NetCare
Life & Health Insurance

STANDARD PLAN
MEDICAL
BENEFITS & TERMS

The medical services listed on these two pages are your benefits for the Guam Standard Plan. 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	NON-PARTICIPATING PROVIDERS
ANNUAL DEDUCTIBLE (Subject to UCR)	**None**	**$300 Individual / $900 Family**
PHYSICIAN & OUTPATIENT BENEFITS		
1. Primary Care Office Visit	$10.00 co-payment	70% of UCR
2. Specialist Care Office Visit	$25.00 co-payment	70% of UCR
3. Second Surgical Opinion	$25.00 co-payment	70% of UCR
4. Home Health Care	$10.00 co-payment	70% of UCR
5. Hospice ($50 per day/180 days/Lifetime)	$10.00 co-payment	70% of UCR
6. Outpatient Laboratory Services	100% of covered charges	70% of UCR
7. Outpatient X-ray Services	$10.00 co-payment per x-ray	70% of UCR
8. Outpatient Surgery	$100.00 co-payment	70% of UCR
9. Urgent Care Visit	$25.00 co-payment	70% of UCR
HOSPITALIZATION & INPATIENT BENEFITS		
1. Room & board for semi-private room, intensive care, coronary care & surgery	100% of covered charges at	70% of UCR
2. All other inpatient hospital services including laboratory, x-ray	designated Centers of Care (COC);	70% of UCR
physician services, operating room, anesthesia & medication	*80% of covered charges at all other	
3. Skilled Nursing Facility (Limited to 60-days per contract period)	participating providers - including	70% of UCR
4. Inpatient Mental Health	Guam Memorial Hospital	70% of UCR
*100% of covered charges for the Standard Modified Plan		
MATERNITY CARE		
1. Pre-natal & Post-natal Care (Includes routine ultrasound)	100% of covered charges	70% of UCR
2. Delivery - Hospital Facility	*80% of covered charges	70% of UCR
Delivery - Birthing Center	*$100.00 co-payment	
Delivery (at designated Centers of Care)	100% of covered charges	70% of UCR
3. Circumcision (covered within 30 days from date of birth)	$100.00 co-payment	70% of UCR
4. Non-Spouse Maternity (Limited $500 outpatient pre-natal services per contract perioc	$10.00 co-payment	70% of UCR
*100% of covered charges for the Standard Modified Plan		
EMERGENCY BENEFITS		
1. On & Off-island emergency facility, physician services, laboratory, x-rays	$50.00 co-payment	$50.00 co-payment
2. Ambulance Service (Limited to ground transportation)	$50.00 co-payment	$50.00 co-payment
NON-EMERGENCY BENEFITS		
Non-emergency treatment in a hospital emergency room	50% of covered charges	50% of UCR
ROUTINE ANNUAL EXAM/PREVENTIVE CARE		
1. Well-Baby Care (Up to age 2; Limited to 5 visits per contract period)	100% of covered charges	70% of UCR
2. Annual Physical Exam	100% of covered charges	70% of UCR
3. Anuual Gynecological Exam	100% of covered charges	70% of UCR
4. Annual Mammogram (over 40 years of age)	100% of covered charges	70% of UCR
5. Annual Eye Exam (maximum of $50 per contract period)	100% of covered charges	70% of UCR
6. Routine Immunizations	100% of covered charges	70% of UCR
7. Health Screening/Outpatient Laboratory/Outpatient X-ray	100% of covered charges	70% of UCR
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-day	50% of AWP
3. Non-Formulary drugs	$30.00 co-payment / $60.00 for 90-day	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.	80% of covered charges	70% of UCR
CARDIAC CARE		
1. Specialist Care Office Visit	$25.00 co-payment	70% of UCR
2. Cardiac Surgery	100% of covered charges @ COC;	70% of UCR
*100% of covered charges for the Standard Modified Plan	*80% of covered charges at par providers	
CHEMOTHERAPY, RADIATION THERAPY, NUCLEAR MEDICINE	80% of covered charges	70% of UCR
CONGENITAL DISEASES		
(Limited to $15,000 per Contract Period)		
1. Specialist Care Office Visit	80% of covered charges	70% of UCR
2. Hospitalization	80% of covered charges	70% of UCR
STERILIZATION PROCEDURES (Outpatient Tubal Ligation or Vasectomy)	$100.00 co-payment	70% of UCR
BLOOD & BLOOD DERIVATIVES (Limited to cost of administration only)	100% of covered charges	70% of UCR
ORGAN TRANSPLANT COVERAGE (Limited to $50,000 Lifetime)	80% of covered charges	70% of UCR
ALLERGY TESTING (Limited to $500 per Contract Period)	$10.00 co-payment	70% of UCR
ACUPUNCTURE (Limited to $1,000 per Contract Period)	No co-payment	Not Covered
CHIROPRACTIC (Limited to $1,000 per Contract Period)	$10.00 co-payment	70% of UCR
SLEEP MEDICINE (Evaluation, Diagnosis, Treatment, Equipment)	80% of covered charges	70% of UCR
(Limited to $5,000 per Contract Period)		
HYPERBARIC OXYGEN TREATMENT (HBO)	80% of covered charges	70% of UCR
(Limited to $5,000 per Contract Period)		
PHYSICAL THERAPY (Limited to $1,500 per Contract Period)	$25.00 co-payment	70% of UCR
SPEECH THERAPY (Limited to $400 per Contract Period/100 2-hr sessions lifetime)	$25.00 co-payment	70% of UCR
DURABLE MEDICAL EQUIPMENT (DME)	80% of covered charges	Not Covered
Includes standard hospital bed, standard wheelchair, crutches, oxygen concentrator, bili-lite, nebulizer. Limited to rental only.		

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
CHRONIC ORTHOPEDIC CONDITION (Limited to $50,000 per Contract Period)		
1. Primary & Specialty Care Office Visit	80% of covered charges	70% of UCR
2. Hospitalization	80% of covered charges	70% of UCR
ALCOHOL/SUBSTANCE ABUSE TREATMENT (OUTPATIENT) Maximum of $8,000 per member per contract period Lifetime maximum of $16,000 per member	$10.00 of covered charges	70% of UCR
MENTAL HEALTH (OUTPATIENT)		
Fist 20 visits	$10.00 co-payment	70% of UCR
All visits thereafter	80% of covered charges	70% of UCR
RECONSTRUCTIVE BREAST SURGERY		
1. Primary & Specialty Care Office Visit	80% of covered charges	70% of UCR
2. Hospitalization/Surgery	80% of covered charges	70% 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		
FITNESS REWARD (Limited to participating Fitness Centers and attendance participation of 8 times per month).	Up to $100.00 Cash Reward	Not Covered
WELLNESS BENEFIT	80% of covered charges	Not Covered
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.

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. Therefore, the entire family must meet the family deductible before First Dollar benefits apply.

REFERRALS - are not required for primary or specialty care at approved providers within and outside of the service area. However, we recommend for members to contact NetCare for referral assistance and allow ample time (2-4 weeks) to schedule appointments.

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).
- 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.
- 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).
- 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.
- 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.
- Pre-existing conditions and medical conditions excluded and noted on the policy.
- Services provided by the covered person's spouse, child, brother, sister or parents whether by blood or by law.
- 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 Occupational therapy, including hand therapy.
- 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.