NetCare
Life & Health Insurance

PRIME PLAN
MEDICAL
BENEFITS & TERMS

The listed Covered Medical Expenses are benefits for the Guam Prime Plan. Detailed description of benefits, co-payments, deductibles and procedures can be found in your Group Service Agreement or Summary Plan Description. A listing of participating providers can be found in NetCare's Provider Directory by calling NetCare at 671-472-3610 or log on to www.netcarelifeandhealth.com for a copy.

BENEFIT DESCRIPTION	WHAT YOU PAY AT PARTICIPATING PROVIDERS	WHAT YOU PAY AT NON-PARTICIPATING PROVIDERS
ANNUAL DEDUCTIBLE (Subject to UCR)	**None**	**$500 Individual / $1,500 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)	20% of covered charges	Not Covered
6. Outpatient Laboratory Services	No charge	30% of UCR
7. Outpatient X-ray Services	20% of covered charges	30% of UCR
8. Outpatient Surgery	20% of covered charges	30% of UCR
9. Private Duty Nursing	20% of covered charges	30% of UCR
10. Urgent Care Visit	20% of covered charges	30% of UCR
HOSPITALIZATION & INPATIENT BENEFITS		
1. Room & board for semi-private room, intensive care, coronary care & surgery	No charge for covered charges at designated Centers of Care (COC) / 20% of covered charges at all other participating providers - including Guam Memorial Hospital	30% of UCR
2. All other inpatient hospital services including laboratory, x-ray physician services, operating room, anesthesia & medication		30% of UCR
3. Skilled Nursing Facility (Limited to 60-days per Contract Period)		30% of UCR
4. Inpatient Mental Health		30% of UCR
MATERNITY CARE		
1. Pre-natal & Post-natal Care Visits (Includes one routine ultrasound)	No charge	30% of UCR
2. Delivery - Hospital Facility & Birthing Center	20% of covered charges	30% of UCR
3. Delivery - At designated Centers of Care	No charge	30% of UCR
4. Delivery - Professional Fee	No charge	30% of UCR
5. Breastfeeding Equipment (Limited to rental only)	No charge	30% of UCR
6. Circumcision (Covered within 30 days from date of birth)	20% of covered charges	30% of UCR
EMERGENCY BENEFITS		
1. On & Off-island emergency facility, physician services, laboratory, x-rays	20% of covered charges	20% of covered charges
2. Ambulance Service (Limited to ground transportation due to bona fide emergency)	20% of covered charges	20% of covered charges
NON-EMERGENCY BENEFITS		
Non-emergency treatment in a hospital emergency room	20% of covered charges	20% of covered charges
ROUTINE ANNUAL EXAM/PREVENTIVE CARE -Preventive services guidelines established by the U.S. Preventive Services Task Force with Grade A or B		
1. Well-Baby/Child Care	No charge	30% of UCR
2. Annual Physical Exam	No charge	30% of UCR
3. Annual Gynecological Exam	No charge	30% of UCR
4. Annual Mammogram (Over 40 years of age)	No charge	30% of UCR
5. Routine Eye Exam (Limited to 1 visit per Contract Period)	No charge	Not Covered
6. Routine Immunizations (Per CDC Guidelines)	No charge	30% of UCR
7. Health Screening/Outpatient Laboratory/Outpatient X-ray	No charge	30% of UCR

PRESCRIPTION DRUGS	**Retail**	**Mail**	**Out of Network**
Limited to generics unless specified by physician (additional co-pay may apply)	**Member Pays**	**Member Pays**	**Member Pays**
1. Generic drugs	$ 5.00 co-payment	$ 0.00 co-payment for 90-days	50% of AWP
2. Brand name drugs	20% of covered drug	$30.00 co-payment for 90-days	50% of AWP
3. Non-Formulary drugs	30% of covered drug	$60.00 co-payment for 90-days	50% of AWP
4. Injectable drugs	30% of covered drug	30% of covered drug (+shipping)	50% of AWP

Contraceptives, including injectable contraceptives, are covered at no charge for generic retail & generic mail order at participating provider. Brand & non-formulary contraceptives at participating providers and all prescriptions filled at a non-participating providers/out-of-network are subject to co-payment & co-insurance benefits.

ACUPUNCTURE (Limited to $1,000 per Contract Period)	20% of covered charges	Not Covered
AIDS TREATMENT	20% of covered charges	50% of UCR
ALCOHOL/SUBSTANCE ABUSE TREATMENT (OUTPATIENT)	20% of covered charges	30% of UCR
ALLERGY TESTING/TREATMENT (Limited to $500 per Contract Period)	20% of covered charges	30% of UCR
BLOOD & BLOOD DERIVATIVES (Limited to cost of administration only)	20% of covered charges	30% of UCR
CARDIAC CARE	No charge for covered charges at	
1. Specialist Care Office Visit	designated Centers of Care (COC) /	30% of UCR
2. Cardiac Surgery	20% of covered charges at all other participating providers - including Guam Memorial Hospital	30% of UCR
CHEMOTHERAPY, RADIATION THERAPY, NUCLEAR MEDICINE	20% of covered charges	30% of UCR
CHIROPRACTIC CARE (Limited to $1,000 per Contract Period)	20% of covered charges	30% of UCR
CHRONIC ORTHOPEDIC CONDITION (Limited to $50,000 per Contract Period)		
1. Primary & Specialty Care Office Visit	20% of covered charges	30% of UCR
2. Hospitalization	20% of covered charges	30% of UCR
CONGENITAL DISEASES (Limited to $15,000 per Contract Period)		
1. Specialist Care Office Visit / Hospitalization	20% of covered charges	30% of UCR
DIAGNOSTIC TESTING		
MRI, CT Scan, Ultrasound, Cardiac Stress Test, Cardiac Catherization, Coronary Angiography, Bone Scan, Biopsy and any other diagnostic procedures. Limited to one test per Contract Period per anatomical region. Pre-certification required.	20% of covered charges	30% of UCR
DURABLE MEDICAL EQUIPMENT (DME) Includes standard hospital bed, standard wheelchair, crutches, oxygen concentrator, bili-lite, nebulizer. Limited to rental only.	20% of covered charges	Not Covered

BENEFIT DESCRIPTION	WHAT YOU PAY AT PARTICIPATING PROVIDERS	WHAT YOU PAY AT NON-PARTICIPATING PROVIDERS
FITNESS REWARD (Limited to participating Fitness Centers and attendance participation of 8 times per month).	Plan pay up to $100.00 Cash Reward	Not Covered
HYPERBARIC OXYGEN TREATMENT(HBO) (Limited to $5,000 per Contract Period)	20% of covered charges	30% of UCR
MENTAL HEALTH (OUTPATIENT)		
First 20 visits	20% of covered charges	30% of UCR
All visits thereafter	60% of covered charges	30% of UCR
OCCUPATIONAL THERAPY (Limited to 10 visits per Contract Period)	20% of covered charges	30% of UCR
ORGAN TRANSPLANT COVERAGE (Limited to $50,000 Lifetime)	20% of covered charges	30% of UCR
PHYSICAL THERAPY (Limited to 20 visits per Contract Period)	20% of covered charges	30% of UCR
RECONSTRUCTIVE BREAST SURGERY		
1. Primary & Specialty Care Office Visit	20% of covered charges	30% of UCR
2. Hospitalization/Surgery	20% of covered charges	30% of UCR
Limited to the following: ●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		
SLEEP MEDICINE Evaluation, Diagnosis, Treatment, Equipment (Limited to $5,000 per Contract Period)	20% of covered charges	30% of UCR
SPEECH THERAPY (Limited to 20 visits per Contract Period)	20% of covered charges	30% of UCR
STERILIZATION (Outpatient Tubal Ligation or Vasectomy)	No charge	30% of UCR
WELLNESS (Guidelines established by the U.S. Preventive Services Task Force) Member co-insurance may be reimbursed upon program completion	20% of covered charges	Not Covered
GROUP TERM LIFE INSURANCE (See policy provisions for coverage details)	Plan pays $5,000 Basic + $5,000 AD&D	
CONTRACT PERIOD MAXIMUM	Plan pays $2,000,000.00	
ANNUAL OUT-OF-POCKET MAXIMUM		
1. Per Individual Per Contract Period	$2,000.00	Not Applicable
2. Per Family Per Contract Period	$6,000.00	Not Applicable

COVERED CHARGES - The charge 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. The Eligible Charge will be the lesser of the actual charge of the negotiated charge for Participating Provider services. For non-participating provider services, the Eligible Charge will be the lesser of the actual charge or UCR in the geographic region where the service was rendered

DEDUCTIBLE - The dollar amount applied to 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.

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

REFERRALS - Referrals are not required for primary or specialty care at approved providers within and outside of the service area. However, we recommend for members to contact NetCare for referral assistance and allow ample time (2-4 weeks) to schedule appointments.

UCR - Usual Customary & Reasonable charges of the geographical location where service was rendered based on the current Medicare RBRVS/DRG.

Medical Exclusions: Services 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.
- 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 entitle 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 health care provider.
- 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 not 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 (ie. 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.
- 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 a non-human artificial or mechanical organ, breast implants, penile prosthesis, cornea, intra-ocular lenses, artificial joints and limbs, etc. except for cardiac pacemakers and stents.
- 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 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.
- Services provided by the covered person's spouse, child, brother, sister or parents whether by blood or by law.
- 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 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 (ie. 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.
- Whole blood and blood derivatives.
- 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.