NetCare
Life & Health Insurance

ADVANTAGE PLAN POS MEDICAL

BENEFITS & TERMS

The listed Covered Medical Expenses are your benefits for the Advantage Plan POS. Detailed description of your benefits, co-payments, deductibles and procedures please refer to 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
PHYSICIAN & OUTPATIENT BENEFITS	
1. Primary Care Office Visit @ PCP	$10.00 co-payment
2. Specialist Care & Non-PCP Office Visit	$25.00 co-payment
3. Second Surgical Opinion	$25.00 co-payment
4. Home Health Care	$25.00 co-payment
5. Hospice ($50 per day/180 days Lifetime)	$25.00 co-payment
6. Outpatient Laboratory Services	No charge
7. Outpatient X-ray Services	$10.00 co-payment per x-ray
8. Outpatient Surgery	$100.00 co-payment
9. Private Duty Nursing	$25.00 co-payment
10. Urgent Care Visit	$25.00 co-payment
HOSPITALIZATION & INPATIENT BENEFITS	
1. Room & board for semi-private room, intensive care, coronary care & surgery All other inpatient hospital services including laboratory, x-ray physician services, operating room, anesthesia & medication	$100.00 co-payment per day for the first 5-days
2. Pre-Admission Testing	$25.00 co-payment
3. Skilled Nursing Facility (Limited to 60-days per Contract Period)	$100.00 co-payment per day for the first 5-days
4. Inpatient Mental Health	$100.00 co-payment per day for the first 5-days
MATERNITY CARE	
1. Pre-natal & Post-natal Care Visits (Includes one routine ultrasound)	No charge
2. Delivery - Hospital Facility	$100.00 co-payment per day for the first 5-days
3. Delivery - Birthing Center (Limited to Guam only)	$100.00 co-payment
4. Delivery - Professional Fee	No charge
5. Breastfeeding Equipment (Limited to rental only)	No charge
6. Circumcision (Covered within 30 days from date of birth)	$50.00 co-payment
EMERGENCY BENEFITS	
1. On & Off-island emergency facility, physician services, laboratory, x-rays	$100.00 co-payment
2. Ambulance Service (Limited to ground transportation due to bona fide emergency)	$100.00 co-payment
NON-EMERGENCY BENEFITS -Non-emergency treatment in a hospital emergency room	$100 co-payment plus 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
2. Annual Physical Exam	No charge
3. Annual Gynecological Exam	No charge
4. Annual Mammogram (Over 40 years of age)	No charge
5. Routine Eye Exam (Limited to 1 visit per Contract Period)	No charge
6. Routine Immunizations (Per CDC Guidelines)	No charge
7. Health Screening/Outpatient Laboratory/Outpatient X-ray	No charge

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.

ALCOHOL/SUBSTANCE ABUSE TREATMENT (OUTPATIENT)	$25.00 co-payment
BLOOD & BLOOD DERIVATIVES (Limited to cost of administration only)	$25.00 co-payment
CARDIAC CARE	
1. Specialist Care Office Visit	$25.00 co-payment
2. Cardiac Surgery	$100.00 co-payment per day for the first 5-days
CHEMOTHERAPY, RADIATION THERAPY, NUCLEAR MEDICINE (Limited to $15,000 per Contract Period)	$100.00 co-payment per procedure
CHIROPRACTIC (Limited to $1,000 per Contract Period)	$10.00 co-payment
CHRONIC ORTHOPEDIC CONDITION (Limited to $50,000 per Contract Period)	
1. Primary Care Office Visit @ PCP, Specialist Care Office Visit, Non-PCP Visit	20% of covered charges
2. Hospitalization	20% of covered charges
CONGENITAL DISEASES (Limited to $15,000 per Contract Period)	
1. Primary Care Office Visit @ PCP	$10.00 co-payment
2. Specialist Care Office Visit or Non-PCP	$25.00 co-payment
3. Hospitalization (Hospital & Inpatient Benefits Apply)	$100.00 co-payment per day for the first 5-days
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.	$100.00 co-payment per procedure Approval based on medical review
DURABLE MEDICAL EQUIPMENT (DME) Includes standard hospital bed, standard wheelchair, crutches, oxygen concentrator, bili-lite, nebulizer. Limited to rental only.	$100.00 co-payment
FITNESS REWARD (Limited to participating Fitness Centers and attendance 8 times/month)	Plan pays up to $100.00 Cash Reward
PHYSICAL THERAPY (Limited to 20 visits per Contract Period)	$25.00 co-payment

BENEFIT DESCRIPTION	WHAT YOU PAY AT PARTICIPATING PROVIDERS
MENTAL HEALTH (OUTPATIENT)	
First 20 visits	$25.00 co-payment
All visits thereafter	$50.00 co-payment plus 20% of covered charges
OCCUPATIONAL THERAPY (Limited to 10 visits per Contract Period)	$25.00 co-payment
RECONSTRUCTIVE BREAST SURGERY	
1. Primary Care Office Visit @ PCP	$10.00 co-payment
2. Specialist Care or Non-PCP Office Visit	$25.00 co-payment
3. Hospitalization/Surgery	$100.00 co-payment per day for the first 5-days
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	
SPEECH THERAPY (Limited to 20 visits per Contract Period)	$25.00 co-payment
STERILIZATION (Outpatient Tubal Ligation or Vasectomy @ PCP or Surgicenter)	No charge
WELLNESS (Guidelines established by the U.S. Preventive Services Task Force)	20% of covered charges
Member co-insurance may be reimbursed upon program completion	
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
2. Per Family Per Contract Period	$6,000.00

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

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. 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.

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

PRIMARY CARE PROVIDER (PCP) - A PCP, who provides primary or routine care, is required for each enrolled member.

PROVIDER NETWORK - Covered benefits and services are payable at participating providers within the service area. Services at non-participating providers outside the service area are not payable benefits, except when rendered at an emergency room.

REFERRALS - Referrals are not required for primary or specialty care within the service area. Referrals, approved by NetCare, are required before services rendered outside of Guam, except for emergency room services.

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).
- Acupuncture
- 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 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.
- 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, sterilization unless medically necessary, cost of care and treatment for reversal of sterilization and treatment or correction of infertility.
- Inpatient services related to non-spouse maternity (e.g. ectopic pregnancy, antepartum hemorrhage.
- 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 date of surgery, 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, school, 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 at providers outside of NetCare's specified Advantage Plan provider network except for emergency care.
- 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 and services related to organ transplant.
- 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, sleep evaluation & diagnosis.
- 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.