

The listed Covered Medical Expenses are benefits for the CNMI 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 at [www.netcarelifeandhealth.com](http://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
<b>ANNUAL DEDUCTIBLE</b>	<b>None</b>	<b>\$500 Individual / \$1,500 Family</b>
<b>PHYSICIAN &amp; OUTPATIENT BENEFITS</b>		
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
6. Outpatient Laboratory Services	20% of covered charges	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
<b>HOSPITALIZATION &amp; INPATIENT BENEFITS</b>		
1. Room & board for semi-private room, intensive care, coronary care & surgery	20% of covered charges	30% of UCR
2. All other inpatient hospital services including laboratory, x-ray, physician services, operating room, anesthesia & medication	per admission at Participating Providers in Saipan, Guam, Philippines, Asia, Hawaii and U.S.	30% of UCR
3. Inpatient Mental Health		30% of UCR
<b>MATERNITY CARE</b>		
1. Pre-natal & Post-natal Care Visits (Includes one routine ultrasound)	No Charge for covered charges	30% of UCR
2. Delivery - Hospital Facility (Hospitalization & Inpatient Benefits Apply)	20% of covered charges	30% of UCR
3. Delivery - Professional Fee	20% of covered charges	30% of UCR
4. Breastfeeding Equipment (Limited to rental only)	No Charge for covered charges	30% of UCR
5. Circumcision (Covered within 30 days from date of birth)	20% of covered charges	30% of UCR
<b>EMERGENCY BENEFITS</b>		
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 UCR
<b>NON-EMERGENCY BENEFITS (Non-emergency treatment in a hospital emergency room)</b>		
	50% of covered charges	50% of UCR
<b>ROUTINE ANNUAL EXAM/PREVENTIVE CARE (Preventive guidelines established by the U.S. Preventive Services Task Force with Grade A or B)</b>		
1. Well-Baby/Child Care	No Charge for covered charges	30% of UCR
2. Annual Physical Exam	No Charge for covered charges	30% of UCR
3. Annual Gynecological Exam	No Charge for covered charges	30% of UCR
4. Annual Mammogram (Over 40 years of age)	No Charge for covered charges	30% 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	30% of UCR
7. Health Screening/Out-patient Laboratory/Out-patient X-ray	No Charge for covered charges	30% of UCR
<b>PRESCRIPTION DRUGS</b>		
Limited to generics unless specified by physician (additional co-pay may apply)	<b>Retail</b> Member Pays	<b>Mail</b> Member Pays
1. Generic drugs	\$ 5.00 co-payment	\$ 0.00 co-payment for 90-days
2. Brand name drugs	20% of covered drug	\$30.00 co-payment for 90-days
3. Non-Formulary drugs	30% of covered drug	\$60.00 co-payment for 90-days
4. Injectable drugs	30% of covered drug	30% of covered drug (+shipping)
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 or co-insurance.		
<b>AIDS COVERAGE</b>		
	20% of covered charges	50% of UCR
<b>ALCOHOL/SUBSTANCE ABUSE TREATMENT (Limited to 10 Outpatient Visits)</b>		
	20% of covered charges	30% of UCR
<b>BLOOD &amp; BLOOD DERIVATIVES (Limited to cost of administration only)</b>		
	20% of covered charges	30% of UCR
<b>CARDIAC CARE (Limited to \$30,000 per Contract Period)</b>		
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. Cardiac Surgery (Limited to Centers of Care)	20% of covered charges	30% of UCR
<b>CHEMOTHERAPY, RADIATION THERAPY, NUCLEAR MEDICINE</b>		
(Limited to \$20,000 per Contract Period)	20% of covered charges	30% of UCR
<b>CHIROPRACTIC (Limited to \$250 per Contract Period)</b>		
	20% of covered charges	30% of UCR
<b>CHRONIC ORTHOPEDIC CONDITION (Limited to \$5,000 per Contract Period)</b>		
1. Primary & Specialty Care Office Visit	20% of covered charges	30% of UCR
2. Hospitalization	20% of covered charges	30% of UCR
<b>CONGENITAL DISEASES (Limited to \$10,000 per Contract Period)</b>		
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. Hospitalization (Hospital & Inpatient Benefits Apply)	20% of covered charges	30% of UCR
<b>DIAGNOSTIC TESTING</b>		
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	30% of UCR
<b>DURABLE MEDICAL EQUIPMENT (DME)</b>		
Includes standard hospital bed, standard wheelchair, crutches, oxygen concentrator, bili-lite, nebulizer. Limited to rental only.	20% of covered charges	Not Covered
<b>MENTAL HEALTH (Limited to 10 Outpatient Visits)</b>		
	20% of covered charges	30% of UCR
<b>OCCUPATIONAL THERAPY (Limited to 5 visits per Contract Period)</b>		
	20% of covered charges	30% of UCR

BENEFIT DESCRIPTION	WHAT YOU PAY AT PARTICIPATING PROVIDERS	WHAT YOU PAY AT NON-PARTICIPATING PROVIDERS
<b>ORGAN TRANSPLANT COVERAGE</b> (Limited to \$20,000 Lifetime)	20% of covered charges	30% of UCR
<b>PHYSICAL THERAPY</b> (Limited to 8 visits per Contract Period)	20% of covered charges	30% of UCR
<b>SPEECH THERAPY</b> (Limited to 5 visits per Contract Period)	20% of covered charges	30% of UCR
<b>STERILIZATION PROCEDURES</b> (Outpatient Tubal Ligation or Vasectomy)	No Charge for covered charges	30% of UCR
<b>RECONSTRUCTIVE BREAST SURGERY</b>		
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		
<b>WELLNESS</b> (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
<b>CONTRACT PERIOD MAXIMUM</b>	Plan pays \$2,000,000.00	
<b>ANNUAL OUT-OF-POCKET MAXIMUM</b>		
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. NetCare approved referrals are required for all services rendered in Hawaii and 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.