care 12
  - Specialty care 12
  - Transitional care 13
  - Hospital care 13
  - If you are hospitalized when your enrollment begins 13
- You need prior Plan approval for certain services 13
  - Inpatient hospital admission 13
  - Other Services 13
- How to request precertification for an admission or get prior authorization for Other services 14
- What happens when you do not follow the precertification rules when using non-network facilities 15
- If you disagree with our pre-service claim decision 15
  - To reconsider a non-urgent care claim 15
  - To reconsider an urgent care claim 16
  - To file an appeal with OPM 16

Section 4. Your costs for covered services 17
- Copayments 17
- Cost-sharing 17
- Deductible 17
- Coinsurance 17
- Your catastrophic protection out-of-pocket maximum 17
- Carryover 18
- When Government facilities bill us 18

Section 5. High and Standard Option Benefits Overview 21
- Benefit Description 21

High Deductible Health Plan Benefits 59
Section 5. High Deductible Health Plan Benefits Overview 61
Non-FEHB benefits available to Plan members 101
Covered Services....101
Section 6. General exclusions – things we don't cover 102
Section 7. Filing a claim for covered services 103
Section 8. The disputed claims process....106
Section 9. Coordinating benefits with other coverage 109
When you have other health coverage 109
What is Medicare? 109
• Should I enroll in Medicare? 110
• The Original Medicare Plan (Part A or Part B)....110
• Tell us about your Medical coverage 110
• Medicare Advantage (Part C)....111
• Medicare prescription drug coverage (Part D)....111
Clinical Trials 111
TRICARE and CHAMPVA 113
Workers' Compensation 113
Medicaid....113
When other Government agencies are responsible for your care 113
When others are responsible for injuries....113
When you have Federal Employees Dental and Vision Plan (FEDVIP)coverage 113
Section 10. Definitions of terms we use in this brochure....114
Section 11. FEHB Facts 117
Coverage Information 117
• No pre-existing condition limitation....117
• Where you can get information about enrolling in the FEHB Program 117
• Types of coverage available for you and your family....117
• Children's Equity Act 118
• When benefits and premiums start....119
• When you retire 119
When you lose benefits 119
• When FEHB coverage ends....119
• Upon divorce 120
• Temporary Continuation of Coverage (TCC)....120
• Converting to individual coverage 120
• Getting a Certificate of Group Health Plan Coverage 120
Section 12. Other Federal Programs 122
The Federal Flexible Spending Account Program - FSAFEDS....122
The Federal Employees Dental and Vision Insurance Program – FEDVIP....122
The Federal Long Term Care Insurance Program – FLTCIP....123
Pre-existing Condition Insurance Program (PCIP)....123
Index....125
Summary of benefits for the High and Standard Option of TakeCare Health Plan - 2012....126
Summary of benefits for the High Deductible Health Plan Option of TakeCare Health Plan - 2012....128
2012 Rate Information for - TakeCare Health Plans....130

Introduction

This brochure describes the benefits of TakeCare Health Plans under our contract (CS 2825) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. The address for the TakeCare administrative offices is:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2012, and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means TakeCare.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.

- Please review your claims history periodically for accuracy to ensure services that were never rendered are not being billed to your account.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.

- If the provider does not resolve the matter, call us at 1/671-647-3526 and explain the situation.

- If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:

- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)

- Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)

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

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking to.

- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

"Exactly what will you be doing? "
"About how long will it take?"
"What will happen after surgery?"
"How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

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

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illness that could have been prevented if the hospital had taken proper precautions.

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

Section 1. Facts about our Plans

For the health maintenance organization (HMO), we require you to see specific physicians, hospitals, and other providers that are contracted with us. For the High Deductible Health Plan (HDHP), we do not require you to see a specific physician, hospital or other providers that contract with us. However, in order to get the most coverage, we recommend you utilize in-network providers. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory. We give you a choice of enrollment in a High Option, a Standard Option, or a High Deductible Health Plan (HDHP).

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

For the HMO plan, when you receive services from in-network Plan providers you will not have to submit claim forms or pay bills. You pay only the copayment and coinsurance. HDHP plan members pay the coinsurance and deductibles as described in this brochure. Once you've accumulated the total deductible you will have to submit the deductible claim form together with all the required documents. When you receive emergency care from non-Plan providers, you may have to pay 100% of the claim and seek reimbursement from the plan.

You should join an HMO plan or HDHP because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

This plan is a "grandfathered health plan" under the Affordable Care Act. A grandfathered plan must preserve basic health coverage that was already in effect when the law passed. Specifically, this plan cannot eliminate all or substantially all benefits to diagnose or treat a particular condition; it cannot increase your coinsurance (the percentage of a bill you pay); and any increases in deductibles, out-of-pocket limits, and other copayments (the fixed-dollar amount you pay) must be minimal.

As a grandfathered health plan (or option), this plan (or option) has also decided to follow immediate reforms that apply to non-grandfathered plans.

Questions regarding what protections apply may be directed to us at 1-671-647-3526. You can also read additional information from the U.S Department of Health and Human Services at www.healthcare.gov.

How we pay providers

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

General features of our High and Standard Options

Our HMO plan offers both High and Standard Option and there are no deductibles to meet.

General features of our High Deductible Health Plan (HDHP)

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

Preventive care services

Preventive care services are generally paid as first dollar coverage. Preventive benefits, as determined by US Preventive Services Task Force Guidelines (USPSTF) are covered at 100% for in network services. The USPSTF guidelines can be located at http://www.ahrq.gov/clinic/uspstfix.htm.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services. The annual deductible is $3,000 for Self only or $6,000 for Self and Family enrollment.

In-network and out-of network benefits have separate deductibles.

Health Savings Account (HSA)

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

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

Health Reimbursement Arrangement (HRA)

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

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

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. **HDHP Option:** Your annual out-of-pocket expenses for covered services, including deductibles and coinsurance, cannot exceed $5,000 for Self Only enrollment, or $10,000 for Self and Family enrollment for in-network and $10,000 for Self Only, or $20,000 for Self and Family enrollment for out-of-network. **High Option:** Your annual out-of-pocket expenses for covered services, including copayments and coinsurance, cannot exceed $2,000 for Self Only, or $6,000 for Self and Family enrollment. **Standard Option:** Your annual out-of-pocket expenses for covered services, including copayments and coinsurance, cannot exceed $3,000 for Self Only, or $9,000 for Self and Family enrollment. However, some expenses do not count toward the out-of-pocket maximum. See page 17-18 for details.

Health education resources and accounts management tools

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

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- **TakeCare has met all the licensing requirements needed on Guam, in the Commonwealth of the Northern Mariana Islands and the Republic of Belau (Palau) to conduct business as an insurance company.**
- **TakeCare has been operating on Guam for over 35 years.**
- **We are a for-profit organization.**

If you want more information about us, call 1-671-647-3526, or write to TakeCare at P.O. Box 6578, Tamuning, Guam 96931. You may also contact us by fax at 1-671-647-3542 or visit our web site at www.takecareasia.com

Your medical and claims records are confidential

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

Service Area

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

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

Ordinarily, you must get your care from providers who contracts with us. Whenever you require services from a specialist, you must first seek prior authorization and approval from TakeCare Medical Management Department so that we coordinate your specialty care services. Emergency care services do not require prior approval. We will not pay for any specialty care services out of our service area unless the services have prior approval.

Ordinarily, you must get your care from providers who contracts with us. *Whenever you require services from a*specialist, you must first seek prior authorization and approval from TakeCare Medical Management Department so that we coordinate your specialty care services. Emergency care services do not require prior approval. We will not pay for any specialty care services out of our service area unless the services have prior approval. If you or a covered family member moves outside of our service area, you can enroll in another plan. If your dependent lives out of the service area (for example, if your child goes to college in another state), he/she must still receive prior approval before being treated by a specialist.

Participating Providers / Contracted Network

We encourage you to access your benefits through our Participating Providers/Contracted Network to minimize higher out of pocket expenses for you and your dependents. Participating Providers 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 our members. Please view or download the most current TakeCare Provider Directory at www.takecareasia.com for the most updated list of Participating Providers.

Specialty* services outside our service area must be prior authorized and approved even if your Plan option has an out of network benefit.** This is to ensure that these services are covered under your Plan, help you coordinate your care and minimize your out of pocket expenses. (see page 13- You need prior Plan approval for certain services). Members may coordinate services for their approved referrals with Non-Participating/Out-of-Network Providers of their choice through their out-of network benefit. However, because we do not have contracts with non-network providers, some ***may require payment from ***you*** at the time of service. If this occurs, you will need to seek reimbursement from TakeCare for the eligible charges. (see page 104 - Filing a claim for covered services.)

For out-of-network care, members will pay 30% of the usual, customary and reasonable charges based on our Participating Provider contracts and any difference between the actual billed charges and our eligible services. Some services may not be covered under your Plan.

Medicare beneficiaries may only receive services at a Plan participating Medicare contracted facility. (see page 11 - *Where you get covered care*).

Section 2. How we change for 2012

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program wide Change

- Sections 3, 7, and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148.

Plan now covers the following for High, Standard and HDHP option:

- Organ/Tissue transplants for:
  - Epithelial ovarian cancer
  - Childhood rhabdomyosarcoma
  - Advanced Childhood Kidney cancers
  - Advanced Ewing Sarcoma
  - Mantle Cell (Non Hodgkin's lymphoma) Preventive

Changes to High Option:

- Your share of the non-postal premium will stay the same for Self Only and decrease for Self and Family. See page 130.
- Preventive Services (based on US Preventive Services Task Force Guidelines) - 100% coverage with no maximum limits for in-network services. See pages 24, 55 and 70.
- Emergency Care Services - No maximum limit per occurrence. See page 21.
- Out-of-Network Benefit - Member will be responsible for 30% of Plan eligible charges and any difference between Plan eligible charges and billed charges. See pages 9, 21, 23.
- Prescription Drug - Member copayment will increase for allergy serums and contraceptive injectables. See page 27.

Changes to Standard Option:

- Your share of the non-postal premium will stay the same for Self Only or Self and Family. See page 130.
- Preventive Services (based on US Preventive Services Task Force Guidelines) - 100% coverage with no maximum limits for in-network services. See pages 24-25.
- Emergency Care Services - No maximum limit per occurrence. See page 21.
- Out-of-Network Benefit - Member will be responsible for 30% of Plan eligible charges and any difference between Plan eligible charges and billed charges. See pages 9, 21, 23.
- Prescription Drug - Member copayment will increase for allergy serums and contraceptive injectables. See page 27.

Changes to HDHP Option:

- Your share of the non-postal premium will stay the same for Self Only and increase for Self and Family. See page 130.
- Emergency Care Services - No maximum limit per occurrence for out-of-network services. See page 90.
- Preventive Services (based on US Preventive Services Task Force Guidelines) - 100% coverage with no maximum limits for in-network services. See page 70.
- Emergency Care Services - No maximum limit per occurrence. See page 90.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-671-647-3526 or write to us at TakeCare Insurance Company, Inc., P.O. Box 6578 Tamuning, Guam 96931.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance, and you will not have to file claims. (HDHP Plan) You get care from any licensed provider or licensed facility. How much you pay depends on whether you use a Plan provider and facility or non-network provider or facility. If you use your out-of-network program, you can get care from non-Plan providers but it will cost you more.

Medicare beneficiaries may only receive services at a Plan participating Medicare contracted facility in Guam, Saipan, Hawaii, and the Continental United States. 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 will not be covered.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our web site: www.takecareasia.com

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our web site www.takecareasia.com.

- **Non-network providers and facilities**

Providers and facilities not in the Plan's network are considered non-network providers and facilities. You can get care from non-network providers, but it will likely cost you more.

HDHP Plan members can access care from any licensed provider or facility.

High and Standard Option members may access non-network providers, but will incur member coinsurance of 30% of Plan eligible chargers and also be responsible for any difference between Plan eligible charges and the billed amount. **Because we do not have agreements or contracts with out-of-network providers, they may require full payment during the time of service**. If this occurs, TakeCare will reimburse you for the eligible charges. (see page 104 - *Filing a claim for covered services.*)

Note: Certain services **always require *prior approval,*** regardless of whether they are rendered in-network or out-of network, (see page 13 - *You need prior Plan approval for certain services*). If you self refer to a provider and or facility for services which require prior authorization, those services will not be covered.

Members may coordinate services for their approved referrals with out-of network (non-participating) providers of their choice through their out-of network benefit.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. In selecting a primary care physician, call the TakeCare Customer Service Department at 1-671-647-3526. You may have a different primary care physician for each family member. **(HDHP Plan)** You do not need to select a primary care physician and you do not need written referrals to see a specialist for medical services. The provider must be participating for services to be covered in-network. See pages 13 for services requiring prior approval from TakeCare Medical Management.

- **Primary care**

Your primary care physician can be a family practitioner, internist, Obstetrician gynecologist, or pediatrician for children under 18 years of age. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us at 1-671-647-3526. We will help you select a new one. You may change your primary care physician anytime. Your change to the new primary care physician will be effective immediately.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. You may see an OB/GYN within your provider group without a referral.

You may access mental health care and behavioral health care through your primary care physician for an initial consultation. You must return to your primary care physician after your consultation with the specialist. If your specialist recommends additional visits or services, your primary care physician will review the recommendation and authorize the visits or services as appropriate. You should not continue seeing the specialist after the initial consultation unless your primary care physician and the Plan's Medical Management Department has authorized the referral.

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

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

- **Transitional care**

  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
  - reduce our service area and you enroll in another FEHB Plan;

  You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us at 1-671-647-3526, or if we drop out of the Program, contact your new plan.

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

- **Hospital care**

  Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility. (HDHP Plan) In most cases, your Network physician will make necessary hospital arrangement and supervise your care. This includes admission to a skilled nursing or other type of facility. Because you are still responsible for ensuring that we are asked to precertify your care, you should always ask your physician or hospital whether they have contacted TakeCare. If you are using a non-network provider or facility, you are responsible for contacting TakeCare at 1-671-647-3526.

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

  We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-671-647-3526. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services.*

- **Inpatient hospital admission**

  Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other Services**

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

  - All surgical procedures
  - Audiological exams
  - Bariatic surgery

- Bone density studies
- CT scans
- Growth Hormone Therapy (GHT)
- Hospitalization
- MRIs
- Oncology consultations
- Out-of-area hospitalization
- Plastic/reconstructive consultation and procedures
- Podiatry consultations and procedures
- Sleep studies
- Specilaty care referrals, consultations and procedures
- Specialty care follow up (testing and procedures)
- Transplants
- Other procedures including colonoscopy and endoscopy

Emergency services do not require pre-authorization. However, you or your family member must notify the Plan within 48 hours, or as soon as is reasonably possible, in order for the services to be covered.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 1-671-647-3526 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of planned days of confinement.

- **Non-urgent care claims**

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

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

- **Urgent care claims**

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

- **Emergency inpatient admission**

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

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

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

What happens when you do not follow the precertification rules when using non-network facilities

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

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

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

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

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

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

2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your costs for covered services

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

Copayments

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

Example: When you see your primary care physician you pay a copayment of $20 per office visit for High Option or $25 per office visit for Standard Option and when you go in the hospital, you pay $100 copayment per day up to $500 maximum per inpatient admission for High Option or $150 copayment per day up to $750 maximum per inpatient admission for Standard Option.

Cost-sharing

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible for High Deductible Health Plan (HDHP).

Example: For the HDHP Plan option, you pay 20% co-insurance for your in-network services and 30% of our allowance for your out-of- network services.

Deductible

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

High and Standard Option, there is **no calendar year deductible.**

High Deductible Health Plan (HDHP)

You must satisfy your annual deductible before your medical coverage begins. The calendar year deductible for:

In-Network - $3,000 for Self Only enrollment or $6,000 for Self and Family enrollment each calendar year. The family deductible can be satisfied when at least two (2) covered family members have met their individual deductible then benefits are payable for all family members.

Out-of-network - $3,000 for Self Only enrollment or $6,000 for Self and Family enrollment each calendar year. The family deductible can be satisfied when at least two (2) covered family members have met their individual deductible then benefits are payable for all family members.

A TakeCare deductible claim form should be filled out immediately and kept safe to ensure accurate and complete information on all doctors, lab or pharmacy visits. It is your responsibility to track and submit deductible expenses (e.g. encounter tickets, invoices, receipts) and the required documentation. All claim forms should be submitted to the TakeCare Customer Service Department.

Your catastrophic protection out-of-pocket maximum

After your (copayments and coinsurance) total $2,000 per person or $6,000 per self and family enrollment (**High Option**) and $3,000 per person or $9,000 per self and family enrollment (**Standard Option**), in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments or coinsurance for these services: (applies to High, Standard and HDHP option)

- *Prescription Drugs*
- *Contraceptive Devices*

- *Dental Services*
- *Vision Hardware*
- *Chiropractic Services*
- *Other supplemental benefits*
- *Payments made in excess of eligible charges*
- *Services not covered*

HDHP

Expenses applicable to out-of-pocket maximums – Only the deductible and those out-of-pocket expenses resulting from the application of coinsurance percentage (except any penalty amounts) may be used to satisfy the out-of-pocket maximums.

Note: For the HDHP, once you have met your deductible and satisfied your out-of-pocket maximums, eligible medical expenses will be covered at 100%.

If you have met your deductible, the following Out-of-pocket maximum would apply:

Self Only:	**Self and Family:**
In-network: $5,000	In-network: $10,000
Out-of-network: $10,000	Out-of-network: $20,000

The following cannot be included in the accumulation of out-of-pocket expenses:

- Expenses in excess of our eligible charge or maximum benefit limitations or expenses not covered under the plan.
- Expenses for the services listed above.

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

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

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

When Government facilities bill us

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

Section 5. High and Standard Option Benefits

See page 10 for how our benefits changed this year. Page 126 are benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High and Standard Option Benefits Overview 21
Section 5(a). Medical services and supplies provided by physicians and other health care professionals 23
- Diagnostic and treatment services 23
- Lab, X-ray and other diagnostic tests 24
- Preventive care, adult 24
- Preventive care, children 25
- Maternity care 26
- Family planning 26
- Infertility services 27
- Allergy care 27
- Treatment therapies 28
- Physical and occupational therapies 28
- Cardiac Rehabilitation 29
- Speech therapy 29
- Hearing services (testing, treatment, and supplies) 29
- Vision services (testing, treatment, and supplies) 30
- Foot care 31
- Orthopedic and prosthetic devices 31
- Durable medical equipment (DME) 32
- Home health services 33
- Chiropractic 33
- Alternative treatments 34
- Educational classes and programs 34

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals 35
- Surgical procedures 35
- Reconstructive surgery 36
- Oral and maxillofacial surgery 37
- Organ/tissue transplants 38
- Anesthesia 43

Section 5(c). Services provided by a hospital or other facility, and ambulance services 44
- Inpatient hospital 44
- Outpatient hospital or ambulatory surgical center 45
- Skilled nursing care facility benefits 46
- Hospice care 47
- Ambulance 47

Section 5(d). Emergency services/accidents 48
- Emergency within our service area 49
- Emergency outside our service area 49
- Ambulance 49

Section 5(e). Mental health and substance abuse benefits 50
- Professional Services 50
- Diagnostics 51
- Inpatient hospital or other covered facility 51

Outpatient hospital or other covered facility....51
Section 5(f). Prescription drug benefits....53
Covered medications and supplies....54
Section 5(g). Dental benefits....55
Accidental injury benefit....55
Service....55
Section 5(h). Special features....57
FHP Health Center – Urgent Care Center....57
Health Improvement Programs....58
Summary of benefits for the High and Standard Option of TakeCare Health Plan - 2012....126
Medical services provided by physicians:....126
Diagnostic and treatment services provided in the office....126
Services provided by a hospital:....126
Inpatient....126
Outpatient....126
Emergency benefits:....126
In-area....126
Out-of-area....126
Mental health and substance abuse treatment:....126
Prescription drugs:....127
Retail pharmacy - 30 day supply....127
Mail order - 90 day supply....127
Dental care:....127
Vision care:....127
Special features:....127
Protection against catastrophic costs (out-of-pocket maximum):....127
2012 Rate Information for - TakeCare Health Plans....130

Section 5. High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at 1-671-647-3526 or at our Website at www.takecareasia.com.

Each option offers unique features.

	You Pay	
Benefit Description	**High Option**	**Standard Option**
Office visit copay	***In-network:*** $20 ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Emergency Benefits In area		
• At a doctor's office	$20 per PCP office visit; $40 per specialist visit	$25 per PCP office visit; $40 per specialist visit
• Urgent care	$20 per office visit during office hour; $40 per visit after office hour	$25 per office visit during office hour; $40 per visit after office hour
• Hospital Emergency room	$50 per emergency room visit	$75 per emergency room visit
Emergency Benefits Out of area		
• At doctor's office, Urgent care or Hospital ER	$50 per emergency room vist	20% of the charges
Specialist visit copay	***In-network:*** $40 per visit	***In-network:*** $40 per visit
Out-of-Network Benefit	30% of Plan eligible charges and any difference between eligible charges and billed amount	30% of Plan eligible charges and any difference between eligible charges and billed amount
Prescription drugs	$10 for generic formulary drugs $15 for brand maintenance drugs $25 for brand formulary drugs $50 for non-formulary drugs $100 for specialty drugs	$15 for generic formulary drugs $20 for brand maintenance drugs $40 for brand formulary drugs $80 for non-formulary drugs $100 for specialty drugs
Outpatient services (including surgery)	***In-network:*** $100 copayment for outpatient facility per visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $150 copayment for outpatient facility per visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Inpatient hospital copay	***In-network:*** $100 copayment per day up to $500 maximum per inpatient admission	***In-network:*** $150 copayment per day up to $750 maximum per inpatient admission

Benefit Description - continued on next page

	You Pay	
Benefit Description (cont.)	**High Option**	**Standard Option**
	Out-of-network: 30% copay of eligible charges and any difference between eligible charges and billed charges	***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Chiropractic services	***In-network:*** All charges above $25 per visit 10 visits per calendar year ***No out-of-network benefit***	***In-network:*** All charges above $25 per visit 10 visits per calendar year **No *out-of-network* benefit**
Prescription eyeglasses or contact lenses benefit available at FHP Vision Center only	***In-network:*** Member pays all charges above $100 ***No out-of-network benefit***	***In-network:*** Member pays all charges above $100 ***No out-of-network benefit***
Adult hearing aid benefit	***In-network:*** $300 per ear every two years ***No out-of-network benefit***	***In-network:*** $300 per ear every two years ***No out-of-network benefit***
Dental services	***In-network:*** Nothing for preventive services and scheduled allowance for other services.	***In-network:*** Nothing for preventive services. **All other dental services are *not covered.***

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- For out-of-network services, the member will be responsible for 30% of Plan eligible chargers and any difference between Plan eligible charges and the billed amount.
- A written referral for ***specialty care*** must be approved by TakeCare's Medical Management Department. ***Primary care*** services do not require prior approval. However, if you would like assistance with the coordination of any out-of-network primary care services please contact TakeCare's Medical Management Department at 1-671-647-3526.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including Medicare.

Benefit Description	You Pay	
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinion	***In-network:*** $20 per PCP office visit; $40 per specialist visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network***: $25 per PCP office visit ; $40 per specialist visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Professional services of physicians • During a hospital stay • In a skilled nursing facility	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
At home	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Off-island care for services* requiring prior authorization*, without prior authorization, except in the case of emergency*	*All charges*	*All charges*

Benefit Description	You Pay	
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • Electrocardiogram and EEG	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
• X-rays • Non-routine mammograms • Ultrasound	***In-network:*** $20 copayment in addtion to regular office visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 copayment in addtion to regular office visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Prior authorization required for the following services: • CT Scan • Echocardiogram • MRI	***In-network:*** $40 copayment in addtion to regular office visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $40 copayment in addtion to regular office visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Preventive care, adult	**High Option**	**Standard Option**
• Routine physical once a year • Well Woman Care (based on US Preventive Task Force Guidelines) Routine screenings (based on to US Preventive Task Force Guidelines) such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy, screening - every five years starting at age 50 - Double contrast barium enema - every five years starting at age 50	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges ***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges ***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
- Colonoscopy screening- based on US Preventive Services Task Force Guidelines (prior authorization required)	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network***: Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
Routine Pap test	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Routine mammogram — covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel*	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• Childhood immunizations recommended by the American Academy of Pediatrics • Well-child care immunizations	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network***: Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
• Well-child care charges for routine examinations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22)	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel*	*All charges*	*All charges*

Benefit Description	You Pay	
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care **Note**: Here are some things to keep in mind: • You do not need to pre-authorize your normal delivery. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. The newborn must be enrolled within 60 days of birth. • Surgical benefits, not maternity benefits, apply to circumcision. See section 5(b) • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	***In-network:*** $20 per PCP office visit ; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit $150 copayment for outpatient facility; $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Routine sonograms to determine fetal age, size or sex*	*All charges*	*All charges*
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) **Note:** We cover oral contraceptives, contraceptive patches and rings, contraceptive diaphragms and cervical caps under the prescription drug benefit.	***In-network:*** $20 per PCP office visit; $40 per specialist visit **Note**: Injectable contraceptive drugs require an additional copay of $75 ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit **Note:** Injectable contraceptive drugs require an additional copay of $75 ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*	*All charges*

Family planning - continued on next page

Benefit Description	You Pay	
Family planning (cont.)	**High Option**	**Standard Option**
• *Genetic counseling* • *Intra-uterine hormone releasing IUD*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: (Up to three cycles per pregnancy attempt) - intravaginal insemination (IVI) - intracervical insemination (ICI) • Injectable fertility drugs **Note**: We cover oral fertility drugs under the prescription drug benefit.	***In-network***: $20 per PCP office visit; $40 per specialist visit **Note**: Injectable fertility drugs require an additional copay of $15 ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In*-network:** 50% of charges ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *zygote transfer* • *Intrauterine insemination (IUI)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment • Allergy injections	***In-network:*** $20 per PCP office visit; $40 per specialist visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
• Allergy serum	***In-network:*** Injectable allergy serums require an additional copay of $75 ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges.	***In-network:*** Injectable allergy serums require an additional copay of $75 ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges.
Not covered: • *Provocative food testing and sublingual allergy desensitization*	*All charges*	*All charges*

Benefit Description	You Pay	
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and Radiation therapy **Note:** High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 38. • Respiratory and inhalation therapy • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) **Note:** Growth hormone is covered under the prescription drug benefit. **Note:** – We only cover GHT when we pre-authorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need to prior Plan approval for certain services* on page 13.	***In-network:*** $20 per PCP office visit: $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges.	***In-network:*** $25 per PCP office visit; $40 per specialist visit $150 copayment for outpatient facility; $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges.
• Dialysis - hemodialysis and peritoneal dialysis	***In-network:*** $20 per PCP office visit; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Physical and occupational therapies	**High Option**	**Standard Option**
Unlimited outpatient services and up to two (2) consecutive months per condition for the services of each of the following: • qualified physical therapists • occupational therapists **Note:** We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.	***In-network:*** $40 per specialist visit; nothing for home visits; nothing during covered inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $40 per specialist visit; nothing for home visits; nothing during covered inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs, lifestyle modification programs*	*All charges*	*All charges*

Physical and occupational therapies - continued on next page

Benefit Description	You Pay	
Physical and occupational therapies (cont.)	**High Option**	**Standard Option**
• *Equipment, supplies or customized devices related to rehabilitative therapies, except those provided under Section 5(a) Durable Medical Equipment.* • *Services provided by schools or government programs* • *Developmental and Neuroeducational testing and treatment beyond initial diagnosis* • *Hypnotherapy* • *Psychological testing* • *Vocational rehabilitation*	*All charges*	*All charges*
Cardiac Rehabilitation	**High Option**	**Standard Option**
Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 90 days for inpatient rehabilitation	***In-network:*** $40 per specialist visit; nothing for home visits; nothing during covered inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $40 per specialist visit; nothing for home visits; nothing during covered inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Speech therapy	**High Option**	**Standard Option**
Unlimited visits for the services of: • Qualified Speech Therapist **Note**: All therapies are subject to medical necessity	***In-network:*** $40 per specialist visit; nothing for home visits; nothing during covered inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $40 per specialist visit; nothing for home visits; nothing during covered inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children* • External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants		

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

Benefit Description	You Pay	
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*		
• Hearing testing and treatment for adults when medically necessary • Hearing testing for children through age 17 (see *Preventive care, children*) • Hearing aid testing and evaluation for adults • Hearing aid benefits and limits: (see *Orthopedic and prosthetic devices*)	***In-network:*** $20 per PCP office visit; $40 per specialist visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Hearing services that are not shown as covered* • *Hearing aids, testing and examinations for children*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
Medical and surgical benefits for the diagnosis and treatment of diseases of the eye	***In-network:*** $20 per PCP office visit; $40 per specialist visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
• Prescription eyeglasses or contact lenses (benefit is available at FHP Vision Center only)	***In-network:*** All charges above $100 ***No out-of-network benefit***	***In-network:*** All charges above $100 ***No out-of-network benefit***
Annual Eye Examinations • Plan Pays $30 maximum allowance towards basic vision exams • Plan Pays $50 maximum allowance towards comprehensive exam Note: See *Preventive care, children* for eye exams for children	***In-network***: $20 per PCP office visit; $40 per specialist visit and all charges over the plans maximum allowance for a basic or comprehensive exam ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network***: $25 per PCP office visit; $40 per specialist visit and all charges over the plans maximum allowance for a basic or comprehensive exam ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Refractions	***In-network:*** $20 per visit at FHP Vision Center; $40 per visit outside FHP Vision Center ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per visit at FHP Vision Center; $40 per visit outside FHP Vision Center ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Eye exercises and orthoptics (vision therapy)*	*All charges*	*All charges*

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

Benefit Description	You Pay	
Vision services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
• *Radial keratotomy and other refractive surgery such as LASIK surgery*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
Foot care and Podiatry services **Note:** When you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes, routine foot care may be covered.	***In-network:*** $20 per PCP visit; $40 per specialist visit ***Out-of-network***: 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network***: $25 per PCP visit; $40 per specialist visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Routine footcare including: cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above.* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery).*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy (up to two (2) surgical bras per benefit year) • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants **Note:** For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical and anesthesia services.* For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) *Services provided by a hospital or other facility, and ambulance services.*	***In-network:*** $20 per PCP visit; $40 per specialist visit -plus an additional 10% of the cost ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP visit; $40 per specialist visit -plus an additional 10% of the cost ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
• Orthopedic devices, such as braces	***In-network:*** $20 per PCP visit; $40 per specialist visit -plus an additional 10% of the cost	All charges - **Benefits are not available under Standard Option**

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
	Out-of-network: 30% copay of eligible charges and any difference between eligible charges and billed charges	
• External hearing aid for adults (limited to $300 per ear every two (2) years)	***In-Network:*** All charges above $300 per ear every two years ***No out-of-network benefit***	All charges above $300 per ear every two years ***No-out-of-network benefit***
Not covered: • *Orthopedic and corrective shoes* • *Arch supports, foot orthotics, heel pads and heel cups* • *Artificial joints and limbs* • *Corsets, trusses, elastic stockings, support hose, stump hose and other supportive devices* • *Lumbosacral supports* • *Splints* • *Over-the-counter (OTC) items* • *Dual chamber pacemaker* • *Other internal prosthetics such as heart valves, automatic implantable cardioverter defibrillator (AICD) and other implantable devices not specified above.* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Manual hospital beds • Standard manual wheelchairs • Crutches/walk aids • CPAP (Continuous Positive Airway Pressure) • BPAP (Bi-Level Positive Airways Pressure) • Blood Glucose Monitors (provided by FHP Pharmacy)	***In-network:*** Any deposit required towards rental or purchase ***No out-of-network benefit***	All Charges - **Benefits are not available under Standard Option**

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
Note: Call us at 1-671-647-3526 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	***In-network:*** Any deposit required towards rental or purchase ***No out-of-network benefit***	All Charges - **Benefits are not available under Standard Option**
Not covered: • *Motorized wheelchairs* • *Insulin pumps*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide while under an active treatment plan with a home health agency including services such as: - Oxygen therapy, intravenous therapy and medications. - Services ordered by a physician for members who are confined to the home. - Nursing - Medical supplies included in the home health plan of care. - Physical therapy, speech therapy, occupational therapy, and respiratory therapy.	**In-network:** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network***: Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not covered • *Nursing care requested by, or for the convenience of the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative.*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
Chiropractic services - You may self refer to a participating chiropractor for up to 10 visits per calendar year. Services are limited to: • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	***In-network:*** All charges above $25 per visit and after 10th visit ***No out-of-network benefit***	***In-network:*** All charges above $25 per visit and after 10th visit ***No out-of-network benefit***

Benefit Description	You Pay	
Alternative treatments	**High Option**	**Standard Option**
No benefit	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Coverage is limited to programs administered through TakeCare Health Education Department only: • Cardiac Risk Management Class • Diabetes Management • 8 Weeks to Wellness • 5 Days of Fitness Program • Children's Health Improvement Program **Note:** Please call the TakeCare Customer Service Department at 1-671-647-3526 to find out if your class or program has a nominal charge.	Some programs may have a nominal charge	Some programs may have a nominal charge

• Tobacco Cessation programs including individual/group/telephone counseling, and over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.
• List of FDA approved cessation medications:
  • Nicotrol Nasal Spray
  • Nicotrol Inhaler
  • Chantix
  • Zyban
  • Bupropion hydrochloride
  • Nicorette Gum
  • Nicorette DS Gum
  • Habitrol Transdermal film
  • Nicoderm CQ Transdermal system
  • Commit lozenge
  • Nicorette lozenge
  • Nicotine Film
  • Nicotine Polacrilex, Gum, Chewing; Buccal
  • Thrive (Nicotine Polacrilex) Gum, Chewing; Buccal
  • Nicotine Polacrilex, Trocher/Lozenge
  • Nicotine Patch
  • Varenicline
	Nothing for counseling for up to two quit attempts per year
	
	Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
		Nothing for counseling for up to two quit attempts per year
		
		Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRE-AUTHORIZATION FOR SOME SURGICAL PROCEDURES.** Please refer to the prior authorization information shown in Section 3 to be sure which services require prior authorization and identify which surgeries require pre-authorization.
- A written referral for ***specialty care*** must be approved by TakeCare's Medical Management Department. ***Primary care*** services do not require prior approval. However, if you would like assistance with the coordination of any out-of-network primary care services please contact TakeCare's Medical Management Department at 1-671-647-3526.

Benefit Description	You Pay	
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Circumcision • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity (bariatric surgery). Surgery is limited to Roux-en-Y bypass and vertical banded gastroplasty. **Note**: The Following conditions must be met: - Eligible members must be age 18 or over - Eligible members must weigh 100 pounds or 100% over their normal weight according to current underwriting standards	***In-network:*** $20 per PCP office visit; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit $150 copayment for outpatient facility; $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges

Surgical procedures - continued on next page

Benefit Description	You Pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
- Eligible members must meet the National Institute of Health Guidelines, which can be found at www.weightlossandaesthetics.com/therapy.html - We may require you to participate in a non-surgical multidisciplinary program approved by us for six months prior to your bariatric surgery - We will determine the provider for the non-surgical program and surgery based on quality and outcomes. • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information. • Cardiac surgery for the implantation of stents, leads and pacemaker • Cardiac surgery for the implantation of valves (Plan pays for the cost of procedure only.) • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns **Note:** Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	***In-network:*** $20 per PCP office visit; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit $150 copayment for outpatient facility; $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care on page 31* • *Services and supplies provided for circumcisions performed beyond thirty-one (31) days from the date of birth that are not determined to be medically necessary.*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery	***In-network:*** $20 per PCP office visit; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit $150 copayment for outpatient facility; $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges

Reconstructive surgery - continued on next page

Benefit Description	You Pay	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements *(see Prosthetic devices)* **Note:** If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	***In-network:*** $20 per PCP office visit; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit $150 copayment for outpatient facility; $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • TMJ surgery and other related non-dental treatment	***In-network:*** $20 per PCP office visit; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit $150 copayment for outpatient facility; $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*	*All charges*

Oral and maxillofacial surgery - continued on next page

Benefit Description	You Pay	
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
• *Dental services related to treatment of TMJ*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ transplants** are covered. These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	***In-network:*** $20 per PCP office visit; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit $150 copayment for outpatient facility; $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de nova and treated) - Recurrent germ cell tumors (including testicular cancer)	***In-network:*** $20 per PCP office visit; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit $150 copayment for outpatient facility; $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	***In-network:*** $20 per PCP office visit; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission	***In-network:*** $25 per PCP office visit; $40 per specialist visit $150 copayment for outpatient facility; $150 copayment per day up to $750 maximum per inpatient admission

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer	***In-network:*** $20 per PCP office visit; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit $150 copayment for outpatient facility; $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	***In-network:*** $20 per PCP office visit; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit $150 copayment for outpatient facility; $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listedbelow are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma(CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed)	***In-network:***$20 per PCP office visit; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit $150 copayment for outpatient facility; $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Amyloidosis - Neuroblastoma	***In-network:***$20 per PCP office visit; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit $150 copayment for outpatient facility; $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. **Limited Benefits** • Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. • Bone marrow stem cell donor search and testing for compatible unrelated donors up to $15,000 per procedure at a National Preferred Transplant Facility when you are the intended recipient. **Transportation, food and lodging** - If you live over 60 miles from the transplant center and the services are pre-authorized by us: • Transportation limited to you and one escort to a National Preferred Transplant Network or other Company Approved Transplant Facility.	***In-network:*** $20 per PCP office visit; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit $150 copayment for outpatient facility; $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Lodging and food; you receive a $125 allowance per day for housing and food. This allowance excludes liquor and tobacco. **Note:** We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/ stem cell transplant donors in addition to the testing of family members. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast cancer • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Colon cancer • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma • Multiple sclerosis • Myeloproliferative disorders (MSDs) • Non-small cell lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle cell anemia • Autologous Transplants for	***In-network:*** $20 per PCP office visit; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit $150 copayment for outpatient facility; $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	***In-network:*** $20 per PCP office visit; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit $150 copayment for outpatient facility; $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	Nothing

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 10 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRE-AUTHORIZATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require pre-authorization.
- Referrals to doctors or facilities not on Guam can only be made to those under contract to provide service off-island. A written referral must be made by a Plan provider and approved by the TakeCare Medical Management Department.
- If you would like assistance with the coordination of any out-of-network services please contact TakeCare's Medical Management Department at 1-671-647-3526.

Benefit Description	You pay	
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets **Note**: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	***In-network:*** $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** charges$150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays and pathology tests • Administration of blood and blood products • Dressings, splints, casts and sterile tray services • Medical supplies and equipment including oxygen • Anesthetics, including nurse anesthetist services	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• Rehabilitative therapies - See 5(a) for benefit limitation	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Any inpatient hospitalization for dental procedure* • *Blood and blood products, whether synthetic or natural* • *Custodial care* • *Internal prosthetics except for those covered under Section 5(a) Prosthetic and Orthopedic Devices.* • *Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Take-home items*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts and sterile tray services • Medical supplies including oxygen • Anesthetics and anesthesia service **Note:** We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	***In-network:***$20 per PCP office visit; $40 per specialist visit $100 copayment for outpatient facility; $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per PCP office visit; $40 per specialist visit $150 copayment for outpatient facility; $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
• Non-routine mammograms • Ultrasound • X-rays	***In-network:*** $20 copayment in addition to regular office visit copay	***In-network:*** $25 copayment in addition to regular office visit copay

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay	
Outpatient hospital or ambulatory surgical center (cont.)	**High Option**	**Standard Option**
	In-network: $20 copayment in addition to regular office visit copay ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges. $20 copayment in addition to regular office visit copay	***In-network:*** $25 copayment in addition to regular office visit copay ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges. $25 copayment in addition to regular office visit copay
Prior authorization required for the following services: • CT Scan • Echocardiogram • MRI	***In-network:*** $40 copayment in addition to regular office visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges $40 copayment in addition to regular office visit	***In-network:*** $40 copayment in addition to regular office visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges $40 copayment in addition to regular office visit
Not covered: • *Blood and blood products, whether synthetic or natural*	*All charges*	*All charges*
Skilled nursing care facility benefits	**High Option**	**Standard Option**
Skilled nursing facility (SNF): The Plan provides a comprehensive range of benefits when full-time skilled nursing care and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. *Standard Option – 60 days per calendar year* *High Option – 100 days per calendar year* All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Custodial care*	*All Charges*	*All Charges*

Benefit Description	You pay	
Hospice care	**High Option**	**Standard Option**
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility when approved by TakeCare's Medical Management Department. Services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. Services include: • Inpatient and outpatient care • Family counseling **Note:** This benefit is limited to a maximum of up to 180 days per lifetime.	***In-network:*** Nothing **No out-of-network benefit**	***In-network:*** Nothing **No out-of-network benefit**
Not covered: • *Independent nursing, homemaker services*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Local ground ambulance service when medically necessary	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not covered: • *Transport that the Plan determined are not medically necessary* • *Air ambulance services*	All charges	All charges

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 10 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency?

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

Emergencies within our service area: If you receive emergency care within our service area that results in your hospitalization, you must contact the TakeCare Customer Service Department at 1-671-647-3526 within 48 hours unless it was not reasonably possible to do so.

When you need urgent care while you are in our service area, call your PCP. Your PCP can assess the situation and decide what type of care you need. Ask your PCP about after-hours and "on-call" procedures now, before you need these services. If your PCP's office is closed, you may access the FHP Urgent Care Center.

Emergencies outside our service area: If you receive emergency or urgent care outside our service area, you must contact the TakeCare Customer Service Department at 1-671-647-3526 within 48 hours, unless it was not reasonably possible to do so, to let us know what has happened and where you went for care; **otherwise, your care will not be covered**. If you are hospitalized outside the service area, we may arrange for your transfer to a Plan facility as soon as it is medically appropriate to do so.

When you have to file a claim: Please refer to Section 8 for information on how to file a claim, or contact our Customer Service Department at 1-671-647-3526.

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

Benefit Description	You pay	
Emergency within our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office • Emergency care at FHP Urgent Care Center	$20 per PCP office visit	$25 per PCP office visit
• Emergency care as an outpatient at a hospital including doctors' services **Note**: We waive the ER copay if you are admitted to the hospital and inpatient copay will apply	$50 copay per emergency room visit	$75 copay per emergency room visit
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services **Note**: We waive the ER copay if you are admitted to the hospital and inpatient copay will apply	$50 copay per emergency room visit	20% of charges
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Professional ambulance service when medically necessary. **Note**: See 5(c) for non-emergency service.	Nothing	Nothing
Not covered: • *Transport that the Plan determined are not medically necessary* • *Air ambulance*	*All charges*	*All charges*

Section 5(e). Mental health and substance abuse benefits

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible for facility care, or the inpatient deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay	
Professional Services	**High Option**	**Standard Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits)	***In-network:*** $20 per specialist visit ; $100 copayment for outpatient facility per visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per specialist visit; $150 copayment for outpatient facility per visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges

Professional Services - continued on next page

Benefit Description	You pay	
Professional Services (cont.)	**High Option**	**Standard Option**
• Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	***In-network:*** $20 per specialist visit ; $100 copayment for outpatient facility per visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per specialist visit; $150 copayment for outpatient facility per visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Diagnostics	**High Option**	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	***In-network:*** $20 per office visit; $100 copyment for outpatient facility per visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $25 per office visit; $150 copyment for outpatient facility per visit ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	***In-network:*** $100 copayment per day up to $500 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** $150 copayment per day up to $750 maximum per inpatient admission ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	***In-network:***$100 copayment ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:***$150 copayment ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
Not Covered	**High Option**	**Standard Option**
• *Services we have not approved* • *Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary*	*All charges*	*All charges*

Not Covered - continued on next page

Benefit Description	You pay	
Not Covered (cont.)	**High Option**	**Standard Option**
Note: *OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*	*All charges*

Pre-authorization	To be eligible to receive these enhanced mental health and substance abuse benefits you must follow your treatment plan and all of our network authorization processes. Please call 1-671-647-3526 for more information.
Special transitional benefit	If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2011, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions: If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause. If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2011, the 90 day period ends before January 1 and this transitional benefit does not apply.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 10 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them**. You must fill the prescription at a Plan pharmacy, or by mail for a maintenance medication
- **We use a formulary.** The TakeCare Formulary is a list of over 1600 prescription drugs that Plan physicians use as a guide when prescribing medications for patients. The Formulary plays an important role in providing safe, effective and affordable prescription drugs to TakeCare members. It also allows us to work together with physicians and pharmacies to ensure that our members are getting the drug therapy they need. A Pharmacy and Therapeutics Committee consisting of Plan physicians and pharmacists evaluate prescription drugs based on safety, effectiveness, quality treatment and overall value. The committee considers first and foremost the safety and effectiveness of a medication before reviewing the cost. TakeCare physicians will request prior authorization for some non-formulary drugs. A Plan physician may initiate the prior authorization request simply by phoning, faxing, or emailing in the request. Requests are generally processed within ten minutes although a few require up to 2 working days when additional information is needed from the physician. ***Note**: Formulary is subject to change.*
- **These are the dispensing limitations**. Prescription drugs will be dispensed for up to a 30-day supply or one commercially prepared unit per copayment (i.e., one inhaler, one vial of ophthalmic medication, one tube of ointment). For drugs that could be habit forming, the prescription unit is set at a smaller quantity for the protection and safety of our members.
  - A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the non-formulary copayment.
  - Updating of prior authorizations may be required. Clinical edits (limitations) can be used for safety reasons, quantity limitations and benefit plan exclusions and may require preauthorization.
  - Prescription drugs can also be obtained through the mail order program for up to a 90 days supply of oral medication; 6 vials of insulin; or 3 commercially prepared units (i.e., inhaler, vials ophthalmic medication or topical ointments or creams). Call 1(800) 361-4542 for mail order customer service. You pay two (2) copayments for a 90 day supply of medications through mail order.
- **Why use generic drugs?** To reduce your out-of-pocket expenses! A generic drug is the chemical equivalent of a corresponding brand name drug. Generic drugs are less expensive than brand name drugs; therefore, you may reduce your out-of-pocket costs by choosing to use a generic drug.
- **When you do have to file a claim:** Please refer to Section 7 for information on how to file a pharmacy claim, or contact our Customer Service Department at 1-671-647-3526.
- **Our Pharmacy Benefit Manager website**: www.envisionrx.com

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Disposable needles and syringes for the administration of covered medications; lancets • Oral contraceptive drugs (Injectable and implantable contraceptive drugs are covered under Section 5(a) Family Planning) **Note**: If there is no generic equivalent available, you will still have to pay the non-formulary copay.	**Retail Pharmacy - (30 day supply)** $10 for Generic formulary $15 for Brand maintenance $25 for Brand formulary $50 for Non-formulary $100 for Specialty drug **Mail Order - (90 days supply)** $20 for Generic formulary $30 for Brand maintenance $50 for Brand formulary $100 for Non-formulary $200 for Specialty drugs	**Retail Pharmacy - (30 day supply)** $15 for Generic formulary $20 for Brand maintenance $40 for Brand formulary $80 for Non-formulary $100 for Specialty drugs **Mail Order - (90 days supply)** $30 for Generic formulary $40 for Brand maintenance $80 for Brand formulary $160 for Non-formulary $200 for Specialty drugs
• Contraceptive diaphragms • Growth hormone	$5 each	$5 each
• Drugs for sexual dysfunction are covered when Plan criteria is met. Contact TakeCare for dose limits at 1-671-647-3526	50% per prescription unit or refill up to the dosage limits and all charges above that limit	50% per prescription unit or refill up to the dosage limits and all charges above that limit
• Oral fertility drugs	50% per prescription unit or refill up to the dosage limits and all charges above that limit	50% per prescription unit or refill up to the dosage limits and all charges above that limit
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies or approved referrals* • *Drugs or substances not approved by the Food and Drug Administration (FDA)* • *Hospital take-home drugs* • *Medical supplies (such as dressing, and antiseptics)* • *Weight loss medications including anorexients, anti-obesity agents, appetite suppressants, or anorexiogenic agents* • *Non-prescription medicines* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them unless listed in the formulary* • *Replacement of lost, stolen or destroyed medication* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 34.)	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See section 10 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 10 about coordinating benefits with other coverage, including with Medicare.
- Dental services are limited to $1,500 Plan maximum per member per benefit year (High Option and Standard Option).

Benefit Description	You Pay	
Accidental injury benefit	**High Option**	**Standard Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. **Note:** If you are outside the service area and receive services from a non-plan dentist, we will reimburse you up to $100.00.	Nothing	Nothing

Dental Benefits	You Pay	
Service	**High Option**	**Standard Option**
OFFICE VISIT X-rays, including bitewings (once a year) and panoramic (once every three years) oral examination and treatment plan; vitality test; and oral cancer exam	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
PREVENTIVE SERVICES Prophylaxis (once every 6 month); sealants (up to age 12); annual topical application of fluoride (up to age 12);	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges	***In-network:*** Nothing ***Out-of-network:*** 30% copay of eligible charges and any difference between eligible charges and billed charges
RESTORATIVE DENTISTRY Amalgam -one, two or three surfaces; composite--one or two surfaces—anterior	***In-network:*** 20% of covered charges ***Out-of-network:*** 50% copay of eligible charges and any difference between eligible charges and billed charges	All charges

Service - continued on next page

Dental Benefits	You Pay	
Service (cont.)	**High Option**	**Standard Option**
SIMPLE EXTRACTIONS Simple extraction for fully erupted teeth only	***In-network:*** 20% of covered charges ***Out-of-network:*** 50% copay of eligible charges and any difference between eligible charges and billed charges	All charges
PROSTHODONTICS Full and partial dentures; crowns and bridges; repair; relining and/or reconstruction of dentures	***In-network:*** 75% of covered charges ***Out-of-network:*** 95% copay of eligible charges and any difference between eligible charges and billed charges	All charges
PRESCRIPTION DRUGS	All charges	All charges

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
FHP Health Center – Urgent Care Center	Extended care hours are available to Plan members. If your primary care physician's clinic is closed, you may access FHP's Urgent Care services. Hours of operations are: Monday to Friday – 9:00am to 9:00pm Saturday – 9:00am to 8:00pm Sunday and Holidays – 10:00am to 6:00pm Phone: 1-671-646-5825 Saipan Clinic Hours of operation: Monday to Friday – 9:00am to 6:00pm Saturday – 9:00am to 1:00pm Sunday and Holidays – Closed Phone: 1-670-235-0994/96

Health Improvement Programs	The following programs are available to all TakeCare members: Please call Customer Service at 1-671-647-3526 for more information. **Cardiac Risk Management Class:** Discuss how to manage your diabetes through education on the medication, glucose monitoring, prevention strategies, and nutrition information. The healthy heart class focuses on how to lower your cholesterol and blood pressure through education on nutrition, disease specific information, and stress management. **Diabetes Management Program:** designed to assist members with diabetes to manage the disease through intervention such as telephonic counseling, one on one appointments, access to health education classes, and case management. **8 Weeks to Wellness:** is an 8 week program that involves group sessions and fitness activities that promote awareness on healthy lifestyle and encourage physical activity. **5 Days of Fitness Program:** a fitness-based program available to all TakeCare members and their dependents for FREE. The program offers different classes that members can participate in. **Tobacco Cessation Program:** highly effective self-paced smoking cessation program designed to meet individual needs. The major components are counselor support and interactive member materials. **Health Risk Assessment (HRA):** a computer based assessment tool that provides a thorough wellness-based health assessment addressing all major lifestyle factors, personal and family history, symptoms, functional health status and quality of life, health interests, readiness to change, and self-efficacy. **Children's Health Improvement Program (CHIP)**: is a combination of classroom, fitness and nutrition counseling strategies offered to children, adolescents and their families with the goal of promoting a healthier lifestyle and counteracting and preventing childhood obesity.

High Deductible Health Plan Benefits

See page 129 for benefits summary of HDHP option.

Section 5. High Deductible Health Plan Benefits Overview 61
Section 5. Savings – HSAs and HRAs 64
If You Have an HSA 68
If You Have an HRA 69
Preventive care 70
Section 5. Traditional medical coverage subject to the deductible 72
Section 5(a). Medical services and supplies provided by physicians and other health care professionals 73
- Diagnostic and treatment services 73
- Lab, X-ray and other diagnostic tests 73
- Maternity care 74
- Family planning 74
- Infertility services 74
- Allergy care 75
- Treatment therapies 75
- Physical and occupational therapies 75
- Cardiac Rehabilitation 76
- Speech therapy 76
- Hearing services (testing, treatment, and supplies) 76
- Vision services (testing, treatment, and supplies) 77
- Foot care 77
- Orthopedic and prosthetic devices 77
- Durable medical equipment (DME) 78
- Home health services 79
- Chiropractic 79
- Alternative treatments 79
- Educational classes and programs 79

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals 80
- Surgical procedures 80
- Reconstructive surgery 81
- Oral and maxillofacial surgery 82
- Organ/tissue transplants 82
- Anesthesia 85

Section 5(c). Services provided by a hospital or other facility, and ambulance services 86
- Inpatient hospital 86
- Outpatient hospital or ambulatory surgical center 87
- Skilled nursing care facility benefits 87
- Hospice care 88
- Ambulance 88

Section 5(d). Emergency services/accidents 89
- Emergency within our service area 90
- Emergency outside our service area 90
- Ambulance 90

Section 5(e). Mental health and substance abuse benefits 91
- Professional services 91
- Diagnostics 92

Inpatient hospital or other covered facility 92
Outpatient hospital and other covered facility 92
Section 5(f). Prescription drug benefits 94
Covered medications and supplies 95
Section 5(g). Dental benefits 97
Accidental injury benefit 97
Service 97
Section 5(h). Special features 98
FHP Health Center –Urgent Care Center 98
Health Improvement Programs 99
Section 5(i). Health education resources and account management tools 100
Health education resources 100
Account management tools 100
Consumer choice information 100
Care support 100
Summary of benefits for the High Deductible Health Plan Option of TakeCare Health Plan - 2012 128
2012 Rate Information for - TakeCare Health Plans 130

Section 5. High Deductible Health Plan Benefits Overview

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

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 1-671-647-3526 or at our web site at www.takecareasia.com.

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

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

With this Plan, preventive care is covered in full per calendar year and is not subject to Plan's deductible. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: in-network preventive care services; traditional medical coverage health care that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

- **Preventive care**

  The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations. These services are covered at 100%, if you use an in-network provider, and is not subject to deductible. The services are described in Section 5 *Preventive care*.

- **Traditional medical coverage**

  After you have paid the Plan's deductible ($3,000 for Self Only enrollment and $6,000 for Self and Family enrollment), we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays 80% for in-network and 70% for out-of-network care.

  Covered services include:

  - Medical services and supplies provided by physicians and other health care professionals
  - Surgical and anesthesia services provided by physicians and other health care professionals
  - Hospital services; other facility or ambulance services
  - Emergency services/accidents
  - Mental health and substance abuse benefits
  - Prescription drug benefits

- **Savings**

  Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 62 for more details).

- **Health Savings Accounts (HSA)**

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2012, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $78.00 for a Self Only enrollment or $205.83 for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is $3,100 for an individual and $6,250 for a family coverage. See maximum contribution information on page 57. You can use funds in your HSA to help pay your health plan deductible**.** You own your HSA, so the funds can go with you if you change plans or employment.

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

HSA features include:

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

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA health care flexible spending account (such as FSAFEDS offers – see Section 12), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

- **Health Reimbursement Arrangements (HRA)**

If you aren't eligible for an HSA, for example you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You **must** notify us that you are ineligible for an HSA.

In 2012, we will give you an HRA credit of $936 per year for a Self Only enrollment and $2,470 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by ASC Trust Fund
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment

- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP
- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements.

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

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $5,000 for individual or $10,000 for family enrollment. If you use non-network providers, your out-of-pocket maximum is $10,000 for individual and $20,000 for family. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

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

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

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	You are responsible for establishing an HSA for yourself with ASC Trust, Bank of Guam and Merrill Lynch as this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS). Upon establishing an HSA for yourself, you should also inform the Plan about your account information for us to coordinate the premium pass through deposits to your account.	ASC Trust is the HRA fiduciary for this Plan.
Fees	Set-up fee is paid by the HDHP. You may incur additional fees beyond your quarterly administrative fee. $10.00 per quarter administrative fee charged by ASC Trust Fund $12.50 per quarter administrative fee charged by Merrill Lynch $15.00 per quarter administrative fee charged by Bank of Guam.	$10.00 per quarter administrative fee charged by ASC.
Eligibility	You must: • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA benefits in the last three months • Complete and return all banking paperwork.	You must enroll in this HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.
Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP.	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.

	In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).	
• **Self Only enrollment**	For 2012, a monthly premium pass through of $78.00 will be made by the HDHP directly into your HSA each month.	For 2012, your HRA annual credit is $936 (prorated for length of enrollment).
• **Self and Family enrollment**	For 2012, a monthly premium pass through of $205.83 will be made by the HDHP directly into your HSA each month.	For 2012, your HRA annual credit is $2,470 (prorated for lenght of enrollment).
Contributions/credits	The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $3,100 for individual and $6,250 for family. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12-month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSAs earn tax-free interest (does not affect your annual maximum contribution). Catch-up contribution discussed on page 68.	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.
• **Self Only enrollment**	You may make an annual maximum contribution of $2,164.	You cannot contribute to the HRA

• **Self and Family enrollment**	You may make an annual maximum contribution of $3,780.	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods: • Visa Debit card • ATM Cards • Checks	For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through the HDHP. For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you upon your request.
Distributions/ withdrawals • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA. See IRS Publication 502 for a list of eligible medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA. See IRS Publication 502 for a list of eligible medical expenses. Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • TakeCare receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. • TakeCare receives the completed Premium pass-through form back from you.	Funds are not available until: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The entire amount of your HRA will be available to you upon your enrollment in the HDHP.

	• The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you. After TakeCare receives the enrollment and contributions from OPM and your HSA account has been created and funded, the enrollee can withdraw funds up to the amount contributed for any expenses incurred on or after the date the HSA was initially established.	
Account owner	FEHB enrollee	TakeCare Insurance Company
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 63 for HSA eligibility.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If You Have an HSA

If you have an HSA

- **Contributions**

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

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

- **Catch-up contributions**

  If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. The allowable catch-up contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury web site at www.ustreas.gov/offices/public-affairs/hsa/.

- **If you die**

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

- **Qualified expenses**

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

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

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

- **Non-qualified expenses**

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

- **Tracking your HSA balance**

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

- **Minimum reimbursements from your HSA**

  You can request reimbursement in any amount.

If You Have an HRA

- **Why an HRA is established**

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

- **How an HRA differs**

  Please review the chart on page 64 which details the differences between an HRA and an HSA. The major differences are:

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

Preventive care

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
Preventive care, adult	**HDHP Option**
Routine screenings (based on US Preventive Task Force Guidelines), such as: • Blood tests • Urinalysis • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test — one annually for men age 50 and older Colorectal Cancer Screening, including • Fecal occult blood test yearly starting at age 50, • Sigmoidoscopy screening — every five years starting at age 50, • Double contrast barium enema — every five years starting at age 50; • Colonoscopy screening — every 10 years starting at age 50 (prior authorization required) • Routine well-woman exam including Pap test, one visit every 12 months from last date of service • Routine mammogram — covered for women age 35 and older, as follows: - From age 35 through 39, one during this five year period - From age 40 through 64, one every calendar year - At age 65 and older, one every two consecutive calendar years	**Not subject to deductible** **In-network** – Nothing **Out-of-network** – 30% of our Plan eligible charges and any difference between our eligible charges and billed amount.
• Routine physicals which include: - one exam every 24 months up to age 65 - one exam every 12 months age 65 and older • Routine exams limited to: - one routine eye exam every 12 months - one routine OB/GYN exam every 12 months including 1 Pap smear and related services	**Not subject to deductible** **In-network** – Nothing **Out-of-network** –30% of our Plan eligible charges and any difference between our eligible charges and billed amount.

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**HDHP Option**
- one routine hearing exam every 24 months	**Not subject to deductible** **In-network** – Nothing **Out-of-network** –30% of our Plan eligible charges and any difference between our eligible charges and billed amount.
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	**Not subject to deductible** **In-network** – Nothing **Out-of-network** –30% of our Plan eligible charges and any difference between our eligible charges and billed amount.
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure*	*All Charges*
Preventive care, children	**HDHP Option**
Professional services, such as: • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Childhood immunizations recommended by the American Academy of Pediatrics • Examinations, such as: - Eye exam through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction	**Not subject to deductible** **In-network –** Nothing **Out-of-network –**30% of our Plan eligible charges and any difference between our eligible charges and billed amount.
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Immunizations, boosters, and medications for travel*	*All Charges*

Section 5. Traditional medical coverage subject to the deductible

Important things you should keep in mind about these benefits:

- Traditional medical coverage does not begin to pay until you have satisfied your deductible.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network preventive care is covered at 100% (see page 70) and is not subject to the calendar year deductible.
- The deductible is $3,000 for Self Only or $6,000 for Self and Family enrollment. The family deductible can be satisfied when two or more family members have met their individual deductible. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, in-network benefits apply only when you use a network provider. Out-of-network benefits apply when you do not use a network provider. Your dollars will generally go further when you use network providers.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total $5,000 for Self Only or $10,000 for Self and Family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan's eligible charges).
- In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits apply.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible…
Deductible before Traditional medical coverage begins	**High Option**
You must satisfy your deductible before your Traditional medical coverage begins. The Self and Family deductible can be satisfied after two (2) or more family members meet the individual deductible. Once your Traditional medical coverage begins, you will be responsible for your coinsurance amounts for eligible expenses or copayments for eligible prescriptions, until you reach the catastrophic protection out-of-pocket maximum. After you meet the deductible, we pay the eligible charge (less your coinsurance) until you meet the annual catastrophic out-of-pocket maximum. Please refer to Section 4 for services/expenses that do not count towards your out-of-pocket maximum.	100% of eligible charges until you meet the deductible of $3,000 per person or $6,000 per family enrollment. **In-network**: After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket. **Out-of-network**: After you meet the deductible, you pay the indicated coinsurance based on our eligible charges and any difference between our eligible charge and the billed amount.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $3,000 for Self Only enrollment or $6,000 for Self and Family enrollment each calendar year. The family deductible can be satisfied when two or more family members have met their individual deductible. The deductible applies to all benefits in this Section unless we indicate differently.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- *After you have satisfied your deductible*, coverage begins for traditional medical services. However, you will pay more for out-of-network services. For out-of network services, the member will be responsible for 30% of Plan eligible charges and any difference between Plan eligible charges and the billed amount.
- See Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible…
Diagnostic and treatment services	**HDHP Option**
Professional services of physicians • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinion • During a hospital stay • In a skilled nursing facility	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Lab, X-ray and other diagnostic tests	**HDHP Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • Electrocardiogram and EEG	**In-network** – Nothing **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
• X-rays • Non-routine mammograms • CT Scans/Echocardiogram/MRI (prior authorization required) • Ultrasound	**In-network** – 20% coinsurance **Out-of-network** – 30% of our Plan eligible charges and any difference between our eligible charges and billed amount

Benefit Description	You pay After the calendar year deductible…
Maternity care	**HDHP Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care **Note**:Here are some things to keep in mind: • You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. The newborn must be enrolled within 60 days of birth. • Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered : *Routine sonograms to determine fetal age, size or sex*	*All charges*
Family planning	**HDHP Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) **Note:** We cover oral contraceptives under the prescription drug benefit.	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling* • *Intra-uterine hormone releasing IUD*	*All Charges*
Infertility services	**HDHP Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: (up to three cycles per pregnancy attempt) - intravaginal insemination (IVI) - intracervical insemination (ICI)	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization*	*All Charges*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	**HDHP Option**
- *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *Zygote transfer* • *Intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All Charges*
Allergy care	**HDHP Option**
• Testing and treatment	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
• Allergy Injections - Allergy serum	$150 Injectable copay
Not covered: • *Provocative food testing and sublingual allergy desensitization*	*All Charges*
Treatment therapies	**HDHP Option**
• Chemotherapy and Radiation therapy **Note**: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on page 83. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) **Note:** Growth hormone is covered under the prescription drug benefit. We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other *services under You need prior Plan approval for certain services* on page 13.	**In-network** – 20% coinsurance **Out-of-network –** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Physical and occupational therapies	**HDHP Option**
Unlimited outpatient services and up to two (2) consecutive months per condition for the services of each of the following: • qualified physical therapists • occupational therapists **Note:** We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered:	*All Charges*

Physical and occupational therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Physical and occupational therapies (cont.)	**HDHP Option**
• *Long-term rehabilitative therapy* • *Exercise programs, lifestyle modification programs* • *Equipment, supplies or customized devices related to rehabilitative therapies, except those provided under Section (a) Durable Medical Equipment* • *Services provided by schools or government programs* • *Developmental and Neuroeducational testing and treatment beyond initial diagnosis* • *Hypnotherapy* • *Psychological testing* • *Vocational Rehabilitation*	*All Charges*
Cardiac Rehabilitation	**HDHP Option**
Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 90 days for inpatient rehabilitation.	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Speech therapy	**HDHP Option**
Unlimited visits for the services of a qualified Speech Therapist **Note**: All therapies are subject to medical necessity	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Hearing services (testing, treatment, and supplies)	**HDHP Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children* • External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	
• Hearing testing and treatment for adults when medically indicated for other than hearing aids • Hearing exams for children through age 17, (see *Preventive care, children)*	**In-network**– 20% coinsurance **Out-of-network** – 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Vision services (testing, treatment, and supplies)	**HDHP Option**
Medical and surgical benefits for the diagnosis and treatment of diseases of the eye Annual eye examinations: Plan pays $30 maximum allowance towards basic vision exams Plan pays $50 maximum allowance towards comprehensive exam **Note**: See *Preventive care, children* for eye exams for children	**In-network**– 20% coinsurance **Out-of-network –** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount All charges over the allowance for basic or comprehensive exam
• Prescription eyeglasses or contact lenses • Refractions	**In-network -** All charges above $100 at FHP Vision Center only **Out-of-network -** All charges **In-network** - 20% of coinsurance **Out-of-network** - 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered: • *Eye exercises and orthoptics (vision therapy)* • *Radial keratotomy and other refractive surgery suchas LASIK*	*All Charges*
Foot care	**HDHP Option**
Foot care and Podiatry services **Note**: When you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes routine foot care may be covered	**In-network**– 20% coinsurance **Out-of-network –** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered: • *Routine foot care including: cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All Charges*
Orthopedic and prosthetic devices	**HDHP Option**
• Artificial eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy (up to (2) surgical bras per benefit year) • Internal prosthetic devices, such as pacemakers, stents, leads, intraocular lens implants, cochlear implants, and surgically implanted breast implant following mastectomy. **Note**: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • External hearing aids	**In-network**– 20% coinsurance **Out-of-network –** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	**HDHP Option**
• Orthopedic devices, such as braces	**In-network**– 20% coinsurance **Out-of-network –** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered: • *Orthopedic and corrective shoes* • *Arch supports, foot orthotics, heel pads and heel cups* • *Artificial joints and limbs* • *Corsets, trusses, elastic stockings, support hose, stump hose and other supportive devices* • *Lumbosacral supports* • *Splints* • *Over-the-counter (OTC) items* • *Dual chamber pacemaker* • *Other internal prosthetics such as heart valves, automatic implantable cardioverter defibrillator (AICD) and other implantable devices not specified above.* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All Charges*
Durable medical equipment (DME)	**HDHP Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Manual hospital beds; • Standard manual wheelchairs; • Crutches/walk aids • CPAP (Continuous Positive Airway Pressure) • BPAP (Bi-Level Positive Airways Pressure) • Blood Glucose Monitors (provided by FHP Pharmacy) **Note**: Call us at 1-671-647-3526 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	**In-network**– Nothing **Out-of-network –** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered: • *Motorized wheel chairs* • *Insulin pumps*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Home health services	**HDHP Option**
Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide while under an active treatment plan with a home health agency including services such as: • Oxygen therapy, intravenous therapy and medications. • Services ordered by a physician for members who are confined to the home. • Nursing • Medical supplies included in the home health plan of care. • Physical therapy, speech therapy, occupational therapy, and respiratory therapy.	**In-network**– Nothing **Out-of-network –** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative.*	*All Charges*
Chiropractic	**HDHP Option**
Chiropractic services - You may self refer to a participating chiropractor for up to 10 visits per calendar year. Services are limited to: • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	**In-network –** All charges above $25 per visit and all charges after 10th visit **Out-of-network –** All charges
Alternative treatments	**HDHP Option**
No benefit	*All charges*
Educational classes and programs	**HDHP Option**
Coverage is limited to programs administered through TakeCare Health Education Department only. See page 34 for a list of available health education classes and wellness programs. **Note:** Please call the TakeCare Customer Service Department at 1-671-647-3526 to find out if your class or program has a nominal charge.	Some programs may have a nominal charge
• Tobacco Cessation programs, including individual/group/telephone, counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. See page 34 for a list of FDA approved cessation medications.	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The deductible is $3,000 for Self Only enrollment or $6,000 for Self and Family enrollment each calendar year. The family deductible can be satisfied when two or more family members have met their individual deductible. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRE-AUTHORIZATION FOR SOME SURGICAL PROCEDURES.** Please refer to the preauthorization information shown in Section 3 to be sure which services require preauthorization and identify which surgeries require preauthorization.

Benefit Description	You pay After the calendar year deductible…
Surgical procedures	**HDHP Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Circumcision • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery). Surgery is limited to Roux-en-Y bypass and vertical banded gastroplasty. **Note:** The Following conditions must be met: - Eligible members must be age 18 or over - Eligible members must weigh 100 pounds or 100% over their normal weight according to current underwriting standards - Eligible members must meet the National Institute of Health guidelines, which can be found at www.weightlossandaesthetics.com/therapy.html	**In-network**– 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	**HDHP Option**
- We may require you to participate in a non-surgical multidisciplinary program approved by us for six (6) months prior to your bariatric surgery - We will determine the provider for the non-surgical program and surgery based on quality and outcomes. • Insertion of internal prosthetic devices. See 5(a) *Orthopedic and prosthetic devices* for device coverage information • Cardiac surgery for the implantation of stents, leads and pacemaker • Cardiac surgery for the implantation of valves • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns **Note**: Generally, we pay for internal prostheses (devices) according to where the procedure is done. Plan pays for the cost of the insertion only.	**In-network**– 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care on page 77* • *Services and supplies provided for circumcisions performed beyond thirty-one (31) days from the date of birth that are not determined to be medically necessary*	*All Charges*
Reconstructive surgery	**HDHP Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) **Note**: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	**In-network**– 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered:	*All Charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…
Reconstructive surgery (cont.)	**HDHP Option**
• *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All Charges*
Oral and maxillofacial surgery	**HDHP Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures • TMJ surgery and other related non-dental treatment	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental services related to treatment of TMJ*	*All Charges*
Organ/tissue transplants	**HDHP Option**
These **solid organ transplants** are covered. These **solid organ transplants**are subject to medical necessity and experimental/ investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Lung: Single/double or lobar lung • Pancreas • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**HDHP Option**
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma (de novo and treated) - AL Amyloidosis	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount.
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia - Chronic lymphocytic leukemia /small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Marrow Failure and Related Disorders (i.e. Fanconi's PNH, pure red cell aplasia) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Hemoglobinopathy - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplant for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Neuroblastoma - Amyloidosis - Multiple myeloma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**HDHP Option**
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH,Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma.	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount.
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. Limited Benefits	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**HDHP Option**
• Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. • Bone marrow stem cell donor search and testing for compatible unrelated donors up to $15,000 per procedure at a National Preferred Transplant Facility when you are the intended recipient. **Transportation food and lodging –** If you live over 60 miles from the transplant center and the services are pre-authorized by us: • Transportation limited to you and one escort to a National Preferred Transplant Network or other Company Approved Transplant Facility. • Lodging and food; you receive a $125 allowance per day for housing and food. This allowance excludes liquor and tobacco. **Note:** We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All Charges*
Anesthesia	**HDHP Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The deductible is $3,000 for Self Only enrollment or $6,000 for Self and Family enrollment each calendar year. The family deductible can be satisfied when two or more family members have met their individual deductible. The deductible applies to all benefits in this section unless we indicate differently.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRE-AUTHORIZATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require preauthorization.

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital	**HDHP Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets **Note**: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	**In-network**– 20% coinsurance **Out-of-network –** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Other hospital services and supplies, such as: • Operating, recovery, maternity and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Rehabilitative therapies - See Section 5(a) for benefit limitation	**In-network**– 20% coinsurance **Out-of-network –** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered: • *Any inpatient hospitalization for dental procedure* • *Blood and blood products, whether synthetic or natural*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital (cont.)	**HDHP Option**
• *Custodial care* • *Internal prosthetics except for those covered under Section 5(a) Prosthetic and Orthopedic Devices* • *Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Take-home items*	*All charges*
Outpatient hospital or ambulatory surgical center	**HDHP Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts and sterile tray services • Medical supplies including oxygen • Anesthetics and anesthesia service **Note**: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
• Non-routine mammograms • Ultrasound • CT scan/MRI (prior authorization required) • Plain film X-rays	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Skilled nursing care facility benefits	**HDHP Option**
Skilled nursing facility (SNF): The Plan provides a comprehensive range of benefits when full-time skilled nursing care and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. *Limited to 100 days per calendar year* All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	**In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered: Custodial care	*All charges*

Benefit Description	You Pay After the calendar year deductible...
Hospice care	**HDHP Option**
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility when approved by TakeCare's Medical Management Department. Services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six (6) months or less. Services include: • inpatient and outpatient care • family counseling **Note**: This benefit is limited to a maximum of up to 180 days per lifetime	**In-network** – Nothing ***No out-of-network benefit***
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	**HDHP Option**
Local professional ambulance service when medically necessary	**In-network** – Nothing **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered: • *Transport that we determine are not medically necessary* • *Air ambulance services*	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $3,000 for Self Only enrollment or $6,000 for Self and Family enrollment each calendar year. The family deductible can be satisfied when two or more family members have met their individual deductible. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

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

Emergencies within our service area: If you receive emergency care within our service area that results in your hospitalization, you must contact the TakeCare Customer Service Department at 1-671-647-3526 within 48 hours unless it was not reasonably possible to do so.

When you need urgent care while you are in our service area, call your PCP. Your PCP can assess the situation and decide what type of care you need. Ask your PCP about after-hours and "on-call" procedures now, before you need these services. If your PCP's office is closed, you may access the FHP Urgent Care Center.

Emergencies outside our service area: If you receive emergency or urgent care outside our service area, you must contact the TakeCare Customer Service Department on 1-671-647-3526 within 48 hours, unless it was not reasonably possible to do so, to let us know what has happened and where you went for care.

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	**HDHP Option**
• Emergency care at a doctor's office • Emergency care at FHP Urgent Care Center • Emergency care as an outpatient in a hospital, including doctors' services **Note**: We waive the ER copay if you are admitted to the hospital.	**In-network** - $75 per ER visit **Out-of-network –** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Emergency outside our service area	**HDHP Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services **Note**: We waive the ER copay if you are admitted to the hospital.	**In-network** - $75 per ER visit **Out-of-network –** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	**HDHP Option**
Professional ambulance service when medically necessary. **Note**: See 5(c) for non-emergency service.	**In-network** – Nothing **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered: • *Transport that the Plan determined are not medically necessary* • *Air ambulance*	*All charges*

Section 5(e). Mental health and substance abuse benefits

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible for facility care, or the inpatient deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay After the calendar year deductible…
Professional services	**HDHP Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions. **In-network** – 20% coinsurance **Out-of-network–** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling	In-network - 20% coinsurance Out-of-network - 30% of our Plan eligible charges and any difference between our eligible charges and billed amount

Professional services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Professional services (cont.)	**HDHP Option**
• Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	In-network - 20% coinsurance Out-of-network - 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Diagnostics	**HDHP Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	In-network - 20% coinsurance Out-of-network - 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Inpatient hospital or other covered facility	**HDHP Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	In-network - 20% coinsurance Out-of-network - 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Outpatient hospital and other covered facility	**HDHP Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	In-network - 20% coinsurance Out-of-network - 30% of our Plan eligible charges and any difference between our eligible charges and billed amount
Not covered	**HDHP Option**
• *Services we have not approved* • *Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary and appropriate* ***Note:*** *OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Pre-authorization	To be eligible to receive these enhanced mental health and substance abuse benefits you must follow your treatment plan and all of our network authorization processes. Please call 1-671-647-3526 for more information.
Special transitional benefit	If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2011, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions:

	• If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause. If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2011, the 90 day period ends before January 1 and this transitional benefit does not apply.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $3,000 for Self Only enrollment or $6,000 for Self and Family enrollment each calendar year. The family deductible can be satisfied when two or more family members met their individual deductible. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a plan pharmacy, a non-network pharmacy, or by mail. We pay a higher level of benefits when you use a network pharmacy.
- **We use a formulary.** The TakeCare Formulary is a list of over 1600 prescription drugs that Plan physicians use as a guide when prescribing medications for patients. The Formulary plays an important role in providing safe, effective and affordable prescription drugs to TakeCare members. It also allows us to work together with physicians and pharmacies to ensure that our members are getting the drug therapy they need. A Pharmacy and Therapeutics Committee consisting of Plan physicians and pharmacists evaluate prescription drugs based on safety, effectiveness, quality treatment and overall value. The committee considers first and foremost the safety and effectiveness of a medication before reviewing the cost. TakeCare physicians will request prior authorization for some non-formulary drugs. A Plan physician may initiate the prior authorization request simply by phoning or faxing in the request. Requests are generally processed within ten minutes although a few require up to 2 working days when additional information is needed from the physician. **Note:** *Formulary is subject to change.*
- **These are the dispensing limitations.** Prescription drugs will be dispensed for up to a 30-day supply or one commercially prepared unit per copayment (i.e., one inhaler, one vial of ophthalmic medication, one tube of ointment). For drugs that could be habit forming, the prescription unit is set at a smaller quantity for the protection and safety of our members.
  - A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the non-formulary copayment.
  - Updating of prior authorizations may be required. Clinical edits (limitations) can be used for safety reasons, quantity limitations and benefit plan exclusions and may require preauthorization.
  - Prescription drugs can also be obtained through the mail order program for up to a 90 days supply of oral medication; 6 vials of insulin; or 3 commercially prepared units (i.e., inhaler, vials ophthalmic medication or topical ointments or creams). For mail order customer service call 1(800) 361-4542 or visit www.envisionrx.com. You pay two (2) copayments for a 90 day supply of medications through in-network mail order and 30% of network prices after deductible for out-of-network. Out-of-network mail order is **not** covered.
- **Why use generic drugs?** To reduce your out-of-pocket expenses! A generic drug is the chemical equivalent of a corresponding brand name drug. Generic drugs are less expensive than brand name drugs; therefore, you may reduce your out-of-pocket costs by choosing to use a generic drug
- **When you do have to file a claim:** Please refer to Section 7 for information on how to file a pharmacy claim, or contact our Customer Service Department at 1-671-647-3526**.**

- **Our Pharmacy Benefit Manager website: www.envisionrx.com**

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies	**HDHP Option**
We cover the following medications and supplies prescribed by your attending physician and obtained from a Plan pharmacy or through our mail order program or an out-of-network retail pharmacy: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Oral contraceptive drugs (Injectable and implantable contraceptive drugs are covered under Section 5(a) Family Planning) • Contraceptive diaphragms • Growth hormone • Injectable fertility drugs	**Note:** If there is no generic equivalent available, you will still have to pay the non-formulary copay **In-network:** • **Retail Pharmacy (30 day supply)** - $20 for generic formulary - $40 for brand formulary - $80 for each non-formulary - $100 for specialty drugs - $150 for injectable drugs • **Mail Order: (90 day supply)** - $40 for generic formulary - $80 for brand formulary - $160 for each non-formulary - $200 for specialty drugs - $300 for injectable drugs **Out-of-network:** • **Retail Pharmacy (30 day supply)** 30% of network prices after deductible • **Mail Order:** *All charges – not a benefit*
Insulin and Diabetic supplies, such as disposable needles and insulin syringes and lancets per TakeCare's formulary.	**In-network -** $100 copay for 30 day supply **Mail Order -** $200 copay for 90 day supply **Out-of-network –** 30% of network price after deductible **Mail Order:** *All charges – not a benefit*
• Drugs for sexual dysfunction are covered when Plan criteria are met. Contact TakeCare for dose limits at 1-671-647-3526 • Oral fertility drugs	**In-network**– 50% per prescription unit or refill up to the dosage limits **Out-of-network –** 30% of network price after deductible
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs or substances not approved by the Food and Drug Administration (FDA)* • *Hospital take-home drugs* • *Medical supplies (such as dressing and antiseptics)* • *Weight loss medications including anorexients, anti-obesity agents, appetite suppressants, or anorexiogenic agents* • *Non-prescription medicines*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	**HDHP Option**
• *Vitamins, nutrients and food supplements even if a physician prescribes or administers them unless listed in the formulary* • *Replacement of lost, stolen or destroyed medication* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 34.)	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

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

Benefit Description	You Pay
Accidental injury benefit	**HDHP Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. **Note**: If you receive services from a non-plan dentist, we will reimburse you up to $100.00	Nothing

Dental benefits	You Pay
Service	**HDHP Option**
OFFICE VISIT X-rays, including bitewings (once a year) and panoramic (once every three years) oral examination and treatment plan; vitality test; and oral cancer exam	Nothing
PREVENTIVE SERVICES Prophylaxis (once every 6 month); sealants (up to age 12); annual topical application of fluoride (up to age 12);	Nothing
RESTORATIVE DENTISTRY Amalgam –one, two or three surfaces; composite—one or two surfaces —anterior	20% of covered charges
SIMPLE EXTRACTIONS Simple extraction for fully erupted teeth only	20% of covered charges
PROSTHODONTICS Full and partial dentures; crowns and bridges; repair; relining and/or reconstruction of dentures	75% of covered charges
PRESCRIPTION DRUGS	All charges

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
FHP Health Center – Urgent Care Center	Extended care hours are available to Plan members. If your primary care physician's clinic is closed, you may access FHP's Urgent Care services. Urgent Care Hours of Operation: Monday to Friday – 9:00am to 9:00pm Saturday – 9:00am to 8:00pm Sunday and Holidays – 10:00am to 6:00pm Phone: 1-671-646-5825 Saipan Clinic Hours of Operation: Monday to Friday – 8:00am to 6:00pm Saturday – 9:00am to 1:00pm Sunday and Holidays – Closed Phone: 1-670-235-0994/96

Health Improvement Programs	The following programs are available to all TakeCare members: Please call Customer Service at 1-671-647-3526 for more information. **Cardiac Risk Management Program:** Discuss how to manage your diabetes through education on the medication, glucose monitoring, prevention strategies, and nutrition information. The healthy heart class focuses on how to lower your cholesterol and blood pressure through education on nutrition, disease specific information, and stress management. **Diabetes Management:** designed to assist members with diabetes to manage the disease through intervention such as telephonic counseling, 1:1 appointments, access to health education classes, and case management. **8 Weeks to Wellness:** is an 8 week program that involves group sessions and fitness activities that promote awareness on healthy lifestyle and encourage physical activity. **5 Days of Fitness Program:** a fitness-based program available to all TakeCare members and their dependents for FREE. Each day of the week offers a class that members can participate in. **Tobacco Cessation Program:** highly effective self-paced smoking cessation program designed to meet individual needs. The major components are counselor support and interactive member materials. **Health Risk Assessment (HRA):** a computer based assessment tool that provides a thorough wellness-based health assessment addressing all major lifestyle factors, personal and family history, symptoms, functional health status and quality of life, health interests, readiness to change, and self-efficacy. **Children's Health Improvement Program (CHIP)**: is a combination of classroom, fitness and nutrition counseling strategies offered to children, adolescents and their families with the goal of promoting a healthier lifestyle and counteracting and preventing childhood obesity.

Section 5(i). Health education resources and account management tools

Special features	Description
Health education resources	The following classes are offered through FHP Health Education: • Cardiac Risk Management Program • Diabetes Management Class • Children's Health Improvement Program • 8 Weeks to Wellness • Tobacco Cessation Class • 5 Days of Fitness
Account management tools	If you have an **HSA:** • You will receive a statement outlining your account balance and activity • You may also access your account on-line at: - Bank of Guam - www.bankofguam.com - ASC Trust Corporation - www.ascpac.com - Merrill Lynch - www.ml.com If you have an **HRA:** • You will receive a statement outlining your account balance and activity • You may also access your account on-line at: - ASC Trust Corporation - www.ascpac.com
Consumer choice information	As a member of this HDHP, you may choose any provider. However, you will reduce your out-of-pocket expense if you see a network provider. Directories are available online at www.takecareasia.com Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.takecareasia.com
Care support	Patient safety information is available online at www.takecareasia.com TakeCare provides support to members with chronic illnesses. TakeCare's case management program offers supportive services to members with multiple chronic conditions to reduce occurrence of catastrophic events and costly hospital admission.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 1-671-647-3526 or visit their website at www.takecareasia.com.

Supplemental Dental Coverage
TakeCare offers a dental plan to supplement the dental coverage provided in the TakeCare FEHBP plan option you have selected. Enrollment in the supplemental dental coverage will be coordinated with your FEHB dental coverage. The supplemental dental plan covers services provided by participating dental providers and provides coverage as follows:

Supplemental Dental Benefits	You pay	
Covered Services	**High Option**	**Standard Option**
DIAGNOSTIC SERVICE Routine x-rays (full mouth series are limited to once every three years and include eighteen x-rays or four bitewings, two PAs and a panograph), clinical examinations and diagnostic treatment planning (exams are limited to one per benefit year for members 12 and older).	Nothing	30% of eligible charges
PREVENTIVE SERVICE Routine teeth cleaning (prophylaxis) and fluoride treatment (limited to twice a year). Sealants for children only up to the age of twelve (12).	Nothing	30% of eligible charges
RESTORATIVE SERVICE Routine fillings (silver amalgam and anterior composite). Posterior composites are not covered, however, an allowance for a comparable silver amalgam restoration will be made. The difference in fees is the member's responsibility.	Nothing	30% of eligible charges
SIMPLE EXTRACTIONS Simple non-surgical extractions of fully erupted teeth only. Extractions solely for purposes of orthodontic treatment are not covered. Surgical extractions of unerupted or impacted teeth and general anesthesia are not covered.	Nothing	30% of eligible charges
ENDODONTICS Root canal fillings, pulp treatment	50% of covered charges	70% of eligible charges
PERIODONTICS Consultation, evaluation, and treatment of soft tissue and bones supporting teeth, subgingival curettage, gross scaling (excessive calculus removal), subgingival scaling and root planing, periodontal maintenance (applicable only to members undergoing or who have completed periodontal treatment) and periodontal surgery.	50% of covered charges	70% of eligible charges
PROSTHODONTICS Full and partial dentures; repairs, relining and/or reconstruction of dentures. Porcelain and/or gold crowns and bridges, space maintainers, resin and stainless steel crowns. Occlusal guards are not covered.	50% of covered charges	70% of eligible charges
PRESCRIPTION DRUGS • Coverage is limited to prescription drugs dispensed at FHP Pharmacy only	50% of eligible charges	All charges
SEDATION • General anesthesia when specifically recommended by the dentist as a necessity • Nitrous oxide or analgesia for member under 13 years old	All Charges	All Charges

Dental Plan Maximum - The supplemental dental plan will pay a maximum of $1,500 per member per calendar year.

For more details on the coverage and cost of the supplemental dental plan and how to enroll, call 1/671-647-3526.

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see Emergency services/accidents).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible. **If you see non-plan physician you may have to pay for the services and file a claim.**

There are four types of claims. Three of the four types - Urgent care claims, Pre-service claims, and Concurrent review claims - usually involve access to care where you need to request and receive our advance approval to receive coverage for a particular service or supply covered under this Brochure. See Section 3 for more information on these claims/requests and Section 10 for the definitions of these three types of claims.

The fourth type - Post-service claims - is the claim for payment of benefits after services or supplies have been received.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 1-671-647-3526 or at our Web site at www.takecareasia.com.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

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

Submit your claims to:

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

Deadline for filing your claim

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

Urgent care claims procedures

If you have an urgent care claim, please contact our Customer Service Department at 1-671-647-3526. Urgent care claims must meet the definition found in Section 10 of this brochure, and most urgent care claims will be claims for access to care rather than claims for care already received. We will notify you of our decision not later than 24 hours after we receive the claim as long as you provide us with sufficient information to decide the claim. If you or your authorized representative fails to provide sufficient information to allow us to, we will inform you or your authorized representative of the specific information necessary to complete the claim not later than 24 hours after we receive the claim and a time frame for our receipt of this information. We will decide the claim within 48 hours of (i) receiving the information or (ii) the end of the time frame whichever is earlier.

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

Concurrent care claims procedures

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment as an appealable decision. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

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

Pre-service claims procedures

As indicated in Section 3, certain care requires Plan approval in advance. We will notify you of our decision within 15 days after the receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

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

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

Post-service claims procedures

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

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

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

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit http://www.takecareasia.com/FEHBClaimsInformation.php

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

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

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: TakeCare Customer Service Department, P.O. Box 6578, Tamuning, Guam 96931; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within:

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

120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

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

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

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

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

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

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (671) 647-3526. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. eastern time.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 1-671-647-3526. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payor, we will pay the benefits described in this brochure.

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

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-800-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

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

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-671-647-3526.

We do not waive any costs if the Original Medicare Plan is your primary payor.

- **Tell us about your Medical coverage**

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Clinical Trials

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

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

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan covers some of these costs, providing the plan determines the services are medically necessary. For more specific information. (See Pages 34 and 74).
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, TakeCare does **not** cover these costs.

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

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Catastrophic limit

A catastrophic limit is the annual amount you pay for deductibles, copayments and coinsurance. See page 17 for specific amounts.

Clinical Trials Cost Categories

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 17.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 17.

Cost-sharing

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

Covered services

Care we provide benefits for, as described in this brochure.

Custodial Care

Any type of care provided according to Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post hospital Skilled Nursing Facility care; or c) is a level such that you have reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. Custodial care includes any type of care where the primary purpose is to attend to your daily living activities which do not require the continuing attention of trained medical or paramedical personnel. Examples include but not limited to assistance in walking, getting in and out of bed, bathing, dressing, feeding, changes of dressing of non-infected wounds, residential care and adult day care, protective and supportive care including educational services and rest cures. Day to day care that can be provided by a non-medical individual or custodial care that lasts longer than 90 days may be considered Long Term Care. Custodial care is not covered.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page17.

Eligible Charge	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. For participating providers, eligible charges shall be the contracted rate paid by TakeCare. For all non-participating provider services, eligible charges shall be the same as the usual, customary and reasonable charges in the geographic area. In addition, the member shall be responsible for any amount by which the usual, customary and reasonable fees in the geographic area exceed the amount TakeCare is obligated to pay the provider for the covered services rendered.
Experimental or investigational services	Our Benefit Interpretation Policy Committee determines whether or not treatments, procedures and drugs are no longer considered experimental or investigational. Our determinations are based on the safety and efficacy of new medical procedures, technologies, devices and drugs.
Health Reimbursement Arrangement (HRA)	An HRA is a tax-sheltered account designed to reimburse medical expenses.The fund in this type of account can best be described as "credits". These credits are applied toward your medical expenses until they are exhausted at which time you must pay any remaining deductible and coinsurance amounts up to the catastrophic limit.
Health Savings Account (HSA)	An HSA is a consumer-oriented tax advantaged savings account. HSAs allow for tax deductible contributions as well as tax free earnings and withdrawals for qualified medical expenses.
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
Medical necessity	Medical necessity refers to medical services or hospital services which are determined by us to be: • Rendered for the treatment or diagnosis of an injury or illness; and • Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and • Not furnished primarily for the convenience of the member, the attending physician, or other provider of service; and • Furnished in the most economically efficient manner which may be provided safely and effectively to the member.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance by our contracted rate with the participating provider. If the charges exceed our contracted rate, you will be responsible for the excess over the allowance in addition to your coinsurance.
Premium pass through contribution to HSA/ HRA	The amount of money we contribute to your HSA or HRA. In 2011, for each month you are eligible for an HSA contribution, we will deposit $78.00 into your account as a Self Only enrollee or $205.83 into your account as a Self and Family enrollee. If you are not eligible for an HSA we will contribute a total of $988 annually into your HRA as Self Only enrollee or $2,470 as Self and Family enrollee. Our contribution to your HRA will be prorated depending on your HRA eligibility date.
Us/We	Us and We refer to TakeCare
You	You refers to the enrollee and each covered family member.
Urgent care claims	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law. A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-671-647-3526. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

- **Post-service claims** Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

- **Pre-service claims** Those claims (1) that require pre-certification, prior approval, or a referral and (2) where failure to obtain pre-certification, prior approval, or a referral results in a reduction of benefits.

Section 11. FEHB Facts

Coverage Information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment
- How you can cover your family members
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
- What happens when your enrollment ends
- When the next open season for enrollment begins

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure .

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2012 benefits of your old plan or option**. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2011 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

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

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, *the Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

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

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

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

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage(TCC) under the FEHB Program*. See also the FEHB Web site www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12. Other Federal Programs

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program - *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA) –** Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA) –** Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA) –** Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee, you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**
FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.

Class D (Orthodontic) services with up to a 24-month waiting period for dependent children up to age 19.

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/vision and www.opm.gov/insure/dental . These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337, (TTY 1-877- 889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com .

Pre-existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool than that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY): 1-866-561-1604.

Index

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

Accidental injury.....37, 55, 60, 82,97
Allergy.....27, 75
Allogeneic transplant.....38, 40, 42, 83, 87
Alternative treatments.....34, 79
Ambulance.....32, 44, 47, 49, 61, 86, 88, 90
Anesthesia...5, 32, 35, 43, 45, 61, 80, 85, 87, 101
Autologous bone marrow transplant...28, 75
Biopsy.....35, 80
Blood.....24, 44, 45, 46, 70, 73, 84, 86, 87
Casts.....44, 45, 86, 87
Catastrophic protection (out-of-pocket maximum).....8, 17, 18, 61, 64, 72
Changes for 2012.....10
Chemotherapy.....28, 75
Chiropractic.....18, 22, 34, 79
Cholesterol.....24, 58, 70, 99
Claims...99, 103, 106, 110, 111, 115, 116, 119
Coinsurance.....7, 8, 11, 17, 18, 114
Colorectal cancer screening.....24, 70
Congenital anomalies.....35, 37, 80, 81
Contraceptive drugs.....26, 54, 74, 95
Crutches.....32, 78
Deductible.....7, 17, 19, 72, 115
Definitions.....115
Dental care.....55, 98, 127
Diagnostic and treatment services...23, 73, 126, 128
Donor expenses.....41, 85
Dressings.....44, 45, 86, 87
Durable medical equipment.....32, 78
Emergency.....14, 15, 48, 89
Experimental or investigational.....102, 115
Eyeglasses.....22, 30, 77
Family planning.....26, 74
Fecal occult blood test.....24, 70
Fraud.....3, 119
General exclusions.....102
Hearing services.....29, 76
Home health services.....33, 79
Hospital Care.....13, 44, 86
Immunizations.....25, 70, 71
Infertility.....27, 74
Inpatient hospital benefits...13, 22, 44, 51, 86, 92
Insulin.....53, 54, 95, 96
Magnetic Resonance Imagings (MRIs) 14, 24, 46, 73, 87
Mammogram(s).....24, 25, 45, 70, 73, 87
Maternity benefits.....26, 74
Medicaid.....113
Medicare.....2, 8, 9, 11, 62, 64, 68, 69, 109
Mental Health/Substance Abuse Benefits 12, 50, 61, 91, 126
Newborn care.....26, 74
Non-FEHB benefits.....101, 119
Nurse
- Licensed Practical Nurse (LPN)...33, 79
- Nurse Anesthetist (NA).....44, 86
- Registered Nurse.....33, 79

Occupational therapy.....28, 33, 75, 79
Office visits.....17, 21
Oral and maxillofacial surgical.....37, 82
Out-of-Network.....9, 10, 11, 23
Oxygen.....33, 44, 45, 79, 86, 87
Pap test.....24, 25, 70, 73
Physician.....7, 9, 11
Precertification.....13, 14, 15
Prescription drugs...21, 34, 53, 56, 95, 97,102, 104, 127, 129
Preventive care.....7, 24, 61, 70, 97,101,128
Prior approval.....9, 11, 12, 13
Prosthetic devices.....31, 77
Psychologist.....50, 91
Radiation therapy.....28, 75
Room and board.....44, 51, 86, 92, 114
Second surgical opinion.....23, 73
Service Area.....9, 11, 48
Skilled nursing facility care...23, 43, 46, 73, 85, 87, 114
Social worker.....50, 91
Speech therapy.....29, 33, 76, 79
Splints.....32, 44, 78, 86
Subrogation.....113
Substance abuse.....12, 50, 61, 91, 126
Surgery
- Oral.....37, 82
- Outpatient...21, 36, 37, 45, 51, 87, 92, 126
- Reconstructive.....36, 81

Syringes.....54, 95
Temporary Continuation of Coverage (TCC).....112, 119
Transplants.....38, 82
Treatment therapies.....28, 75
Vision care.....71, 122
Vision services.....30, 77, 113, 127
Wheelchairs.....32, 78
Workers Compensation.....113
X-rays.....24, 41, 44, 45, 55, 73, 84, 86, 87

Summary of benefits for the High and Standard Option of TakeCare Health Plan - 2012

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page, we summarize specific expenses we cover. For more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	**High Option** - Office visit copayment: $20 primary care $40 specialist **Standard Option** - Office visit copayment: $25 primary care $40 specialist for	23
Services provided by a hospital:		
• Inpatient	**High Option** - $100 copayment per day up to $500 maximum per inpatient admission **Standard Option** - $150 copayment per day up to $750 maximum per inpatient admission	44
• Outpatient	**High Option** - $100 copayment per visit **Standard Option -** $150 copayment per visit	45
Emergency benefits:		
• In-area	**High Option** - $50 copayment per emergency room visit **Standard Option** - $75 copayment per emergency visit	49
• Out-of-area	**High Option** - $50 copayment per emergency room visit and all charges after $1,000 **Standard Option** - 20% of first $1,000 and all charges after $1,000	49
Mental health and substance abuse treatment:	Regular cost-sharing **High Option** $20 per PCP visit $100 copayment for outpatient facility $100 copayment per day up to $500 maximum per inpatient admission **Standard Option** $25 per PCP visit $150 copayment for outpatient facility $150 copayment per day up to $750 maximum per inpatient admission	50

Benefits	You pay	Page
Prescription drugs:		53
• Retail pharmacy - 30 day supply	**High Option** - $10 generic formulary $15 brand maintenance $25 brand formulary $50 non-formulary $100 specialty drugs **Standard Option** - $15 generic formulary $20 brand maintenance $40 brand formulary $80 non-formulary $100 specialty drugs	54
• Mail order - 90 day supply	2 copayments for 3 months supply	54
Dental care:	**High Option** - Nothing for preventive services and scheduled allowance for other services. **Standard Option -** Nothing for preventive services. All other dental services are *not covered*.	55
Vision care:	**High Option** - Office visit copayment: $20 primary care $40 specialist **Standard Option** - Office visit copayment: $25 primary care $40 specialist	30
Special features:		57
Protection against catastrophic costs (out-of-pocket maximum)**:**	**High Option** - Nothing after $2,000 per person or $6,000 per Self & Family enrollment per calendar year. **Standard Option -** Nothing after $3,000 per person or $9,000 per Self & Family enrollment per calendar year. Some costs do not count toward this protection	17

Summary of benefits for the High Deductible Health Plan Option of TakeCare Health Plan - 2012

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover. For more detail, look inside. If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

In 2012 for each month you are eligible for the HSA, TakeCare will deposit $78.00 per month for Self Only enrollment or $205.83 per month for Self and Family enrollment to your HSA. For HSA, you must satisfy your calendar year deductible of $3,000 for Self Only or $6,000 for Self and Family before using your HSA. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of $1,040 for Self Only or $2,665 for Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

Below, an asterisk (*) means the item is subject to the $3,000 for individual or $6,000 for family enrollment per calendar year deductible. And, after we pay, you generally pay any difference between our eligible charge and the billed amount if you use a Non-Participating physician or other health care professional.

Benefits	You Pay	Page
In-network medical preventive care	Nothing at a network provider	70
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	**In-network –** 20% coinsurance* **Out-of-network –** 30% of our Plan eligible charges and any difference between our eligible charges and billed amount *	73
Services provided by a hospital:		
• Inpatient	**In-network** – 20% coinsurance* **Out-of-network** – 30% of our Plan eligible charges and any difference between our eligible charges and billed amount *	86
• Outpatient	**In-network** – 20% coinsurance* **Out-of-network** – 30% of our Plan eligible charges and any difference between our eligible charges and billed amount *	87
Emergency benefits:		89
• In-area	**In-network** - $75 per ER visit **Out-of-network** – All charges until deductible is met then 30% of our eligible charges *	90
• Out-of-area	**In-network** - $75 per ER visit **Out-of-network** – All charges until deductible is met then 30% of our eligible charges*	90
Mental health and substance abuse treatment:	**In-network** – 20% coinsurance*	91

	Out-of-network – 30% of our Plan eligible charges and any difference between our eligible charges and billed amount *	
Prescription drugs:		94
• Retail pharmacy	**In-network:** • **Retail Pharmacy (30 day supply)** - $20 for generic formulary - $40 for brand formulary - $80 for each non-formulary - $100 specialty drugs - $150 for Injectable drugs **Out-of-network:** • **Retail Pharmacy (30 day supply)** 30% of network prices after deductible	95
• Mail order	**In-network: (90 day supply)** • $40 for generic formulary • $80 for brand formulary • $160 for each non-formulary • $200 for specialty drugs • $300 for Injectable drugs **Out-of-network:** *All charges – not a benefit*	95
Dental care:	Nothing for preventive services and scheduled allowance for other services.	97
Vision care:	**In-network** – 20% coinsurance* **Out-of-network** – 30% of our Plan eligible charges and any difference between our eligible charges and billed amount *	77
Special features:		98
Annual deductible	**In-network -** $3,000 – Self Only; $6,000 Self and Family **Out-of-network** - $3,000 – Self Only; $6,000 Self and Family	72
Protection against catastrophic costs (out-of-pocket maximum)	**In-network** - $5,000 – Self Only; $10,000 Self and Family **Out-of-network** - $10,000 – Self Only; $20,000 Self and Family	72

2012 Rate Information for - TakeCare Health Plans

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal Category 1 rates apply to career employees covered by the National Postal Mail Handlers Union (NPMHU), National Association of Letter Carriers (NALC) and Postal Police bargaining units.

Postal Category 2 rates apply to other non-APWU, non-PCES, non-law enforcement Postal Service career employees, including management employees, and employees covered by the National Rural Letter Carriers' Association bargaining unit.

Special Guides to Benefits are published for American Postal Workers Union (APWU) employees (see RI 70-2A) including Material Distribution Center, Operating Services and Information Technology/Accounting Services employees and Nurses; Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees (see RI 70-2IN), Postal Career Executive Service (PCES) employees (see RI 70-2EX), and noncareer employees (see RI 70-8PS).

Career APWU employees hired before May 23, 2011, will have the same rates as the Category 2 rates shown below. In the Guide to Benefits for APWU Employees (RI 70-2A) this will be referred to as the "Current" rate; otherwise, "New" rates apply.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center

1-877-477-3273, option 5

TTY: 1-866-260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable *Guide to Federal Benefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	JK1	172.35	57.45	373.43	124.47	37.92	35.62
High Option Self and Family	JK2	414.35	189.51	897.76	410.60	143.47	137.71
Standard Option Self Only	JK4	152.90	50.97	331.29	110.43	33.64	31.60
Standard Option Self and Family	JK5	403.79	134.59	874.87	291.62	88.83	83.45
HDHP Option Self Only	KX1	112.68	37.56	244.14	81.38	24.79	23.29
HDHP Option Self and Family	KX2	296.90	98.96	643.28	214.42	65.32	61.36