NetCare
Life & Health Insurance

ADVANTAGE PLAN POS
MEDICAL
Schedule of Benefits

The medical services listed on these pages are medical benefits for the ADVANTAGE PLAN POS. This POS Medical Plan is a summation of benefits. Detailed description of benefits, co-payments, deductibles & procedures are found in your Summary Plan Description, Summary of Benefit Coverage, or Uniform Glossary. A listing of participating providers can be found in NetCare's Provider Directory. Copies of these documents may be obtained by calling NetCare at 671-472-3610 or www.netcarelifeandhealth.com

BENEFIT DESCRIPTION	WHAT YOU PAY AT PARTICIPATING PROVIDERS
DEDUCTIBLE (Subject to UCR)	NONE
PHYSICIAN & OUTPATIENT BENEFITS	
1. Primary Care Office Visit at PCP	$10 co-pay
2. Specialist Care Office Visit & Non-PCP Office Visit	$25 co-pay
3. Second Surgical Opinion	$25 co-pay
4. Home Health Care	$25 co-pay
5. Hospice ($50 per day/180 days Lifetime) Pre-certification required	$25 co-pay
6. Injections (Does not include Specialty and Orthopedic Injections)	$25 co-pay
7. Outpatient Laboratory Services	$10 co-pay
8. Outpatient X-ray Services	$10 co-pay per x-ray
9. Outpatient Surgery (Pre-certification required)	$100 co-pay
10. Private Duty Nursing	$25 co-pay
URGENT CARE	
1. Clinic Setting	$25 co-pay
2. Hospital Setting	$100 co-pay
HOSPITALIZATION (Inpatient Services) All inpatient admissions require a NetCare approved referral within 48 hours of admission.	
1. Room & board for semi-private room, intensive care, coronary care & surgery; All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia, medication & physician's services	• Centers of Care - No charge for covered inpatient charges. • GMHA & GRMC - $100 per day for the first 5 inpatient days. • Other Hospitals - 20% of covered inpatient charges.
2. Skilled Nursing Facility - Limited to 60 days per contract period	
3. Inpatient Mental Health & Chemical/Substance Treatment	
EMERGENCY & NON-EMERGENCY SERVICES	
1. On or Off-island Emergency services	20% of covered charges
2. Non-emergency services rendered in a hospital emergency room	$100 co-pay plus 20% of covered charges
3. Ambulance Service (limited to ground transportation)	$100 co-pay
ROUTINE ANNUAL EXAMS & IMMUNIZATIONS - Preventive guidelines established by U.S. Preventive Services Task Force, Grades A or B	
Preventive Care for Adults, Child & Baby	
1. Routine Annual Physical Exam - Limited to one exam per contract period	No Charge
2. Routine Annual Gynecological Exam - Limited to one exam per contract period	No Charge
3. Routine Annual Mammograms - Age 40+	No Charge
4. Routine Annual Eye Exam - Limited to one exam per contract period	No Charge
5. Routine Annual Immunizations - Per CDC Guidelines	No Charge
6. Routine Annual Health Screening	No Charge
7. Routine Annual Outpatient Laboratory & Outpatient X-ray	No Charge

PRESCRIPTION DRUGS (www.optumrx.com)

Out of pocket maximum $3,000 Individual/$9,000 Family	**Retail/Pharmacy**	**Mail Order**	**Out of Network**
1. Generic drugs	$ 5 per unit	$ 0 (90 days)	50% of AWP
2. Brand drugs	$ 15 per unit	$ 0 (90 days)	50% of AWP
3. Non-formulary drugs	30% of covered charges	$150 (90 days)	Not Covered
4. Injectables	30% of covered charges	30% + shipping	Not Covered

Additional information can be found within this document.

ALLERGY - Testing & Treatment limited to $500 per Contract Period	$25 co-pay
AUTISM SPECTRUM DISORDER	20% of covered charges
BLOOD, BLOOD PRODUCTS & DERIVATIVES Limited to $50,000 per Contract Period	20% of covered charges
CARDIAC CARE	
Specialist Office Visit	$25 co-pay
Cardiac Surgery (Pre-certification required)	• Centers of Care - No charge for covered inpatient charges. • GMHA & GRMC - $100 per day for the first 5 inpatient days. • Other Hospitals - 20% of covered inpatient charges.
CHEMICAL DEPENDENCY/SUBSTANCE ABUSE (OUTPATIENT)	$25 co-pay

Advantage Plan POS

BENEFIT DESCRIPTION	WHAT YOU PAY AT PARTICIPATING PROVIDERS
DEDUCTIBLE (Subject to UCR)	NONE
CHEMOTHERAPY, RADIATION THERAPY & NUCLEAR MEDICIN Pre-certification required	$100 co-pay per procedure
CHIROPRACTIC - Limited to $2,000 per Contract Period	$10 co-pay
CHRONIC ORTHOPEDIC DEFORMITY & CONDITIONS Pre-certification required Limited to $50,000 per Contract Period for all related services	20% of covered charges
CONGENITAL DISEASES - Limited to $15,000 per Contract Period. Pre-certification required.	
1. Primary Care Office Visit at PCP	$10 co-pay
2. Specialist Care Office Visit & Non-PCP Office Visit	$25 co-pay
3. Hospitalization (Hospitalization & Inpatient Benefits apply)	$100 co-pay per day for the first 5 inpatient days
DIAGNOSTIC TESTING MRI, Mammogram, CT Scan, EKG, Ultrasound, Cardiac Stress Test, Cardiac Catherization, Coronary Angiography, Bone Scan, Biopsy and any other diagnostic procedure. Limited to one test per anatomical region per contract period. Pre-certification required. Approval based on medical review.	$100 co-pay per procedure
DURABLE MEDICAL EQUIPMENT (DME) Includes standard hospital bed, standard wheelchair, crutches, portable commode, oxygen concentrator, bili-lite, nebulizer, wigs after chemotherapy. Limited to rental only. Pre-certification required.	$100 co-pay
FITNESS BENEFIT & REWARD Limited to participating fitness centers and attendance 8 times/month	Plan pays up to $180 Cash Reward
MATERNITY CARE All inpatient admissions require a NetCare approved referral within 48 hours of admission.	
1. Pre-natal / Post-natal Care Visit (Includes one routine ultrasound)	No Charge
2. Delivery: Hospital Facility	$100 co-pay for the first 5 inpatient days
3. Delivery: Birthing Center (Limited to Guam)	$100 co-pay
4. Delivery: Centers of Care	No Charge
5. Delivery: Professional Fee	No Charge
6. Circumcision: Within 30 days of date of birth (Pre-certification required)	$50 co-pay
7. Breastfeeding Equipment (limited to rental only)	No Charge
MENTAL HEALTH TREATMENT (OUTPATIENT)	
First 20 visits	$25 co-pay
All visits thereafter	$50 co-pay plus 20% of covered charges
OCCUPATIONAL THERAPY Maximum of 10 visits per Contract Period. Pre-certification required.	$25 co-pay
PHYSICAL THERAPY Maximum of 20 visits per Contract Period. Pre-certification required.	$25 co-pay
RECONSTRUCTIVE BREAST SURGERY Limited to the following in accordance with the Women's Health & Cancer Rights Act of 1998. Pre-certification required.	
1. Primary Care Office Visit at PCP	$10 co-pay
2. Specialist Care Office Visit & Non-PCP Office Visit	$25 co-pay
3. Hospitalization (Hospitalization & Inpatient Benefits apply)	$100 co-pay per day for the first 5 inpatient days
•Reconstruction of the breast on which a Mastectomy was performed due to cancer •Surgery and reconstruction of other breast to produce symmetrical appearance •Prostheses and treatment of physical complication, including Lymphedemas & wigs	
SPEECH THERAPY (OUTPATIENT) Limited to 20 visits per Contract Period. Pre-certification required.	$25 co-pay
STERILIZATION PROCEDURES Outpatient Tubal Ligation or Vasectomy at PCP or Surgicenter Pre-certification required	No Charge
WELLNESS Member co-insurance may be reimbursed upon program completion	20% of covered charges

GROUP TERM LIFE INSURANCE (optional group benefit)	Plan pays $5,000 Basic + $5,000 AD&D
ANNUAL PLAN MAXIMUM	Unlimited
LIFETIME MAXIMUM	Unlimited
ANNUAL OUT-OF-POCKET MAXIMUM	
1. Per Individual Per Contract Period	$2,000.00
2. Per Family Per Contract Period	$6,000.00

CENTERS OF CARE shall be defined as a Participating Provider that is a Hospital or Ambulatory Surgical Center located outside of the Service Area. The Hospital or Ambulatory Surgical Center shall be a Participating Provider at the time services are rendered to the Covered Person and shall be specifically designated by name as a Center of Care in the more recent of NetCare's most current brochure or NetCare's most current updated Provider Directory.

COVERED CHARGES for Participating Providers are charges determined by NetCare to be the maximum amount that it will pay for a covered service to a health care provider. Any applicable co-payment will apply to the Eligible Charge. Covered Charges or Eligible Charges shall be defined as the reimbursement amounts agreed between the Company and the Participating Provider.

NON-GRANDFATHERED STATUS DISCLOSURE - This group health plan believes this plan is a non-grandfathered health plan under the Patient Protection and Affordable Care Act. Being a non-grandfathered health plan means that your policy includes certain consumer protections. Questions may be directed at NetCare at 671-472-3610 or EBSA at www.dol.gov/ebsa or DHHS at www.healthreformgov.

PHILIPPINE CARE - All covered benefits/services rendered at NetCare's Philippine Centers of Care are 100% of covered charges, subject to pre-certification requirements, approved referrals and plan benefit limits.

PRIMARY CARE PROVIDER (PCP) - A PCP is a physician who provides primary or routine care. Each enrolled member is paneled to a PCP by election or assignment. Member out-of-pocket expense is determined by care at a PCP or non-PCP. A specialist provider may be chosen as a PCP provided the specialist allows primary or routine patient care.

PRESCRIPTION DRUGS - NetCare adopted a mandatory generic program, which means prescription drugs are limited to covered generic drugs. Additional charges will apply for non-generic prescription drugs that include copayment of the non-generic drug plus the ingredient cost difference of the non-generic and generic drug. Contraceptives, including injectable contraceptives, are covered at no charge for generic retail & generic mail order at participating providers. Brand & non-formulary contraceptives at participating providers are subject to Plan benefits. Specialty drugs purchased on Guam & Hawaii are limited to Kmart Pharmacy. Preventive drug benefits are payable based on guidelines established by the U.S. Preventive Services Task Force grades A or B. Injectable drug copayments for specific drug classes may fall under another copayment tier. Please refer to NetCare's current drug formulary for coverage and copayment tier.

PROVIDER NETWORK - Covered benefits and services are limited to participating providers on Guam. Charges for services rendered outside Guam and at non-participating providers are not covered by the plan.

REFERRALS - Referrals are not required for primary, specialty or covered ancillary services at participating providers on Guam. There is no coverage or payable benefits for services rendered outside Guam unless approved by NetCare, limited to Philippines.

RESIDENCY - Enrollment is limited to members who live on Guam and do not reside outside Guam for more than 90 consecutive days per Contract Period. A NetCare approved authorization is required for members receiving continuous medical care outside Guam that is not for long term medical treatment.

SERVICE AREA - The service area for this policy shall be defined as Guam.

UCR means Usual, Customary & Reasonable charges of the geographical location where service was rendered based on the current Medicare RBRVS/DRG. Charges in excess of UCR are not payable by the plan.

MEDICAL EXCLUSIONS

Medical services listed below are NOT covered by NetCare

- Airfare (unless criteria as set forth by the Plan has been met).
- Acupuncture.
- Biofeedback and other forms of self-care or self-help training.
- Blood derivatives used for experimental purposes.
- Care for military service connected disabilities to which a member is legally entitled.
- Care and services normally covered by Medicare Parts A & B for which the member is eligible and entitled to at no cost, but declined to enroll.
- Care or services rendered by immediate relatives or members of the enrollee's household, rendered as a duly licensed medical practitioner employed by a healthcare providers.
- Chronic Brain Syndrome, or custodial care charges resulting from senile deterioration.
- Cost of care or treatment related to diseases, illness, or injuries where payment is provided for under local laws or programs, federal acts, industrial insurance, automobile insurance or Worker's Compensation programs.
- Custodial care, domiciliary or convalescent care, or rest cures.
- Dental services except for surgical procedures as a result of accidental injury to natural teeth or jaw. Such services do no include include capping, bridges or retainers as benefits.
- Elective cosmetic treatment including but not limited to breast implants (unless after mastectomy due to cancer) cosmetic eye surgery (i.e. Lasik), etc.
- Emergency treatment provided outside the service area if the need for care could have been foreseen before departing the service area.
- Executive Physical Exams/Executive Check-up (Inpatient Physical Exam).
- Experimental medical, surgical and other health-care procedures.

MEDICAL EXCLUSIONS (continued)

Medical services listed below are NOT covered by NetCare

- Gastric Bypass, stapling or reversal, surgical correction (except as approved by the Plan).
- Hearing Aids.
- Hip Joint replacement surgery and all related treatment and services.
- Hyperbaric Oxygen Treatment (HBO).
- Implants including but not limited to dissolvable implants, non-human artificial or mechanical organ, breast implants, penile prosthesis, cornea, intra-ocular lenses, artificial joints and limbs, etc. except for cardiac pacemakers, cardiac stents, & covered contraceptive devices.
- Infertility services and care related to conception by artificial means, including artificial insemination, in-vitro fertilization and embryo transfers, sterilization unless medically necessary, cost of care and treatment for reversal of sterilization and treatment or correction of infertility.
- Inpatient and outpatient services and care provided to dependents of a non-spouse dependent.
- Intentionally self-inflicted injury, while sane or insane unless or from a domestic violence dispute.
- Injury or illness incurred as a result of attempted suicide.
- Interrupted pregnancy (non-medically necessary), non-life threatening abortions unless medically necessary.
- Living expenses including meals, hotel rooms, transportation, etc.
- Long term rehabilitation including but not limited to physical therapy, speech therapy, hand therapy, and occupational therapy.
- Medical treatment and services related to End Stage Renal Disease, including Dialysis.
- Nasal reconstruction except to correct a deformity as a result of an accidental injury which occurred within 90-days of the date of surgery, or the removal or treatment of cancer of the nose.
- Non-medical treatment of obesity (except as approved by the Plan).
- Orthopedic and external prosthetic devices including but not limited to shoes, orthotics, artificial limbs, etc.
- Over-the-counter drugs or drugs for which a prescription from a licensed physician is not required under federal law, inclusive of OTC contraceptives and devices and all non FDA approved drugs.
- Personal comfort items, such as but not limited to telephone, television, guest trays, electrical power, water and disposal systems, baths and pools at their installation, hospital room installation, hospital room upgrades & surcharges.
- Physical examinations and all services related thereto when required for obtaining or continuing employment, insurance, schooling, governmental licensing or sports activities.
- Pre-existing conditions and medical conditions excluded and noted on the policy.
- Prenatal ultrasound (except as approved by the Plan). Routine ultrasounds are limited to one per pregnancy term. Subsequent ultrasounds are not covered unless medically necessary and approved by the Plan.
- Prescription drugs not included in NetCare's mandatory generic drug program, unless approved by the Plan.
- Preventive care & services rendered at participating specialist providers, except for OB/GYN related services.
- Services provided by the covered person's spouse, child, brother, sister or parents whether by blood or by law.
- Services rendered by a non-participating provider, except for emergency care & services.
- Services rendered outside Guam other than at NetCare's direct contracted providers and NetCare's Centers of Care.
- Services rendered outside Guam without a NetCare approved referral.
- Services rendered for pre-certified benefits not approved by NetCare.
- Specialty drugs purchased at pharmacies other than Kmart Pharmacies in Guam & Hawaii. Specialty drugs purchased in the Continental United States and Philippines are not limited to Kmart Pharmacy and are subject to plan benefits.
- State & local taxes, administrative fees and handling/shipping charges.
- Temporomandibular (jaw) joint disorders and related diseases (TMJ).
- The purchases and/or fitting of eyeglasses or contact lenses (unless Vision Care Rider is elected), radical keratotomy or lasik.
- Transsexual surgery and related services.
- Treatment & services related to hepatitis without a NetCare approved prior authorization and strict criteria satisfaction.
- Treatment and services related to Organ Transplant.
- Treatment and services related to sleeping disorders, sleep evaluation & diagnosis.
- Treatment of acne related services, including prescription drugs.
- Treatment for adult circumcision procedures, if provided solely for cosmetic or religious purposes.
- Treatment for services and supplies related to sexual dysfunction (i.e. Viagra)
- Treatment for injuries sustained in the commission of an illegal act including but not limited to drunk driving (driving while intoxicated, or with an alcohol level of .08 or greater on the Draeger Alco Test, or blood alcohol level of 100-250 MG/DL).
- Treatment of injuries or illnesses sustained as a result of war or any acts of war, declared or undeclared.
- Treatment of injuries while participating in hazardous sports, such as but not limited to off-road, skydiving, etc.
- Any portion of an expense, charge or fee that exceeds the eligible charges and the Usual, Customary and Reasonable charge.
- Benefits and services not specified as covered.

NetCare
Life & Health Insurance

SMARTCHOICE *1500* PLAN

MEDICAL

Schedule of Benefits

The medical services listed on these pages are medical benefits for the Guam SMARTCHOICE Plan. This HDHP Medical Plan is a summation of benefits. Detailed description of benefits, co-payments, deductibles & procedures are found in your Summary Plan Description, Summary of Benefit Coverage, or Uniform Glossary. A listing of participating providers can be found in NetCare's Provider Directory. Copies of these documents may be obtained by calling NetCare at 671-472-3610 or at www.netcarelifeandhealth.com

BENEFIT DESCRIPTION	WHAT YOU PAY AT PARTICIPATING PROVIDERS	WHAT YOU PAY AT NON-PARTICIPATING PROVIDERS
DEDUCTIBLE (Subject to UCR)	**$1,500 Individual / $3,000 Family**	**$3,000 Individual / $6,000 Family**
PHYSICIAN & OUTPATIENT BENEFITS		
1. Primary Care Office Visit	20% of covered charges	30% of UCR
2. Specialist Care Office Visit	20% of covered charges	30% of UCR
3. Second Surgical Opinion	20% of covered charges	30% of UCR
4. Home Health Care	20% of covered charges	30% of UCR
5. Hospice ($50 per day/180 days Lifetime) Pre-certification required	20% of covered charges	30% of UCR
6. Injections (Does not include Specialty and Orthopedic Injections)	20% of covered charges	30% of UCR
7. Outpatient Laboratory Services	20% of covered charges	30% of UCR
8. Outpatient X-ray Services	20% of covered charges	30% of UCR
9. Outpatient Surgery (Pre-certification required)	20% of covered charges	30% of UCR
10. Private Duty Nursing	20% of covered charges	30% of UCR
URGENT CARE		
1. Clinic Setting	20% of covered charges	30% of UCR
2. Hospital Setting	20% of covered charges	
HOSPITALIZATION (Inpatient Services) All inpatient admissions require a NetCare approved referral within 48 hours of admission.		
1. Room & board for semi-private room, intensive care, coronary care & surgery; All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia, medication & physician's services 2. Skilled Nursing Facility - Limited to 60 days per contract period 3. Inpatient Mental Health & Chemical/Substance Treatment	• Centers of Care - No charge for covered inpatient charges. • GMHA & GRMC - 20% of covered inpatient charges. • Other Hospitals - 20% of covered inpatient charges.	30% of UCR
EMERGENCY & NON-EMERGENCY SERVICES		
1. On or off-island hospital emergency room service	20% of covered charges	20% of covered charges
2. Non-emergency services rendered in a hospital emergency room	50% of covered charges	50% of covered charges
3. Ambulance Service (limited to ground transportation)	20% of covered charges	20% of covered charges
ROUTINE ANNUAL EXAMS & IMMUNIZATIONS - Preventive guidelines established by U.S. Preventive Services Task Force, Grades A or B		
Preventive Care for Adults, Child & Baby (*Deductible does not apply to Routine Annual services*)		
1. Routine Annual Physical Exam - Limited to one exam per contract period	No Charge	30% of UCR
2. Routine Annual Gynecological Exam - Limited to one exam per contract period	No Charge	30% of UCR
3. Routine Annual Mammograms - Age 40+	No Charge	30% of UCR
4. Routine Annual Eye Exam - Limited to one exam per contract period	No Charge	Not Covered
5. Routine Annual Immunizations - Per CDC Guidelines	No Charge	30% of UCR
6. Routine Annual Health Screening	No Charge	30% of UCR
7. Routine Annual Outpatient Laboratory & Outpatient X-ray	No Charge	30% of UCR

PRESCRIPTION DRUGS (www.optumrx.com)	**Retail/Pharmacy**	**Mail Order**	**Out of Network**
1. Generic drugs	20% of covered charges	20% + shipping	Not Covered
2. Brand drugs	20% of covered charges	20% + shipping	Not Covered
3. Non-formulary drugs	50% of covered charges	50% + shipping	Not Covered
4. Injectables	50% of covered charges	50% + shipping	Not Covered

Additional drug information can be found within this document.

ACUPUNCTURE - Limited to $2,000 per Contract Period	20% of covered charges	30% of UCR
ALLERGY - Testing & Treatment limited to $500 per Contract Period	20% of covered charges	30% of UCR
AUTISM SPECTRUM DISORDER	20% of covered charges	30% of UCR
BLOOD, BLOOD PRODUCTS & DERIVATIVES Limited to $50,000 per Contract Period	20% of covered charges	30% of UCR
CARDIAC CARE		
Specialist Office Visit Cardiac Surgery (Pre-certification required)	20% of covered charges • Centers of Care - No charge for covered inpatient charges. • GMHA & GRMC - 20% of covered inpatient charges. • Other Hospitals - 20% of covered inpatient charges.	30% of UCR
CHEMICAL DEPENDENCY/SUBSTANCE ABUSE (OUTPATIENT)	20% of covered charges	30% of UCR

SmartChoice*1500* Plan

BENEFIT DESCRIPTION	WHAT YOU PAY AT PARTICIPATING PROVIDERS	WHAT YOU PAY AT NON-PARTICIPATING PROVIDERS
DEDUCTIBLE (Subject to UCR)	**$1,500 Individual / $3,000 Family**	**$3,000 Individual / $6,000 Family**
CHEMOTHERAPY, RADIATION THERAPY & NUCLEAR MEDICINE Pre-certification Required	20% of covered charges	30% of UCR
CHIROPRACTIC - Limited to $2,000 per Contract Period	20% of covered charges	30% of UCR
CHRONIC ORTHOPEDIC DEFORMITY & CONDITIONS Pre-certification Required Limited to $50,000 per Contract Period for all related services	20% of covered charges	30% of UCR
CONGENITAL DISEASES Pre-certification Required Limited to $15,000 per Contract Period for all related services	20% of covered charges	30% of UCR
DIAGNOSTIC TESTING MRI, Mammogram, CT Scan, EKG, Ultrasound, Cardiac Stress Test, Cardiac Catherization, Coronary Angiography, Bone Scan, Biopsy and any other diagnostic procedure. Limited to one test per anatomical region per contract period. Pre-certification required. Approval based on medical review.	20% of covered charges	30% of UCR
DURABLE MEDICAL EQUIPMENT (DME) Includes standard hospital bed, standard wheelchair, crutches, portable commode, oxygen concentrator, bili-lite, nebulizer, wigs after chemotherapy. Limited to rental only. Pre-certification required.	20% of covered charges	30% of UCR
FITNESS BENEFIT & REWARD (*Deductible does not apply)* Plan pays up to $15 per month (up to $180 per Contract Period) for attendance 8 times per month at participating gym or fitness center.	Plan pays up to $180 Cash Reward	
HYPERBARIC OXYGEN TREATMENT (HBO) Pre-certification Required Limited to $5,000 per Contract Period for all related services.	20% of covered charges	30% of UCR
MATERNITY CARE All inpatient admissions require a NetCare approved referral within 48 hours of admission.		
1. Pre-natal / Post-natal Care Visit (Includes one routine ultrasound) *(Deductible does not apply to Pre-natal & Post-natal Care Visits)*	No Charge	30% of UCR
2. Delivery: Hospital Facility	20% of covered charges	30% of UCR
3. Delivery: Birthing Center (Limited to Guam)	20% of covered charges	Not Covered
4. Delivery: Centers of Care	No Charge	30% of UCR
5. Delivery: Professional Fee	No Charge	30% of UCR
6. Circumcision: Within 30 days of date of birth. Pre-certification required.	20% of covered charges	30% of UCR
7. Breastfeeding Equipment (limited to rental only)(*Deductible does not apply)*	No Charge	30% of UCR
MENTAL HEALTH TREATMENT (OUTPATIENT)		
First 20 visits	20% of covered charges	30% of UCR
All visits thereafter	60% of covered charges	30% of UCR
OCCUPATIONAL THERAPY Maximum of 10 visits per Contract Period. Pre-certification required.	20% of covered charges	30% of UCR
ORGAN TRANSPLANT COVERAGE Limited to $50,000 lifetime for all related services. Pre-certification required.	20% of covered charges	30% of UCR
PHYSICAL THERAPY Maximum of 20 visits per Contract Period. Pre-certification required.	20% of covered charges	30% of UCR
RECONSTRUCTIVE BREAST SURGERY Limited to the following in accordance with the Women's Health & Cancer Rights Act of 1998. Pre-certification required. •Reconstruction of the breast on which a Mastectomy was performed due to cancer •Surgery and reconstruction of other breast to produce symmetrical appearance •Prostheses and treatment of physical complication, including Lymphedemas & wigs	20% of covered charges	30% of UCR
SLEEP MEDICINE Limited to $5,000 per Contract Period. Pre-certification required	20% of covered charges	30% of UCR
SPEECH THERAPY (OUTPATIENT) Limited to 20 visits per Contract Period. Pre-certification required.	20% of covered charges	30% of UCR
STERILIZATION PROCEDURES (*Deductible does not apply)* Outpatient Tubal Ligation or Vasectomy. Pre-certification required.	No Charge	30% of UCR
WELLNESS - Guidelines established by U.S. Preventive Services Task Force Member co-insurance may be reimbursed upon program completion *(Deductible does not apply to Wellness Programs)*	20% of covered charges	Not Covered

ANNUAL PLAN MAXIMUM	Unlimited	
LIFETIME MAXIMUM	Unlimited	
ANNUAL OUT-OF-POCKET MAXIMUM		
1. Per Individual Per Contract Period	$5,250.00	Not Applicable
2. Per Family Per Contract Period	$10,500.00	Not Applicable

COVERED CHARGES for Participating Providers are charges determined by NetCare to be the maximum amount that it will pay for a covered service to a health care provider. Any applicable co-payment will apply to the Eligible Charge. Covered Charges or Eligible Charges shall be defined as the reimbursement amounts agreed between the Company and the Participating Provider.

CENTERS OF CARE shall be defined as a Participating Provider that is a Hospital or Ambulatory Surgical Center located outside of the Service Area. The Hospital or Ambulatory Surgical Center shall be a Participating Provider at the time services are rendered to the Covered Person and shall be specifically designated by name as a Center of Care in the more recent of NetCare's most current brochure or NetCare's most current updated Provider Directory.

DEDUCTIBLE is the dollar amount applied to non-participating providers for covered benefits only. Non-covered benefits are not applicable toward your annual deductible. The individual deductible does not apply toward the family deductible amount. Therefore, the entire family must meet the family deductible before First Dollar benefits apply.

NON-GRANDFATHERED STATUS DISCLOSURE - This group health plan believes this plan is a non-grandfathered health plan under the Patient Protection and Affordable Care Act. Being a non-grandfathered health plan means that your policy includes certain consumer protections. Questions may be directed at NetCare at 671-472-3610 or EBSA at www.dol.gov/ebsa or DHHS at www.healthreformgov.

PHILIPPINE CARE - All covered benefits/services rendered at NetCare's Philippine Centers of Care are 100% of covered charges after the deductible is satisfied, subject to pre-certification requirements and plan benefit limits. The annual deductible must be satisfied before covered charges are payable.

PRESCRIPTION DRUGS - NetCare adopted a mandatory generic program, which means prescription drugs are limited to covered generic drugs. Additional charges will apply for non-generic prescription drugs that include copayment of the non-generic drug plus the ingredient cost difference of the non-generic and generic drug. Contraceptives, including injectable contraceptives, are covered at no charge for generic retail & generic mail order at participating providers. Brand & non-formulary contraceptives at participating providers are subject to Plan benefits. Specialty drugs purchased on Guam & Hawaii are limited to Kmart Pharmacy. Preventive drug benefits are payable based on guidelines established by the U.S. Preventive Services Task Force grades A or B. Injectable drug copayments for specific drug classes may fall under another copayment tier. Please refer to NetCare's current drug formulary for coverage and copayment tier.

PROVIDER NETWORK - Covered benefits and services rendered outside Guam are available at NetCare's direct contracted providers and NetCare's Centers of Care.

REFERRALS - Referrals are not required for primary, specialty or covered ancillary services on Guam. Covered benefits and services rendered outside Guam require a NetCare approved referral. No coverage will be provided outside Guam without a NetCare approved referral.

RESIDENCY - Enrollment is limited to members who live on Guam and do not reside outside Guam for more than 90 consecutive days per Contract Period. A NetCare approved authorization is required for members receiving continuous medical care outside Guam that is not for long term medical treatment.

SERVICE AREA - The service area for this policy shall be defined as Guam, CNMI and Palau.

UCR means Usual, Customary & Reasonable charges of the geographical location where service was rendered based on the current Medicare RBRVS/DRG. Covered services and annual deductibles at Non-participating Providers are subject to UCR. Charges in excess of UCR are not payable by the plan.

MEDICAL EXCLUSIONS

Medical services listed below are NOT covered by NetCare

- Airfare (unless criteria as set forth by the Plan has been met).
- Biofeedback and other forms of self-care or self-help training.
- Blood derivatives for experiemental purposes.
- Care for military service connected disabilities to which a member is legally entitled.
- Care and services normally covered by Medicare Parts A & B for which the member is eligible and entitled to at no cost, but declined to enroll.
- Care or services rendered by immediate relatives or members of the enrollee's household, rendered as a duly licensed medical practitioner employed by a healthcare providers.
- Chronic Brain Syndrome, or custodial care charges resulting from senile deterioration.
- Cost of care or treatment related to diseases, illness, or injuries where payment is provided for under local laws or programs, federal acts, industrial insurance, automobile insurance or Worker's Compensation programs.
- Custodial care, domiciliary or convalescent care, or rest cures.
- Dental services except for surgical procedures as a result of accidental injury to natural teeth or jaw. Such services do no include include capping, bridges or retainers as benefits.
- Elective cosmetic treatment including but not limited to breast implants (unless after mastectomy due to cancer) cosmetic eye surgery (i.e.. Lasik), etc.
- Emergency treatment provided outside the service area if the need for care could have been foreseen before departing the service area.
- Executive Physical Exams/Executive Check-up (Inpatient Physical Exam).

MEDICAL EXCLUSIONS (continued)

Medical services listed below are NOT covered by NetCare

- Experimental medical, surgical and other health-care procedures.
- Gastric Bypass, stapling or reversal, surgical correction (except as approved by the Plan).
- Hearing Aids.
- Hip Joint replacement surgery and all related treatment and services.
- Implants including but not limited to dissolvable implants, non-human artificial or mechanical organ, breast implants, penile prosthes cornea, intra-ocular lenses, artificial joints and limbs, etc. except for cardiac pacemakers, cardiac stents, & covered contraceptive devic
- Infertility services and care related to conception by artificial means, including artificial insemination, in-vitro fertilization and embryo transfers, sterilization unless medically necessary, cost of care and treatment for reversal of sterilization and treatment or correction of infertility.
- Inpatient and outpatient services and care provided to dependents of a non-spouse dependent.
- Intentionally self-inflicted injury, while sane or insane unless or from a domestic violence dispute.
- Injury or illness incurred as a result of attempted suicide.
- Interrupted pregnancy (non-medically necessary), non-life threatening abortions unless medically necessary.
- Living expenses including meals, hotel rooms, transportation, etc.
- Long term rehabilitation including but not limited to physical therapy, speech therapy, hand therapy, and occupational therapy.
- Medical treatment and services related to End Stage Renal Disease, including Dialysis
- Nasal reconstruction except to correct a deformity as a result of an accidental injury which occurred within 90-days of the date of surgery, or the removal or treatment of cancer of the nose.
- Non-medical treatment of obesity (except as approved by the Plan).
- Orthopedic and external prosthetic devices including but not limited to shoes, orthotics, artificial limbs, etc.
- Over-the-counter drugs or drugs for which a prescription from a licensed physician is not required under federal law, inclusive of OTC contraceptives and devices and all non FDA approved drugs.
- Personal comfort items, such as but not limited to telephone, television, guest trays, electrical power, water and disposal systems, baths and pools at their installation, hospital room installation, hospital room upgrades & surcharges.
- Physical examinations and all services related thereto when required for obtaining or continuing employment, insurance, schooling, governmental licensing or sports activities.
- Pre-existing conditions and medical conditions excluded and noted on the policy.
- Prenatal ultrasound (except as approved by the Plan). Routine ultrasounds are limited to one per pregnancy term. Subsequent ultrasounds are not covered unless medically necessary and approved by the Plan.
- Prescription drugs not included in NetCare's mandatory generic drug program, unless approved by the Plan.
- Services provided by the covered person's spouse, child, brother, sister or parents whether by blood or by law.
- Services rendered outside Guam other than NetCare's direct contracted providers and NetCare's Centers of Care.
- Services rendered outside Guam without a NetCare approved referral.
- Services rendered for pre-certified benefits not approved by NetCare.
- Specialty drugs purchased at pharmacies other than Kmart Pharmacies in Guam & Hawaii. Specialty drugs purchased in the Continental United States and Philippines are not limited to Kmart Pharmacy and are subject to plan benefits.
- State & local taxes, administrative fees and handling/shipping charges.
- Temporomandibular (jaw) joint disorders and related diseases (TMJ).
- The purchases and/or fitting of eyeglasses or contact lenses (unless Vision Care Rider is elected), radical keratotomy or lasik.
- Transsexual surgery and related services.
- Treatment & services related to hepatitis without a NetCare approved prior authorization and strict criteria satisfaction.
- Treatment of acne related services, including prescription drugs.
- Treatment for adult circumcision procedures, if provided solely for cosmetic or religious purposes.
- Treatment for services and supplies related to sexual dysfunction (i.e.. Viagra)
- Treatment for injuries sustained in the commission of an illegal act including but not limited to drunk driving (driving while intoxicated, or with an alcohol level of .08 or greater on the Draeger Alco Test, or blood alcohol level of 100-250 MG/DL).
- Treatment of injuries or illnesses sustained as a result of war or any acts of war, declared or undeclared.
- Treatment of injuries while participating in hazardous sports, such as but not limited to off-road, skydiving, etc.
- Any portion of an expense, charge or fee that exceeds the eligible charges and the Usual, Customary and Reasonable charge.
- Benefits and services not specified as covered.