NetCare
Life & Health Insurance

ADVANTAGE PLAN HMO
MEDICAL
Benefits & Terms

The medical services listed on these pages are medical benefits for the ADVANTAGE PLAN HMO Plan. This HMO 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
DEDUCTIBLE (Subject to UCR)	**NONE**
PHYSICIAN & OUTPATIENT BENEFITS	
1. Primary Care Office Visit at PCP	$10 co-pay
2. Specialist Care 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)	$25 co-pay
6. Outpatient Laboratory Services	$10 co-pay
7. Outpatient X-ray Services	$10 co-pay per x-ray
8. Outpatient Surgery	$100 co-pay
9. Private Duty Nursing	$25 co-pay
10. Urgent Care Visit	$25 co-pay
HOSPITALIZATION (Inpatient Services)	
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 (when not followed by admission)	$100 co-pay
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	No Charge
8. Routine Annual Outpatient X-ray	No Charge

PRESCRIPTION DRUGS (www.optumrx.com)

Out of pocket maximum $2,000 Individual/$6,000 Family	**Retail/Pharmacy**	**Mail Order**	**Out of Network**
1. Generic drugs	$ 5 per unit	$ 0 (90 days)	Not Covered
2. Brand drugs	$ 15 per unit	$ 0 (90 days)	Not Covered
3. Non-formulary drugs	30% of covered charges	$150 (90 days)	Not Covered
4. Injectables	30% of covered charges	30% + shipping	Not Covered

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.

ALLERGY - Testing & Treatment limited to $500 per Contract Period	$25 co-pay	
AUTISM SPECTRUM DISORDER Diagnosis, treatment & behavioral therapy is limited per Contract Period to $50,000 up to age 8 years and $25,000 from ages 9 to 21 years.	20% of covered charges	30% of UCR
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	• Centers of Care - No charge for covered inpatient charges. • GMHA & GRMC - $100 per day for the first 5 inpatient days. • Other Hospitals - $100 per day for the first 5 inpatient days.	

Advantage Plan HMO

BENEFIT DESCRIPTION	WHAT YOU PAY AT PARTICIPATING PROVIDERS
DEDUCTIBLE (Subject to UCR)	**NONE**
CHEMICAL DEPENDENCY/SUBSTANCE ABUSE (OUTPATIENT)	$25 co-pay
CHEMOTHERAPY, RADIATION THERAPY & NUCLEAR MEDICINE	$100 co-pay per procedure
CHIROPRACTIC - Limited to $2,000 per Contract Period	$10 co-pay
CHRONIC ORTHOPEDIC DEFORMITY & CONDITIONS	
Limited to $50,000 per Contract Period for all related services	20% of covered charges
CONGENITAL DISEASES - Limited to $15,000 per Contract Period	
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.	$100 co-pay
FITNESS BENEFIT & REWARD	Plan pays up to $180 Cash Reward
Limited to participating fitness centers and attendance 8 times per month	
MATERNITY CARE	
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	$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	$25 co-pay
PHYSICAL THERAPY	
Maximum of 20 visits per Contract Period	$25 co-pay
RECONSTRUCTIVE BREAST SURGERY	
Limited to the following in accordance with the Women's Health & Cancer Rights Act of 1998	
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	$25 co-pay
STERILIZATION PROCEDURES	
Outpatient Tubal Ligation or Vasectomy at PCP or Surgicenter	No Charge
Pre-certification is required	
WELLNESS - Guidelines established by U.S. Preventive Services Task Force	20% of covered charges
Member co-insurance may be reimbursed upon program completion	

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 physician who provides primary or routine care. Each enrolled member must elect a PCP. The Affordable Care Act allows a member to elect a specialist provider as a PCP, provided the specialist allows primary or routine patient care.

PROVIDER NETWORK - Covered benefits and services are payable at participating providers within the service area. Services at non-participating providers and services outside the service area are not covered benefits.

REFERRALS - Referrals approved by NetCare are required for non-primary care and all services rendered outside Guam prior to services rendered. Emergency care and services at an emergency facility do not require a NetCare approved referral.

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

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.
- 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.

MEDICAL EXCLUSIONS (continued)

Medical services listed below are NOT covered by NetCare

- 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.
- 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 when rendered for emergency care & services.
- Services rendered at providers outside of NetCare's service area unless approved by NetCare.
- Services rendered at a non-PCP without a NetCare approved referal.
- 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 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.