NetCare
Life & Health Insurance

CNMI PREFERRED PLAN

MEDICAL

BENEFITS & TERMS

The listed Covered Medical Expenses are benefits for the CNMI Preferred 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 at www.netcarelifeandhealth.com or by calling NetCare at 671-472-3610 for a copy.

BENEFIT DESCRIPTION	WHAT YOU PAY AT PARTICIPATING PROVIDERS	WHAT YOU PAY AT NON-PARTICIPATING PROVIDERS
ANNUAL DEDUCTIBLE	**None**	**$200 Individual / $600 Family**
PHYSICIAN & OUTPATIENT BENEFITS		
1. Primary Care Office Visit	$5.00 co-payment	20% of UCR
2. Specialist Care Office Visit	$25.00 co-payment	20% of UCR
3. Second Surgical Opinion	$25.00 co-payment	20% of UCR
4. Home Health Care	$5.00 co-payment	20% of UCR
6. Outpatient Laboratory Services	$5.00 co-payment	20% of UCR
7. Outpatient X-ray Services	$5.00 co-payment	20% of UCR
8. Outpatient Surgery	$5.00 co-payment	20% of UCR
9. Private Duty Nursing	$5.00 co-payment	20% of UCR
10. Urgent Care Visit	$5.00 co-payment	20% of UCR
HOSPITALIZATION & INPATIENT BENEFITS		
1. Room & board for semi-private room, intensive care, coronary care & surgery	No charge for covered charges	20% of UCR
2. All other inpatient hospital services including laboratory, x-ray	per admission at Participating	20% of UCR
physician services, operating room, anesthesia & medication	Providers in Saipan, Guam, Philippines,	
3. Inpatient Mental Health	Asia, Hawaii and U.S.	20% of UCR
MATERNITY CARE		
1. Pre-natal & Post-natal Care Visits (Includes one routine ultrasound)	No Charge for covered charges	20% of UCR
2. Delivery - Hospital Facility (Hospitalization & Inpatient Benefits Apply)	No Charge for covered charges	20% of UCR
3. Delivery - Professional Fee	No Charge for covered charges	20% of UCR
4. Breastfeeding Equipment (Limited to rental only)	No Charge for covered charges	20% of UCR
5. Circumcision (Covered within 30 days from date of birth)	$5.00 co-payment	20% of UCR
EMERGENCY BENEFITS		
1. On & Off-island emergency facility, physician services, laboratory, x-rays	$5.00 co-payment	$5.00 co-payment
2. Ambulance Service (Limited to ground transportation due to bona fide emergency)	$5.00 co-payment	$5.00 co-payment
NON-EMERGENCY BENEFITS (Non-emergency treatment in a hospital emergency room)	50% of covered charges	20% of UCR
ROUTINE ANNUAL EXAM/PREVENTIVE CARE (Preventive guidelines established by the U.S. Preventive Services Task Force with Grade A or B)		
1. Well-Baby/Child Care	No Charge for covered charges	20% of UCR
2. Annual Physical Exam	No Charge for covered charges	20% of UCR
3. Annual Gynecological Exam	No Charge for covered charges	20% of UCR
4. Annual Mammogram (Over 40 years of age)	No Charge for covered charges	20% of UCR
5. Routine Eye Exam (Limited to 1 visit per Contract Period)	No Charge for covered charges	Not Covered
6. Routine Immunizations (Per CDC Guidelines)	No Charge for covered charges	20% of UCR
7. Health Screening/Out-patient Laboratory/Out-patient X-ray	No Charge for covered charges	20% 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.			
AIDS COVERAGE	20% of covered charges	50% of UCR
ALCOHOL/SUBSTANCE ABUSE TREATMENT (Limited to 10 Outpatient Visits)	$5.00 co-payment	20% of UCR
BLOOD & BLOOD DERIVATIVES (Limited to cost of administration only)	No Charge for covered charges	20% of UCR
CARDIAC CARE (Limited to $40,000 per Contract Period)		
1. Primary Care Office Visit	$5.00 co-payment	20% of UCR
2. Specialist Care Office Visit	$25.00 co-payment	20% of UCR
3. Cardiac Surgery (Limited to Centers of Care)	No Charge for covered charges	20% of UCR
CHEMOTHERAPY, RADIATION THERAPY, NUCLEAR MEDICINE (Limited to $20,000 per Contract Period)	No Charge for covered charges	20% of UCR
CHIROPRACTIC (Limited to $250 per Contract Period)	$5.00 co-payment	20% of UCR
CHRONIC ORTHOPEDIC CONDITION (Limited to $5,000 per Contract Period)		
1. Primary & Specialty Care Office Visit	20% of covered charges	20% of UCR
2. Hospitalization	20% of covered charges	20% of UCR
CONGENITAL DISEASES (Limited to $10,000 per Contract Period)		
1. Primary Care Office Visit	$5.00 co-payment	20% of UCR
2. Specialist Care Office Visit	$25.00 co-payment	20% of UCR
3. Hospitalization (Hospital & Inpatient Benefits Apply)	No Charge for covered charges	20% of UCR
DIAGNOSTIC TESTING		
MRI, CT Scan, Ultrasound, Cardiac Stress Test, Cardiac Catherization, Coronary Angiography, Bone Scan, Biopsy and any other diagnostic procedures. (Pre-certification may be required for some procedures)	20% of covered charges	20% 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	20% of UCR
MENTAL HEALTH (Limited to 10 Outpatient Visits)	$5.00 co-payment	20% of UCR
OCCUPATIONAL THERAPY (Limited to 5 visits per Contract Period)	$5.00 co-payment	20% of UCR

BENEFIT DESCRIPTION	WHAT YOU PAY AT PARTICIPATING PROVIDERS	WHAT YOU PAY AT NON-PARTICIPATING PROVIDERS
ORGAN TRANSPLANT COVERAGE (Limited to $20,000 Lifetime)	No Charge for covered charges	20% of UCR
PHYSICAL THERAPY (Limited to 8 visits per Contract Period)	$5.00 co-payment	20% of UCR
SPEECH THERAPY (Limited to 5 visits per Contract Period)	$5.00 co-payment	20% of UCR
STERILIZATION PROCEDURES (Outpatient Tubal Ligation or Vasectomy)	No Charge for covered charges	20% of UCR
1. Primary & Specialty Care Office Visit	20% of covered charges	20% of UCR
2. Hospitalization/Surgery	20% of covered charges	20% 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 physcial complication, including Lymphedemas		
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
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 - 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. The entire family must meet the family deductible before First Dollar benefits apply.

EMERGENCY CARE - Coverage for medical emergencies outside of CNMI will be subject to limitations of your Plan. NetCare must be notified immediately for hospitalization.

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

REFERRALS - Referrals are not required for primary or specialty care at approved providers in CNMI, Guam, Asia, Philippines or Hawaii. A NetCare approved referral is required for all services rendered in the Continental United States.

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.

- Acupuncture care & services.
- Airfare.
- Allergy testing and treatment.
- 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 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 health care provider.
- Chronic Brain Syndrome, or custodial care charges resulting from senile deterioration.
- Cost of care and services related to or for replacement of joints and use of prosthetic devices and artificial limbs.
- 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.
- 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.
- Hyperbaric Oxygen Treatment (HBO).
- 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, cost of care and treatment for reversal of sterilization and treatment or correction of infertility.
- 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 ESRD, 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).
- Non-spouse dependent maternity care, inpatient and outpatient, including but not limited to treatment for ectopic pregnancy, antepartum hemorrhage.
- 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.
- Services rendered in the Continental United States without a NetCare approved referral.
- 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.
- Treatment and services related to sleeping disorders.
- 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.