NetCare
Life & Health Insurance

ADVANTAGE PLAN POS

MEDICAL

BENEFITS & TERMS

The medical services listed on these two pages are your benefits for the Advantage Plan POS. For a detailed description of your benefits, co-payments, deductibles and procedures, please refer to your Group Service Agreement or Member Handbook. For a listing of participating providers within our network, please refer to NetCare's Provider Directory or log on to www.netcarelifeandhealth.com

BENEFIT DESCRIPTION	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	100% of covered charges		
7. Outpatient X-ray Services	$10.00 co-payment per x-ray		
8. Outpatient Surgery	$100.00 co-payment		
9. 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 (Includes routine ultrasound)	100% of covered charges		
2. Delivery - Hospital Facility	$100.00 co-payment per day for the first 5-days		
Birthing Center (Limited to Guam only)	$100.00 co-payment		
3. 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)	$100.00 co-payment		
NON-EMERGENCY BENEFITS			
Non-emergency treatment in a hospital emergency room	80% of covered charges after $100 co-payment		
ROUTINE ANNUAL EXAM/PREVENTIVE CARE			
1. Well-Baby Care (Up to age 2; Limited to 5 visits per Contract Period)	100% of covered charges		
2. Annual Physical Exam @ PCP	100% of covered charges		
3. Anuual Gynecological Exam @ PCP	100% of covered charges		
4. Annual Mammogram (over 40 years of age) @ PCP	100% of covered charges		
5. Annual Eye Exam (maximum of $50 per contract period)	100% of covered charges		
6. Routine Immunizations @ PCP	100% of covered charges		
7. Health Screening @ PCP/Outpatient Laboratory/Outpatient X-ray	100% of covered charges		
PRESCRIPTION DRUGS			
Limited to generics unless specified by physician (additional co-pay may apply)	**Retail**	**Mail**	**Out of Network**
1. Generic drugs	$ 0.00 co-payment	$ 0.00 for 90-days	50% of AWP
2. Brand name drugs	$15.00 co-payment	$30.00 for 90-days	50% of AWP
3. Non-Formulary drugs	$30.00 co-payment	$60.00 for 90-days	50% of AWP
4. Injectable drugs	15% per unit	15% plus shipping	50% of AWP
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		
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		
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		
STERILIZATION PROCEDURES (Outpatient Tubal Ligation or Vasectomy @ PCP or Surgicenter)	$50.00 co-payment		
BLOOD & BLOOD DERIVATIVES (Limited to cost of administration only)	$25.00 co-payment		
CHIROPRACTIC (Limited to $1,000 per Contract Period)	$10.00 co-payment		
PHYSICAL THERAPY (Limited to $1,500 per Contract Period)	$25.00 co-payment		
SPEECH THERAPY (Limited to $400 per Contract Period/100 2-hr sessions lifetime)	$25.00 co-payment		
DURABLE MEDICAL EQUIPMENT (DME) Includes standard hospital bed, standard wheelchair, crutches, oxygen concentrator, bili-lite, nebulizer. Limited to rental only.	$100.00 co-payment		
CHRONIC ORTHOPEDIC CONDITION (Limited to $50,000 per Contract Period)			
1. Primary Care Office Visit @ PCP	80% of covered charges		
2. Specialist Care Office Visit or Non-PCP	80% of covered charges		
3. Hospitalization	80% of covered charges		

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	
ALCOHOL/SUBSTANCE ABUSE TREATMENT (OUTPATIENT) (Limited to $8,000 per member per contract period; Lifetime of $16,000 per member)	$25.00 co-payment	
MENTAL HEALTH (OUTPATIENT)		
Fist 20 visits	100% covered after $25.00 co-payment	
All visits thereafter	80% covered after $50.00 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		
FITNESS REWARD (Limited to participating Fitness Centers and attendance participation of 8 times per month).	Up to $100.00 Cash Reward	
WELLNESS BENEFIT	80% of covered charges	
GROUP TERM LIFE INSURANCE (See policy provisions for coverage details)	$5,000 Basic Coverage + $5,000 AD&D	
ANNUAL PLAN MAXIMUM		
1. Individual Lifetime Maximum	$1,000,000.00	
2. Individual Annual Maximum	$200,000.00	
ANNUAL CO-PAYMENT MAXIMUM		
1. Per individual per contract period	$2,000.00	None
2. Per family per contract period	$6,000.00	None

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.

PROVIDER NETWORK - Services must be rendered by participating providers. There is no coverage for services rendered by non-participating providers. For a detailed list participating providers, please refer to NetCare's Provider Directory.

PRIMARY CARE PROVIDER (PCP) - A PCP is required for each enrolled member. Please refer to NetCare's Provider Directory for your PCP election.

REFERRALS - Referrals approved by NetCare are required before services are rendered outside of Guam.

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

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).
- Allergy Testing.
- Acupunture.
- 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 Sydrome, 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 medicall necessary.
- Living expenses including meals, hotel rooms, transportation, etc.
- Long term rehabilitation and physical therapy.
- Medical treatment and services related to 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.
- 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 at providers outside of NetCare's specified Advantage Plan provider network.
- 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 Occupational therapy, including hand therapy.
- 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.